Spine and Peripheral Nerve Section EC Meeting, New Orleans Marriott
1:00-3:30pm, Monday, 29 April 2013

Meeting was called to order by Dr. Groff at 1:15pm

1. Secretary's Report (P. Mummaneni)
    a. Make sure to invite ED's and Presidents of both parent organizations to the Section EC
2. Treasurer's Report (C. Kuntz)
    a. Annual meeting did not make budget. The total medical attendance was 475 (a record) but we had less corporate support than budgeted. The meeting in March 2013 was still profitable but final numbers are pending (See attachment)
3. New Business
    a. Discuss IMAST eblast to Section members and reciprocity with SRS
        i. Eric Potts sent the eblast to Section members re: IMAST (see attachment email) re: the reciprocity of email lists between Spine Section and SRS/IMAST)
    b. OneAsk (Reg Haid)
        i. Changing industry sponsorship rules
        ii. No longer want company named grants/fellowships
            1. Medtronic dropped the Spine Section supported fellowships. But Nuvasive has picked these up and is funding directly to JSDSPN.
        iii. No funding for teaching "off label" issues (Depuy/Synthes)
        iv. The plan now is the section faculty ask companies for funds and then let OneAsk follow up with the companies.
    c. Administrative assistant for section Secretary (See Attached)
        i. Suggestion to place the ½ FTE in Washington office
        ii. Suggestion to place the ½ FTE in CNS office
        iii. Suggestion to place the ½ FTE in AANS office
        iv. Suggestion from Groff and Resnick is to provide funds to Secretary to hire a ½ FTE assistant at their home institution (or an officer's institution) to help with organizing Section activities and to track contracts/grants/funds. Rotate the position with the Secretary position every 3 years or keep the same person across transition of the officers.
        v. Dr. Groff suggested a FTE (1/2 FTE for the Secretary/Treasurer issues and an additional ½ FTE for the Rapid Response Cmte) at a budgeted cost of $100k total per year to be funded by the Section.
        Dr. Groff moved and Dr. Kuntz seconded the motion. The motion was approved.

d. Need to revamp cmte's and eliminate cmte's that don't have reports or new information to update to the EC. The number of cmte's has expanded tremendously over the past five years.
    i. Propose to combine CPT and Payor Response
    ii. Propose to combine ASTM and FDA Drugs and Devices
    iii. Propose to combine Outcomes, NPA, and N2QOD (remove S2QOD)
    iv. Propose to combine AANS PDP and AANS Board Liason
    v. Propose to combine CME and Education
    vi. Propose to combine Joint Tumor Liason with Intersociety Liason

This was moved by Dr. Wolfla and seconded by Dr. Groff and approved.

4. Old Business
    a. Update on Neuropoint SD manuscript (Z. Ghogawala)
        i. Manuscript was sent to JNS Spine. Revisions were requested and the revision is pending. Dr. Ghogawala asked the members to get him the data for the revision ASAP.
    b. Update on MOC Textbook (Cheng, Mummaneni, Groff) (see attachment)
        i. What support will be provided by the publisher?
            1. they will provide some illustrator assistance
            2. we need to decrease our number of spine chapters to fit into 200 pages (4 pages per chapter)
    c. SRS/Section AUC Project for Adult Deformity (McGirt/Mummaneni) (see attachment)
        i. Discuss AUC agreement and annual cost of AUC and Section support ($27k). This has been previously approved. Dr. Kuntz will organize payment.
        ii. John O'toole will follow up on the AUC issue and report back to the section
        iii. Conf call was held between JSDSPN and SRS leadership and the N2QOD deformity module will be developed as a collaboration.
    d. N2QOD update (Praveen/McGirt)
        i. SRS/deformity module: Jeff Coe, Sig Berven, Lloyd Hey
        ii. Section: Praveen, Matt McGirt, Mike Groff
    e. CAST Accreditation of Infolded Fellowships (Mike Groff/Volker Sonntag)
        i. Ask for infolded fellowship to occur in PGY7 resident year, after the chief year is done
        ii. Will be discussed at the Senior Society in June, 2013
        iii. Dr. Wolfla expressed concern re: the NCAST fellowship program and moved that the Spine Section Fellowships Chair contact Dr. Day and Dr. Sonntag re the reservations of the Spine Section on this plan to infold the fellowships. This was seconded by Mummaneni and approved.

f. Wallace Foundation – Zo requested matching funds to continue the awards as done in the past. This was voted and approved byt eh EC on 4/29/13

5. **Committee Reports (Oversight by Chair) (M. Groff)**
    a. Annual Meeting (J. Knightly) – See Slides Attached
    b. Exhibits (Dan Hoh) - **See attached**
        i. **Dr. Groff proposed to increase exhibit fees by 5% and the EC approved.**
    c. Future Sites (I. Kalfas)
        i. Review CNS slides of meeting (Shupak) - **See attached**
            1. Iaian and Regina will explore Swan and Dolphin and Contemporary Disney Hotel and Peabody in Orlando and report back to the group.
            2. a decision for 2017 for Las Vegas vs. Phoenix vs. a California site will be discussed later
    d. Nominating Committee (J. Cheng) – **No new Information**
        i. Section
            1. Chair-Elect: John Hurlbert
            2. Ex-Officio: Marjorie Wang
            3. Slate of officers for 2013-2014:
                a. Chair: Mike Groff
                b. Past-Chair: Joe Cheng
                c. Secretary: Praveen Mummanenni
                d. Treasurer: Charlie Kuntz
                e. SPC: Mike Wang
                f. AMC: Jack Knightly
                g. Member-at-Large: Pat Jacob, Matt McGirt, Zo Ghogawala
                h. Ex-Officio: Daryl Fourney
        ii. Discuss and vote on AANS Nominations – **No new information**
            1. (1) President-Elect:
            2. (1) Vice President: **Ziya Gokaslan**
            3. (2) Directors at Large: **Reg Haid, Charlie Branch**
            4. (2) Nominating Committee Members: **will be discussed with Joe Cheng**
    e. Scientific Program (Mike Wang) **See attached**
6. **Committee Reports (Oversight by Chair-Elect)**
    a. CPT (P. Angevine) – **No new information**
    b. Membership (K. Eichholz) – **See attached.**
        i. Expand member categories

ii. Membership drive
    1. Kurt will need to send reminder emails to people whose membership has lapsed
    2. we need to emphasize benefits of membership like getting the newsletter from Katie Orrico's group
    3. Kurt work with Ashley Hamm from AANS (aeh@aans.org) to get the dropped spine members and nonmenbers from AANS.

c. Newsletter (J. Ratliff) - **No new information**
    i. Request budget for Newsletter ($1000 per issue for Graphic Design)

d. Payor Response (J. Cheng) - **No new information**

e. Rules and Regs (J. Smith) - **No new information**

7. Committee Reports (Oversight by MOL) (M. McGirt)

a. ASTM (J. Coumans) – **No new information**
    i. Report of voting activity for October 2012-present.
    ii. ASTM November 2012 meeting (F4.25 and F4.33 committees)
    iii. Medical and Surgical Materials and Devices Meeting (May 2013)
    iv. Medical and Surgical Materials and Devices Meeting (Nov 2013)

b. FDA Drugs and Devices (C. Sansur) - **No new information**
    i. FDA subcommittee panel mission and leadership opportunities

c. NPA (E. Woodard) - **No new information**
    i. Mike Groff Secretary (Section Chair becomes Secretary) No new information

d. S2QOD/N2QOD (N. Brooks) - **No new information**

e. Outcomes (M. Steinmetz) - **No new information**
    i. Winners: Drs. Ray, Murphy, Doniel

8. Committee Reports (Oversight by MOL) (P. Jacob)

a. Education (F. LaMarca) - **No new information**
    i. AANS Meeting
    ii. CNS Meeting
    iii. ABNS Questions
    iv. Fold in with CME Cmte

b. Fellowships (M. Kaiser) - **No new information**
    i. Promote CAST accreditation
    ii. Maintain fellowship programs
    iii. See new/old business motion
    iv. Dr. Kanter will be new Fellowships Chair

c. Guidelines (J. O'Toole) **See attached**
    i. CNS Guideline development support
        1. Future format for guideline development
    ii. Updates for cervical degen and SCI, lumbar fusion, mets, T/L trauma

iii. Propose access to spine/PN guidelines drafts by our Section committees PRIOR to approval by the JGC.
iv. **Action:** Propose formal letter to JGC and AANS/CNS Guidelines that ALL Section work be accessible by the Section.
v. Update on lumbar surgery guidelines due in 2013.
1. proposal to send to NS Focus/JNS for online publication

d. Research and Awards (J. Chi) **See attached.**
i. Discuss funding issues
ii. Plan for grants and programs
iii. Update on research and awards budget, supporters, current & future contracts
iv. Research support toward industry meeting status
v. People who won NREF awards will not get spine section award monies

9. Committee Reports (Oversight by Ex-Officio) (J. Hurlbert) -

a. AANS PDP (R. Fessler) **- No new information**
i. AANS EPM Section representative
b. AANS Board Liaison (D. Benzel) **- No new information**
c. AANS/CNS Joint Tumor Liaison (L. Rhines) **- No new information**
d. Publications (L. Holly) **- No new information**
i. JNS/Spine Section manuscript solicitation letter to oral platform speakers
ii. June 1 is deadline for JNS submission of Spine and Peripheral nerves Section abstract manuscripts.
iii. NS Focus did publish the abstracts from the section meeting.
e. Web Site (E. Potts) **- No new information**
i. Increase budget for Oral Platform recording
ii. Repository for all our contracts and letters of intent
iii. Wrong level surgery survey – announcement and resend to members.

10. Committee Reports (Oversight by Ex-Officio) (Z. Ghogawala)

a. CME (G. Trost) - **No new information**
i. Single Accreditation System for Graduate Medical Education (MD, DO)
b. NREF (Z. Gokoslan) – **No new information**
i. Format changed this year
1. 6 NREF grant proposals assigned to review
2. Do not know how many spine proposals were received
3. More up to date report at AANS.
a. Results following teleconference prior to our EC meeting.
ii. NREF Review and Grading Committee (Ziya - Liaison) – **No new information**
1. Mike Groff (Committee Chair)

2. Committee: Praveen, Zo, Dan Sciubba, Sanjay Dhall, C. Kuntz, F. Lamarca

c. Spinal Deformity training (M. Schmidt) – **No new information**
    i. See MOC textbook deformity section for chapter assignments
d. Washington Committee (R. Heary/K. Orrico) – **See attached**

11. Committee Reports (Oversight by Ex-Officio) (D. Fourney)

a. COSSS (J. Cheng, I. Kalfas) – **No new information**
    i. COSSS Representatives: Joe Cheng, Ian Kalfas. Alternate: Mike Groff.
    ii. COSSS meeting during LSRS was cancelled due to flight problems from Chicago storms
    iii. Conference call will be scheduled in May.
    iv. Next meeting at CNS

b. Inter-Society Liaison (M. Rosner) – Dr. Rosner unable to attend due to sequester
    i. Add Inter-Section Liaison to job and attend other Section EC's
    ii. Section Partnerships: CSNS, Tumor
    iii. Society Partnerships: AO, SRS, CSRS
        1. AUC cost sharing, see attached.
    iv. Message from Brazilian spine surgeons (see Attached)
c. Peripheral Nerve Task Force (A. Belzberg) – **No new information**
    i. See MOC textbook for chapter assignments for periph nerve
d. Public Relations (S. Dhall) – **No new information**
    i. Cervical trauma and SCI Guidelines published in Neurosurgery
        1. Mobile and web application (Dhall, Potts)
        2. a mailer insert was sent on the recently published cervical trauma guidelines
    ii. Publicize what the Section does
    iii. Alerts: Safety alerts, new devices, etc.
e. Young Neurosurgeons Committee (C. Upadhyaya)
    i. Medical students will have a grant to allow travel to go to AANS from YNC

Item 3a:

Great.

Sent from my iPhone

On Apr 3, 2013, at 9:00 AM, "Eric Potts" <EPotts@goodmancampbell.com<mailto:EPotts@goodmancampbell.com>> wrote:

It will go out at the end of this week.

Eric

Sent from my iPhone

On Apr 2, 2013, at 8:50 PM, "Michael Groff" <mgroff@mac.com<mailto:mgroff@mac.com>> wrote:

Agree. Eric please send it out.
Praveen nice job.
Thanks,
mike

On Apr 2, 2013, at 8:32 PM, "Shaffrey, Chris I *HS" <CIS8Z@hscmail.mcc.virginia.edu<mailto:CIS8Z@hscmail.mcc.virginia.edu>> wrote:

I think everyone has approved.

From: Eric Potts [EPotts@goodmancampbell.com<mailto:EPotts@goodmancampbell.com>]
Sent: Tuesday, April 02, 2013 8:19 PM
To: vmum@aol.com<mailto:vmum@aol.com>
Cc: mgroff@mac.com<mailto:mgroff@mac.com>; Shaffrey, Chris I *HS; mgroff@partners.org<mailto:mgroff@partners.org>; rns@1CNS.ORG<mailto:rns@1CNS.ORG>; dls@1CNS.ORG<mailto:dls@1CNS.ORG>; jknightly@atlanticneurosurgical.com<mailto:jknightly@atlanticneurosurgical.com>; MWang2@med.miami.edu<mailto:MWang2@med.miami.edu>
Subject: Re: SRS IMAST Information

Let me know when everybody approves it and I will send it out.

Eric

Sent from my iPhone

On Apr 1, 2013, at 1:02 AM,
"vmum@aol.com<mailto:vmum@aol.com><mailto:vmum@aol.com>"
<vmum@aol.com<mailto:vmum@aol.com><mailto:vmum@aol.com>> wrote:

eric
i sent this draft to the SRS and Spine Section leadership.
if they approve, pls send it to our members.
tks
praveen
Praveen V. Mummaneni, M.D.
Professor and Vice-Chairman
Dept. of Neurosurgery, University of California at San Francisco
Co-Director: UCSF Spine Center
Secretary: AANS-CNS Joint Section - Spine and Peripheral Nerves
-----Original Message-----
From: Eric Potts
<EPotts@goodmancampbell.com<mailto:EPotts@goodmancampbell.com><mailto:EPotts@goodmancampbell.com>>
To: Michael Groff <mgroff@mac.com<mailto:mgroff@mac.com><mailto:mgroff@mac.com>>
Cc: vmum <vmum@aol.com<mailto:vmum@aol.com><mailto:vmum@aol.com>>; Shaffrey, Chris I *HS
<CIS8Z@hscmail.mcc.virginia.edu<mailto:CIS8Z@hscmail.mcc.virginia.edu><mailto:CIS8Z@hscmail.mcc.virginia.edu>>;
Groff <mgroff@partners.org<mailto:mgroff@partners.org><mailto:mgroff@partners.org>>;
Regina Cns contact <rns@1CNS.ORG<mailto:rns@1CNS.ORG><mailto:rns@1CNS.ORG>>;
Deanne L. Starr <dls@1CNS.ORG<mailto:dls@1CNS.ORG><mailto:dls@1CNS.ORG>>; Jack Knightly
<jknightly@atlanticneurosurgical.com<mailto:jknightly@atlanticneurosurgical.com><mailto:jknightly@atlanticneurosurgical.com>>;
Wang
<MWang2@med.miami.edu<mailto:MWang2@med.miami.edu><mailto:MWang2@med.miami.edu>>
Sent: Thu, Mar 28, 2013 3:23 pm
Subject: Re: SRS IMAST Information

I am out of the office this week, I will send it out late next week. Praveen
send me the form you would like to use.

Eric

Sent from my iPhone

On Mar 28, 2013, at 4:52 PM, "Michael Groff" <mgroff@mac.com<mailto:mgroff@mac.com><mailto:mgroff@mac.com>> wrote:

Modify it to reflect the membership rate and then have Eric send it out.

Thanks,
mike

On Mar 28, 2013, at 5:43 PM, vmum@aol.com<mailto:vmum@aol.com><mailto:vmum@aol.com> wrote:

Michael

Do you want to have eric forward the srs info to our membership electronically?

Shall I modify the form they sent or just send as is?
Pm
Sent from my Verizon Wireless BlackBerry

-----Original Message-----
From: Michael Groff <mgroff@mac.com<mailto:mgroff@mac.com><mailto:mgroff@mac.com>>
Date: Thu, 28 Mar 2013 17:41:10
To: Steven Glassman<sdg12345@aol.com<mailto:sdg12345@aol.com><mailto:sdg12345@aol.com>>
Cc: Shaffrey, Chris I *HS<CIS8Z@hscmail.mcc.virginia.edu<mailto:CIS8Z@hscmail.mcc.virginia.edu><mailto:CIS8Z@hscmail.mcc.virginia.edu>>;
Groff, Michael W.,M.D.<MGROFF@PARTNERS.ORG<mailto:MGROFF@PARTNERS.ORG><mailto:MGROFF@PARTNERS.ORG>>;
Praveen Mummaneni<vmum@aol.com<mailto:vmum@aol.com><mailto:vmum@aol.com>>;
Smith, Justin S *HS (MD-NERS Admin)<JSS7F@hscmail.mcc.virginia.edu<mailto:JSS7F@hscmail.mcc.virginia.edu><mailto:JSS7F@hscmail.mcc.virginia.edu>>;
Joseph S. Cheng MD MS

(joseph.cheng@vanderbilt.edu<mailto:joseph.cheng@vanderbilt.edu><mailto:joseph.cheng@vanderbilt.edu>)<joseph.cheng@vanderbilt.edu<mailto:joseph.cheng@vanderbilt.edu><mailto:joseph.cheng@vanderbilt.edu>>;
dormans@email.chop.edu<mailto:dormans@email.chop.edu><mailto:dormans@email.chop.edu><dormans@email.chop.edu<mailto:dormans@email.chop.edu><mailto:dormans@email.chop.edu>>;
John Hurlbert<jhurlber@ucalgary.ca<mailto:jhurlber@ucalgary.ca><mailto:jhurlber@ucalgary.ca>>;
CKissinger@srs.org<mailto:CKissinger@srs.org><mailto:CKissinger@srs.org><CKissinger@srs.org<mailto:CKissinger@srs.org><mailto:CKissinger@srs.org>>;
SScarborough@srs.org<mailto:SScarborough@srs.org><mailto:SScarborough@srs.org><SScarborough@srs.org<mailto:SScarborough@srs.org><mailto:SScarborough@srs.org>>;
KICHICAGO@aol.com<mailto:KICHICAGO@aol.com><mailto:KICHICAGO@aol.com><KICHICAGO@aol.com<mailto:KICHICAGO@aol.com><mailto:KICHICAGO@aol.com>>;
Tressa Goulding (SRS)<TGoulding@srs.org<mailto:TGoulding@srs.org><mailto:TGoulding@srs.org>>
Subject: Re: SRS IMAST Information

Thanks to everyone.

This is a very meaningful collaboration and we should continue to cultivate it.

mike

On Mar 28, 2013, at 5:27 PM, Steven Glassman <sdg12345@aol.com<mailto:sdg12345@aol.com><mailto:sdg12345@aol.com>> wrote:

I agree
SDG

Sent from my iPhone

On Mar 28, 2013, at 4:58 PM, "Shaffrey, Chris I *HS" <CIS8Z@hscmail.mcc.virginia.edu<mailto:CIS8Z@hscmail.mcc.virginia.edu><mailto:CIS8Z@hscmail.mcc.virginia.edu>> wrote:

This is what has been done in the past and the letter should state it.
There should be a notation for the IMAST registration. The same should hold true for SRS members attending the Joint Section.

From: Groff, Michael W.,M.D.
[MGROFF@PARTNERS.ORG<mailto:MGROFF@PARTNERS.ORG><mailto:MGROFF@PARTNERS.ORG>]
Sent: Thursday, March 28, 2013 4:35 PM
To: Praveen Mummaneni; Shaffrey, Chris I *HS
Subject: Re: SRS IMAST Information

Praveen and Chris,
Are spine section members getting the SRS member rate for registration?
We should do that both ways to put some weight behind the collaboration.
Thanks,
mike
On Mar 28, 2013, at 4:14 PM,
<vmum@aol.com<mailto:vmum@aol.com><mailto:vmum@aol.com><mailto:vmum@aol.com<http://aol.com><mailto:vmum@aol.com<http://aol.com>?>>>
wrote:

Michael
Do you want me to send this out or modify it?

Pm
Sent from my Verizon Wireless BlackBerry

From: "Shahree Scarborough (SRS)"
<SScarborough@srs.org<mailto:SScarborough@srs.org><mailto:SScarborough@srs.org><mailto:SScarborough@srs.org<http://srs.org><mailto:SScarborough@srs.org<http://srs.org>?>>>
Date: Thu, 28 Mar 2013 14:30:29 -0500
To:
<vmum@aol.com<mailto:vmum@aol.com><mailto:vmum@aol.com><mailto:vmum@aol.com<http://aol.com><mailto:vmum@aol.com<http://aol.com>?>>>
Subject: SRS IMAST Information

Hi Praveen,
Attached please find the information about IMAST. I took the same
information we just sent out to all of our member.
Please let me know if you need further information or my assistance on
anything.
Thanks,
~Shahree

Shahree Scarborough
Communications and Program Manager
Scoliosis Research Society
555 E. Wells Street, Suite 1100
Milwaukee, WI 53202-3800

P: (414) 918-3044
F: (414) 276-3349
www.srs.org<http://www.srs.org><http://www.srs.org/<http://www.srs.org<http://www.srs.org/
>>
"Like" SRS on Facebook<http://www.facebook.com/pages/Scoliosis-Research-Society/175960505783365>
Save The Dates
20th IMAST - July 10-13, 2013; Vancouver, British Columbia, Canada
48th Annual Meeting - September 18-21, 2013; Lyon, France

<20th IMAST.doc>

<20th_IMAST Joint Section Draft Praveen March 2013.doc>

Item 3C
From: Michael Groff [mailto:mgroff@mac.com]
Sent: Tuesday, April 16, 2013 1:46 PM
To: Resnick (Daniel)
Cc: Cheng Joseph; Praveen Mummaneni; Ali Rezai; Kuntz Charlie; R. Hurlbert
Subject: Re: spine section administrative support

Dan,

Thanks for reaching out from the CNS side. This is an important step for the spine section so I am putting together a conf call of the officers before giving our reply. I agree with you the degree of cooperation between CNS and AANS has been noteworthy.

Thanks,

mike

On Apr 15, 2013, at 12:23 PM, "Resnick (Daniel)" <resnick@neurosurgery.wisc.edu> wrote:

This sounds like purely an administrative support- the Washington office is not the place for this- KT has enough to do without having to worry about supervising an administrator! Office space in Chicago is much more cost effective than DC in any case. It sounds like you guys would like one of the parent organizations to hire a designated administrator and simply pass through the costs to the section- the section would need to know how much the cost would be and there would need to be a clear understanding of what services would be provided. With your permission (I guess Mike G would be the point man for this) I can forward this to Regina so the CNS can respond. I would recommend that the section run this by the AANS so they can decide if they want to respond as well. There is much greater cooperation at the administrative level these days so a cooperative effort is not out of the question (although from a HR perspective, the person would still need to be hired by one or the other organizations).

From: Cheng, Joseph [mailto:joseph.cheng@Vanderbilt.Edu]
Sent: Monday, April 15, 2013 10:38 AM
To: vmum@aol.com; Resnick (Daniel); Mike Groff
Cc: Ali Rezai
Subject: RE: spine section administrative support

Thanks Praveen. We also discussed that some of our committee support such as Rapid Response overlaps with the Washington office, and may make sense to have this person there. However, I do not know if Katie has the space or the logistics or costs of office space and support, and something we would need to look into as well.

Dan,

Does CNS have a form such as for a job description that we would need to fill out? I assume we would have to do some Human Resources form for this position to determine responsibilities and base salary support.

Regards,

Joe

From: vmum@aol.com [vmum@aol.com]
Sent: Monday, April 15, 2013 9:25 AM
To: Resnick (Daniel); Mike Groff
Cc: Ali Rezai; Cheng, Joseph
Subject: Re: spine section administrative support

We need someone administrative to cover liasing with aans and cns and to
1. Keep track of our accounts in both aans and cns for grants and fellowships
2. Liase with one ask for fund raising
3. Help keep track of our cmtes and help secretary with reports

We wanted this person housed in the washington office to make it easy to liase with both groups.

Mike Groff and Joe cheng may have additional input

Pm

Sent from my Verizon Wireless BlackBerry

From: "Resnick (Daniel)" <resnick@neurosurgery.wisc.edu>

Date: Mon, 15 Apr 2013 08:24:00 -0500

To: Praveen Mummaneni<vmum@aol.com>; Mike Groff<mgroff@mac.com>

Cc: Ali Rezai<ali.rezai@osumc.edu>

Subject: spine section administrative support

Hi Guys-

Ali asked me to drop you a line regarding the section's request for an administrative support person. This is not a new issue and having been AMC/secretary/pres of the section I understand the need. From the CNS side, we need to know bit more about what exactly you would want. Are you looking for an administrative assistant or a meeting services person or a development (fundraising) person? If you are simply looking for an administrative liaison type person that is probably something that could be arranged without too much fuss with either organization. However, if you are looking for someone with more of a professional background we would need to know exactly what you are looking for in order to provide a meaningful proposal. It would be important to know what the section's development plans are regarding meeting support as well.

Dan

Item 4B

ABNS MOC (Joint Section on Disorders of the Spine and Peripheral Nerves 2013)

Main Editor

Chris Shaffrey cis8z@virginia.edu

ABNS MOC Spine Editorial Board Representatives

Joseph Cheng joseph.cheng@vanderbilt.edu

Michael Groff mgroff@mac.com

Praveen Mummaneni vmum@aol.com

ABNS MOC Section Workgroup

Daryl Fourney (SP) daryl.fourney@usask.ca

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John Ratliff (SP) jratliff@stanford.edu

Meic Schmidt (SP) meic.schmidt@hsc.utah.edu

Justin Smith (SP) jss7f@virginia.edu

Marjorie Wang (SP) mwang@mcw.edu

Mike Wang (SP) mwang2@med.miami.edu

ABNS MOC Peripheral Nerve Editorial Board Representatives

Allan Belzberg abelzbe1@jhmi.edu

Michel Kliot KliotM@neurosurg.ucsf.edu

Time Table

TBD

Tentative Format

Case presentation, questions, didactic material, answers, summary, references.

- Thieme to provide a mock-up of the chapter format for Editorial Board meeting in New Orleans on 4/27.

Spine Table of Contents/Section Editors:

I. Basic Science of the Spine (***Marjorie Wang)***
- a. Spinal Anatomy (***Kai-ming Fu)***
- b. Spinal Biomechanics (***Joe Cheng)***
- c. Pathophysiology of Axial Spinal Pain
- d. Pathophysiology of Radiculopathy (***John O'Toole***)
- e. Pathophysiology of Myelopathy (***Marjorie Wang, John O'toole***)
- f. Spinal Cord Injury- ***Shekar Kurpad***
- g. Basic instrumentation techniques with anatomy and biomechanics ***Charley Sansur***
- h. Complication Avoidance In the Spine (Infection, DVT, PE)

II. Spine Imaging and Assessments (***Erica Bisson, Meic Schmidt***)
- a. Radiographs, CT and MRI – ***Meic Schmidt***
- b. Electrophysiological studies including Intraoperative Monitoring***- Uribe, Mummaneni***
- c. Labs: Vit D, Ca++, PTH, PCT, etc.
- d. Special studies: Bone scans, Diffusion tensor imaging, etc.

III. Non-Surgical Management of Spinal Disorders ***(John Hurlbert, Sanjay Dhall)***
- a. Exercise and Rehabilitation
- b. Pharmacological Management
- c. Injections and Spinal Interventions
- d. Spinal Orthoses
- e. Psychosocial Issues of Spinal Pain
- f. Chronic Pain Management

IV. Spinal Trauma (***Michael Groff, Okonkwo***)
- a. Classification and Assessment of Traumatic Spinal Injuries ***dan hoh***
- b. Occipital-Cervical Spine Injuries- ***Sanjay Dhall***
- c. Subaxial Cervical Spine Injuries- ***Dan Resnick***
- d. Thoracolumbar Spine Injuries-***James Harrop***
- **e.** Management of Whiplash, Strain, and Stable Spinal Injuries- **David Okonkwo**

V. Degenerative Spinal Disorders (***Frank LaMarca, Joe Cheng***)
- a. Disc Herniations- ***Scott Meyer, Jack Knightly***
- b. Stenosis
- c. Spondylolisthesis / Spondylolysis **(Park, LaMarca)**
- d. Artificial Discs and Motion - ***Upadhyaya***

VI. Congenital Spinal Disorders (***Ratliff, Daryl Fourney***)
- a. Inflammatory spinal diseases (AS, DISH, etc.)
- b. Achondroplastic dwarfism

c. Spina Bifida

VII. Spinal Deformities (Praveen Mummaneni)

a. Spinal balance including sacropelvic parameters **(*Mummaneni, Charles Kuntz*)**
    i. Including high grade spondylolisthesis
b. Cervical kyphosis and stenosis (***Frank La Marca, Paul Park***)
c. Cervicothoracic junction deformity (***Mike rosner, Tyler Koski***)
d. Thoracolumbar junction deformity (***Justin Smith, Meic Schmidt***)
e. Proximal junctional kyphosis ***(Ames, Uribe***)
f. Two and three column osteotomies ***(Mike Wang, Chestnut***)
g. Sacropelvic fixation - anterior and posterior options (***Kanter, Okonkwo***)

VIII. Intrinsic Abnormalities (***Kai-ming Fu, Charley Sansur)***

a. Syringohydromyelia
b. Tethered Cord
c. Vascular Malformations
d. Inflammatory Arthropathies

IX. Spinal Tumors and Infections (Daryl Fourney, John O'toole)

a. Primary Extradural Spinal Tumors **(Park, LaMarca**)
b. Primary Intradural Spinal Tumors
c. Metastatic Spine Tumors (***Michael Groff)***
d. Spinal Infections Including Post-op (**Mike Wang**)
e. Radiation therapies
f. Chemotherapies

X. Sports Medicine and Spine (***Adam Kanter and Jack Knightly)***

a. Common injuries seen in sports: Stingers, etc. (**Adam Kanter)**
b. Assessment of athletes, return to play criteria, etc. – **Sanjay Dhall**

XI. Associated Spinal Topics ***(Joe Cheng and Juan Uribe***)

a. Revision Spinal Surgeries
b. Anticoagulation in spinal surgery
c. Osteoporosis and Bone Metabolic Diseases
d. Bone Graft Options
e. Guidelines, Spinal Outcomes, and Registries ***– O'toole, Cheng***
f. Socioeconomics of Spine Care: Ethics, costs, patient access, etc.
g. Fundamentals of Healthcare Policy in Spine
h. Role of FDA in Spinal Surgery

Peripheral Nerve Table of Contents/Section Editors (Allan Belzberg, Michel Kliot):

I. Peripheral Nerve Anatomy & Physiology
   a. Anatomy
   b. Physiology

II. Biological Grades of Nerve Injury
   a. Neuropraxic
   b. Axonotometic
   c. Neurtotmetic

III. Entrapment Syndromes
   a. Carpal Tunnel Syndrome
   b. Ulnar Nerve Entrapment Syndrome across the elbow
   c. Thoracic Outlet Syndrome
   d. Suprascapular nerve entrapment
   e. Radial Tunnel Syndrome
   f. Pronator Teres Syndrome
   g. Guyon's Canal
   h. Pyriformis Syndrome
   i. Peroneal Nerve Entrapment Across the Fibular Head
   j. Tarsal Tunnel Syndrome

IV. Other Types of Peripheral Nerve Problems
   a. Neuritis (eg brachial or Parsonnage Turner)
   b. Neuropathies: diabetic, HNPP, Charcot Martie Tooth, Vit B12 deficiency, lead poisoning…
   c. Distinguishing radiculopathy from peripheral nerve entrapment syndromes

V. Peripheral Nerve Masses
   a. Schwannomas
   b. Neurofibromas
   c. Ganglion cysts (intraneural and extraneural)
   d. Malignant nerve sheath tumors
   e. Other types of masses (lipomas, hemagiomas, perineurioma)

Attendance List:

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Praveen Mummaneni vmum@aol.com

AANS Subspecialty MOC Educational Materials Editorial Board conference call

April 27, 2013

2:30-4:30 PM Central Time

New Orleans Marriott, Galerie 6

Agenda

Roll call (editorial board members attached) Harbaugh – 2:30-2:35

Update on project plan Harbaugh – 2:35-2:45

Thieme Template Presentation Kay Conerly (Thieme) – 2:45-3:15

Project Timeline Harbaugh – 3:15 -4:05

Section Content Development All – 4:05 – 4:20

Next steps / New business All – 4:20-4:30

Adjourn 4:30

Editorial Board Members

• AANS - Berger, Couldwell, Harbaugh, Shaffrey

. SNS - Selden

• CV Section - Bendok, Siddiqui

• Pain Section - Pilitsis, Schwalb

• Pediatric Section - Grant, Krieger

- Spine & PN Section - Cheng, Groff, Mummaneni
- Stereotactic & Functional Section - Niemat, Pilitsis
- Trauma & Critical Care - Lu, Stippler
- Tumor Section - McPherson, Sloan

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c. Spinal Outcomes and Registries
d. Healthcare Policy in Spine
e. Role of FDA in Spinal Surgery

MOC Table of Contents for Pain and Peripheral Nerve

A. Pain

a. TN
i. Medical management (incl diff dx)
ii. Patient selection for surgery (include recurrent, deafferentation discussion)
iii. Surgery (all to discuss potential complications)
1. MVD
2. percutaneous procedures
3. radiosurgery

b. Other chronic pain disorders
i. Medical management
ii. Patient selection for surgery (include pain psych)
iii. Surgery (all to discuss potential complications)
1. ablative procedures – DREZ, cordotomy, myelotomy
2. SCS (including anatomy of SC and thalamic pathways for pain and modulation)
3. PNS
4. Cranial stim – DBS and MCS
5. IT pumps (inc medical management of withdrawal and overdose)

B. Peripheral Nerve

a. Medical management of peripheral nerve disorders (inc brachial plexitis; non operative management))

b. Pathophysiology of nerve disorders- (nerve injury classifications, anatomy of brachial/lumbar plexi and major nerves of UE, LE)

c. Perioperative management (MRI; EMG/NCV; timing of surgery)

a. Surgery
i. Decompression
1. surgery for common UE entrapment (s and s also)
2. surgery for common LE entrapments (s and s also)

ii. Surgery for traumatic nerve injury (brachial plexus, outcomes)
iii. Surgery for neuromas and intrinsic lesions (check with peds about NF)
iv. Grafting in PN surgery (outcomes)
v. Nerve transfers in PN surgery (outcomes)
vi. IT baclofen for spasticity (inc management of overdose/withdrawal)
vii. Rhizotomy

MOC Table of Contents for Epilepsy and Movement Disorders, Pain and Peripheral Nerve

A. Epilepsy
a. Medical management of seizures (include status)
b. Patient selection for surgery (include diagnostic studies and neuropsych)
c. Surgery (all to discuss potential complications)
i. Diagnostic surgery (include perioperative management)
ii. Temporal lobectomy
iii. Extratemporal surgery (incl eloquent focus)
iv. VNS

B. Movement disorders
a. Medical management of movement disorders (Diff dx-psp, msa)
b. Patient selection for surgery (include diagnostic studies, CAPSIT and neuropsych)
c. Surgery
i. Framed v. frameless surgery (discuss complications of all and battery placement and change as well)
ii. DBS for PD (STN and Gpi; Perioperative management)
iii. DBS for ET (include previous surgery and redos)
iv. DBS for Dystonia
v. DBS for other conditions (OCD, Depression, Epilepsy, Tourettes)
vi. The role of lesioning in the 21st century

Traumatic Brain Injury

1. Surgical Management of Closed Head Injury\
1.1. EDH
1.2. SDH
1.3. Contusion

2. Non-operative management of closed head injury
2.1. GCS (Classification of TBI, definition of severe TBI, indication of ICP management)
2.2. Mild TBI (Concussion, contusion, risk factors for further work up, return to play, patient education, indication for follow up scan, operative indications, seizure management)
2.3. Severe TBI
2.3.1. Tiers of ICP treatment
2.3.2. Severe TBI guidelines
2.3.3. Indication for ICP monitoring
2.3.4. Techniques of ICP monitoring
2.3.5. Complication of ICP monitoring

3. Decompressive craniectomy
3.1. Indication
3.2. Operative management
3.3. Postoperative complication (hydrocephalus, infections, timing of cranioplasty, post-operative complications (seizures, infection, SDH hematoma)

4. Management of skull fractures
4.1. Comminuted skull fracture
4.2. Skull base fracture
4.3. CSF leak

5. Penetrating head injury (goals and limitations of surgery, recognize which injuries are fatal, pseudo-aneurysms screening and treatment, vasospasm risk, operative and none operative management)

6. Management of blunt vascular injury (Work up (Ct angio, DSA), treatment (ASA, anticoagulation) Follow Up, in the setting of spinal cord and spinal column injury, risk factors)

7. Pediatric

a. birth injuries (cephalohematoma, subdural, epidural, brachial plexus.

b. walker injuries

c. child abuse

d. imaging criteria, home observation?

Neurocritical Care

1. Recognize and diagnose anoxic brain injury

2. Acute respiratory
2.1. Causes of respiratory failure,
2.2. Hypoxemia,
2.3. Hypercapnia,
2.4. Interpret ABG

3. Status epileptics management
3.1. Tier of medication,
3.2. Indication for continues EEG
3.3. Non- convulsive status as DD

4. Brain Death Criteria
4.1. Family discussion, role and type of ancillary studies

5. Classification of Shock

5.1. Neurogenic Shock,
5.2. Septic Shock
5.3. Initial resuscitation and treatment

6. Life threatening infections
6.1. Initial resuscitation,
6.2. Antibiotic therapy,
6.3. source identification and control
6.4. Infection control measures
6.5. CNS infection
6.5.1. Meningitis
6.5.2. Encephalitis
6.5.3. Brain Abscess

7. Electrolyte disturbances
7.1. Hyponatremia
7.2. Hypernatremia

8. Metabolic Disturbances
8.1. Adrenal insufficiency

9. Withdrawal (Symptoms, diagnosis, treatment)
10. Pulmonary Embolism (Presentation, diagnosis, treatment)

11. Preeclampsia
11.1. Posterior reversible encephalopathy syndrome =PRES

12. Anticoagulation reversal
12.1. ASA, Plavix, lovenox, Coumadin, tPA, Heparin

13. TVD prophylaxis
13.1. Means, guidelines

MOC Peripheral Nerve Topics

Peripheral Nerve Anatomy & Physiology

- Anatomy: axon, Schwann cells, extracellular matrix which serves as highway for regeneration
- Physiology: action potential, saltatory conduction

Biological Grades of Nerve Injury: how to diagnose on the basis of NCV and EMG criteria, clinical prognosis following trauma, when to treat medically and when to operate, types of medical treatment, types of surgical treatment with intraoperative monitoring and how decision is made on what type of nerve repair to be done, types of nerve repair (direct repair, graft repair, neurotization), postoperative therapy

- neuropraxic
- axonotometic
- neurtotmetic

Diagnosis and Treatment, Both Medical and Surgical of Common and Uncommon Entrapment Syndromes:

- Carpal Tunnel Syndrome

- Ulnar Nerve Entrapment Syndrome across the elbow

- Thoracic Outlet Syndrome

- Radial Tunnel Syndrome

- Pronator Teres Syndrome

- Guyon's Canal

- Pyriformis Syndrome

- Peroneal Nerve Entrapment Across the Fibular Head

- Tarsal Tunnel Syndrome

Other Types of Peripheral Nerve Problems:

- Neuritis (eg brachial or Parsonnage Turner)
- Neuropathies: diabetic, HNPP, Charcot Martie Tooth, Vit B12 deficiency, lead poisoning…
- Distinguishing radiculopathy from peripheral nerve entrapment syndromes

Peripheral Nerve Masses: Clinical presentation, diagnostic workup (MRI, MRN, Ultrasound, PET Scan, Bone Scan, electrophysiological testing), treatment both medical and surgical (types of surgical approaches)

- Schwannomas
- Neurofibromas
- Ganglion cysts (intraneural and extraneural)
- Malignant nerve sheath tumors
- Other types of masses (lipomas, hemagiomas, perineurioma)

NEURO-ONCOLOGY

TABLE OF CONTENTS

c. Skull base meningiomas
d. Role of radiotherapy and radiosurgery

V. Sellar Tumors
a. Pituitary Adenoma
b. Other sellar tumors - Craniopharyngioma, Rathke's cleft cyst

VI. Anterior Cranial Fossa/Craniofacial Tumors
VII. Ventricular Tumors
a. Colloid cyst
b. Ependymoma
c. Central neurocytoma
d. Miscellaneous ventricular tumors

VIII. Pineal Region Tumors
a. Pineal parenchymal tumors

b. Germ cell tumors
c. Other Pineal tumors

IX. Hemangioblastoma
X. Acoustic Neuroma
a. Surgery
b. Radiotherapy and radiosurgery

XI. Intra-cranial ependymoma
XII. Dermoid/Epidermoid tumors
XIII. Clival Tumors
a. Chordoma
b. Chondrosarcoma
c. Other tumors

XIV. CNS lymphoma
XV. Tumors of the Skull

Item 4c

GRANT AGREEMENT

THIS GRANT AGREEMENT ("Agreement") is made and entered into as of December 15, 2012 (the "Effective Date") by and between DePuy Synthes Spine ("DePuy"), K2M, Inc. ("K2M"), Medtronic Sofamor Danek USA, Inc. ("Medtronic"), the American Association of Neurological Surgeons ("AANS"), on behalf of the American Association of Neurological Surgeons/Congress of Neurological Surgeons Joint Section on Disorders of the Spine and Peripheral Nerves ("AANS/CNS Spine"), Scoliosis Research Society ("SRS"), the Orthopaedic Research and Education Foundation ("OREF"), and the American Association of Neurosurgeons ("AAN"), on behalf of its Neurosurgery Research and Education Foundation ("NREF").

WHEREAS, DePuy, Medtronic and K2M are leading developers and manufacturers of spinal implants and surgical systems, and are committed to advancing the treatment of spinal conditions; and

WHEREAS, SRS is a non-profit, professional organization, made up of physicians and allied health personnel whose primary focus is on providing continuing medical education for health care professionals and on funding/supporting research in spinal deformities, and

WHEREAS, AANS/CNS Spine is a scientific and educational association affiliated with the AANS which is dedicated to advancing the specialty of neurological surgery in order to provide the highest quality of neurosurgical care to the public; and

WHEREAS, NREF is a foundation formed by the AAN in order to support research endeavors and educational opportunities in the specialty of neurological surgery and whereas AAN intends for NREF to be involved in the activities described herein ("NREF's Mission"); and

WHEREAS, OREF is a nonprofit organization that supports research and education on diseases and injuries of bones, joints, nerves, and muscles, including the spine, to enhance

clinical care and to lead to improved health, increased activity, and a better quality of life for patients ("OREF's Mission"); and

WHEREAS, DePuy, Medtronic, K2M, AANS/CNS Spine, and SRS desire to contribute funds designated solely for the Appropriate Use Criteria for Adult Scoliosis Surgery study to OREF and NREF (collectively, the "Grantees") in accordance with the Memorandum of Understanding dated October 13, 2011, between the OREF and AAN, on behalf of NREF, and

WHEREAS, the Grantees will contribute such funds less $29,000 in administrative costs received from DePuy, Medtronic, K2M, AANS/CNS Spine, and SRS to the Collaborative Spine Research Foundation ("CSRF") for the *Appropriateness of Surgical Treatment Approaches for Lumbar Degenerative Scoliosis* study, as described in the Agreement; and

WHEREAS, CSRF will use the funds to manage the 18-month *Appropriateness of Surgical Treatment Approaches for Lumbar Degenerative Scoliosis* study;

NOW THEREFORE, DePuy, Medtronic, K2M, the AANS on behalf of AANS/CNS Spine, and SRS agree to provide, and the Grantees agree to receive, funds which Grantees shall contribute to CSRF, for the sole purposes of managing the *Appropriateness of Surgical Treatment Approaches for Lumbar Degenerative Scoliosis* study subject to the following terms and conditions:

1. Definitions.

The following terms or expressions shall be deemed to have the following meanings:

1.1. "Administrative Costs" shall have the meaning set forth in Section 6.

1.2. "Agreement" shall have the meaning set forth in the first paragraph.

1.3. “Effective Date” shall have the meaning set forth in the first paragraph.

1.4. “First Disbursement” shall have the meaning set forth in Section 2.2.

1.5. “Grant Funds” shall have the meaning set forth in Section 2.1.

1.6. “Grant Period” shall have the meaning set forth in Section 2.1.

1.7. “Grant Supported Activities” shall have the meaning set forth in Section 4.1.

1.8. “Grantees” shall have the meaning set forth in the recitals.

1.9. “Mission” shall have the meaning set forth in the recitals.

1.10. “Second Disbursement” shall have the meaning set forth in Section 2.2.

2. Grant and Grant Disbursement.

2.1. Grant Amount and Period. Subject to receipt of the applicable certifications referenced in Section 3, DePuy, Medtronic, K2M, AANS/CNS Spine, and SRS shall provide Grantees with a grant up to a total amount of $609,000 (the “Grant Funds”) in two payments, the first at full execution of this Agreement, and the second at the beginning of month nine of the Agreement.

2.2. Disbursement. Subject to Section 3, DePuy, Medtronic, K2M, AANS/CNS Spine, and SRS shall disburse the Grant Funds to Grantees according to the following schedule:

2.2.1. within five (5) business days of full execution of this Agreement (the "First Disbursement"), DePuy shall disburse $165,800; Medtronic shall disburse $165,800; K2M shall disburse $165,800; AANS/CNS Spine shall disburse $27,900; and SRS shall disburse $27,900

2.2.2. within five (5) business days of the beginning of the ninth month of this agreement (the "Second Disbursement"); DePuy shall disburse $165,800; Medtronic shall disburse $165,800; K2M shall disburse $165,800; AANS/CNS Spine shall disburse $27,900; and SRS shall disburse $27,900;

2.3. Disbursements Means and Recipients. The Disbursements shall be made by wire transfer or such other means as agreed to by the parties. DePuy, Medtronic, K2M, AANS/CNS Spine, and SRS shall transfer fifty percent (50%) of each disbursement to OREF and fifty percent (50%) to NREF. OREF and NREF will commit such funds, less Administrative Costs as described in Section 6, to CSRF and will disburse such funds to CSRF as needed, as described in the Memorandum of Understanding dated October 13, 2011, between OREF and AAN, on behalf of NREF.

3. Conditions Precedent to Disbursements of Grant Funds.

3.1. Certifications. In order to receive the Grant amount for the second disbursement under the above Section 2.2, each Grantee shall deliver to DePuy, Medtronic, K2M, AANS/CNS Spine, and SRS a certification signed by the Chairperson of the Grantee's Board of Trustees, or other governing body, representing and warranting that (a) the Grantee's Mission and status as an independent, active, not-for-profit organization in good standing under the laws of Illinois, fully qualified as a tax-exempt organization under U.S. law, has not changed; (b) the Grantee is not in violation of this Agreement; (c) all representations and warranties of the Grantee set forth in this Agreement are true and correct as of the date thereof; and (d) the Grantee is conducting, and intends to continue to conduct, the Grant Supported Activities pursuant to the terms of this

Agreement. Each Grantee shall provide the certification to DePuy, Medtronic, K2M, AANS/CNS Spine, and SRS thirty (30) days before the Second Disbursement.

3.2. Failure to Provide Certification. Failure of Grantees to provide any certification described in this Section 3 shall constitute a breach of this Agreement pursuant to Section 7.2.1.

4. Covenants of Grantees.

4.1. Use of Grant Funds. Grant Funds shall be used by the Grantees to contribute funds to the CSRF. CSRF shall use the Grant Funds received by it to award, administer and manage the *Appropriateness of Surgical Treatment Approaches for Lumbar Degenerative Scoliosis* study conducted by the RAND team. The activities described in this Section 4.1 are the "Grant Supported Activities".

4.2. Conflicts of Interest. Grantees shall ensure that any individual who is in a position to control decisions concerning any Grant Supported Activities discloses to Grantees any financial relationship with DePuy, Medtronic, K2M, AANS/CNS Spine, and SRS or any company or organization that manufactures or distributes orthopaedic or neurosurgical implant medical devices occurring within the past twelve (12) months. Grantees shall ensure the proper management of any conflicts of interest, including removal of an individual from any position of control if necessary. Grantees shall remove any individual who fails to disclose such financial relationships from a position of control over the development, management, or execution of any Grant Supported Activity.

4.3. Compliance with Laws. Grantees shall ensure that the *Appropriateness of Surgical Treatment Approaches for Lumbar Degenerative Scoliosis* study is conducted in compliance with all applicable laws, regulations, and guidelines, including, for Studies conducted in the United States, the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations ("HIPAA"), the Health Information Technology for

Economic and Clinical Health Act, Division A, Title XIII of Pub. L. 111-5 and its implementing regulations, 21 C.F.R. Parts 50, 54, 56, 312, and 812, and "good clinical practices" as defined by the United States Food and Drug Administration.

4.4. Accountability. Not more than thirty (30) days nor fewer than fifteen (15) days prior to the beginning of the ninth (9^{th}) month of the Grant Period, Grantees shall provide DePuy, Medtronic, K2M, AANS/CNS Spine, and SRS with a copy of the books of account and other financial records of CSRF and accompanying documentation concerning CSRF's expenditures of the Grant Funds in connection with Grant Supported Activities.

4.5. Announcement. DePuy, Medtronic, K2M, AANS/CNS Spine, and SRS and Grantees agree that prior to a party communicating any information to the public regarding the Agreement; the communicating party shall provide the other parties with a copy of the proposed communication.

5. Representations and Warranties.

5.1. Authority. Each party represents and warrants that it has the right, power, and authority, without the consent of any other person or entity, to sign, execute, and deliver this Agreement and to carry out the obligations contemplated hereby, including, but not limited to, the transfer and receipt, as applicable, of the Grant Funds. All actions required to be taken by each party to authorize the signing, execution, delivery, and performance of this Agreement and all agreements and transactions contemplated hereby have been duly and properly authorized and taken.

5.2. Corporate Status. Each Grantee represents and warrants that it is a not-for-profit organized and in good standing under the laws of Illinois; that it is qualified as a tax-exempt organization under the Internal Revenue Code of 1986 (as amended); that it is not controlled by, and that it otherwise is independent of, any commercial interests; and that it operates in furtherance of the Grantee's Mission.

6. Administrative Costs.

Notwithstanding any other provision of this Agreement, DePuy, Medtronic, K2M, AANS/CNS Spine, and SRS agree that the Grantees will be reimbursed for administrative costs involved in managing and administering the grant. Such costs may include, but are not limited to, legal fees, project management, staff administration, and costs such as printing/postage and

conference calls. The total grant of $609,000 includes $580,000 for the *Appropriateness of Surgical Treatment Approaches for Lumbar Degenerative Scoliosis* study and $29,000 for administrative costs. OREF and AAN/NREF will provide additional administrative services, with a value estimated to be an additional $29,000 as a gift-in-kind to CSRF for this project.

7. Term, Termination, and Renewal.

7.1. Term. This Agreement is effective as of the Effective Date and shall continue in effect until June 1, 2015, or until the earlier termination of this Agreement pursuant to Section 7.2 or 7.3.

7.2. Termination by Funders. DePuy, Medtronic, K2M, AANS/CNS Spine, and SRS may terminate this Agreement immediately, with prompt written notice to Grantees, in the event that:

7.2.1. A Grantee breaches any of the terms of this Agreement; or

7.2.2. Any of the representations and warranties set forth in Section 5.1 or 5.2 is found to be or becomes untrue.

7.3. Termination by Grantees.

7.3.1. A Grantee may terminate this Agreement immediately, upon prompt written notice to DePuy, Medtronic, K2M, AANS/CNS Spine, and SRS, in the event that:

(a) DePuy, Medtronic, K2M, AANS/CNS Spine, and SRS are suspended, excluded or terminated from Medicare, Medicaid, or any other federal health care program, as defined by 42 U.S.C. § 1320a7b(f) or if DePuy, Medtronic, K2M, AANS/CNS Spine, and SRS are convicted of, or pleads to, a felony criminal offense related to its support for scientific research; or

(b) DePuy, Medtronic, K2M, AANS/CNS Spine, and SRS breaches any of the terms of this Agreement, including, but not limited to, any of DePuy, Medtronic, K2M, AANS/CNS Spine, and SRS's representations and warranties in Section 5 of this Agreement; or

(c) A change in federal or state statutes, regulations, principles or interpretations or a ruling or opinion by a court or administrative agency renders any of the material terms of this Agreement unlawful or unenforceable or renders the performance of the Grant Supported Activities by Grantees or CSRF unlawful or unenforceable.

7.3.2. Upon termination by a Grantee for the reasons set forth in Section 7.3.1(c) (to the extent legally permissible), or by DePuy, Medtronic, K2M, AANS/CNS Spine, and SRS pursuant to Section 7.2, Grantees shall return Grant Funds to DePuy, Medtronic, K2M, AANS/CNS Spine, and SRS in accordance with Section 7.4.

7.4. Return of Funds. If any portion of the Grant Funds has been used in a manner inconsistent with the terms of this Agreement, Grantees shall return such amount to DePuy, Medtronic, K2M, AANS/CNS Spine, and SRS within thirty (30) days of discovery of such use. DePuy, Medtronic, K2M, AANS/CNS Spine, and SRS acknowledge and agree that Grantees will have no liability or payment obligation to DePuy, Medtronic, K2M, AANS/CNS Spine, and SRS hereunder if Grantees return the Grant Funds pursuant to this Section 7.4.

7.5. Renewal. Grantees acknowledge and agree that this Grant is only for the Grant Period and nothing herein obligates DePuy, Medtronic, K2M, AANS/CNS Spine, and SRS in any way whatsoever to renew this grant thereafter. Notwithstanding the foregoing, DePuy, Medtronic, K2M, AANS/CNS Spine, and SRS may in its sole discretion decide to consider additional funding for a period following the expiration of this grant. In that event, prior to the Termination Date, the parties shall meet to discuss renewal of DePuy, Medtronic, K2M, AANS/CNS Spine, and SRS's support hereunder for an additional period, which shall be in DePuy, Medtronic, K2M, AANS/CNS Spine, and SRS's sole discretion.

8. Indemnification

8.1. By DePuy, Medtronic, K2M, AANS/CNS Spine, and SRS. DePuy, Medtronic, K2M, AANS/CNS Spine, and SRS shall indemnify and hold harmless Grantees from and against any losses, expenses, damages, liabilities, costs (including, without limitation, interest, penalties and reasonable attorneys' fees and expenses) incurred, assessed, or sustained by or against Grantees with respect to or in connection with any suit, demand, or action by any third party arising out of or resulting from DePuy, Medtronic, K2M, AANS/CNS Spine, and SRS's breach of its obligations under this Agreement.

8.2. By Grantees. Grantees shall indemnify and hold harmless DePuy, Medtronic, K2M, AANS/CNS Spine, and SRS from and against any losses, expenses, damages, liabilities, costs (including, without limitation, interest, penalties and reasonable attorneys' fees and expenses) incurred, assessed, or sustained by or against DePuy, Medtronic, K2M, AANS/CNS Spine, and SRS with respect to or in connection with any suit, demand, or action by any third party arising out of or resulting from (i) the acts or omissions of Grantees in connection with the Grant Supported Activities, and (ii) a Grantee's breach of its obligations under this Agreement.

9. Confidentiality.

DePuy, Medtronic, K2M, AANS/CNS Spine, and SRS and Grantees agree, except as may be required by law or regulation, or in connection with any proceeding relating to a breach of this Agreement, to keep the terms of this Agreement strictly confidential. DePuy, Medtronic, K2M, AANS/CNS Spine, and SRS and Grantees agree not to disclose, characterize, comment on, convey, or reveal the content or nature of this Agreement to any third party without the prior written consent of the other parties except as necessary to comply with a government order or request or any applicable law; provided, however, that disclosure may be made by each party to its legal and tax advisors, but then only on condition that such advisors agree not to further disclose this Agreement or any of its terms or provisions to others.

10. Miscellaneous.

10.1. Funding Intent. DePuy, Medtronic, K2M, AANS/CNS Spine, and SRS and Grantees acknowledge and agree that the grant is being made and accepted to provide financial support, consistent with any applicable federal or state law, to fund spine research and ultimately improve patient care, and is not contingent on the purchase or recommendation of any DePuy,

Medtronic, K2M, AANS/CNS Spine, and SRS products by Grantees or any physician associated with Grantees and is not intended to induce Grantees or any physician associated with Grantees to purchase or recommend DePuy, Medtronic, K2M, AANS/CNS Spine, and SRS products. DePuy, Medtronic, K2M, AANS/CNS Spine, and SRS and Grantees further acknowledge and agree that the grant has not been determined in any manner which takes into account the volume or value of any referrals, financial relationships, or other business arrangements otherwise existing between the parties (or any physician associated with Grantees) for which payment may be made, in whole or in part, under any federal or state health care program, including, without limitation, Medicare or Medicaid.

10.2 Compliance. The parties certify that this Agreement shall be performed and the administration of this Grant will be in accordance with all federal, state and local laws including the federal anti-kickback statute, set forth at 42 U.S.C. § 1320a-7b(b).

10.3 Independence of Parties. This Agreement shall not be deemed to create any relationship of agency, partnership, or joint venture between the parties.

10.4 Entirety of Agreement. This Agreement contains the entire agreement between the parties relating to the subject matter of this Agreement and supersedes all prior written and oral communications between the parties.

10.5 No Waiver. The failure of any party to insist upon the performance of any of the terms and conditions of this Agreement shall not be construed as a waiver of any breach of that provision or of any other provision.

10.6. Assignment. No party may assign any rights or delegate any duties under this Agreement without the express prior written consent of the other parties; provided, however, that DePuy, Medtronic, K2M, AANS/CNS Spine, and SRS may assign this Agreement to an entity that (a) directly or indirectly, is in control of, is controlled by, or is under common control with, DePuy, Medtronic, K2M, AANS/CNS Spine, and SRS, (b) acquires all or substantially all the assets of DePuy, Medtronic, K2M, AANS/CNS Spine, and SRS, or (c) results from a merger or consolidation with, or acquisition of, DePuy, Medtronic, K2M, AANS/CNS Spine, and SRS.

10.7. Amendment. No amendment of this Agreement shall be binding or enforceable on a party unless in writing signed by each of the parties.

10.8. Notices. All notices, requests and other communications to any party under this Agreement shall be in writing and shall be given at the addresses and facsimile numbers set forth below, or such other address or facsimile number as such party may hereafter specify for the purpose by notice to the other party hereto. Notices shall be signed by the notifying party and shall be deemed delivered on the same day if delivered by hand or by confirmed facsimile; shall be deemed delivered on the next business day if by recognized overnight courier; and shall be deemed delivered in five business days if deposited in the United States Mail, certified or registered mail, return receipt requested, postage prepaid.

To DePuy:

DePuy Spine, Inc.

Attn: William C. Horton III, MD
325 Paramount Drive
Raynham, MA 02767

To Medtronic:

Medtronic Sofamor Danek USA, Inc.

Attn: Doug King, Senior Vice President and President

Medtronic Spinal Restorative Therapies Group Medtronic, Inc.

2600 Sofamor Danek Drive

Memphis, TN 38132

To K2M:

K2M, Inc.

Attn: Lane Major, SVP

751 Miller Drive SE
Leesburg, Virginia 20175

To AANS on behalf of AANS/CNS Spine

Attn: Thomas R. Marshall, Executive Director

5550 Meadowbrook Drive

Rolling Meadows, Illinois 60008

To SRS:

Scoliosis Research Society

Attn: Tressa Goulding

555 East Wells Street, Suite 1100
Milwaukee, WI 53202-3823 USA

To OREF:

Orthopaedic Research and Education Foundation

Attn: Donna Rebeck, Chief Financial Officer

6300 North River Road, Suite 700

Rosemont, Illinois 60018

Facsimile: (847) 698-7806

To AAN, on behalf of NREF:

American Association of Neurosurgeons

Attn: Peter Kuhn, Chief Financial Officer

5550 Meadowbrook Drive

Rolling Meadows, Illinois 60008

10.9 Governing Law. This Agreement shall be governed by the laws of the State of Illinois without regard to its conflict of law's provisions.

10.10 Execution. This Agreement may be executed simultaneously in one or more counterparts, each of which shall be deemed an original, but all of which taken together shall constitute one and the same instrument, and facsimile signatures hereon shall be deemed original signatures.

10.11 Further Assurances. From time to time after the Effective Date, each party shall execute, acknowledge, and deliver any further documents and assurances, and shall take any other action consistent with the terms and conditions of this Agreement, that may reasonably be requested by the other parties and necessary or desirable to carry out the purpose of this Agreement.

10.12 Survival. The rights and obligations set forth in 7.3.2 (Termination), 7.4 (Return of Funds), 8 (Indemnification), 9 (Confidentiality), and 10 (Miscellaneous) shall survive the termination of this Agreement.

IN WITNESS WHEREOF, duly authorized representatives of the parties have executed this Agreement as of the date first set forth above.

DEPUY SPINE, INC.

By: _____

MEDTRONIC SOFAMOR DANEK USA, INC.

By: _____

K2M, INC.

By: _____

AMERICAN ASSOCIATION OF NEUROLOGICAL SURGEONS, on behalf of the AANS/CNS JOINT SECTION ON DISORDERS OF THE SPINE AND PERIPHERAL NERVES

By: _____

SCOLIOSIS RESEARCH SOCIETY

By: _____

ORTHOPAEDIC RESEARCH AND EDUCATION FOUNDATION

By: _____

Donna Rebeck, Chief Financial Officer

AMERICAN ASSOCIATION OF NEUROSURGEONS, on behalf of NEUROSURGERY RESEARCH AND EDUCATION FOUNDATION

By: _____

Peter Kuhn, Chief Financial Officer

Item 5B:

Dan,

Strong work putting this together. I agree with the 15% increase as we previously discussed. We can confirm this at the AANS meeting.

Charlie

From: "Hoh,Daniel J" <Daniel.Hoh@neurosurgery.ufl.edu>
To: Michael Groff <mgroff@mac.com>; Charles Kuntz <charleskuntz@yahoo.com>
Cc: "vmum@aol.com" <vmum@aol.com>; "jknightly@atlanticneurosurgical.com" <jknightly@atlanticneurosurgical.com>; "MWang2@med.miami.edu" <MWang2@med.miami.edu>; "kanteras@upmc.edu" <kanteras@upmc.edu>; "Hoh,Daniel J" <Daniel.Hoh@neurosurgery.ufl.edu>
Sent: Friday, April 19, 2013 12:28 PM
Subject: RE: Section Meeting Corporate Support

Here is the data in advance of the AANS meeting (attached Excel file).

The grid lists every company that contributed $$ in any way to the section through the**Annual Meeting** or through **Awards/ Sponsored Lectureships** (thanks Adam for the awards data).

For granularity sake, the **Annual Meeting** contribution is broken down into:

1. ***Meeting Sponsorhip*** (money given directly to the section to pay for meeting activities like receptions, key cards, program book, etc.)

2. ***Meeting Advertising*** (ads in the program book, What's New Sessions, etc.)

3. ***Meeting Exhibits*** (purchasing exhibit booth space)

The **2013 Total Contribution** (Meeting + Awards/ Lectureships) is listed. The planned 15% increase is also listed and then a calculated**2014 Projected Ask** (115% of the 2013 Total).

Just a side note: 38 "smaller supporters" essentially only contributed by purchasing a 10 x 10' booth.

We have been pricing this consistently in the past at $3,400 - 3,600.

Just for reference, a 10 x 10' booth for other society meetings costs:

AANS: $2,900 - 3,100

CNS: $2,900 - 3,100

CSRS: $3,000

NASS: $3,600

AAOS: $3,700

SMISS: $5,000

IMAST: $8,000 (!!!)

If we increase our 10 x 10' booth by 15% that puts our booths at $4,140 which is squarely in the middle (roughly a $500 increase) -- yet will generate over $20,000 from these "smaller supporters" alone (even more when we include the other bigger supporters).

At Mike G. and Charlie's recommendation, I'd like to move forward with increasing the exhibit booths by 15% across the board. I will also work with the CNS office on re-structuring the Meeting Sponsorship and Advertising options to also reflect a 15% increase in these other areas.

Thanks! Dan

PS. Again, this grid only includes Industry contributions through the **Annual Meeting** and **Awards/ Sponsored Lectureship**. I understand that at the EC meeting in New Orleans we will likely be adding onto our "**2014 Projected Ask**" with the budget needs of the various section committees. Thanks.

From: Michael Groff [mgroff@mac.com]
Sent: Friday, April 05, 2013 1:50 PM
To: Charles Kuntz
Cc: vmum@aol.com; Hoh,Daniel J; jknightly@atlanticneurosurgical.com; MWang2@med.miami.edu
Subject: Re: Section Meeting Corporate Support

Dan,

Can you move this forward? If there are roadblocks let me know.

Thanks,

mike

On Apr 3, 2013, at 10:02 AM, Charles Kuntz <charleskuntz@yahoo.com> wrote:

Gentlemen,

I agree with All. The contribution to the S&PN Section for this past year for each company should be forwarded to all of us (including annual meeting, honoraria, and awards). This number should then be increased by 15% for the ask next year. We should have this before the AANS, and Dan should have a copy in hand.

Charli

From: Michael Groff <mgroff@mac.com>
To: vmum@aol.com
Cc: Daniel.Hoh@neurosurgery.ufl.edu; Charleskuntz@yahoo.com; jknightly@atlanticneurosurgical.com; MWang2@med.miami.edu
Sent: Tuesday, April 2, 2013 11:05 PM
Subject: Re: Section Meeting Corporate Support

Praveen,

I think Dan wants to have something in hand at the AANS meeting. Any asks will be done by the section directly within the context of One Ask. It is fine for CNS to construct a prospectus for Dan including all parts of our funding needs. Doing so would be consistent with everything Reg has discussed with me. My only suggestion would be to increase the numbers from last year by 15-20%.

Thanks,

mike

On Apr 2, 2013, at 10:33 PM, vmum@aol.com wrote:

we should discuss this in 3 weeks during the next EC meeting at AANS.

mike, shall i ask reg haid to come to that meeting?

praveen

Praveen V. Mummaneni, M.D.
Professor and Vice-Chairman
Dept. of Neurosurgery, University of California at San Francisco
Co-Director: UCSF Spine Center

Secretary: AANS-CNS Joint Section - Spine and Peripheral Nerves

-----Original Message-----
From: Hoh,Daniel J <Daniel.Hoh@neurosurgery.ufl.edu>
To: vmum <vmum@aol.com>; Mike Groff (mgroff@mac.com) <mgroff@mac.com>; Charleskuntz <Charleskuntz@yahoo.com>; Jack Knightly

<jknightly@atlanticneurosurgical.com>; Mike Wang (MWang2@med.miami.edu) <MWang2@med.miami.edu>
Cc: Hoh,Daniel J <Daniel.Hoh@neurosurgery.ufl.edu>
Sent: Tue, Apr 2, 2013 4:26 pm
Subject: FW: Section Meeting Corporate Support

I would like to have us send out a short-form Exhibitor Prospectus prior to the AANS meeting.

In the prospectus, it would have the pricing and packages for all of the options for supporting the annual meeting (exhibit booth space, sponsorship packages for reception, program book, etc.).

These packages have not changed significantly in price over the last several years (and they haven't for other societies like NASS either -- relatively stable pricing across the board) -- so I think we can publish the same menu of options at the same price as last year.

If you are in agreement, I would like us to go ahead and get that brochure out ASAP. I'd like to talk to companies at the AANS as they are probably formulating their annual budgets now -- and I want to be able to have actual prices in hand so that they can take it back to corporate to secure a dollar amount, early in the fiscal year.

One issue that has come up however is that the Exhibitor Prospectus includes sponsorship packages which are essentially "educational grants" to the annual meeting (the money that pays for the program book, receptions, card keys, etc.). Regina Shupak seemed to think that this particular funding source may no longer be under the purview of the CNS and may become part of the AANS and the OneAsk.

Is this the case? -- and if so, is there any issue with us going ahead and at least putting out the Exhibitor Prospectus with the menu of options/ pricing list?

Thanks, Dan

From: Michele L. Lengerman [mailto:mll@1CNS.ORG]
Sent: Tuesday, April 02, 2013 11:10 AM
To: Hoh,Daniel J
Subject: Section Meeting Corporate Support

Dr. Hoh,

I talked with Regina last night regarding the corporate support for the Section Meeting and whether that is being transitioned to the AANS as part of One Ask. She said that Dr. Mummaneni told her this would be discussed at the Spine EC in New Orleans. Would you be able to reach out to Dr. Mummaneni to verify whether he is okay with publishing an exhibit and corporate support prospectus, using last year's basic format, packages, etc., prior to the AANS Meeting? Or would he like us to hold off until after that discussion?

thank you,

Michele Lengerman

Director of Development & Foundation

Congress of Neurological Surgeons

10 N. Martingale Road, Suite 190

Schaumburg, Illinois 60173

Phone: 847 240 2500

Direct: 847 805 4455

Fax: 847 240 0804

Visit the CNS on line atwww.cns.org.

Mark your calendar now for the 2013 CNS Annual Meeting, October 19-23 in San Francisco, California!

<image001.png> <image002.png>

Item 5C

Year	AANS/CNS Section on DSPN	AANS	AAOS
2013	**March 6-9** Phoenix JW Marriott	April 27-May 2 New Orleans	March 19-23 Chicago
2014	**March 5-8** Orlando Disney	April 5-9 San Francisco	March 12 – 15 New Orleans
2015	**March 4-7** Phoenix	May 2-9 Washington DC	March 24-28 Las Vegas

Item 5E

Dear Dr. Wang,

I want to confirm the AANS/CNS Section on DSPN Scientific Program Committee, taking place in New Orleans on Monday, April 29, 2013 from 4:00 PM to 5:00 PM in Studio 9 of the New Orleans Marriott. Please see the attached function sheet with all the details. Below are the current RSVPs for the meeting. I'll send a reminder to all next week confirming the meeting date, time, and location.

Name	RSVP
Falavigna Asdrubal	No
Beejal Amin	
Allan Belzberg	Yes
Chris Bono	
Charlie Kuntz	Yes
Cheerag Upadhyaya	
Dean Chou	
Charles Sansur	Yes
Daniel Lu	
Dan Refai	Yes
Dom Coric	
Eric Potts	Yes
Jim Harrop	No
John Chi	
Justin Smith	Yes
Uribe Juan	Yes
Adam Kanter	Yes
Jack Knightly- AMC	
Langston Holly	
Lynda Yang	Yes
Luis Tumialan	Yes
Matthew McGirt	

Michael Wang	
Paul Arnold	Yes
Patrick Hsieh	
Robert Galler	
Sanjay Dhall	
Scott Meyer	No
Michael Steinmetz	Yes
Srini Prasad	
Albert Todd	No
Praveen Mummaneni	Yes
Yi Lu	Yes
Zoher Ghogawala	

Please let me know if you have any questions.

Thank you,

Katie

Katie Jenkins

Meetings Manager

Item 6b

Spine Section Membership Committee Report Kurt Eichholz, MD

April 29, 2013

Class	Spring 2013	Spring 2012	Fall 2012	Fall 2011	Spring 2010	Spring 2009	Spring 2008
Active Members	941	953	939	966	991	1009	105
Lifetime Members	290	278	286	274	256	239	22
Resident/Fellow	1530	253	253	105	106	117	14
International	46	41	45	40	39	40	4
Associate	8	8	8	9	8	7	
Adjunct	12	14	14	17	22	17	1
Honorary	1	1	1	1	1	1	
Active + Senior	1231	1231	1225	1240	1247	1248	128

1 Resigned	7 Resigned	5 Resigned	4 Resigne
5 Non-payment	2 Deceased	2 Deceased	3 Decease
2 Suspended	1 Suspended		

Currently our membership numbers are as follows, with last 6 years provided for reference:

- There has been a shift of some active members to lifetime (senior) membership.

- The number of active plus lifetime members has been fairly stable since 2009, since high membership mark in 2008.
- Residents automatically became members last year, accounting for the increased number of resident members.

For reference, the Tumor Section and Cerebrovascular Section have the next highest membership numbers

- CV Section has 403 Active Members
    - 40 new members in last year, 20 of which were transfers from Resident to Active

- Tumor Section has 550 Active Members
    - 55 new members in last year, 32 of which were transfers from Resident to Active

Membership Initiatives

- The Spine Section has a booth on the exhibit floor here in New Orleans. Ashley Hamm, Section Membership Coordinator for the AANS, is working the Booth. She will be answering questions and processing applications for new members.

- Brochures for the Spine Section were made for the Booth. These were made based on the Spring 2012 Issue of CNS Quarterly, and are available at the Spine Section Booth for prospective members.

- An email will be going out in late May/Early June to graduating residents, to remind them to become active members of the Spine Section, once they are an active member of one of the parent organizations (requirement for Spine Section membership).

Dues Collection

- Currently, 251 active members (26%) have not paid their dues (which were due in January). This is on par with previous years.

- These delinquent members receive monthly invoices. Those that are unpaid in June will receive letter from Membership Committee Chair.

Item 8C
Praveen, Mike and Charlie,

The Guidelines budget for the past year was $50,000 with three ongoing guidelines efforts. 2 of those efforts have concluded except for publication costs for the lumbar fusion guidelines. I am not certain what the final costs were for DSPN guidelinesfor 2012-13.

The metastatic spine tumor and thoracolumbar trauma guidelines would be the active guideline efforts for this year with the anticipation of initiating the cervical spine degenerative guideline update sometime in 2014.

In light of this, I would propose that the budget for guidelines remain at $50,000 or about $20,000 per guideline per year (includingfinalization and publication costs for the lumbar fusion guidelines). This budget includes the costs for outsourcing literature searches, article retrieval, webinars/conference calls, in-person meetings, and publication costs. In addition, I will submit new guideline proposals to the CNS guidelines committee for funding but given thenovel nature of that committee, the amount of funding we can secure remains uncertain at this time.

Thanks and let me know what questions I can answer,

John

John O'Toole, MD, MS
Associate Professor of Neurosurgery
Rush University Medical Center
1725 W Harrison, Suite 855

Chicago, IL 60612
office (312) 942-6644

From: vmum@aol.com [vmum@aol.com]
Sent: Saturday, March 30, 2013 11:14 AM
To: mgroff@mac.com; mgroff@partners.org; charleskuntz@yahoo.com; jhurlber@ucalgary.ca; mwang@mcw.edu; joseph.cheng@vanderbilt.edu; jknightly@atlanticneurosurgical.com; MWang2@med.miami.edu; daniel.hoh@neurosurgery.ufl.edu; kurt@eichholzmd.com
Cc: jss7f@virginia.edu; jcoumans@partners.org; msteinmetz@metrohealth.org; flamarca@med.umich.edu; Mgk7@columbia.edu; John O'Toole; JCHI@PARTNERS.ORG;

rfessler@nmff.org; KALFASI@ccf.org; lholly@mednet.ucla.edu; epotts@goodmancampbell.com; trost@neurosurg.wisc.edu; meic.schmidt@hsc.utah.edu; michael.rosner@us.army.mil; belzberg@jhu.edu; sanjaydhall@yahoo.com; cheerag.upadhyaya@gmail.com; kanteras@upmc.edu; matt.mcgirt@vanderbilt.edu; zoher.ghogawala@lahey.org
Subject: Joint Section Spine and Periph Nerves EC issues

Dear cmte chairs

We are planning to organize our funding needs for 2013-2014.

Mike Groff asks that you submit a budget for funding for each of your cmtes and a justification for the budget.

Then we can organize through ONE ASK to secure the funds we need.

please email me, Mike G, and Charlie Kuntz with your proposal.

Also bring this info the next EC meeting which is Monday April 29 at 1-4pm during the AANS in New Orleans.

This meeting is a business essentials meeting and we only invited the officers and cmte chairs to keep the meeting to a workable group.

Here are the folks invited and their cmte chair positions:

Officers			
Chair	Michael	Groff	mgroff@mac.com
Chair Elect			
Chair Past	Joseph	Cheng	joseph.cheng@vanderbilt.edu
Secretary	Praveen	Mummaneni	vmum@aol.com

Treasurer	Charley	Kuntz	charleskuntz@yahoo.com
Future Chair	John	Hurlbert	jhurlber@ucalgary.ca
Ex Officio	Marjorie	Wang	mwang@mcw.edu
Chairs			
Annual Meeting Chair	Jack	Knightly	jknightly@atlanticneurosurgical.com
Scientific Program Chair	Mike	Wang	mwang2@med.miami.edu
Exhibits Chairperson	Daniel	Hoh	daniel.hoh@neurosurgery.ufl.edu
Nominating	Joseph	Cheng	joseph.cheng@vanderbilt.edu
Membership	Kurt	Eicholtz	kurt@eichholzmd.com
Rules and Regulations	Justin	Smith	jss7f@virginia.edu
ASTM	Jean Valery	Coumans	jcoumans@partners.org
Outcomes	Mike	Steinmetz	msteinmetz@metrohealth.org
Education	Frank	LaMarca	flamarca@med.umich.edu
Fellowships	Mike	Kaiser	mgk7@columbia.edu
Guidelines	John	O'Toole	john_otoole@rush.edu
Research and Awards	John	Chi	jchi@partners.org
AANS PDP	Rick	Fessler	rfessler@nmff.org
Future Sites	Ian	Kalfas	kalfasi@ccf.org
Publications	Langston	Holly	lholly@mednet.ucla.edu
Website	Eric	Potts	epotts@goodmancampbell.com
CME	Greg	Trost	trost@neurosurgery.wisc.edu
Spinal Deformity Training	Meic	Schmidt	meic.schmidt@hsc.utah.edu

Inter-Society Liaison	Mike	Rosner	michael.rosner@us.army.mil
Peripheral Nerve TF	Allan	Belzberg	belzberg@jhu.edu
Public Relations	Sanjay	Dhall	sanjaydhall@yahoo.com
Young Neurosurgeons	Cheerag	Upadhyaya	cheerag.upadhyaya@gmail.com
Invite Per Mummaneni	Adam	Kanter	kanteras@upmc.edu
Invite Per Mummaneni	Matt	Mcgirt	matt.mcgirt@vanderbilt.edu
Invite Per Mummaneni	Zoher	Ghogawala	zoher.ghogawala@lahey.org

Praveen V. Mummaneni, M.D.
Professor and Vice-Chairman
Dept. of Neurosurgery, University of California at San Francisco
Co-Director: UCSF Spine Center

Secretary: AANS-CNS Joint Section - Spine and Peripheral Nerves

Item 8D

Here is the “budget” for the fellowships and awards... total is 168K.

Medtronic had sponsored the cloward and Sonntag until last year when they were unable to contribute and nuvasive stepped in.

These funding levels have remained the same for as long as i can remember.

There are a couple of things adam, dan and I were hoping to discuss at the EC meeting regarding funding and application process that i can email you both about next week.

See you at NO soon!

jchi

H. Alan Crockard Int’l Fellowship	$5,000	DePuy Synthes Spine
Sanford Larson Research Award	$30,000	DePuy Synthes Spine
Ronald Apfelbaum Research Award	$15,000	Aesculap
David Cahill Fellowship	$30,000	DePuy Synthes Spine
David Kline Research Award	$15,000	Integra
Ralph Cloward Fellowship	$30,000	NuVasive
Sonntag International Fellowship	$5,000	NuVasive
Regis W. Haid, Jr, Adult Deformity Award	$30,000	Globus
David Kline Lectureship	$5000	Integra
David Kline Dinner	$3000	Integra

Item 10d

Special Fraud Alert: Physician-Owned Entities

March 26, 2013

I. Introduction

This Special Fraud Alert addresses physician-owned entities that derive revenue from selling, or arranging for the sale of, implantable medical devices ordered by their physician-owners for use in procedures the physician-owners perform on their own patients at hospitals or ambulatory surgical centers (ASCs). These entities frequently are referred to as physician-owned distributorships, or "PODs."[1] The Office of Inspector General (OIG) has issued a number of guidance documents on the general subject of physician investments in entities to which they refer, including the 1989 Special Fraud Alert on Joint Venture Arrangements[2] and various other publications. OIG also provided guidance specifically addressing physician investments in medical device manufacturers and distributors in an October 6, 2006 letter.[3] In that letter, we noted "the strong potential for improper inducements between and among the physician investors, the entities, device vendors, and device purchasers" and stated that such ventures "should be closely scrutinized under the fraud and abuse laws."[4] This Special Fraud Alert focuses on the specific attributes and practices of PODs that we believe produce substantial fraud and abuse risk and pose dangers to patient safety.

[4] Id.

II. The Anti-Kickback Statute

One purpose of the anti-kickback statute is to protect patients from inappropriate medical referrals or recommendations by health care professionals who may be unduly influenced by financial incentives. Section 1128B(b) of the Social Security Act (the Act) makes it a criminal

[1] The physician-owned entities addressed in this Special Fraud Alert are sometimes referred to as "physician-owned companies" or by other terminology. For purposes of this Special Fraud Alert, a "POD" is any physician-owned entity that derives revenue from selling, or arranging for the sale of, implantable medical devices and includes physician-owned entities that purport to design or manufacture, typically under contractual arrangements, their own medical devices or instrumentation. Although this Special Fraud Alert focuses on PODs that derive revenue from selling, or arranging for the sale of, implantable medical devices, the same principles would apply when evaluating arrangements involving other types of physician-owned entities.

[2] Special Fraud Alert: Joint Venture Arrangements (August 1989), *reprinted at* 59 Fed. Reg. 65,372, 65,374 (Dec. 19, 1994).

[3] Letter from Vicki Robinson, Chief, Industry Guidance Branch, Department of Health and Human Services, OIG, Response to Request for Guidance Regarding Certain Physician Investments in the Medical Device Industries (Oct. 6, 2006).

offense to knowingly and willfully offer, pay, solicit, or receive any remuneration to induce, or in return for, referrals of items or services reimbursable by a Federal health care program. When remuneration is paid purposefully to induce or reward referrals of items or services payable by a Federal health care program, the anti-kickback statute is violated. By its terms, the statute ascribes criminal liability to parties on both sides of an impermissible "kickback" transaction. Violation of the statute constitutes a felony punishable by a maximum fine of $25,000, imprisonment up to 5 years, or both. Conviction will also lead to exclusion from Federal health care programs, including Medicare and Medicaid. OIG may also initiate administrative proceedings to exclude persons from the Federal health care programs or to impose civil money penalties for fraud, kickbacks, and other prohibited activities under sections 1128(b)(7) and 1128A(a)(7) of the Act.

III. Physician-Owned Distributorships

Longstanding OIG guidance makes clear that the opportunity for a referring physician to earn a profit, including through an investment in an entity for which he or she generates business, could constitute illegal remuneration under the anti-kickback statute. The anti-kickback statute is violated if even one purpose of the remuneration is to induce such referrals.

OIG has repeatedly expressed concerns about arrangements that exhibit questionable features with regard to the selection and retention of investors, the solicitation of capital contributions, and the distribution of profits. Such questionable features may include, but are not limited to: (1) selecting investors because they are in a position to generate substantial business for the entity, (2) requiring investors who cease practicing in the service area to divest their ownership interests, and (3) distributing extraordinary returns on investment compared to the level of risk involved.

PODs that exhibit any of these or other questionable features potentially raise four major concerns typically associated with kickbacks—corruption of medical judgment, overutilization, increased costs to the Federal health care programs and beneficiaries, and unfair competition. This is because the financial incentives PODs offer to their physician-owners may induce the physicians both to perform more procedures (or more extensive procedures) than are medically necessary and to use the devices the PODs sell in lieu of other, potentially more clinically appropriate, devices. We are particularly concerned about the presence of such financial incentives in the implantable medical device context because such devices typically are "physician preference items," meaning that both the choice of brand and the type of device may be made or strongly influenced by the physician, rather than being controlled by the hospital or ASC where the procedure is performed.

We do not believe that disclosure to a patient of the physician's financial interest in a POD is sufficient to address these concerns. As we noted in the preamble to the final regulation for the safe harbor relating to ASCs:

> …disclosure in and of itself does not provide sufficient assurance against fraud and abuse…[because] disclosure of financial interest is often part of a testimonial, i.e., a reason why the patient should patronize that facility. Thus, often patients

are not put on guard against the potential conflict of interest, i.e., the possible effect of financial considerations on the physician's medical judgment.

See 64 Fed. Reg. 63,518, 63,536 (Nov. 19, 1999). Although these statements were made with respect to ASCs, the same principles apply in the POD context.

OIG recognizes that the lawfulness of any particular POD under the anti-kickback statute depends on the intent of the parties. Such intent may be evidenced by a POD's characteristics, including the details of its legal structure; its operational safeguards; and the actual conduct of its investors, management entities, suppliers, and customers during the implementation phase and ongoing operations. Nonetheless, we believe that PODs are inherently suspect under the anti-kickback statute. We are particularly concerned when PODs, or their physician-owners, exhibit any of the following suspect characteristics:

- The size of the investment offered to each physician varies with the expected or actual volume or value of devices used by the physician.
- Distributions are not made in proportion to ownership interest, or physician-owners pay different prices for their ownership interests, because of the expected or actual volume or value of devices used by the physicians.
- Physician-owners condition their referrals to hospitals or ASCs on their purchase of the POD's devices through coercion or promises, for example, by stating or implying they will perform surgeries or refer patients elsewhere if a hospital or an ASC does not purchase devices from the POD, by promising or implying they will move surgeries to the hospital or ASC if it purchases devices from the POD, or by requiring a hospital or an ASC to enter into an exclusive purchase arrangement with the POD.
- Physician-owners are required, pressured, or actively encouraged to refer, recommend, or arrange for the purchase of the devices sold by the POD or, conversely, are threatened with, or experience, negative repercussions (e.g., decreased distributions, required divestiture) for failing to use the POD's devices for their patients.
- The POD retains the right to repurchase a physician-owner's interest for the physician's failure or inability (through relocation, retirement, or otherwise) to refer, recommend, or arrange for the purchase of the POD's devices.
- The POD is a shell entity that does not conduct appropriate product evaluations, maintain or manage sufficient inventory in its own facility, or employ or otherwise contract with personnel necessary for operations.
- The POD does not maintain continuous oversight of all distribution functions.
- When a hospital or an ASC requires physicians to disclose conflicts of interest, the POD's physician-owners either fail to inform the hospital or ASC of, or actively conceal through misrepresentations, their ownership interest in the POD.

These criteria are not intended to serve as a blueprint for how to structure a lawful POD, as an arrangement may not exhibit any of the above suspect characteristics and yet still be found to be unlawful. Other characteristics not listed above may increase the risk of fraud and abuse

3 associated with a particular POD or provide evidence of unlawful intent. For example, a POD that exclusively serves its physician-owners' patient base poses a higher risk of fraud and abuse than a POD that sells to hospitals and ASCs on the basis of referrals from nonowner physicians. The anti-kickback statute is not a prohibition on the generation of profits; however, PODs that generate disproportionately high rates of return for physician-owners may trigger heightened scrutiny. Because the investment risk associated with PODs is often minimal, a high rate of return increases both the likelihood that one purpose of the arrangement is to enable the physician-owners to profit from their ability to dictate the implantable devices to be purchased for their patients and the potential that the physician-owner's medical judgment will be distorted by financial incentives. Our concerns are magnified in cases when the physician-owners: (1) are few in number, such that the volume or value of a particular physician-owner's recommendations or referrals closely correlates to that physician-owner's return on investment, or (2) alter their medical practice after or shortly before investing in the POD (for example, by performing more surgeries, or more extensive surgeries, or by switching to using their PODs' devices on an exclusive, or nearly exclusive basis).

We are aware that some PODs purport to design or manufacture their own devices. OIG does not wish to discourage innovation; however, claims—particularly unsubstantiated claims—by physician-owners regarding the superiority of devices designed or manufactured by their PODs do not disprove unlawful intent. The risk of fraud and abuse is particularly high in circumstances when such physicians-owners are the sole (or nearly the sole) users of the devices sold or manufactured by their PODs.

Finally, because the anti-kickback statute ascribes criminal liability to parties on both sides of an impermissible "kickback" transaction, hospitals and ASCs that enter into arrangements with PODs also may be at risk under the statute. In evaluating these arrangements, OIG will consider whether one purpose underlying a hospital's or an ASC's decision to purchase devices from a POD is to maintain or secure referrals from the POD's physician-owners.

IV. Conclusion

OIG is concerned about the proliferation of PODs. This Special Fraud Alert reiterates our longstanding position that the opportunity for a referring physician to earn a profit, including through an investment in an entity for which he or she generates business, could constitute illegal remuneration under the anti-kickback statute. OIG views PODs as inherently suspect under the anti-kickback statute. Should a POD, or an actual or potential physician-owner, continue to have questions about the structure of a particular POD arrangement, the OIG Advisory Opinion process remains available. Information about the process may be found at: http://oig.hhs.gov/faqs/advisory-opinions-faq.asp.

To report suspected fraud involving physician-owned entities, contact the OIG Hotline at http://oig.hhs.gov/fraud/report-fraud/index.asp or by phone at 1-800-447-8477 (1-800-HHS-TIPS).

Healthcare Reform Update

Congressional Activities

AANS and CNS continue to lead efforts to "reform the reform". Given the fact that President Obama was reelected and the Senate remains in control of the Democrats, House Republican leaders have signaled that they are basically abandoning their efforts to repeal the entire health reform law. Rather, republicans will now pursue a 3-pronged approach:

• Focus on piecemeal repeal where it might be possible to pick up a few Democratic votes (IPAB and medical device excise tax high on this priority list);
• Conduct oversight and investigative hearings into the implementation of the law; and
• Be ready to act with a replacement when the law collapses of its own weight.

Neurosurgery's priority issues remain:

• **Repeal/Modification**

– Independent Payment Advisory Board (IPAB)
– PQRS penalties
– Value-based purchasing modifier
– Public reporting of physician performance data
– Repeal of the medical device tax

• **Implementation**

– Funding for pediatric specialist loan forgiveness
– Funding for emergency care regionalization projects
– Funding for trauma-EMS program

• **Additional Legislation**

– SGR reform
– Medicare private contracting
– Medical liability reform
– Eliminating GME funding caps (and preserving current GME Medicare funding)

• **IPAB Repeal Legislation Reintroduced**. Repealing the IPAB is one of organized neurosurgery's top legislative priorities. To this end, the AANS and CNS, along with the American Society of Anesthesiologists, are leading a physician coalition dedicated to repealing the IPAB. The coalition, representing more than 450,000 physicians across 26 specialty physician groups. On Jan. 23, 2013, Reps. Phil Roe, MD (R-TN) and Allyson Schwartz (D-PA) introduced H.R. 351, the Protecting Seniors' Access to Medicare Act of 2013, which would repeal the Independent Payment Advisory Board (IPAB). The IPAB was created by the Patient Protection and Affordable Care Act and is a government board whose primary purpose is to cut Medicare spending. The bill currently has 146 bipartisan cosponsors. On Feb. 14, 2013, Sen. John Cornyn (R-TX) introduced the companion bill, which has the same name and bill number (S. 351). The senate bill has 31 cosponsors. In early January, the House of Representatives adopted rules for the 113th Congress that included a provision limiting IPAB's authority.

Regulatory Activities

The Obama Administration continues to issue implementing regulations, including those related to Medicaid expansion, health insurance exchanges, insurance market and rate rules, and others. To date the following states have made decisions regarding health insurance exchanges:

• **State --** The state plans to run its own exchange: CA, CO, CT, DC, HI, ID, KY, MD, MA, MN, MS NV, NM, NY, OR, RI, VT, WA

• **Federal --** The state will not set up an exchange, and the federal government will run a fallback exchange instead: AL, AK, AZ, FL, GA, IN, KS, LA, ME, MO, MT, NE, NH, NJ, ND, OH, OK, PA, SC, SD, TN, TX, VA, WI, WY

• **Partnership --** The state will run some functions of the exchange but will leave certain ones to the federal government: AR, DE, IL, IA, MI, NC, UT, WV

In terms of expanding Medicaid coverage, AL, GA, ID, IN, IA, KS, LA, ME, MS, NC, OK, SC, SD, TX, UT, WI, and WY will not be expanding Medicaid coverage to those individuals making under 133% of federal poverty level. AK, AZ, AR, KY, MO, MT, NE, NH, ND, OH, PA, TN, VA, and WV have not yet decided. All others have announced plans to expand Medicaid coverage.

The following outlines key elements of the law that have been implemented (or authorized to be implemented, though some have not been put into effect yet – e.g., IPAB) so far and those scheduled to come on-line in 2013:

2010

• Review of health plan premium increases
• Creation of Medicaid and CHIP Payment Advisory Commission
• Establishment of Comparative Effectiveness Research Institute
• Establishment of Prevention and Public Health Fund
• Medicare Beneficiary Drug Rebate
• Small Business Tax Credits to expand insurance coverage
• Adult Dependent Coverage to Age 26
• Consumer Protections in Insurance
• Insurance Plan Appeals Process
• Coverage of Preventive Benefits
• Health Care Workforce Commission

2011

• Minimum Medical Loss Ratio for Insurers
• Closing the Medicare Drug Coverage Gap
• Increasing Medicare Payments for Primary Care and Rural General Surgeons
• Establishing Center for Medicare and Medicaid Innovation
• Implementing a National Quality Strategy
• Medical Malpractice Grants
• Funding Health Insurance Exchanges
• Reduced Medicaid Payments for Hospital-Acquired Infections
• Establishment of Medicare Independent Payment Advisory Board

2012

• Accountable Care Organizations in Medicare
• Uniform Coverage Summaries for Consumers
• Fraud and Abuse Prevention
• Medicare Value-Based Purchasing
• Reduced Medicare Payments for Hospital Readmissions

2013
• State Notification Regarding Exchanges
• Closing the Medicare Drug Coverage Gap
• Medicare Bundled Payment Pilot Program
• Medicaid Coverage of Preventive Services
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• Increased Medicaid Payments for Primary Care
• Limits on Itemized Deductions for Medical Expenses
• Flexible Spending Account Limits
• Medicare Tax Increase
• Tax on Medical Devices
• Extension of CHIP
• Reductions in Disproportionate Share Hospital Payments

Full implementation of the law is not scheduled to be completed until 2019. For more information about the overview of the law and the implementation timeline go to: http://bit.ly/cEZ39S and http://bit.ly/ygUz9m.

Judicial Activities

Several years ago, the Goldwater Institute filed a lawsuit challenging, among other things, the constitutionality of the Independent Payment Advisory Board (IPAB) on separation-of-powers grounds. The federal district court had dismissed the suit, and on February 19, 2013, the Goldwater Institute filed an appeal with the 9th Circuit Court of Appeals. Page 1 of 42

CODING AND REIMBURSEMENT UPDATE

Medicare Budget and SGR Reform Proposals

• **Going Over the Fiscal Cliff.** On Jan. 1, 2013 Congress passed H.R. 8, the American Taxpayer Relief Act (http://1.usa.gov/UDxOQ7) and the president subsequently signed it into law. The legislation was the latest compromise to prevent the country from going over the so-called "fiscal cliff," and included, among other things, a mix of tax measures and healthcare provisions. Key elements of the bill related to healthcare include:

− Prevents the 26.5 percent Medicare physician pay cut, extending current Medicare payment rates through Dec. 31, 2013.
− Allows physicians to participate in clinical data registries to meet Medicare's quality reporting requirements.
− Extends the geographic work adjustment through Dec. 31, 2013, preventing additional payment reductions for physicians practicing in rural areas.
− Reduces hospital outpatient reimbursement for gamma knife stereotactic radiosurgery to the same level as radiosurgery performed with a linear accelerator.
− Adjusts the equipment utilization rate for advanced imaging services, which may reduce reimbursement to physicians who own imaging equipment.

While the legislation failed to fully repeal the SGR, the inclusion of the clinical data registry piece was the culmination of advocacy efforts of the AANS, CNS and several other medical societies.

Subsequent to the passage of the fiscal cliff bill, the AANS and CNS sent a letter (http://bit.ly/16EyKKN) to all Members of Congress objecting to the radiosurgery payment cuts. Overall, the provision will cut hospital reimbursement by $300 million, decreasing the per-treatment Gamma Knife reimbursement from approximately $8,100 to $3,400 — a 58 percent reduction. We also issued a press release drawing attention to our opposition of the cuts.

• **Medicare Physician Payment Update-SGR.** Every year for more than a decade, physicians have faced a significant Medicare payment cut -- the result of a flawed sustainable growth rate (SGR) formula. Now, once again, physicians face an SGR-driven pay cut of over 25% percent effective Jan. 1, 2014. In addition to the SGR-related cuts, physicians face additional cuts due to the budget sequestration -- 2 percent per year for the next 10 years -- and other cuts related to the Patient Protection and Affordable Care Act (ACA), including PQRS, eRx, EHR, IPAB and others. Under a worst case scenario situation, neurosurgeons could face cuts in excess of 85 percent over the next decade.

− CBO lowers estimate of SGR. On Tuesday, Feb. 5, the Congressional Budget Office (CBO) released its updated Budget and Economic Projections for 2013-2023 (http://1.usa.gov/12kcyFl). Under the projections, the cost of repealing the SGR has dropped dramatically due to lower than expected growth in Medicare physician spending. The new cost of freezing payments for ten years is $138 billion, more than $100 billion less than the previous projection.

− Options for Repeal the SGR Under Consideration. Given the reduction in the cost of repealing the SGR, policymakers and stakeholders are cautiously optimistic that Congress will be able to repeal the SGR this year. As a result, there are several serious proposals now floating around on Capitol Hill.

o The House Energy & Commerce and Ways & Means Committees'' proposal would:
• Repeal the SGR and replace it with a new fee-for-service program that would be based on the quality and efficacy of care;

• Following a few years (unknown at this time) of fixed payments, physicians will receive a base payment (likely 10-15% less than the top achievable rate). Those opting to participate in the new FFS system will be able to choose from a menu of quality improvement options and earn additional reimbursement. These quality improvement measures/options (including reporting to clinical data registries) will, by and large, be developed by the individual specialty societies. Physicians who don't want to participate will receive the base rate.
• Further down the road, an efficiency payment structure will be established, which will also reward physicians for achieving cost and efficiency targets.
• Physicians don't have to remain in this new FFS system and could also opt to participate in other Medicare-approved delivery models approved by Medicare (e.g., ACOs).

The Committees may also incorporate additional items into the reform plan, including:
• IPAB repeal
• Medical liability reform (not necessarily just MICRA-style reforms, but also protections for physicians who are participating in quality improvement programs and are following their specialty clinical practice guidelines)
• Private contracting or balance billing

The AANS and CNS are providing feedback to the Committees.
o Rep. Bill Cassidy's would establish a process allowing all physicians to participation in accountable care organizations – regardless of the size of the practice. This would not be a complete SGR replacement proposal, but rather could be included in a more comprehensive reform bill. Under his plan, physicians may opt to be reimbursed as part of an ACO structure or they can participate in a new structure that uses an Independent Risk Manager (IRM). The IRM will assist smaller groups of physicians to contract global payments with CMS. Finally, while he leaves the option of fee-for-service, reimbursement would be frozen in perpetuity, thus essentially making it a pay cut for those doctors that stay in fee-for-service. Physicians would have to comply with various quality/efficiency metrics as part of these various payment models.

o Reps. Allyson Schwartz & Joe Heck reintroduced their proposal on Feb. 6, 2013. H.R. 574, the Medicare Physician Payment Innovation Act, is virtually identical to legislation that they introduced in the 112th Congress and is available by clicking here: http://1.usa.gov/WcNVsX. The key provisions include:

• Permanently repeals the SGR formula;
• Provides annual positive payment updates for all physicians for four years;
• Ensures access to preventive care, care coordination, and primary care services through increased payment updates for those services;
• Aggressively tests and evaluates new payment and delivery models
• Identifies a variety of unique payment models to provide options for providers across medical specialties, practice types and geographic regions

• Stabilizes payment rates for providers who demonstrate a commitment to quality and efficiency within a fee-for-service model; and
• Ensures long-term stability in the Medicare physician payment system through predictable updates that accurately reflect the cost and value of providing health care services in coordinated care models.

The bill is very primary care centric, and essentially forces physicians into one of several delivery system models. Primary care physicians will receive an additional 2% over all other physicians. Physicians who remain in fee-for-service will be penalized with a 5% pay cut phased-in over time, unless those providers participate in the current PQRS, EHR, etc. Page 3 of 42 programs and those providers are in the top 25% of providers in a certain geographic area. Beginning in 2024, the annual update for all programs will be zero.
The AANS and CNS oppose this legislation.
− Medicare Private Contracting. The AANS and CNS have been working with the Coalition of State Medical and National Specialty Societies to promote legislation to allow private contracting in Medicare without penalty to either patient or physician. Under current law, physicians who wish to privately contract must opt out of Medicare for 2 years and Medicare will not pay any portion of the physician's services. After gaining some limited momentum last year, the Medicare Patient Empowerment Act is again moving forward in the 113thCongress -- S. 236 is sponsored by Sen. Lisa Murkowski (R-AK) and has 3 cosponsors, and Rep. Tom Price, MD (R-GA) introduced HR 1310. The MPEA would allow physicians and patients, on a case-by-case basis, enter into private contracts. The physician would not be forced out of Medicare and the beneficiary would be reimbursed for those services in the amount that Medicare would have otherwise paid.

The AANS and CNS have endorsed both bills. Neurosurgeons are encouraged to go to the My Medicare-My Choice website (http://bit.ly/Xv1Xno) to sign the petition supporting the MPEA.
• American College of Surgeons Value Based Update Proposal. The ACS is in the process of developing a proposal to repeal and replace the SGR with a Value Based Update. The proposal currently has many holes and the AANS and CNS have registered our skepticism and concerns about this as it is currently outlined, as it builds into the system currently flawed PQRS, e-RX, EHR, and value based payment modifier programs. Additionally, the system appears to be overly complicated and based on principles and ideas that are not tested and hence not ready for prime time. The ACS recently contracted with outside experts to further developing the VBU proposal.

2013 Medicare Physician Fee Schedule Final Rule
On Dec. 31, 2012, the AANS and CNS sent a letter to the Centers for Medicare and Medicaid Services (CMS) objecting to a nearly 10 percent reduction in the physician work relative value units (RVUs) recommended by the AMA/Specialty Society Relative Value Scale Update Committee (RUC) for new bundled cervicocerebral angiography codes (CPT 36221-36227). The new values were included in the 2013 Medicare Physician Fee Schedule. The AANS and CNS have asked for an appeal, referred to as "refinement," which will take place in August 2013.
In addition to reducing the value of these services, CMS initially indicated that the bilateral modifier (-50) may not be used to report CPT codes 36222-36228, despite the fact that the new CPT codes are clearly written for unilateral procedures. Typically, codes that are designed for a unilateral procedure are reported with a -50 modifier when done bilaterally, and the payment

amount is 150 percent of the unilateral procedure. However, because of the CMS error, Medicare would pay the same amount whether the procedure is done unilaterally or bilaterally. The AANS and CNS joined eight other societies in pointing out this error to CMS, and on Jan. 29, 2013, CMS staff notified the AANS and CNS that the error will be corrected, and the -50 modifier will in fact be permitted when these procedures are performed bilaterally. The change will be retroactive to Jan.1, 2013. A copy of the final rule is on the web at: http://1.usa.gov/SnmN4s

CPT Coding Issues

The CPT Panel met in early 2013. Patrick Jacob, MD, AANS Advisor to CPT, and Washington office staff attended. The AMA publishes a summary following each meeting which is available at: http://bit.ly/15jiazu. Ongoing CPT issues include:

• **Thrombolysis Codes**. CPT Code 37201 was a non-coronary thrombolysis code that had been used by endovascular surgeons for stroke thrombolysis. The code was eliminated through the bundling initiative for an unrelated renal angiography codes at the RUC and the neurosurgeon use of the code was inadvertently overlooked, requiring neurosurgeons to report the service as an unlisted procedure code. Henry Woo, MD, drafted a CPT Code Change Proposal to create 6 new CPT codes that

describe thrombolytic and non-thrombolytic intracranial infusions. The proposal was reviewed by two panel members at the February 2013 panel who made suggestions for further development. A conference call is planned and interested stakeholders will meet at the May 2013 panel meeting to prepare the proposal for presentation at the October 2013 panel meeting.

• **Category I Proposal for Minimally Invasive Sacroiliac Joint Fusion.** The International Society for the Advancement of Spine Surgery (ISASS) presented a Category I Code request for minimally invasive sacroiliac joint fusion at the February 2013 CPT panel meeting. At the October 2012, CPT panel meeting, the North American Spine Society (NASS) had presented a proposal for a category III (new technology tracking) code for the procedure, which is now reported with CPT Code 27280 *Arthrodesis, sacroiliac joint (including obtaining graft)* or with an unlisted code. ISASS opposed the Category III code but panel members questioned the quality of the literature for the code and did not feel it was ready for Category I.

• **CPT Summit.** The AMA hosted a meeting on Feb. 22, 2013, to discuss issues of concern with the CPT process. Joseph Cheng, MD, CNS CPT Advisor attended and made a presentation highlighting organized neurosurgery's longstanding internal processes and policies for collaborating with industry on new and revised codes. The stated goals of the meeting were twofold. First, to provide insights to stakeholders on the issues most relevant to CPT Editorial Panel meetings (which take place three times per year to update the CPT code set) and the numerous other activities beyond these meetings that also collectively help shape the CPT code set. Second, AMA would like to identify actionable improvements that will enhance the transparency, fairness and responsiveness of the CPT process. Invitees included representatives from selected medical specialty societies, industry, the AMA and the CPT Editorial Panel. Not all specialty societies were invited.

• **CPT Panel and Advisor Nominations.** The AANS and CNS nominated R. Patrick Jacob, MD to the CPT Editorial Panel. The panel has one vacancy starting in October 2013. AANS and CNS also sent a letter to reappoint Joseph Cheng, MD as CNS CPT Advisor and to reappoint Dr. Jacob as AANS advisor, if not appointed to the CPT panel. In addition, Henry Woo, MD was appointed as an alternate AANS advisor.

RUC Issues

The RUC met on Jan. 24-26, 2013. Attending for the AANS and CNS were Greg Przybylski, MD, and Alexander Mason, MD, and Washington Office Staff. Issues for neurosurgery included:

• **CPT Code 22612 Action Plan.** The RUC's Relative Assessment Workgroup (RAW) reviewed CPT code 22612 (*Arthrodesis, posterior or posterolateral technique, single level; lumbar (with lateral transverse technique, when performed))*. The code was identified for review through the CMS High Expenditure Procedural Codes screen. The AANS, CNS, NASS, and AAOS made the case that the RAW should consider that the recently created CPT code 22633, which was implemented in 2012, combines existing codes 22612 and 22630. In the first 9 months of 2012, utilization of CPT codes 22612 and 22630 has decreased significantly as the new bundled code 22633 is being appropriately used to code for combined procedures. Therefore, the groups argued that additional years of future data should be analyzed before the code is resurveyed and the RAW agreed.

• **CPT Codes 63047 and 63048**. The AANS, CNS, NASS, and AAOS presented survey data for CPT Code 63047 (*Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s], [eg, spinal or lateral recess stenosis]), single vertebral segment; lumbar*) and 63048 (*Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s], [eg, spinal or lateral recess stenosis]), single vertebral segment; each additional segment, cervical, thoracic, or lumbar (List separately in addition to code for primary procedure*), which were identified by CMS as high expenditure codes that had not been reviewed since 2006. The presenting specialty societies discussed the survey results and considered possible compelling evidence that the work of this procedure has increased due to changing patient characteristics. With the growing frequency of non-surgical spine intervention, patients are increasingly presenting for surgery having

had prior procedures and studies are beginning to show an increase in the work and length of stay for these patients. Many Medicare and private payors are beginning to require longer waiting periods before spine surgery and during this time patients often receive other intervention, making the patient who do receive surgery more difficult. Ultimately the presenting groups decided to recommend the current value, but stated that they would monitor the trend in patient characteristics and consider asking for revaluation in the future.

• **April RUC Meeting.** At the RUC meeting April 25 through 28, AANS and CNS will join the Society of Interventional Radiologists, the Society of Vascular Surgeons, and several other societies in presenting survey data for a new code for transcatheter placement of an intravascular stent, intrathoracic common carotid artery or innominate artery by retrograde treatment, via open ipsilateral cervical carotid artery exposure. The new code includes access, selective catheterization and radiological supervision and interpretation. The RUC survey was sent to the AANS/CNS Section on Cerebrovascular Surgery.

Coverage Issues

The AANS/CNS Washington Office continues to receive requests for comment on coverage policy from Medicare, private payors, state neurosurgical societies, and individual neurosurgeons. The AANS/CNS Rapid Response to Coverage (RRC) team, led by Joseph Cheng, MD, is working to improve processes to help neurosurgeons address these issues as they arise in their states and regions. Some recent activity is highlighted below:

• **Blue Cross/Blue Shield.** On Jan. 31, 2013, the AANS and CNS received a letter from Blue Cross and Blue Shield Association (BCBSA) thanking the AANS and CNS for providing expert review on coverage policies and giving an update on two policies in particular -- Stereotactic Radiosurgery/ Stereotactic Body Radiotherapy and Computed Tomography (CT) Perfusion Imaging -- for which comments had been provided. Dr. Cheng and the RRC have asked payors to provide feedback on comments submitted to assess the impact of such efforts.

• **Noridian/ISIS Interventional Pain LCD Workgroup.** The AANS and CNS are participating in a multi-specialty pain care group to advise Noridian on coverage policy for pain procedures and intervention and to create model coverage policies. Daryl Fourney, MD, is the representative from organized neurosurgery. The group held a number of conference calls and has established an active e-mail exchange to discuss issues of mutual interest, such as lumbar intralaminar and transforaminal Epidural Steroid Injections (ESIs).

• **State Coverage and Technology Assessment Activities.** The states of Washington, Oregon, and California continue to be particularly active in health coverage policy and technology assessment. The RRC is working to identify and strengthen appropriate input from neurosurgeons for these activities. Below are some highlights from activity in the state of Washington:

− Washington State Health Care Authority

o SRS/SBRT. On Dec. 6, 2012, the Washington State Healthcare Authority (HCA) posted its Stereotactic Radiosurgery (SRS) and Stereotactic Body Radiotherapy (SBRT) coverage determination from Nov. 16, 2012. Trent Tredway, MD, made a presentation on behalf of the

AANS, CNS, and the Washington State Association of Neurological Surgeons (WSANS) at the November meeting. A copy of the final wording is available at: http://1.usa.gov/YqeXJc

o Cervical Fusion for DDD. On March 22, 2013, Joseph Cheng, MD, made a presentation before the Washington State Health Care Association (HCA) Health Technology Clinical Committee (HTCC) as part of their consideration of coverage for Cervical Fusion for degenerative disc disease (DDD). Trent Tredway, MD, served as the panel's invited clinical expert. Dr. Cheng's remarks were based on a Feb. 14, 2013 comment letter submitted by AANS, CNS, and 7 other neurosurgical and orthopaedic organizations: Washington State Association of Neurological Surgeons, Washington State Orthopaedic Association, American Association of Neurological Surgeons, American Association of Orthopaedic Surgeons,

− Minimally Invasive Discectomy. On Feb. 13, 2013, the AANS and CNS sent comments regarding Wellpoint's draft policy on minimally invasive discectomy (automated percutaneous, endoscopic, or tubular) that considers the procedure investigational. The comments were coordinated by Kurt M. Eichholz, MD. The AANS and CNS raised a number of concerns about the draft policy including an inadequate definition of endoscopic discectomy, a fundamental misrepresentation of the procedure, and a flawed analysis of the literature.
− Intracranial Stenting. On Jan. 2, 2013, the AANS and CNS sent comments to Wellpoint in response to their request for review of Carotid, Vertebral and Intracranial Artery Angioplasty with or without Stent Placement. The review was led by Henry Woo, MD in consultation with the AANS/CNS Section on Cerebrovascular Surgery. Wellpoint was particularly interested in expert opinion on the use of intracranial artery stent placement with or without angioplasty for the treatment of symptomatic cerebral vasospasm following subarachnoid hemorrhage (SAH). In addition, they asked for comments on ethical issues with randomized controlled trials of intracranial artery stent placement with or without angioplasty for symptomatic cerebral vasospasm, compared to sham or other controls, to determine whether this strategy improved health outcomes for individuals with symptomatic cerebral vasospasm associated with SAH and on any contraindications to intracranial artery stent placement with or without angioplasty and long-term outcomes concerns related to intracranial artery stenting and angioplasty following SAH.
− Cranial Bands. On Feb. 7, 2013, the AANS and CNS responded to Wellpoint's request for comments on Cranial Bands. The response was coordinated by David Gruber, MD in consultation with the AANS/CNS Pediatric Section and was generally supportive of Wellpoint's policy.
− Feedback on Comments Submitted. On March 15, 2013, Wellpoint sent a letter thanking AANS and CNS for providing comments on Wellpoint coverage proposals. Procedures reviewed in 2012 by AANS and CNS at the request of Wellpoint included Annulus Closure After Discectomy, Stereotactic Radiosurgery and Stereotactic Body Radiation Therapy, Surgical and Ablative Treatments for Chronic Headaches, Computed Tomography (CT) Perfusion Imaging, Interspinous Fixation Devices, Carotid, Vertebral and Intracranial Artery Angioplasty with or without Stent Placement.

• **Medicare National Coverage**

− MEDCAC Considers PET Scans**.** On Jan. 30. 2013, the CMS Medicare Evidence Development Coverage Advisory Committee (MEDCAC) met to consider Beta Amyloid Positron Emission Tomography (PET) in Dementia and Neurodegenerative Disease. Medicare currently covers PET imagining for some indications but does not cover beta amyloid PET imaging. Jeffrey Cozzens, MD, recommended by AANS and CNS, served on the panel. Details on the meeting are, including panel voting and a webcast, are available at: http://go.cms.gov/WwW9IB

Other Medicare Issues

• **Medicare Program; Part B Inpatient Billing in Hospitals.** CMS published a proposed rule in the *Federal Register* on March 18, 2013, to revise the current policy on Part B billing following the denial of a Part A inpatient hospital claim found to be not reasonable and necessary. Under current policy, if a hospital incorrectly bills Medicare for Part A hospitalization services, rather than less-expensive Part B physician care, the wrong setting of care billing error would cause the hospital to forfeit all reimbursement for services. Hospitals claim that Medicare's recovery audit contractors (RAC), who are paid a percentage of the money they recover from hospitals, have targeted these lucrative setting-of-care decisions and that hospitals have been collectively denied

hundreds of millions of dollars by Medicare because of disputes over the differences between inpatient and outpatient care. The new ruling directs Medicare judges to allow hospitals to claim Part B inpatient costs in cases where the setting of care was initially wrong and to also separately bill Medicare for some Part B

− Place-of-Service Coding Errors
− Use of Modifiers During the Global Surgery Period
− Non-Hospital-Owned Physician Practices Using Provider-Based Status
− Payments to Providers Subject to Debt Collection

• **Physician Owned Distributorships (PODs)**. On March 26, 2013, the HHS Office of Inspector General (OIG) issued a Special Fraud Alert regarding Physician-Owned Distributorships, or PODs (http://1.usa.gov/YmT6Fy). The alert spells out a series of POD characteristics that raise major red flags. A couple of salient quotes state:

− *"We are particularly concerned about the presence of such financial incentives in the implantable medical device context because such devices typically are 'physician preference items,' meaning that both the choice of brand and the type of device may be made or strongly influenced by the physician, rather than being controlled by the hospital or ASC where the procedure is performed…We do not believe that disclosure to a patient of the physician's financial interest in a POD is sufficient to address these concerns."*

− *"OIG is concerned about the proliferation of PODs. This Special Fraud Alert reiterates our longstanding position that the opportunity for a referring physician to earn a profit, including through an investment in an entity for which he or she generates business, could constitute illegal remuneration under the anti-kickback statute. OIG views PODs as inherently suspect under the anti-kickback statute."*

The AANS and CNS are considering developing a position statement on this topic.

• **GAO Report on Medicare Program Integrity.** On Nov. 13, 2012, the General Accountability Office (GAO) released a report entitled *Medicare Program Integrity: Greater Prepayment Control Efforts Could Increase Savings and Better Ensure Proper Payment.* The GAO concluded that use of prepayment edits saved Medicare at least $1.76 billion in fiscal year 2010, but savings would have been greater had prepayment edits been more widely used. GAO illustrated this point using analysis of a limited number of national policies and local coverage determinations (LCD), which are established by each Medicare administrative contractor (MAC) to specify coverage rules in its jurisdiction. GAO identified $14.7 million in payments in fiscal year 2010 that appeared to be inconsistent with four national policies and therefore improper. GAO believes that these payments and more than $100 million in payments inconsistent with three selected LCDs could have been identified using automated edits. The report is available on the web at: http://1.usa.gov/XzSQ1A.

• **Impact of Medicare Elimination of Consultation Codes.** The Jan. 14, 2013 issue of the *Journal of Internal Medicine* included an article, which concluded that the elimination of Medicare Consultation Codes led to a net increase in spending on visits to both primary care physicians and specialists. Higher prices, partially owing to the subjectivity of codes in the physician fee schedule, explained the spending increase, rather than higher volumes. Prior to 2010, Medicare payments for consultations (commonly billed by specialists) were substantially higher than for office visits of similar complexity (commonly billed by primary care physicians). In January 2010, Medicare eliminated consultation payments from the Part B Physician Fee

Schedule and increased fees for office visits. This change was intended to be budget neutral and to decrease payments to specialists while increasing payments to primary care physicians. The authors assessed the impact of this policy on spending, volume, and complexity for outpatient office encounters in 2010 and found an increase in payments to both primary care and specialist physicians.

• **MedPAC March 2013 Report.** The Medicare Payment Advisory Commission (MedPAC) is required annually to review Medicare payment policies and make recommendations to the Congress. The principal focus of the report is the Commission's recommendations for annual rate adjustments under Medicare's various FFS payment systems, or sector "updates." The Commission bases its update recommendation for each sector on an assessment of payment adequacy, including beneficiary access to care (supply of providers, service use, access surveys); quality of care; providers' access

to capital; and provider costs and Medicare payments (where available). The Commission's recommendations for 2014 of interest to neurosurgery include:

− Inpatient and outpatient hospitals. The Congress should increase payment rates for the inpatient and outpatient prospective payment systems in 2014 by 1 percent. For inpatient services, the Congress should also require the Secretary of Health and Human Services to use the difference between the statutory update and the recommended 1 percent update to offset increases in payment rates due to documentation and coding changes and to recover past overpayments.

− Physicians and other health professionals

o The Congress should repeal the sustainable growth rate (SGR) system and replace it with a 10-year path of statutory fee-schedule updates. This path is comprised of a freeze in current payment levels for primary care and, for all other services, annual payment reductions followed by a freeze. The Commission is offering a list of options for the Congress to consider if it decides to offset the cost of repealing the SGR system within the Medicare program.

o The Congress should direct the Secretary to regularly collect data—including service volume and work time—to establish more accurate work and practice expense values. To help assess whether Medicare's fees are adequate for efficient care delivery, the data should be collected from a cohort of efficient practices rather than a sample of all practices. The initial round of data collection should be completed within three years.

o The Congress should direct the Secretary to identify overpriced fee-schedule services and reduce their relative value units (RVUs) accordingly. To fulfill this requirement, the Secretary could use the data collected under the process in recommendation 2 (above). These reductions should be budget neutral within the fee schedule. Starting in 2015, the Congress should specify that the RVU reductions achieve an annual numeric goal—for each of five consecutive years—of at least 1.0 percent of fee-schedule spending.

o Under the 10-year update path specified in recommendation 1 (above), the Congress should direct the Secretary to increase the shared savings opportunity for physicians and health professionals who join or lead two-sided risk accountable care organizations (ACOs). The Secretary should compute spending benchmarks for these ACOs using 2011 fee-schedule rates.

− Ambulatory surgical centers

o The Congress should eliminate the update to the payment rates for ambulatory surgical centers for calendar year 2014. The Congress should also require ambulatory surgical centers to submit cost data.

o The Congress should direct the Secretary to implement a value-based purchasing program for ambulatory surgical center services no later than 2016. (First recommended in March 2012).

As the House and Senate seek to implement their budget reconciliation plans, the recommendations made by MedPAC in its annual report to Congress, if implemented, are said to possibly reduce Medicare spending by $30 billion over five years. The MedPAC Chairman has also testified that the SGR physician payment formula be replaced to help ensure that Medicare costs are constrained and that quality is improved. He said that the cost of a doc fix could be partially offset through reforms to SNF and home health payments.
A copy of the March 2013 MedPAC report is available at: http://1.usa.gov/YdP6qPPage 11 of 42

Quality Improvement
Update

Administrative Issues

Pursuant to the discussions at the March 1, 2013 Washington Committee meeting, the AANS and CNS leadership have approved the establishment of a new Washington Committee task force, which will be charged with developing a proposed strategic plan/roadmap for organized neurosurgery's quality improvement activities, including the structure and membership of the Quality Improvement Workgroup. The goal is for organized neurosurgery to develop a comprehensive plan so we can ensure that all aspects of our specialty are in sync as we move forward. Finding synergies among all these disparate programs is essential to minimize the burden on our members and maximize the benefits that can be derived by all stakeholders.
The task force will be named the National Quality Initiatives in Neurosurgery (NQIN), and it will be chaired by Tony Asher, MD and Dan Resnick, MD. The tentative timeline for operations is as follows:

• April2013: Initial status report (to be presented at AANS Board, CNS Executive Committee and Neurosurgery Summit meetings
• July 2013: Draft Report (to be presented at Washington Committee Meeting
• Fall 2013: Interim Final Report (to be presented at CNS Executive Committee, Neurosurgery Summit and AANS Board meetings)
• December 2013: Final Report (to be presented at Washington Committee Meeting) We will reevaluate the status of the task force later this year, and if it is deemed worthwhile, the group will continue to operate as necessary.

The members of the task force would represent a wide swath of organized neurosurgery, with many of its members wearing multiple hats so as to maximize representation, while at the same time keep the group to a manageable and functioning size. All the major players involved with quality improvement in neurosurgery would be represented, including the:

• American Association of Neurological Surgeons (AANS)
• American Board of Neurological Surgery (ABNS)
• AANS/CNS Coding and Reimbursement Committee
• Congress of Neurological Surgeons (CNS)
• Council of State Neurosurgical Societies (CSNS)
• AANS/CNS Joint Guidelines Committee (JGC)
• National Neurosurgery Quality Outcomes Database (N2QOD)
• NeuroPoint Alliance (NPA)
• Neurosurgery Residency Review Committee (RRC)
• AANS/CNS Quality Improvement Workgroup (QIW)
• Society of Neurological Surgeons (SNS)

Medicare Physician Quality Improvement System (PQRS)

• **Bonus/Penalties 2013-15.** Under the PQRS program, physicians who successfully participate are entitled to 0.5% bonus payment in 2012; however under the Patient Protection and Affordable Care Act (ACA), the bonus payment is phased out and beginning in 2016, physicians who do not

participate will receive 2% payment cuts. Physicians who participate in qualified PQRS-MOC programs are eligible for an additional 0.5% bonus payment through 2014. To address the impending penalties, the AANS and CNS recently signed onto an AMA-led coalition letter asking CMS to reevaluate the penalty timelines and extensively commented on the issue in response to the 2013 Proposed Physician Fee Schedule Rule. We also recommended in our comments that CMS recognize physician participation in quality improvement activities, like reporting through a specialty clinical data registry, outside of PQRS as a way to qualify for the PQRS.

• **Applicable Measures.** CMS will maintain the measures that were applicable to neurosurgical practices, including perioperative measures, measures related to stroke and cancer care, and measure groups related to low back pain and ischemic vascular disease and several additional measures for 2013, including some epilepsy/seizure measures. In order to assist physicians with avoiding the payment cuts in 2015, CMS is allowing physicians to report one PQRS measure or measure group during the payment adjustment period. For 2015, the payment adjustment period is Jan. 1-Dec. 31, 2013. An additional option to avoid the penalty allows physicians to elect to use the administrative claims-based reporting for a set of administrative claims-based measures, but physicians must select and designate this option to CMS.

• **Registry Participation**. Based on discussions with CMS for neurosurgeons to receive credit for participating in N2QOD (see section: NeuroPoint Alliance for more information), we submitted a proposal for two measures groups: low back pain and universal neurosurgery care. After further review, it was determined resources would not be well spent developing the measures. N2QOD is in the process of becoming a PQRS approved registry and has met the first requirement of three. N2QOD will have the capability of reporting the perioperative care measure group.

The recently passed American Taxpayer Relief Act includes language to allow physicians to satisfy PQRS by participating in a qualified clinical data registry. To meet the mandate, CMS in February released a Request for Proposal (RFI) to solicit information on ways in which physicians might use clinical quality measures data reported to specialty boards, specialty societies, regional health care quality organizations or other non-federal reporting programs to also report under the Physician Quality Reporting System (PQRS), as well as the Electronic Health Record (EHR) Incentive Program. The RFI also seeks input on ways by which the entities already collecting clinical data for other reporting programs can also submit this data on behalf of physicians and group practices for reporting under the PQRS and the EHR Incentive Program. Finally, CMS is requesting information regarding the above mentioned section of the American Taxpayer Relief Act. The agency is explicitly seeking information from medical specialty societies, boards, and registries, other third party registry vendors, and physicians using registries to report quality measures. We can likely anticipate a formal proposal for all of this to be included in the 2014 Medicare Physician Fee Schedule Proposed Rule, which will be issued in late spring/early summer. As a side note, at the December Washington Committee meeting, CMS had informed us the agency was also considering ways to streamline the various programs (i.e., PQRS, electronic medical records/meaningful use, Value-Based Payment Modifier, Maintenance of Certification, etc.) and allow physicians participating in meaningful quality improvement

activities to satisfy these various programs; thus reducing the regulatory burden and redundancy of current participation.

Public Reporting: Physician Compare

The ACA required CMS to establish a Physician Compare website by January 1, 2011. This website is intended to provide patients with basic data about physicians, including information about their participation status in the PQRS, e-prescribing and EHR incentive programs. The site is a disaster and not functioning well at all and the AANS, CNS and others have written to CMS complaining about the problems and once again voiced our concerns within neurosurgery's 2013 Proposed Physician Fee Schedule comments. Under the ACA, CMS is required to implement a plan by 2013 for making physician *performance* data (including quality, efficiency, and patient experience data) available to the public, so the fact that the site cannot even function with basic information is cause for additional alarm. CMS has acknowledged the issues with the website and it is currently undergoing extensive revisions. Page 13 of 42

Washington staff has been extensively involved in the website revisions by providing feedback and meeting with CMS' contractor.

CMS recently announced that starting in 2013 it will publicly post performance data for a defined set of measures that apply to group practices participating in the PQRS Group Practice Reporting Option (GPRO) and ACOs participating in the Shared Savings Program. Over the next five years, CMS will expand public reporting to include patient experience data and actions taken to avoid preventable hospitalizations by group practices and ACOs, PQRS performance data for individual physicians, and information on physicians who qualified for the PQRS Maintenance of Certification incentive. Neurosurgery is against the expansion and believes that until CMS can work out the kinks with the website and provide an action plan that accurately assesses care, physician performance data should not be publicly reported.

Availability of Medicare Data for Performance Measurement

The ACA also authorizes CMS to make Medicare data available to "qualified entities" for the evaluation of the performance of providers by Jan. 1, 2012. CMS did not make many of our requested changes. However, the rule does make the change to allow for using claims data in addition to registry data and to partner with additional entities to meet the requirements. Additionally, on June 5, 2012, CMS formally launched a new office dedicated to the management, use and dissemination of health data. The new Office of Information Products and Data Analytics (OIPDA) will oversee CMS' portfolio of information and help make the development, use and dissemination of data a core function of the agency.

Physician Resource Use Reports and Value-Based Modifier

Under the ACA, Congress directed CMS to refine and expand its current efforts to provide confidential feedback reports comparing the cost and quality of care across physicians, known as the Physician Resource Use Feedback Program. The budget neutral Value-Based Payment Modifier (VBPM) will apply to payments of group of physicians of 100 or more starting in 2015 and to all physicians by 2017. Originally, CMS proposed the VBPM would apply to groups of physicians of 25 or more in 2015, but due to extensive advocacy they expanded the definition. Physician groups subject to the modifier can avoid all negative adjustments simply by participating in PQRS. In this case, physicians will receive neither a value-bonus nor pay cut under this new program. Physicians can, however, elect to be paid according to the measured cost and quality of services provided in 2013 and 2014. Any payment adjustment will be applied to 2015 and 2016 Medicare payments, respectively.

• **Setting the value-based bonuses and penalties.** CMS has proposed a differential payment modifier to adjust Medicare physician pay in 2015. The agency would generate a report comparing an eligible doctor's quality of care and Medicare's costs for that care in the 2013 performance period to that of his or her peers. Large practices that successfully participate in the Medicare physician quality reporting system either can accept a 0% pay adjustment or vie for higher adjustments by accepting risk under a tiered modifier structure. Physicians assigned to a high-quality, low-cost category could receive bonuses of up to 2% in 2015, while the pay of doctors giving the costliest care at the lowest quality would be cut by up to 1%. Large practices that fail to meet PQRS requirements automatically would receive the full 1% cut.

Assessment	**Low cost**	**Average cost**	**High cost**
High quality	2.0%*	1.0%*	0.0%
Average	1.0%*	0.0%	-0.5%

quality			
Low quality	0.0%	-0.5%	-1.0%

Item 11b

TO
AANS CNS
Dr. JOSEPH CHENG

The 13th Congress of Spine Surgery was carried thanks to a group of individuals and organizations that strove for the success of this meeting.

I would like to particularly thank to AANS/CNS by the support over the years.

We are sure that this conference always drives us towards a greater value - our commitment to Research, Development and the Practice of Spine Surgery throughout the world.

Thank you very much.

Ricardo Vieira Botelho
Chairman
Congress of Spinal Surgery – São Paulo – Brazil

AANS/CNS Section on Disorders of the Spine
Statement of Financial Position
As of March 31, 2013

	Current Year 03/31/13	Prior Year 03/31/12
ASSETS		
Checking & Short Term Investments	$608,177	$607,692
Accounts Receivable, net of Allowance for Uncollectible Accounts	367,189	2,475
Long-Term Investment Pool, at Market	2,693,180	2,501,600
TOTAL ASSETS	$3,668,545	$3,111,767
LIABILITIES AND NET ASSETS		
Liabilities		
Accounts Payable and Current Liabilities	$30,000	$80,000
Deferred Contribution Revenue		15,000
Deferred Dues	75,450	37,968
Total Liabilities	**$105,450**	**$132,968**
Net Assets		
Unrestricted	$3,087,544	$2,985,837
Unrestricted - Fellowships	$52,000	$52,000
Net Revenue (Expense)	423,552	(59,039)
Total Net Assets	**$3,563,095**	**$2,978,799**
TOTAL LIABILITIES AND NET ASSETS	$3,668,545	$3,111,767

AANS/CNS Section on Disorders of the Spine
Statement of Activities
For the Nine Months Ending March 31, 2013

	FY '11 Final	FY '12 Final	YTD FY '13	FY '13 Budget
REVENUES				
Membership Dues	$52,903	$48,290	$48,881	$48,800
Mailing List Sales	885	690	345	0
Fellowship/Award Sponsorship	205,000	71,895	100,000	168,000
Miscellaneous Revenue	104	0	0	0
Contributions for Operating Expenses	8,439	6,189	6,545	7,187
Annual Meeting Revenue	959,225	951,576	934,155	1,016,055
TOTAL REVENUES & SUPPORT	$1,226,556	$1,078,640	$1,089,926	$1,240,042
EXPENSES				
Audio Visual	$1,724	$1,197	$6,964	$2,000
Bank Fee	604	498	753	498
Contributions & Affiliations	75,000	191,500	0	140,000
Decorating	540	385	0	550
Food & Beverage	5,914	7,023	2,467	6,500
Gifts & Gratuities	0	164	439	0
Honoraria & Awards	186,273	152,787	155,000	226,050
Office & other Supplies	335	387	115	350
Photocopy	2	3	0	25
Postage & Distribution	1,073	1,163	554	1,500
Printing/Typesetting	7	0	0	0
Newsletter Professional Fees	0	0	900	0
Speaker Expenses	0	1,457	0	0
Staff Travel	0	0	740	250
Telephone	143	1,193	143	2,200
Volunteer Travel	19,966	0	2,254	6,500
Website	908	0	1,930	12,500
Staff Coordination	8,439	6,189	7,056	7,187
Miscellaneous	7,500	0	0	0
Guidelines Development	4,420	27,303	9,073	50,000
Annual Meeting Expense	676,514	671,561	675,017	664,927
TOTAL EXPENSES	$989,362	$1,062,810	$863,405	$1,121,037
Investment Earnings	175,898	85,875	196,131	115,096
NET REVENUE	$413,092	$101,705	$422,652	$234,101

AANS/CNS Section on Disorders of the Spine
Annual Meeting
For the Nine Months Ending March 31, 2013

	FY '11 Final	FY '12 Final	YTD FY '13	FY '13 Budget
Revenues				
Registration Fees	254,570	270,351	269,430	294,155
Exhibitor Fees	360,155	331,125	662,500	720,400
Exhibitor Sponsorship Revenue	342,500	347,500	0	0
Special Event Revenues	2,000	2,600	2,225	1,500
Total Revenues	959,225	951,576	934,155	1,016,055
Expenses				
Scientific Program	251,810	234,240	288,636	277,722
Abstract Management	0	0	12,145	20,560
Program Book	0	0	26,846	24,762
Opening Reception	0	0	99,390	95,079
Social Events/General	156,184	154,396	0	0
Committee Dinners/Events	0	0	59,015	54,506
Exhibit Program	48,660	49,600	36,800	86,437
Advanced Registration	0	52,149	50,382	63,912
On-Site Registration	54,587	0	0	0
Annual Meeting Promotion	52,464	60,624	13,128	20,200
On-Site Coordination	12,809	18,024	9,067	17,537
Annual Meeting Planning Cmte	0	2,528	4,608	4,212
Staff Coordination	100,000	100,000	75,000	0
Total Expenses	676,514	671,561	675,017	664,927
Net Excess (Loss)	282,711	280,015	259,138	351,128

Congress of Neurological Surgeons

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

Overview Analysis 2007-Current

CNS Meeting Management

CNS provides meeting management services to the Spine Section including:

- Logistics
- Registration and Housing Services
- Budgeting and General Meeting accounting
- Marketing
- Service to our corporate partners
- Faculty and scientific program management
- Abstract management for scientific program and for journal
- ACCME accreditation service
- Future sites research and contracting

CNS Meeting Management

CNS does NOT currently service:

- Committee Coordination
- Governance oversight
- Spine Section website
- Fellowship funding or grant follow-up
- General Financial services
- Membership recruitment, retention or service

Any of these services could be provided if the spine section is interested.

Attendance History

	2007 Phoenix	2008 Orlando	2009 Phoenix	2010 Orlando	2011 Phoenix	2012 Orlando	As of 2/26/13 Phoenix
Subtotal Medical	392	460	470	451	435	449	453
Subtotal Other (sp/gst)	134	171	119	105	73	121	70
Subtotal Exhibitors	478	471	508	512	492	411	365
Grand Total	1004	1102	1097	1068	1000	1011	888

International Attendance

Year	Location	Int'l Medical	Total Medical	Partner Society Attendance
2013	Phoenix	53*	453*	Ireland = 11
2012	Orlando	84	449	Brazil = 25
2011	Phoenix	92	435	Turkey = 35
2010	Orlando	83	451	Taiwan = 15

***as of 3/4/13**

Annual Meeting Fiscal History

	Revenue	Expenses	Subtotal Net	Management Fees	Final Net
2007	$915,425	$495,835	$419,590	$80,000	$339,590
2008	$961,534	$538,406	$423,128	$80,000	$343,128
2009	$1,043,635	$546,647	$496,988	$80,000	$416,988
2010	$1,037,804	$558,582	$479,222	$100,000	$379,222
2011	$959,225	$574,039	$385,186	$100,000	$285,186
2012	$951,575	$570,445	$381,130	$100,000	$281,130

Corporate & Exhibits Summary

	Companies	Exhibit Revenue	Corporate Support Revenue
2007	64	$407,800	$274,500
2008	65	$382,200	$302,000
2009	70	$427,225	$337,500
2010	63	$372,240	$389,159
2011	59	$360,155	$342,500
2012	60	$329,700	$347,500
2013	58	$301,000	$362,500

Exhibits History Detail

	Square Feet	New Exhibitors	Total Companies	Islands	Total Revenue
2013	8,400	12	58	3	$301,000
2012	9,000	15	60	4	$329,700
2011	9,800	14	59	6	$365,200
2010	10,100	14	63	6	$371,100
2009	11,900	23	72	6	$427,225
2008	10,200	17	64	7	$382,200
2007	12,500	*	64	8	$407,800

* New exhibitor data not recorded in 2007

Exhibits History Detail

Retention Rate	2008 Exhibitors	2009 Exhibitors	2010 Exhibitors	2011 Exhibitors	2012 Exhibitors
1 Year	66.2%	62.9%	65.1%	67.8%	70.0%
2 Year	50.8%	48.6%	52.4%	64.4%	NA
3 Year	43.1%	44.3%	50.8%	NA	NA
4 Year	38.5%	40.0%	NA	NA	NA
5 Year	30.2%	NA	NA	NA	NA

Note: One-year, two-year and three-year retention rates are increasing. This positive trend may indicate that efforts over recent years may be helping improve exhibitor satisfaction.

Corporate Support/ Advertising History Detail

	Companies	Corporate Support Revenue
2007	12	$274,500
2008	15	$302,000
2009	13	$337,500
2010	7	$389,159
2011	11	$342,500
2012	13	$347,500
2013	12	$357,500

CME Hours

	General CME	Elective CME	Max CME to be Claimed
2007	17.25	12	29.25
2008	18.75	10	26.75
2009	18.5	10	26.5
2010	18.25	10	26.25
2011	19	10	27
2012	18.75	8	26.75
2013	16.5	9.0	25.5

In 2008-2012 a maximum of 8 Elective CME could be claimed based on session overlap.

Sessions

	Special Courses	Lunch Symposia	Committee Meetings	Total (Not including GSS/Exhibit Hall)
2007	9	0	2	11
2008	9	6	2	17
2009	8	3	4	15
2010	9	5	8	22
2011	9	5	8	22
2012	10	5	7	22
2013	9	5	8	22

COMMITTEE MEETINGS:
DSPN Scientific Program Committee
DSPN EC Meeting
Corporate Demo
Corporate Summit
SANS MOC Author's Meeting
DSPN Guidelines Committee Meeting
DSPN Officers Meeting
Journal of Neurosurgery: Spine Editorial Board meeting

2012 Annual Meeting Evaluation Findings

- 57% of Attendees state the primary reasons for attending the meeting is for the Scientific Sessions.
- 42.1% of Attendees state their ROI for attending the meeting is Excellent.
- 89.5% of Attendees state they visited the exhibit hall and the majority said they spent an hour in the hall each day.
- Educational Content is an extremely important criteria for attending the meeting, whereas Entertainment Appeal, Distance from Home, Length of Meeting, Fees and Sleeping Room Rates are Somewhat Important.

2012 Annual Meeting Evaluation Findings cont.

- 92% feel that a 2-3 day meeting is the ideal duration for this section meeting.
- The following are Extremely Unimportant when deciding to attend the meeting: Golf, Spa, Disney Access and Family Friendly Activities.
- 66% feel that Easy Flight Access is Extremely Important when deciding to attend.
- Over 40% of attendees surveyed feel that this section meeting is more valuable than the CNS and the AANS larger meetings.
- Orlando Medical Attendees count has been fairly consistent whereas Phoenix fluctuates by 35-70 attendees

Summary of Data

- Since 2010, Exhibit Revenue has been declining
  - Overall Reduction in Island Space
    - Globus & NuVasive reduced from island to inline in 2011
    - Depuy/Synthes merger (Loss of 1 booth)
    - Medtronic (20x30 usually in Phoenix – this year only 20x20)
    - Alphatec Spine declined in 2013 (20x20 in 2012)
  - Low retention rate – Only 30% over 5 years.
    - Year over year retention has shown slight increases annually since 2010
  - Exhibitor evaluations site lack of ROI, lack of traffic and attendee interest/interaction.

Summary of Data

- Function space has been increased
  - Added Society Meetings beginning in 2011
  - 2013 Divided Platform and Poster Presentations more prominently (using more meeting space)
  - Beginning in 2010, Committee meetings have grown, from 4-10 (actual count varies per year)

- Social Event expenses have grown significantly, partially due to:
  - Past Chairs' Dinner attendance increased by 76%
  - Young Neurosurgeons Dinner attendance fluctuates by 50% for some years
  - Chairman's Dinner expenses and attendance has increased by over 15% consistently.

Future Sites Summary

Year	AANS/CNS Section on DSPN	AANS	AAOS
2013	**March 6-9** Phoenix JW Marriott	April 27-May 2 New Orleans	March 19-23 Chicago
2014	**March 5-8** Orlando Disney Swan/Dolphin	April 5-9 San Francisco	March 12 – 15 New Orleans
2015	**March 4-7** Phoenix JW Marriott	May 2-9 Washington DC	March 24-28 Las Vegas

Future Sites Summary

2014: Orlando, Florida
Walt Disney World Swan & Dolphin
March 5-8, 2014

Cancellation Risk: Cancellation a year prior to the meeting requires responsibility for 100% of the contracted sleeping rooms at profit rate only of 80%. (1700 sleeping room nights x $215.20 = $365,840)

Reduction Risk: Prior to March 30 we can reduce the room block by 15% without penalty. Recommend proceeding as we've already seen a reduction in exhibitor registration. Came close this year at the JW with not meeting our room block requirements.

2014 Attrition Policy: Must utilize 1275 of the contracted 1700 nights. (75%)

Food and Beverage Minimum: $205,000 (10% slippage allowable) = $184,500

Future Sites Summary

2015: Phoenix, Arizona
JW Marriott Desert Ridge
March 4-7, 2015

Cancellation Risk: Cancel by September 3, 2013, we would owe **$102,432.**
Cancel between Sept. 4, 2013 and March 3, 2014, we would owe $204,864.
Cancel between March 4, 2014 and arrival, we would owe $409,728.

Reduction Risk: One year out we can reduce without penalty. One year out we can adjust function space needs. May require negotiation. Suggest any adjustments for 2015 be handled within 30days of the 2013 meeting to optimize negotiation power.

2014 Attrition Policy: Must utilize 1232 of the contracted 1760 room nights (70%) or attrition damages would apply. If not met, damages are figured on profit at 75% of sleeping room rate.

Food and Beverage Minimum: Based on a schedule provided within agreement, estimated at $163,611 with allowable slippage of 20% and based on profit at a total liability of **$98,166.**

For your consideration

- Releasing exhibit hall function space does not eliminate expense in existing agreements.
- Function space is complimentary based on utilizing contracted sleeping rooms & reaching F&B minimums.
- F&B spend ranges from $175k - $245k.
- 50% of the contracted sleeping room nights are currently utilized by exhibitor representatives.
- Finalizing your future site needs is important.

  Availability should be reserved at minimum five years out. Your choices will be limited for 2016/2017.

For your consideration

Recommendations:

- 2014: Reduce hotel room nights as allowable within agreement to minimize possibility of attrition damages. Exhibit floor and associated representatives have decreased in recent years.
- 2015: Negotiate with JW Marriott based on future plans for Spine Section Meeting. Reduce function space (if desired), Reduce room block (if desired), may reduce food and beverage minimum.
- 2016 and beyond: Send RFP's (non-Disney properties for maximum flexibility) to venues based on desired new meeting format and space needs within the next 30 days to establish a measurement of proposals for current meeting format vs. new meeting format.
- In New Orleans at the next Spine Section EC Meeting, review variables between the two meeting formats.
- Proceed to secure 2016 and beyond based on this review and associated decision.

For your consideration

- If the exhibit hall is eliminated:
  - It eliminates only approximately $19,000 in expenses.
  - How will the remaining $300,000 in revenue be secured to support the rest of the meeting expenses?
  - Is there a chance that corporate will come up with an additional $300,000 in support annually on top of the $350,000 already being provided in corporate support?

Congress of Neurological Surgeons

Thank You!

Congress of Neurological Surgeons

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

Future Sites 2016 - 2019

Future Sites Summary

Year	AANS/CNS Section on DSPN	AANS	AAOS
2014	**March 5-8** Orlando Disney Swan/Dolphin	April 5-9 San Francisco	March 12 – 15 New Orleans
2015	**March 4-7** Phoenix JW Marriott	May 2-9 Washington DC	March 24-28 Las Vegas

Meeting Site Options 2016 &2018
Orlando

- Loews Royal Pacific Resort at Universal Studios
- Renaissance Orlando at Sea World
- Gaylords Palms Resort
- Rosen Shingle Creek
- Hilton Orlando
- Peabody Orlando
- Disney Swan/Dolphin
- Disney Contemporary Resort
- Westin Diplomat (Ft Lauderdale)

Unavailable/Inadequate Space

2016 &2018

- JW Marriott Orlando
- Omni Resort
- Westin Orlando
- Ritz Carlton Orlando
- Hyatt Regency Grand Cypress
- Disney Yacht & Beach Club
- Portofino

Peabody Orlando

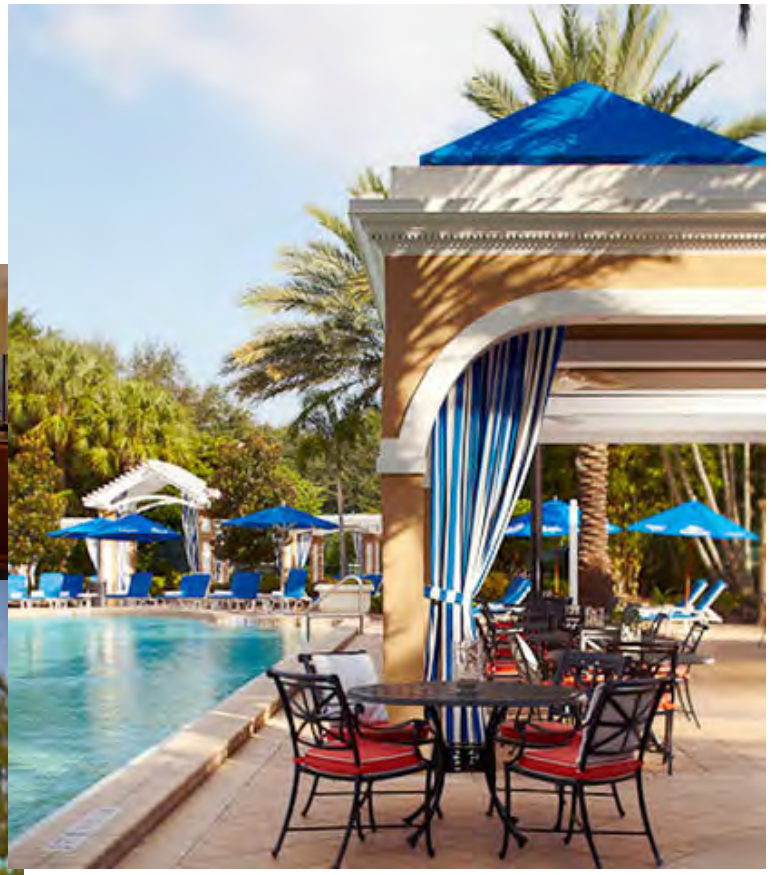
Dates Available:
March 9-12, 2016
Not available in March of 2017

Room Rate:
$259/night

Renaissance Orlando at Sea World

Dates Available:
March 9-12, 2016
March 7-10, 2018
March 14-17, 2018

Room Rate:
2016: $219/night
2018: $229/night



Rosen Shingle Creek

Dates Available:
March 9-12, 2016
March 14-17, 2018

Room Rate:
2016: $239/night
2018: $239/night

Disney Swan and Dolphin Resort

Dates Available:
March 9-12, 2016
March 14-17, 2018

Room Rate:
2016: $276/night
2018: $286/night

Gaylord Palms Resort

Dates Available:
March 29- April 2, 2016
March 12-19, 2018
March 19-26, 2018

Room Rate:
2016: $229/night
2018: $254/night

Disney's Contemporary Resort

Dates Available:
March 2-5, 2016
March 7-10, 2018

Room Rate:
2016: $240/night
2018: $255/night

Loews Royal Pacific Resort at universal Studios

Dates Available:
March 5-11, 2016
March 3-9, 2018

Room Rate:
2016: $230/night
2018: $230/night

Westin Diplomat

Dates Available:
March 9-12, 2016

Room Rate:
2016: $309/night

Meeting Site Options 2017 &2019
Las Vegas

- Paris Las Vegas (not available in 2017)
- Planet Hollywood
- Rio All Suites Hotel & Casino
- Bally's Resort

Unavailable

2017 &2019

- Caesar's Palace
- Mandalay Bay
- Renaissance Las Vegas
- Venetian
- Encore
- Riviera
- MGM
- Aria
- Bellagio
- Cosmopolitan

Inadequate Space

2017 &2019

- Four Seasons Las Vegas
- Trump International
- Signature
- Palms
- Westin
- JW Marriott
- Green Valley Ranch
- M Resort

Paris, Las Vegas

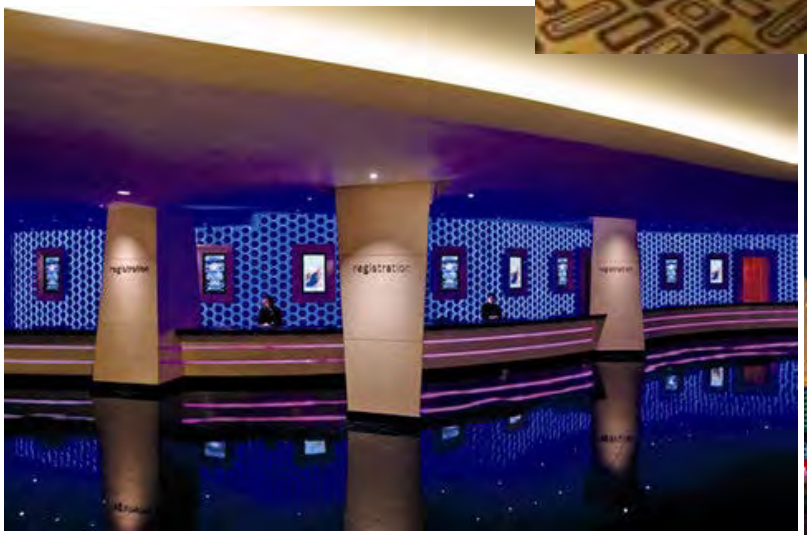
Dates Available:
March 11-17, 2019
Not available in March of 2017

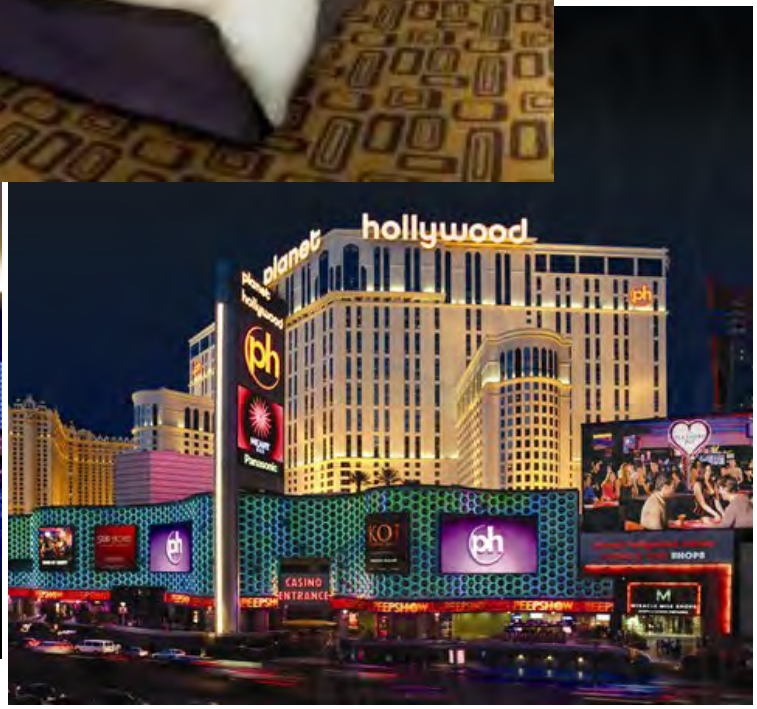
Room Rate:
$189/night

Planet Hollywood Las Vegas

Dates Available:
March 6-12, 2017
March 4-10, 2019
March 11-17, 2019

Room Rate:
2017: $189/night
2019: $179/night

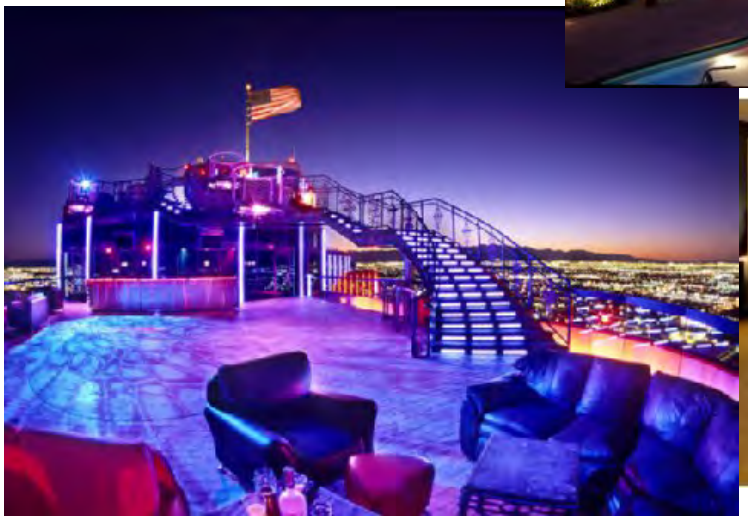




Rio, Las Vegas

Dates Available:
March 6-12, 2017
March 4-10, 2019
March 11-17, 2019

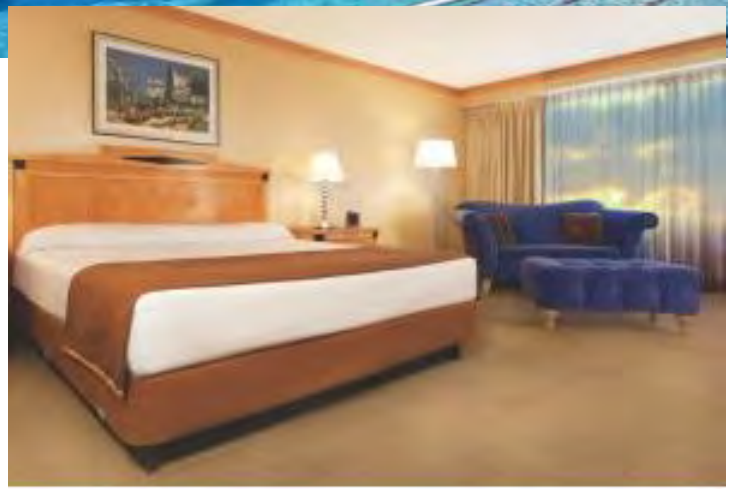
Room Rate:
2017: $159/night
2019: $169/night



Bally's, Las Vegas

Dates Available:
March 6-12, 2017
March 4-10, 2019
March 11-17, 2019

Room Rate:
2017: $189/night
2019: $179/night



Phoenix

Marriott Desert Ridge

- Renegotiate rooms rates if booked for 2017 & 2019
- 2015: $349
- 2017: $359
- 2019: $369

Attendance History

	2007 Phoenix	2008 Orlando	2009 Phoenix	2010 Orlando	2011 Phoenix	2012 Orlando	As of 2/26/13 Phoenix
Subtotal Medical	392	460	470	451	435	449	453
Subtotal Other	134	171	119	105	73	121	70
Subtotal Exhibitors	478	471	508	512	492	411	365
Grand Total	1004	1102	1097	1068	1000	1011	888

Annual Meeting Fiscal History

	Revenue	Expenses	Net
2007	$915,425	$495,835	$419,590
2008	$961,534	$538,406	$423,128
2009	$1,043,635	$546,647	$496,988
2010	$1,037,804	$558,582	$479,222
2011	$959,225	$574,039	$385,186
2012	$951,575	$570,445	$381,130

Corporate & Exhibits Summary

	Companies	Exhibit Revenue	Corporate Support Revenue
2007	64	$407,800	$274,500
2008	65	$382,200	$302,000
2009	70	$427,225	$337,500
2010	63	$372,240	$389,159
2011	60	$360,155	$342,500
2012	63	$331,125	$347,500
2013	58	$301,000	$357,500

2012 Annual Meeting: Evaluation Findings

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- Educational Content is Extremely Important
- 66% feel that easy flight access is Extremely Important when deciding to attend.
- Entertainment Appeal, Distance from Home, length of meeting, fees, Room Rates: Somewhat Important.
- Golf, spa, Disney access, family friendly activities are Extremely Unimportant .

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Recommendations

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  - Will vendors come up with an additional $300,000 in support annually on top of the $350,000 they already provide?

Washington Update
April 2013

Healthcare Reform Update

Congressional Activities

AANS and CNS continue to lead efforts to "reform the reform". Given the fact that President Obama was reelected and the Senate remains in control of the Democrats, House Republican leaders have signaled that they are basically abandoning their efforts to repeal the entire health reform law. Rather, republicans will now pursue a 3-pronged approach:

- Focus on piecemeal repeal where it might be possible to pick up a few Democratic votes (IPAB and medical device excise tax high on this priority list);
- Conduct oversight and investigative hearings into the implementation of the law; and
- Be ready to act with a replacement when the law collapses of its own weight.

Neurosurgery's priority issues remain:

- **Repeal/Modification**
  - – Independent Payment Advisory Board (IPAB)
  - – PQRS penalties
  - – Value-based purchasing modifier
  - – Public reporting of physician performance data
  - – Repeal of the medical device tax

- **Implementation**
  - – Funding for pediatric specialist loan forgiveness
  - – Funding for emergency care regionalization projects
  - – Funding for trauma-EMS program

- **Additional Legislation**
  - – SGR reform
  - – Medicare private contracting
  - – Medical liability reform
  - – Eliminating GME funding caps (and preserving current GME Medicare funding)

- **IPAB Repeal Legislation Reintroduced**. Repealing the IPAB is one of organized neurosurgery's top legislative priorities. To this end, the AANS and CNS, along with the American Society of Anesthesiologists, are leading a physician coalition dedicated to repealing the IPAB. The coalition, representing more than 450,000 physicians across 26 specialty physician groups. On Jan. 23, 2013, Reps. Phil Roe, MD (R-TN) and Allyson Schwartz (D-PA) introduced H.R. 351, the Protecting Seniors' Access to Medicare Act of 2013, which would repeal the Independent Payment Advisory Board (IPAB). The IPAB was created by the Patient Protection and Affordable Care Act and is a government board whose primary purpose is to cut Medicare spending. The bill currently has 146 bipartisan cosponsors. On Feb. 14, 2013, Sen. John Cornyn (R-TX) introduced the companion bill, which has the same name and bill number (S. 351). The senate bill has 31 cosponsors. In early January, the House of Representatives adopted rules for the 113th Congress that included a provision limiting IPAB's authority.

Regulatory Activities

The Obama Administration continues to issue implementing regulations, including those related to Medicaid expansion, health insurance exchanges, insurance market and rate rules, and others. To date the following states have made decisions regarding health insurance exchanges:

- **State --** The state plans to run its own exchange: CA, CO, CT, DC, HI, ID, KY, MD, MA, MN, MS NV, NM, NY, OR, RI, VT, WA

- **Federal --** The state will not set up an exchange, and the federal government will run a fallback exchange instead: AL, AK, AZ, FL, GA, IN, KS, LA, ME, MO, MT, NE, NH, NJ, ND, OH, OK, PA, SC, SD, TN, TX, VA, WI, WY

- **Partnership --** The state will run some functions of the exchange but will leave certain ones to the federal government: AR, DE, IL, IA, MI, NC, UT, WV

In terms of expanding Medicaid coverage, AL, GA, ID, IN, IA, KS, LA, ME, MS, NC, OK, SC, SD, TX, UT, WI, and WY will not be expanding Medicaid coverage to those individuals making under 133% of federal poverty level. AK, AZ, AR, KY, MO, MT, NE, NH, ND, OH, PA, TN, VA, and WV have not yet decided. All others have announced plans to expand Medicaid coverage.

The following outlines key elements of the law that have been implemented (or authorized to be implemented, though some have not been put into effect yet – e.g., IPAB) so far and those scheduled to come on-line in 2013:

2010

- Review of health plan premium increases
- Creation of Medicaid and CHIP Payment Advisory Commission
- Establishment of Comparative Effectiveness Research Institute
- Establishment of Prevention and Public Health Fund
- Medicare Beneficiary Drug Rebate
- Small Business Tax Credits to expand insurance coverage
- Adult Dependent Coverage to Age 26
- Consumer Protections in Insurance
- Insurance Plan Appeals Process
- Coverage of Preventive Benefits
- Health Care Workforce Commission

2011

- Minimum Medical Loss Ratio for Insurers
- Closing the Medicare Drug Coverage Gap
- Increasing Medicare Payments for Primary Care and Rural General Surgeons
- Establishing Center for Medicare and Medicaid Innovation
- Implementing a National Quality Strategy
- Medical Malpractice Grants
- Funding Health Insurance Exchanges
- Reduced Medicaid Payments for Hospital-Acquired Infections
- Establishment of Medicare Independent Payment Advisory Board

2012

- Accountable Care Organizations in Medicare
- Uniform Coverage Summaries for Consumers
- Fraud and Abuse Prevention
- Medicare Value-Based Purchasing
- Reduced Medicare Payments for Hospital Readmissions

2013

- State Notification Regarding Exchanges
- Closing the Medicare Drug Coverage Gap
- Medicare Bundled Payment Pilot Program
- Medicaid Coverage of Preventive Services

- Increased Medicaid Payments for Primary Care
- Limits on Itemized Deductions for Medical Expenses
- Flexible Spending Account Limits
- Medicare Tax Increase
- Tax on Medical Devices
- Extension of CHIP
- Reductions in Disproportionate Share Hospital Payments

Full implementation of the law is not scheduled to be completed until 2019. For more information about the overview of the law and the implementation timeline go to: http://bit.ly/cEZ39S and http://bit.ly/ygUz9m.

Judicial Activities

Several years ago, the Goldwater Institute filed a lawsuit challenging, among other things, the constitutionality of the Independent Payment Advisory Board (IPAB) on separation-of-powers grounds. The federal district court had dismissed the suit, and on February 19, 2013, the Goldwater Institute filed an appeal with the 9th Circuit Court of Appeals.

CODING AND REIMBURSEMENT UPDATE

Medicare Budget and SGR Reform Proposals

- **Going Over the Fiscal Cliff.** On Jan. 1, 2013 Congress passed H.R. 8, the American Taxpayer Relief Act (http://1.usa.gov/UDxOQ7) and the president subsequently signed it into law. The legislation was the latest compromise to prevent the country from going over the so-called "fiscal cliff," and included, among other things, a mix of tax measures and healthcare provisions. Key elements of the bill related to healthcare include:

  - Prevents the 26.5 percent Medicare physician pay cut, extending current Medicare payment rates through Dec. 31, 2013.
  - Allows physicians to participate in clinical data registries to meet Medicare's quality reporting requirements.
  - Extends the geographic work adjustment through Dec. 31, 2013, preventing additional payment reductions for physicians practicing in rural areas.
  - Reduces hospital outpatient reimbursement for gamma knife stereotactic radiosurgery to the same level as radiosurgery performed with a linear accelerator.
  - Adjusts the equipment utilization rate for advanced imaging services, which may reduce reimbursement to physicians who own imaging equipment.

  While the legislation failed to fully repeal the SGR, the inclusion of the clinical data registry piece was the culmination of advocacy efforts of the AANS, CNS and several other medical societies.

  Subsequent to the passage of the fiscal cliff bill, the AANS and CNS sent a letter (http://bit.ly/16EyKKN) to all Members of Congress objecting to the radiosurgery payment cuts. Overall, the provision will cut hospital reimbursement by $300 million, decreasing the per-treatment Gamma Knife reimbursement from approximately $8,100 to $3,400 — a 58 percent reduction. We also issued a press release drawing attention to our opposition of the cuts.

- **Medicare Physician Payment Update-SGR.** Every year for more than a decade, physicians have faced a significant Medicare payment cut -- the result of a flawed sustainable growth rate (SGR) formula. Now, once again, physicians face an SGR-driven pay cut of over 25% percent effective Jan. 1, 2014. In addition to the SGR-related cuts, physicians face additional cuts due to the budget sequestration -- 2 percent per year for the next 10 years -- and other cuts related to the Patient Protection and Affordable Care Act (ACA), including PQRS, eRx, EHR, IPAB and others. Under a worst case scenario situation, neurosurgeons could face cuts in excess of 85 percent over the next decade.

  - CBO lowers estimate of SGR. On Tuesday, Feb. 5, the Congressional Budget Office (CBO) released its updated Budget and Economic Projections for 2013-2023 (http://1.usa.gov/12kcyFI). Under the projections, the cost of repealing the SGR has dropped dramatically due to lower than expected growth in Medicare physician spending. The new cost of freezing payments for ten years is $138 billion, more than $100 billion less than the previous projection.

  - Options for Repeal the SGR Under Consideration. Given the reduction in the cost of repealing the SGR, policymakers and stakeholders are cautiously optimistic that Congress will be able to repeal the SGR this year. As a result, there are several serious proposals now floating around on Capitol Hill.

    - The House Energy & Commerce and Ways & Means Committees'' proposal would:
      - Repeal the SGR and replace it with a new fee-for-service program that would be based on the quality and efficacy of care;

- Following a few years (unknown at this time) of fixed payments, physicians will receive a base payment (likely 10-15% less than the top achievable rate). Those opting to participate in the new FFS system will be able to choose from a menu of quality improvement options and earn additional reimbursement. These quality improvement measures/options (including reporting to clinical data registries) will, by and large, be developed by the individual specialty societies. Physicians who don't want to participate will receive the base rate.
- Further down the road, an efficiency payment structure will be established, which will also reward physicians for achieving cost and efficiency targets.
- Physicians don't have to remain in this new FFS system and could also opt to participate in other Medicare-approved delivery models approved by Medicare (e.g., ACOs).

The Committees may also incorporate additional items into the reform plan, including:

- IPAB repeal
- Medical liability reform (not necessarily just MICRA-style reforms, but also protections for physicians who are participating in quality improvement programs and are following their specialty clinical practice guidelines)
- Private contracting or balance billing

The AANS and CNS are providing feedback to the Committees.

o Rep. Bill Cassidy's would establish a process allowing all physicians to participation in accountable care organizations – regardless of the size of the practice. This would not be a complete SGR replacement proposal, but rather could be included in a more comprehensive reform bill. Under his plan, physicians may opt to be reimbursed as part of an ACO structure or they can participate in a new structure that uses an Independent Risk Manager (IRM). The IRM will assist smaller groups of physicians to contract global payments with CMS. Finally, while he leaves the option of fee-for-service, reimbursement would be frozen in perpetuity, thus essentially making it a pay cut for those doctors that stay in fee-for-service. Physicians would have to comply with various quality/efficiency metrics as part of these various payment models.

o Reps. Allyson Schwartz & Joe Heck reintroduced their proposal on Feb. 6, 2013. H.R. 574, the Medicare Physician Payment Innovation Act, is virtually identical to legislation that they introduced in the 112th Congress and is available by clicking here: http://1.usa.gov/WcNVsX. The key provisions include:

- Permanently repeals the SGR formula;
- Provides annual positive payment updates for all physicians for four years;
- Ensures access to preventive care, care coordination, and primary care services through increased payment updates for those services;
- Aggressively tests and evaluates new payment and delivery models
- Identifies a variety of unique payment models to provide options for providers across medical specialties, practice types and geographic regions
- Stabilizes payment rates for providers who demonstrate a commitment to quality and efficiency within a fee-for-service model; and
- Ensures long-term stability in the Medicare physician payment system through predictable updates that accurately reflect the cost and value of providing health care services in coordinated care models.

The bill is very primary care centric, and essentially forces physicians into one of several delivery system models. Primary care physicians will receive an additional 2% over all other physicians. Physicians who remain in fee-for-service will be penalized with a 5% pay cut phased-in over time, unless those providers participate in the current PQRS, EHR, etc.

programs and those providers are in the top 25% of providers in a certain geographic area. Beginning in 2024, the annual update for all programs will be zero.

The AANS and CNS oppose this legislation.

- Medicare Private Contracting. The AANS and CNS have been working with the Coalition of State Medical and National Specialty Societies to promote legislation to allow private contracting in Medicare without penalty to either patient or physician. Under current law, physicians who wish to privately contract must opt out of Medicare for 2 years and Medicare will not pay any portion of the physician's services. After gaining some limited momentum last year, the Medicare Patient Empowerment Act is again moving forward in the 113thCongress -- S. 236 is sponsored by Sen. Lisa Murkowski (R-AK) and has 3 cosponsors, and Rep. Tom Price, MD (R-GA) introduced HR 1310. The MPEA would allow physicians and patients, on a case-by-case basis, enter into private contracts. The physician would not be forced out of Medicare and the beneficiary would be reimbursed for those services in the amount that Medicare would have otherwise paid.

  The AANS and CNS have endorsed both bills. Neurosurgeons are encouraged to go to the My Medicare-My Choice website (http://bit.ly/Xv1Xno) to sign the petition supporting the MPEA.

- American College of Surgeons Value Based Update Proposal. The ACS is in the process of developing a proposal to repeal and replace the SGR with a Value Based Update. The proposal currently has many holes and the AANS and CNS have registered our skepticism and concerns about this as it is currently outlined, as it builds into the system currently flawed PQRS, e-RX, EHR, and value based payment modifier programs. Additionally, the system appears to be overly complicated and based on principles and ideas that are not tested and hence not ready for prime time. The ACS recently contracted with outside experts to further developing the VBU proposal.

2013 Medicare Physician Fee Schedule Final Rule

On Dec. 31, 2012, the AANS and CNS sent a letter to the Centers for Medicare and Medicaid Services (CMS) objecting to a nearly 10 percent reduction in the physician work relative value units (RVUs) recommended by the AMA/Specialty Society Relative Value Scale Update Committee (RUC) for new bundled cervicocerebral angiography codes (CPT 36221-36227). The new values were included in the 2013 Medicare Physician Fee Schedule. The AANS and CNS have asked for an appeal, referred to as "refinement," which will take place in August 2013.

In addition to reducing the value of these services, CMS initially indicated that the bilateral modifier (-50) may not be used to report CPT codes 36222-36228, despite the fact that the new CPT codes are clearly written for unilateral procedures. Typically, codes that are designed for a unilateral procedure are reported with a -50 modifier when done bilaterally, and the payment amount is 150 percent of the unilateral procedure. However, because of the CMS error, Medicare would pay the same amount whether the procedure is done unilaterally or bilaterally. The AANS and CNS joined eight other societies in pointing out this error to CMS, and on Jan. 29, 2013, CMS staff notified the AANS and CNS that the error will be corrected, and the -50 modifier will in fact be permitted when these procedures are performed bilaterally. The change will be retroactive to Jan.1, 2013. A copy of the final rule is on the web at: http://1.usa.gov/SnmN4s

CPT Coding Issues

The CPT Panel met in early 2013. Patrick Jacob, MD, AANS Advisor to CPT, and Washington office staff attended. The AMA publishes a summary following each meeting which is available at: http://bit.ly/15jiazu. Ongoing CPT issues include:

- **Thrombolysis Codes**. CPT Code 37201 was a non-coronary thrombolysis code that had been used by endovascular surgeons for stroke thrombolysis. The code was eliminated through the bundling initiative for an unrelated renal angiography codes at the RUC and the neurosurgeon use of the code was inadvertently overlooked, requiring neurosurgeons to report the service as an unlisted procedure code. Henry Woo, MD, drafted a CPT Code Change Proposal to create 6 new CPT codes that

describe thrombolytic and non-thrombolytic intracranial infusions. The proposal was reviewed by two panel members at the February 2013 panel who made suggestions for further development. A conference call is planned and interested stakeholders will meet at the May 2013 panel meeting to prepare the proposal for presentation at the October 2013 panel meeting.

- **Category I Proposal for Minimally Invasive Sacroiliac Joint Fusion**. The International Society for the Advancement of Spine Surgery (ISASS) presented a Category I Code request for minimally invasive sacroiliac joint fusion at the February 2013 CPT panel meeting. At the October 2012, CPT panel meeting, the North American Spine Society (NASS) had presented a proposal for a category III (new technology tracking) code for the procedure, which is now reported with CPT Code 27280 *Arthrodesis, sacroiliac joint (including obtaining graft)* or with an unlisted code. ISASS opposed the Category III code but panel members questioned the quality of the literature for the code and did not feel it was ready for Category I.

- **CPT Summit.** The AMA hosted a meeting on Feb. 22, 2013, to discuss issues of concern with the CPT process. Joseph Cheng, MD, CNS CPT Advisor attended and made a presentation highlighting organized neurosurgery's longstanding internal processes and policies for collaborating with industry on new and revised codes. The stated goals of the meeting were twofold. First, to provide insights to stakeholders on the issues most relevant to CPT Editorial Panel meetings (which take place three times per year to update the CPT code set) and the numerous other activities beyond these meetings that also collectively help shape the CPT code set. Second, AMA would like to identify actionable improvements that will enhance the transparency, fairness and responsiveness of the CPT process. Invitees included representatives from selected medical specialty societies, industry, the AMA and the CPT Editorial Panel. Not all specialty societies were invited.

- **CPT Panel and Advisor Nominations.** The AANS and CNS nominated R. Patrick Jacob, MD to the CPT Editorial Panel. The panel has one vacancy starting in October 2013. AANS and CNS also sent a letter to reappoint Joseph Cheng, MD as CNS CPT Advisor and to reappoint Dr. Jacob as AANS advisor, if not appointed to the CPT panel. In addition, Henry Woo, MD was appointed as an alternate AANS advisor.

RUC Issues

The RUC met on Jan. 24-26, 2013. Attending for the AANS and CNS were Greg Przybylski, MD, and Alexander Mason, MD, and Washington Office Staff. Issues for neurosurgery included:

- **CPT Code 22612 Action Plan.** The RUC's Relative Assessment Workgroup (RAW) reviewed CPT code 22612 (*Arthrodesis, posterior or posterolateral technique, single level; lumbar (with lateral transverse technique, when performed)).* The code was identified for review through the CMS High Expenditure Procedural Codes screen. The AANS, CNS, NASS, and AAOS made the case that the RAW should consider that the recently created CPT code 22633, which was implemented in 2012, combines existing codes 22612 and 22630. In the first 9 months of 2012, utilization of CPT codes 22612 and 22630 has decreased significantly as the new bundled code 22633 is being appropriately used to code for combined procedures. Therefore, the groups argued that additional years of future data should be analyzed before the code is resurveyed and the RAW agreed.

- **CPT Codes 63047 and 63048**. The AANS, CNS, NASS, and AAOS presented survey data for CPT Code 63047 (*Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s], [eg, spinal or lateral recess stenosis]), single vertebral segment; lumbar*) and 63048 (*Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s], [eg, spinal or lateral recess stenosis]), single vertebral segment; each additional segment, cervical, thoracic, or lumbar (List separately in addition to code for primary procedure*), which were identified by CMS as high expenditure codes that had not been reviewed since 2006. The presenting specialty societies discussed the survey results and considered possible compelling evidence that the work of this procedure has increased due to changing patient characteristics. With the growing frequency of non-surgical spine intervention, patients are increasingly presenting for surgery having

had prior procedures and studies are beginning to show an increase in the work and length of stay for these patients. Many Medicare and private payors are beginning to require longer waiting periods before spine surgery and during this time patients often receive other intervention, making the patient who do receive surgery more difficult. Ultimately the presenting groups decided to recommend the current value, but stated that they would monitor the trend in patient characteristics and consider asking for revaluation in the future.

- **April RUC Meeting.** At the RUC meeting April 25 through 28, AANS and CNS will join the Society of Interventional Radiologists, the Society of Vascular Surgeons, and several other societies in presenting survey data for a new code for transcatheter placement of an intravascular stent, intrathoracic common carotid artery or innominate artery by retrograde treatment, via open ipsilateral cervical carotid artery exposure. The new code includes access, selective catheterization and radiological supervision and interpretation. The RUC survey was sent to the AANS/CNS Section on Cerebrovascular Surgery.

Coverage Issues

The AANS/CNS Washington Office continues to receive requests for comment on coverage policy from Medicare, private payors, state neurosurgical societies, and individual neurosurgeons. The AANS/CNS Rapid Response to Coverage (RRC) team, led by Joseph Cheng, MD, is working to improve processes to help neurosurgeons address these issues as they arise in their states and regions. Some recent activity is highlighted below:

- **Blue Cross/Blue Shield.** On Jan. 31, 2013, the AANS and CNS received a letter from Blue Cross and Blue Shield Association (BCBSA) thanking the AANS and CNS for providing expert review on coverage policies and giving an update on two policies in particular -- Stereotactic Radiosurgery/ Stereotactic Body Radiotherapy and Computed Tomography (CT) Perfusion Imaging -- for which comments had been provided. Dr. Cheng and the RRC have asked payors to provide feedback on comments submitted to assess the impact of such efforts.

- **Noridian/ISIS Interventional Pain LCD Workgroup.** The AANS and CNS are participating in a multi-specialty pain care group to advise Noridian on coverage policy for pain procedures and intervention and to create model coverage policies. Daryl Fourney, MD, is the representative from organized neurosurgery. The group held a number of conference calls and has established an active e-mail exchange to discuss issues of mutual interest, such as lumbar intralaminar and transforaminal Epidural Steroid Injections (ESIs).

- **State Coverage and Technology Assessment Activities.** The states of Washington, Oregon, and California continue to be particularly active in health coverage policy and technology assessment. The RRC is working to identify and strengthen appropriate input from neurosurgeons for these activities. Below are some highlights from activity in the state of Washington:

  - Washington State Health Care Authority

    - SRS/SBRT. On Dec. 6, 2012, the Washington State Healthcare Authority (HCA) posted its Stereotactic Radiosurgery (SRS) and Stereotactic Body Radiotherapy (SBRT) coverage determination from Nov. 16, 2012. Trent Tredway, MD, made a presentation on behalf of the AANS, CNS, and the Washington State Association of Neurological Surgeons (WSANS) at the November meeting. A copy of the final wording is available at: http://1.usa.gov/YqeXJc

    - Cervical Fusion for DDD. On March 22, 2013, Joseph Cheng, MD, made a presentation before the Washington State Health Care Association (HCA) Health Technology Clinical Committee (HTCC) as part of their consideration of coverage for Cervical Fusion for degenerative disc disease (DDD). Trent Tredway, MD, served as the panel's invited clinical expert. Dr. Cheng's remarks were based on a Feb. 14, 2013 comment letter submitted by AANS, CNS, and 7 other neurosurgical and orthopaedic organizations: Washington State Association of Neurological Surgeons, Washington State Orthopaedic Association, American Association of Neurological Surgeons, American Association of Orthopaedic Surgeons,

AOSpine North America, Cervical Spine Research Society, Congress of Neurological Surgeons, AANS/CNS Joint Section on Disorders of the Spine and Peripheral Nerves, North American Spine Society (NASS). In the letter, the groups raise a number of concerns about the technical assessment such as the imprecise definition of DDD, questionable choice of articles upon which the report is based, and an inadequate assessment of the risks of alternatives to fusion. More information, including Dr. Cheng's presentation, is available on the web at: http://1.usa.gov/10aQWoQ

- Carotid Artery Stenting. The Washington State HCA HTCC will consider Carotid Artery Stenting at a meeting on Sept. 20, 2013. The AANS and CNS submitted a letter to the Washington State HCA on Dec. 11, 2012 commenting on proposed key questions for a technology assessment for Carotid Artery Stenting (CAS) expected to be published on or before June 28, 2013. In the letter, the AANS and CNS stated the importance of distinguishing between primary and secondary stroke prevention. Moreover, the AANS and CNS contend that the key questions must further separate consideration of extracranial and intracranial atherosclerotic disease, as blurring carotid disease, intracranial atherosclerotic disease (ICAD), and materially different catheter-based treatments will ultimately limit the HCA's ability to draw meaningful conclusions from the technical assessment. The HCA Health Technology Clinical Committee (HTCC) will meet to determine coverage policy for CAS on Sept. 20, 2013. More information is available at: http://1.usa.gov/12WWnfP.

– Washington State Bree Collaborative

- Spine Care. The Washington State Robert Bree Collaborative, a consortium of public and private health care purchasers, health carriers and providers appointed by the governor to identify concerns with quality and variation in health care and to recommend evidence-based strategies for improvement, will meet on March 27, 2013 to consider a number of issues, including spine care. Gary Franklin, MD, a neurologist and Medical Director for the Washington State Department of Labor and Industries, the agency that oversees the state workers' compensation program, heads the Bree Collaborative spine task force, and has proposed that hospitals be required to report spine care data to the Surgical Care Outcomes Assessment Program (SCOAP) as a condition of payment. In January, the Bree Collaborative recommended accepting SCOAP participation as the "community standard" for spine surgery performed in the hospital setting, with plans to later expand the recommendation to include spine procedures performed in the ambulatory surgery center and radiology suite settings. The recommendation will be discussed at the March 27 meeting. More information is available at: http://1.usa.gov/Xa08i9

– California Technology Assessment

- Thrombectomy. On March 6, 3013, Alex Khalessi, MD, presented comments on behalf of AANS and CNS before the California Technology Assessment Forum (CTAF) on the use of thrombectomy devices for emergent treatment of acute ischemic stroke. Dr. Khalessi expressed concerns about a technical assessment commissioned by the CTAF that concluded that Mechanical Thrombectomy failed to improve health outcomes. More information is available at: http://bit.ly/X92Wv1. Dr. Khalessi's presentation addressed the following issues:
  1) poor natural history data of untreated, confirmed large vessel occlusion (LVO),
  2) data demonstrating the clinical benefit of endovascular therapy in the relevant target LVO population,
  3) improved technical performance of stent retriever technology acknowledged by the CTAF brief but distinct from recent endovascular stroke studies, and
  4) value of mechanical thrombectomy for the large proportion of iv tPA ineligible patients who present with an LVO and lack a competing treatment option.

- **Wellpoint**. Wellpoint continues to seek the opinion of the AANS and CNS on coverage issue, including the following:

- Minimally Invasive Discectomy. On Feb. 13, 2013, the AANS and CNS sent comments regarding Wellpoint's draft policy on minimally invasive discectomy (automated percutaneous, endoscopic, or tubular) that considers the procedure investigational. The comments were coordinated by Kurt M. Eichholz, MD. The AANS and CNS raised a number of concerns about the draft policy including an inadequate definition of endoscopic discectomy, a fundamental misrepresentation of the procedure, and a flawed analysis of the literature.

- Intracranial Stenting. On Jan. 2, 2013, the AANS and CNS sent comments to Wellpoint in response to their request for review of Carotid, Vertebral and Intracranial Artery Angioplasty with or without Stent Placement. The review was led by Henry Woo, MD in consultation with the AANS/CNS Section on Cerebrovascular Surgery. Wellpoint was particularly interested in expert opinion on the use of intracranial artery stent placement with or without angioplasty for the treatment of symptomatic cerebral vasospasm following subarachnoid hemorrhage (SAH). In addition, they asked for comments on ethical issues with randomized controlled trials of intracranial artery stent placement with or without angioplasty for symptomatic cerebral vasospasm, compared to sham or other controls, to determine whether this strategy improved health outcomes for individuals with symptomatic cerebral vasospasm associated with SAH and on any contraindications to intracranial artery stent placement with or without angioplasty and long-term outcomes concerns related to intracranial artery stenting and angioplasty following SAH.

- Cranial Bands. On Feb. 7, 2013, the AANS and CNS responded to Wellpoint's request for comments on Cranial Bands. The response was coordinated by David Gruber, MD in consultation with the AANS/CNS Pediatric Section and was generally supportive of Wellpoint's policy.

- Feedback on Comments Submitted. On March 15, 2013, Wellpoint sent a letter thanking AANS and CNS for providing comments on Wellpoint coverage proposals. Procedures reviewed in 2012 by AANS and CNS at the request of Wellpoint included Annulus Closure After Discectomy, Stereotactic Radiosurgery and Stereotactic Body Radiation Therapy, Surgical and Ablative Treatments for Chronic Headaches, Computed Tomography (CT) Perfusion Imaging, Interspinous Fixation Devices, Carotid, Vertebral and Intracranial Artery Angioplasty with or without Stent Placement.

- **Medicare National Coverage**

  - MEDCAC Considers PET Scans**.** On Jan. 30. 2013, the CMS Medicare Evidence Development Coverage Advisory Committee (MEDCAC) met to consider Beta Amyloid Positron Emission Tomography (PET) in Dementia and Neurodegenerative Disease. Medicare currently covers PET imagining for some indications but does not cover beta amyloid PET imaging. Jeffrey Cozzens, MD, recommended by AANS and CNS, served on the panel. Details on the meeting are, including panel voting and a webcast, are available at: http://go.cms.gov/WwW9IB

Other Medicare Issues

- **Medicare Program; Part B Inpatient Billing in Hospitals.** CMS published a proposed rule in the *Federal Register* on March 18, 2013, to revise the current policy on Part B billing following the denial of a Part A inpatient hospital claim found to be not reasonable and necessary. Under current policy, if a hospital incorrectly bills Medicare for Part A hospitalization services, rather than less-expensive Part B physician care, the wrong setting of care billing error would cause the hospital to forfeit all reimbursement for services. Hospitals claim that Medicare's recovery audit contractors (RAC), who are paid a percentage of the money they recover from hospitals, have targeted these lucrative setting-of-care decisions and that hospitals have been collectively denied hundreds of millions of dollars by Medicare because of disputes over the differences between inpatient and outpatient care. The new ruling directs Medicare judges to allow hospitals to claim Part B inpatient costs in cases where the setting of care was initially wrong and to also separately bill Medicare for some Part B

outpatient services that would otherwise have been "bundled" into the Part A bill because they occurred within three days of the hospitalization. The ruling is expected to affect thousands of hospital claims currently pending in the appeals process and to cut $4.8 billion in Medicare payments to hospitals over the next five years. CMS is accepting comments on the proposed rule through May 17, 2013. A copy of the proposed rule is available at: http://1.usa.gov/Xaz6XW

- **Medicare Hospital (Part A) and Medicare Supplementary Insurance (Part B).** The March 18, 2013, *Federal Register* also included a similar but separate interim rule on the same topic as the one described above that would immediately implement the proposal to compensate hospitals based on Part B rates if a RAC determines that the procedure should have been an outpatient procedure but imposes a one-year time limit for Part B claims, which would apply even if a RAC took longer than a year to appeal a claim. Again, the revised policy is intended as an interim measure until CMS can finalize a policy to address the issues raised by the Administrative Law Judge and Medicare Appeals Council decisions currently pending. The American Hospital Association issued a statement, available at http://bit.ly/13uCcJf announcing that it will not drop ongoing litigation it has brought against CMS, noting that the "proposed rule threatens to undermine the progress made on this important issue. Under the proposal, hospitals will be able to rebill CMS only within the narrow time frame of one year from when patient services were provided. Since the recovery audit contractor typically reviews claims that are more than a year old, the practical effect would be that hospitals would again not be fairly reimbursed for the care they provide Medicare patients." The interim policy is effective immediately and copy is available at: http://1.usa.gov/Zstc1X.

- **IOM Geographic Variation Report.** On March 22, 2013, the Institute of Medicine (IOM) released an Interim Report entitled *Geographic Variation in Health Care Spending and Promotion of High-Value Care*. In 2009, Congress asked the Secretary of the U.S. Department of Health and Human Services, Kathleen Sebelius, to sponsor two IOM studies focused on geographic payments under Medicare, independent of final health reform legislation. The first study, released on July 17, 2012, evaluated the accuracy of geographic adjustment factors used for Medicare payment, which alter physician and hospital payments based on specific, geographically-based input prices. The study released on March 22, 2013, is the second study designed to investigate geographic variation in health care spending and quality and to analyze Medicare payment polices that might encourage high-value care, including adoption of a geographically-based value index, that would modify provider payments based on composite measures of cost and quality of geographic-area performance. The preliminary report found that basing Medicare reimbursements on a geographic value index would likely "reward low-value providers in high-value regions and punish high-value providers in low-value regions." A copy of the interim report is available on the web at: http://bit.ly/WTXPgH

- **ICD-10-CM.** On Feb. 12, 2013, the AMA received a letter from CMS in response to a multi-specialty request asking that implementation of ICD-10-CMS be scrapped, in favor of implementing an improved ICD-9 system. In the letter, CMS states their opposition to further delaying ICD-10-CM implementation. The AANS and CNS had also suggested bypassing ICD-10-CM in favor of ICD-11-CM, which will be adopted worldwide in a few years. On Sept. 5, 2012, CMS issued a final rule in the *Federal Register* (http://1.usa.gov/PPb1gB) announcing a one-year delay for implementing the ICD-10 diagnosis and procedure codes. The new compliance date is Oct. 1, 2014.

- **HHS OIG 2013 Work Plan.** The Office of Inspector General of the U.S. Department of Health and Human Services (OIG) has released its 2013 Work Plan (available at: http://1.usa.gov/PatqZX). In the plan, the OIG provides a voluntary compliance document to help guide providers in updating Medicare compliance efforts. The AMA has also developed resources to help physician with compliance, available on the web at: http://bit.ly/w6ZDod. Areas of focus for physicians outlined in the 2013 OIG Work Plan include:

  - Medicare and Medicaid Incentive Payments for Electronic Health Records
  - Potentially Inappropriate E & M Payments in 2010 relating to EHR documentation
  - Noncompliance With Assignment Rules and Excessive Billing of Beneficiaries
  - Error Rate for Incident-To Services Performed by Nonphysicians

- Place-of-Service Coding Errors
- Use of Modifiers During the Global Surgery Period
- Non-Hospital-Owned Physician Practices Using Provider-Based Status
- Payments to Providers Subject to Debt Collection

- **Physician Owned Distributorships (PODs)**. On March 26, 2013, the HHS Office of Inspector General (OIG) issued a Special Fraud Alert regarding Physician-Owned Distributorships, or PODs (http://1.usa.gov/YmT6Fy). The alert spells out a series of POD characteristics that raise major red flags. A couple of salient quotes state:

  - *"We are particularly concerned about the presence of such financial incentives in the implantable medical device context because such devices typically are 'physician preference items,' meaning that both the choice of brand and the type of device may be made or strongly influenced by the physician, rather than being controlled by the hospital or ASC where the procedure is performed…We do not believe that disclosure to a patient of the physician's financial interest in a POD is sufficient to address these concerns."*

  - *"OIG is concerned about the proliferation of PODs. This Special Fraud Alert reiterates our longstanding position that the opportunity for a referring physician to earn a profit, including through an investment in an entity for which he or she generates business, could constitute illegal remuneration under the anti-kickback statute. OIG views PODs as inherently suspect under the anti-kickback statute."*

  The AANS and CNS are considering developing a position statement on this topic.

- **GAO Report on Medicare Program Integrity.** On Nov. 13, 2012, the General Accountability Office (GAO) released a report entitled *Medicare Program Integrity: Greater Prepayment Control Efforts Could Increase Savings and Better Ensure Proper Payment.* The GAO concluded that use of prepayment edits saved Medicare at least $1.76 billion in fiscal year 2010, but savings would have been greater had prepayment edits been more widely used. GAO illustrated this point using analysis of a limited number of national policies and local coverage determinations (LCD), which are established by each Medicare administrative contractor (MAC) to specify coverage rules in its jurisdiction. GAO identified $14.7 million in payments in fiscal year 2010 that appeared to be inconsistent with four national policies and therefore improper. GAO believes that these payments and more than $100 million in payments inconsistent with three selected LCDs could have been identified using automated edits. The report is available on the web at: http://1.usa.gov/XzSQ1A.

- **Impact of Medicare Elimination of Consultation Codes.** The Jan. 14, 2013 issue of the *Journal of Internal Medicine* included an article, which concluded that the elimination of Medicare Consultation Codes led to a net increase in spending on visits to both primary care physicians and specialists. Higher prices, partially owing to the subjectivity of codes in the physician fee schedule, explained the spending increase, rather than higher volumes. Prior to 2010, Medicare payments for consultations (commonly billed by specialists) were substantially higher than for office visits of similar complexity (commonly billed by primary care physicians). In January 2010, Medicare eliminated consultation payments from the Part B Physician Fee Schedule and increased fees for office visits. This change was intended to be budget neutral and to decrease payments to specialists while increasing payments to primary care physicians. The authors assessed the impact of this policy on spending, volume, and complexity for outpatient office encounters in 2010 and found an increase in payments to both primary care and specialist physicians.

- **MedPAC March 2013 Report.** The Medicare Payment Advisory Commission (MedPAC) is required annually to review Medicare payment policies and make recommendations to the Congress. The principal focus of the report is the Commission's recommendations for annual rate adjustments under Medicare's various FFS payment systems, or sector "updates." The Commission bases its update recommendation for each sector on an assessment of payment adequacy, including beneficiary access to care (supply of providers, service use, access surveys); quality of care; providers' access

to capital; and provider costs and Medicare payments (where available). The Commission's recommendations for 2014 of interest to neurosurgery include:

- Inpatient and outpatient hospitals. The Congress should increase payment rates for the inpatient and outpatient prospective payment systems in 2014 by 1 percent. For inpatient services, the Congress should also require the Secretary of Health and Human Services to use the difference between the statutory update and the recommended 1 percent update to offset increases in payment rates due to documentation and coding changes and to recover past overpayments.

- Physicians and other health professionals

  - The Congress should repeal the sustainable growth rate (SGR) system and replace it with a 10-year path of statutory fee-schedule updates. This path is comprised of a freeze in current payment levels for primary care and, for all other services, annual payment reductions followed by a freeze. The Commission is offering a list of options for the Congress to consider if it decides to offset the cost of repealing the SGR system within the Medicare program.

  - The Congress should direct the Secretary to regularly collect data—including service volume and work time—to establish more accurate work and practice expense values. To help assess whether Medicare's fees are adequate for efficient care delivery, the data should be collected from a cohort of efficient practices rather than a sample of all practices. The initial round of data collection should be completed within three years.

  - The Congress should direct the Secretary to identify overpriced fee-schedule services and reduce their relative value units (RVUs) accordingly. To fulfill this requirement, the Secretary could use the data collected under the process in recommendation 2 (above). These reductions should be budget neutral within the fee schedule. Starting in 2015, the Congress should specify that the RVU reductions achieve an annual numeric goal—for each of five consecutive years—of at least 1.0 percent of fee-schedule spending.

  - Under the 10-year update path specified in recommendation 1 (above), the Congress should direct the Secretary to increase the shared savings opportunity for physicians and health professionals who join or lead two-sided risk accountable care organizations (ACOs). The Secretary should compute spending benchmarks for these ACOs using 2011 fee-schedule rates.

- Ambulatory surgical centers

  - The Congress should eliminate the update to the payment rates for ambulatory surgical centers for calendar year 2014. The Congress should also require ambulatory surgical centers to submit cost data.

  - The Congress should direct the Secretary to implement a value-based purchasing program for ambulatory surgical center services no later than 2016. (First recommended in March 2012).

As the House and Senate seek to implement their budget reconciliation plans, the recommendations made by MedPAC in its annual report to Congress, if implemented, are said to possibly reduce Medicare spending by $30 billion over five years. The MedPAC Chairman has also testified that the SGR physician payment formula be replaced to help ensure that Medicare costs are constrained and that quality is improved. He said that the cost of a doc fix could be partially offset through reforms to SNF and home health payments.

A copy of the March 2013 MedPAC report is available at: http://1.usa.gov/YdP6qP

Administrative Issues

Pursuant to the discussions at the March 1, 2013 Washington Committee meeting, the AANS and CNS leadership have approved the establishment of a new Washington Committee task force, which will be charged with developing a proposed strategic plan/roadmap for organized neurosurgery's quality improvement activities, including the structure and membership of the Quality Improvement Workgroup. The goal is for organized neurosurgery to develop a comprehensive plan so we can ensure that all aspects of our specialty are in sync as we move forward. Finding synergies among all these disparate programs is essential to minimize the burden on our members and maximize the benefits that can be derived by all stakeholders.

The task force will be named the National Quality Initiatives in Neurosurgery (NQIN), and it will be chaired by Tony Asher, MD and Dan Resnick, MD. The tentative timeline for operations is as follows:

- April2013: Initial status report (to be presented at AANS Board, CNS Executive Committee and Neurosurgery Summit meetings
- July 2013: Draft Report (to be presented at Washington Committee Meeting
- Fall 2013: Interim Final Report (to be presented at CNS Executive Committee, Neurosurgery Summit and AANS Board meetings)
- December 2013: Final Report (to be presented at Washington Committee Meeting) We will reevaluate the status of the task force later this year, and if it is deemed worthwhile, the group will continue to operate as necessary.

The members of the task force would represent a wide swath of organized neurosurgery, with many of its members wearing multiple hats so as to maximize representation, while at the same time keep the group to a manageable and functioning size. All the major players involved with quality improvement in neurosurgery would be represented, including the:

- American Association of Neurological Surgeons (AANS)
- American Board of Neurological Surgery (ABNS)
- AANS/CNS Coding and Reimbursement Committee
- Congress of Neurological Surgeons (CNS)
- Council of State Neurosurgical Societies (CSNS)
- AANS/CNS Joint Guidelines Committee (JGC)
- National Neurosurgery Quality Outcomes Database (N^2QOD)
- NeuroPoint Alliance (NPA)
- Neurosurgery Residency Review Committee (RRC)
- AANS/CNS Quality Improvement Workgroup (QIW)
- Society of Neurological Surgeons (SNS)

Medicare Physician Quality Improvement System (PQRS)

- **Bonus/Penalties 2013-15.** Under the PQRS program, physicians who successfully participate are entitled to 0.5% bonus payment in 2012; however under the Patient Protection and Affordable Care Act (ACA), the bonus payment is phased out and beginning in 2016, physicians who do not

participate will receive 2% payment cuts. Physicians who participate in qualified PQRS-MOC programs are eligible for an additional 0.5% bonus payment through 2014. To address the impending penalties, the AANS and CNS recently signed onto an AMA-led coalition letter asking CMS to reevaluate the penalty timelines and extensively commented on the issue in response to the 2013 Proposed Physician Fee Schedule Rule. We also recommended in our comments that CMS recognize physician participation in quality improvement activities, like reporting through a specialty clinical data registry, outside of PQRS as a way to qualify for the PQRS.

- **Applicable Measures.** CMS will maintain the measures that were applicable to neurosurgical practices, including perioperative measures, measures related to stroke and cancer care, and measure groups related to low back pain and ischemic vascular disease and several additional measures for 2013, including some epilepsy/seizure measures. In order to assist physicians with avoiding the payment cuts in 2015, CMS is allowing physicians to report one PQRS measure or measure group during the payment adjustment period. For 2015, the payment adjustment period is Jan. 1-Dec. 31, 2013. An additional option to avoid the penalty allows physicians to elect to use the administrative claims-based reporting for a set of administrative claims-based measures, but physicians must select and designate this option to CMS.

- **Registry Participation**. Based on discussions with CMS for neurosurgeons to receive credit for participating in N^2QOD (see section: NeuroPoint Alliance for more information), we submitted a proposal for two measures groups: low back pain and universal neurosurgery care. After further review, it was determined resources would not be well spent developing the measures. N^2QOD is in the process of becoming a PQRS approved registry and has met the first requirement of three. N2QOD will have the capability of reporting the perioperative care measure group.

  The recently passed American Taxpayer Relief Act includes language to allow physicians to satisfy PQRS by participating in a qualified clinical data registry. To meet the mandate, CMS in February released a Request for Proposal (RFI) to solicit information on ways in which physicians might use clinical quality measures data reported to specialty boards, specialty societies, regional health care quality organizations or other non-federal reporting programs to also report under the Physician Quality Reporting System (PQRS), as well as the Electronic Health Record (EHR) Incentive Program. The RFI also seeks input on ways by which the entities already collecting clinical data for other reporting programs can also submit this data on behalf of physicians and group practices for reporting under the PQRS and the EHR Incentive Program. Finally, CMS is requesting information regarding the above mentioned section of the American Taxpayer Relief Act. The agency is explicitly seeking information from medical specialty societies, boards, and registries, other third party registry vendors, and physicians using registries to report quality measures. We can likely anticipate a formal proposal for all of this to be included in the 2014 Medicare Physician Fee Schedule Proposed Rule, which will be issued in late spring/early summer. As a side note, at the December Washington Committee meeting, CMS had informed us the agency was also considering ways to streamline the various programs (i.e., PQRS, electronic medical records/meaningful use, Value-Based Payment Modifier, Maintenance of Certification, etc.) and allow physicians participating in meaningful quality improvement activities to satisfy these various programs; thus reducing the regulatory burden and redundancy of current participation.

Public Reporting: Physician Compare

The ACA required CMS to establish a Physician Compare website by January 1, 2011. This website is intended to provide patients with basic data about physicians, including information about their participation status in the PQRS, e-prescribing and EHR incentive programs. The site is a disaster and not functioning well at all and the AANS, CNS and others have written to CMS complaining about the problems and once again voiced our concerns within neurosurgery's 2013 Proposed Physician Fee Schedule comments. Under the ACA, CMS is required to implement a plan by 2013 for making physician *performance* data (including quality, efficiency, and patient experience data) available to the public, so the fact that the site cannot even function with basic information is cause for additional alarm. CMS has acknowledged the issues with the website and it is currently undergoing extensive revisions.

Washington staff has been extensively involved in the website revisions by providing feedback and meeting with CMS' contractor.

CMS recently announced that starting in 2013 it will publicly post performance data for a defined set of measures that apply to group practices participating in the PQRS Group Practice Reporting Option (GPRO) and ACOs participating in the Shared Savings Program. Over the next five years, CMS will expand public reporting to include patient experience data and actions taken to avoid preventable hospitalizations by group practices and ACOs, PQRS performance data for individual physicians, and information on physicians who qualified for the PQRS Maintenance of Certification incentive. Neurosurgery is against the expansion and believes that until CMS can work out the kinks with the website and provide an action plan that accurately assesses care, physician performance data should not be publicly reported.

Availability of Medicare Data for Performance Measurement

The ACA also authorizes CMS to make Medicare data available to "qualified entities" for the evaluation of the performance of providers by Jan. 1, 2012. CMS did not make many of our requested changes. However, the rule does make the change to allow for using claims data in addition to registry data and to partner with additional entities to meet the requirements. Additionally, on June 5, 2012, CMS formally launched a new office dedicated to the management, use and dissemination of health data. The new Office of Information Products and Data Analytics (OIPDA) will oversee CMS' portfolio of information and help make the development, use and dissemination of data a core function of the agency.

Physician Resource Use Reports and Value-Based Modifier

Under the ACA, Congress directed CMS to refine and expand its current efforts to provide confidential feedback reports comparing the cost and quality of care across physicians, known as the Physician Resource Use Feedback Program. The budget neutral Value-Based Payment Modifier (VBPM) will apply to payments of group of physicians of 100 or more starting in 2015 and to all physicians by 2017. Originally, CMS proposed the VBPM would apply to groups of physicians of 25 or more in 2015, but due to extensive advocacy they expanded the definition. Physician groups subject to the modifier can avoid all negative adjustments simply by participating in PQRS. In this case, physicians will receive neither a value-bonus nor pay cut under this new program. Physicians can, however, elect to be paid according to the measured cost and quality of services provided in 2013 and 2014. Any payment adjustment will be applied to 2015 and 2016 Medicare payments, respectively.

- **Setting the value-based bonuses and penalties.** CMS has proposed a differential payment modifier to adjust Medicare physician pay in 2015. The agency would generate a report comparing an eligible doctor's quality of care and Medicare's costs for that care in the 2013 performance period to that of his or her peers. Large practices that successfully participate in the Medicare physician quality reporting system either can accept a 0% pay adjustment or vie for higher adjustments by accepting risk under a tiered modifier structure. Physicians assigned to a high-quality, low-cost category could receive bonuses of up to 2% in 2015, while the pay of doctors giving the costliest care at the lowest quality would be cut by up to 1%. Large practices that fail to meet PQRS requirements automatically would receive the full 1% cut.

Assessment	Low cost	Average cost	High cost
High quality	2.0%*	1.0%*	0.0%
Average quality	1.0%*	0.0%	-0.5%
Low quality	0.0%	-0.5%	-1.0%

* Physicians who score in these categories who treat high-risk beneficiaries could receive an additional one percentage point in bonus money.

The AANS and CNS have many concerns about this fee-adjuster, including questions related to per capita versus episode-based assessments of resource use; attribution methods; integration of cost and

quality data; proper risk adjustment methodologies; appropriate sample sizes; and other statistical concerns. And these concerns remain, particularly after the April release of prototype Quality and Research Use Reports (QRURs) to physicians in Iowa, Kansas, Missouri and Nebraska. The next round of reports will be released in mid-December to California, Iowa, Illinois, Kansas, Michigan, Minnesota, Missouri, Nebraska and Wisconsin. The reports provide little value in regards to quality and cost information. In an effort to address the issue, CMS plans on holding a focus session in December with specialty staff and a select group of physicians to gain information on how to improve the QRURs and to train physicians on how to discuss the reports with their peers.

The AANS and CNS 2013 have criticized the flawed methodology CMS intends to use for the value-modifier and QRURs. We have recommended that CMS re-evaluate its decision to use 2013 as the basis for applying the 2015 VBPM, due to CMS essentially instituted the provision two years before the statutory mandate and the numerous flaws with the pilot reports. Due to comments CMS received, the VBPM will only apply to groups of physicians of 100 or more, as opposed to 25 or more physicians in 2015. CMS also expanded the deadline for groups to elect how they want the VBPM to apply to the practice. Practices have until Oct. 15, 2013 to inform CMS of their status. In addition, concerns with CMS' proposal to calculate a total per capita cost measures for all beneficiaries and per capita cost measures for beneficiaries with four specific chronic conditions. A suggested alternative to CMS is for physicians to be compared to their specialty and not all of medicine. Through the Alliance, we have submitted detailed feedback and recommendations to CMS on improving the program, as well as met in person in December with a follow-up meeting held in March.

Episode Grouper/Bundled Payments

The Middle Class Tax Relief and Job Creations Act of 2012 mandates that DHHS conduct a study that examines options for bundled or episode-based payments, to cover physicians' services currently paid under the physician fee schedule for one or more prevalent chronic conditions (such as cancer, diabetes, and congestive heart failure) or episodes of care for one or more major procedures (such as medical device implantation). In conducting the study, the Secretary shall consult with medical professional societies and other relevant stakeholders. Ultimately the "vast majority" of services and patients will be included in episodes and most likely will cover about 80% of Medicare costs. The term "bundling" can refer to a variety of ways by which payment units are broadened to include more services.

For services paid under the Medicare PFS, bundling has sometimes referred to either combining sets of codes that describe services usually furnished together or making explicit payment for coordination of care and care management. In the context of Congress' mandate for a study that examines options for bundled or episode-based payments, bundling refers to possible ways to reduce the overall number of service units billed to encourage judicious use of services within a particular scope of services. CMS has chosen the AMA/Brandeis software to test bundles. For chronic conditions, the episode would be a calendar year. If the condition continued to the next year, a new episode would be started. For procedures, the episode would begin with a principal procedure being coded and the episode would include 3 days prior and 90 post-discharge. For acute medical events without a procedure (such as a heart attack without an associated procedure or pneumonia) the episode would be 30 days from the event. For post-acute care in a facility the episode would be the length of stay in the facility. For system-related failure the episode would be the length of stay—admission through discharge. System failure care is not included in other episodes.

AMA recently put out a call for workgroup members to define musculoskeletal episodes of care, which includes spine. Neurosurgery intends to nominate John Ratliff, MD to represent neurosurgery on the workgroup. The work that comes out of this workgroup is important. It potentially will be the framework and foundation for future episodes of care definitions in CMS programs.

- **Included in the "Bucket".** In the prototype, an episode included all physician services and facility services that were considered "typical" for such an episode, as developed by the advisory panels. Part B and D Drugs were left out in the prototype. CMS intends to include them but has not worked out how to link them up.

Based on extensive conversations neurosurgery has had with CMS, they indicated that they would very much welcome the specialties input on what an appropriate bundle would look like and what are appropriate episodes of care. Neurosurgery recommended to CMS carotid stenosis and grade 1 single level Spondylolisthesis. In order to move forward beyond recommending the two conditions, a partner is needed in CMS. The development of episode groupers is not an easy task and requires methodological expertise outside our current capabilities. Thus, we have requested for CMS to work with us and put us in contact with its contractor, Brandeis. We have received little traction so far from CMS besides requesting the best way to define carotid stenosis or single level spondylolisthesis using data fields on administrative claims. John Ratliff, MD responded by recommending CMS define the treatment episodes by a CPT code linked to a specific diagnosis. He highlighted that there are limitations to ICD-9 based analysis; for instance 738.4 refers to nearly any acquired spondylolisthesis, regardless of grade or cause.

- **HCI3.** Neurosurgery was recently approached by Health Care Incentives Improvement Institute (HCI3) on assisting them with creating a bundle on laminectomy and back pain with radiculopathy. HCI3 is one of the subcontractor's working with Brandeis. HCI3 has indicated the spine bundles will not be incorporated into the current CMS contract, but the second scope of work, which has yet to be awarded. Spine will not go to CMS for review until 2014. HCI3 also intends to pilot test the bundles with the commercial insurers first. Based on conversations we have had with HCI3 and the initial work they presented to neurosurgery, it is clear they are clueless with regard to anatomy, physiology of neurosurgical procedures, especially with laminectomy. They have initially lumped all of laminectomy into the same episode. The positive is they have admitted they are unfamiliar with neurosurgical procedures so they are asking for organized neurosurgery's help. Also, they are basing episode of care on procedure codes not DRG codes, which will help define procedures readily and help delineate back surgery from back procedures (pain management, chiropractic, etc.). This will require a fair amount of time, but if it will help appropriately define episodes of care for spine and help members the effort will be worth it; especially if it helps separate neurosurgeons from non-surgeon spine procedures and their costs.

  Of note, previously, the workgroup we put together to choose clinical episodes to suggest to CMS picked symptomatic carotid stenosis and surgical treatment of degenerative spondylolisthesis with stenosis. Neither produced much interest from CMS. Similarly, HCI3 is looking for something broader than a single surgery for a single diagnosis. HCI3 wants "Laminectomy", as in all laminectomies

- **Bundled Payments for Care Improvement (BPCI) Initiative**. On Jan. 31, 2013, the Centers for Medicare & Medicaid Services (CMS) through CMMI, announced the health care organizations selected to participate in the Bundled Payments for Care Improvement initiative (BPCI). This initiative is separate from the episode grouper project CMS is working on that will eventually influence the value based payment modifier. The BPCI is testing new models at a smaller scale and potentially inform the physician value modifier and other payment models (e.g., expanding bundling, ACOs).

  Under the Bundled Payments for Care Improvement initiative, organizations will enter into payment arrangements that include financial and performance accountability for episodes of care. The initiative includes four bundled payment models covering various elements of hospital, physician and post-acute services and payments targeting 48 diseases and conditions. Spine and stroke are part of the 48 diseases and conditions. Based on conversations with participating sites, it does not appear risk-adjustment is involved and CMS will determine rates based on historic Medicare data so there is no room for negotiation. There is concern the models will lead to cherry picking and physicians will only enroll healthy patients and send sick patients to tertiary care or academic facilities. For more information go to: http://1.usa.gov/XXmPzE. For the list of facilities go to: http://1.usa.gov/Tmiolq.

Health Information Technology

- **e-Prescribing Program.** The 2012 Medicare Physician Fee Schedule sets forth comprehensive requirements for the 2013 eRx incentive payments, additional requirements for the 2013 payment penalty, and requirements for the 2014 payment penalty. No eRx incentives or penalties are authorized beyond 2014. The current schedule for eRx incentives and penalties is as follows:

– Incentive payments for successful e-prescribers: 1.0 percent for 2012; 0.5 percent for 2013
– Penalties for those who are not successful e-prescribers: 1.0 percent for 2012; 1.5 percent for 2013; and 2.0 percent for 2014

In response to pressure from medicine, including the AANS and CNS, CMS released revisions to the program expanding qualified exemptions to the 2013 penalty, including situations where state or local law prohibits e-Rx. In addition, CMS has proposed two additional hardship exemptions in 2013 for physician practices participating in the EHR incentive program:

- Eligible Professionals or Group Practices Who Achieve Meaningful Use During Certain 2013 and 2014 eRx Payment Adjustment Reporting Periods
- Eligible Professionals or Group Practices Who Demonstrate Intent to Participate in the EHR Incentive Program and Adoption of Certified EHR Technology

- **Electronic Health Record-Meaningful Use.** The American Recovery and Reinvestment Act (ARRA) included $19 billion in federal grants to encourage physicians to adopt electronic health record (EHR) systems. Beginning in 2015, physicians who are not meaningful users of EHR will face penalties – up to 5% in later years. The stages of meaningful use are intended to take providers from a process oriented measure set in Stage 1, which requires providers to collect and report various measures, to using that collected information to make decisions about the delivery of healthcare by Stage 3.

  – State 1 and 2. Stages 1 and 2 each require meeting 20 total objectives, but stage 2 makes mandatory some EHR measures that are optional for stage 1, such as whether the electronic systems can incorporate clinical laboratory test results. Other measures stay the same but have higher thresholds, such as a requirement that EHRs send more than 50 percent of applicable prescriptions electronically, up from more than 40 percent. The number of required core set measures goes up to 17 in stage 2 from 15 in stage 1. Physicians also must choose and comply with three out of six additional "menu" set measures, as well as report at least nine clinical quality measures.

    The Stage 2 final rule mandates that doctors meet a larger number of core objectives — and stricter guidelines for some of those objectives already in place — during the next part of the three-stage program. Physicians also must adopt and demonstrate meaningful use of EHR systems by Oct. 1, 2014, or be assessed a 1% penalty from Medicare.

    For a Summary of CMS Stage 2 EHR Incentive Program and Breakdown of Stage 1 versus Stage 2 go to: http://bit.ly/RQMgWC and http://bit.ly/OWNb1n.

  – Stage 3. The HIT Policy Committee in December released their pre-rulemaking proposal on Stage 3. The Stage 3 objectives, for the most part, reiterate the Stage 2 goals, with higher thresholds for demonstrating meaningful use. The proposed requirements will go into effect in 2016. The AANS and CNS submitted comments in response to this proposal, pointing out the unique challenges of specialty care and voicing our concerns that the proposed Stage 3 requirements would be overly burdensome for specialists, thereby preventing neurosurgeons from complying with the program's requirements. The AANS and CNS also highlighted our concern that the Stage 3 recommendations are being made without considering how providers — especially neurosurgeons and other specialists — have fared with meeting the criteria used in Stages 1 and 2 of the EHR Incentive Program. Additionally, we cited the need for CMS to better align the agency's various quality improvement programs, given the fact that these programs will become punitive in future years. Finally, we highlighted neurosurgery's clinical data registry, the National Neurosurgery Quality and Outcomes Database (N^2QOD), noting that comprehensive "registry data can be used to develop specialty specific quality and outcomes measures that will be more meaningful than current 'check box' measures contained in the EHR Incentive Program." Click here for a copy of our comments: http://bit.ly/X4iLxb

In an effort to further accelerate and advance interoperability and health information exchange beyond what is currently being done through the Office of the National Coordinator (ONC) and the Electronic Health Record (EHR) Incentive Program, the Center for Medicare and Medicaid Services (CMS) has decided to delay any Stage 3 Meaningful Use rulemaking until next year. In the interim, CMS is reaching out to stakeholders, through a request for information (RFI) for advice on how new payment models affect implementation of electronic health records. The Stage 3 delay is a request neurosurgery has made to CMS numerous times. Neurosurgery plans on responding to this and voicing our continued concerns with the EHR Incentive Program and its associated timelines. Neurosurgery plans on responding to the RFI.

- Legislation. In an effort to try and address the impending penalties, specifically for small group practices, the AANS and CNS signed onto a letter asking Congress to delay the penalties. As a result, Rep. Diane Black re-introduced her bill in March. This legislation would make common sense reforms, including:

    - Creating a hardship exemption for solo practitioners and physicians in and near retirement to avoid exacerbating workforce shortages;
    - Shortening the gap between the performance period and the application of the penalty;
    - Expanding options for participation in the incentive program and improving quality measures through incorporation of specialty-led registries;
    - Increasing participation among rural health care providers;
    - Tailoring requirements to meet specific needs of certain specialties; and
    - Establishing an appeals process before application of penalties.

  The AANS and CNS with the Alliance, also recently met with a key member of the HIT Policy Committee to discuss specialty specific issues and a possible specialty pipeline for achieving meaningful use.

Additional ACA Provisions Targeted Toward Quality and Efficiency

The ACA authorizes the creation of a new Center for Medicare and Medicaid Innovation (CMMI) to test new payment and treatment models that improve coordination, quality and efficiency. The ACA provides $10 billion over 10 years for new demonstration projects and pilot programs to test payment models designed to catalyze transformation of the delivery system, moving it away from fee for service and toward care coordination. In a recent hiccup, the Congressional Budget Office released a briefing paper last January that concluded CMS' demonstrations aimed at enhancing the quality of health care and improving the efficiency of health care delivery in Medicare's fee-for-service programs have not reduced Medicare spending. In nearly every program involving disease management and care coordination, spending was either unchanged or increased relative to the spending that would have occurred in the absence of the program, when the fees paid to the participating organizations were considered. Despite these concerns, the program is moving forward full-speed-ahead, although some in Congress are pressing for more oversight and details about this program's funded projects.

Shared Savings Program and Accountable Care Organizations

The ACA created the authority to establish ACOs — coordinated networks of providers that would be rewarded by Medicare for collaborating to redesign care processes that result in improved coordination, quality and cost-efficiency. Medicare ACOs will be operational in 2012. Additionally, because of all the criticism levied on the Obama Administration for an overly restrictive ACO rule, CMS created the Pioneer ACO Model. The Pioneer ACO Model was designed specifically for organizations with experience offering coordinated, patient-centered care, and operating in ACO-like arrangements. CMS has selected 32 organizations selected to participate in the Pioneer ACO Model. The AANS and CNS continue to support efforts to experiment with innovative models of healthcare delivery, but question the ability of the shared savings model to bring value to a system that is currently plagued by more fundamental problems, such as the flawed SGR. Finally, we are concerned that ACOs are nothing more than capitated managed care plans that ultimately will restrict patient access to vital medical services.

Hospital Quality Initiatives

The AANS and CNS continue to monitor various hospital quality initiatives as they apply to neurosurgeons. Topics include the hospital readmissions, payment reductions for hospital acquired conditions (e.g., surgical site infections), SCIP measures (e.g., clipping vs. shaving) and the application of quality requirements to outpatient departments. Hospitals that did not submit quality data in 2011 received a 2% pay cut in 2012. In April, CMS released the 2013 Inpatient Prospective Payment Rule and the AANS and CNS provided comments on such issues as the safe surgery checklist, hospital wide readmission program, Medicare spending per beneficiary measure and the proposed removal of the SCIP VTE measure.

Comparative Effectiveness Research

CER was considerably expanded with the passage of ACA, which established the new Patient Centers Outcomes Research Institute (PCORI). 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). On June 1, 2012, neurosurgeon Matthew J. McGirt, MD, chaired a physician-patient roundtable discussion on comparative effectiveness research (CER) and the current work plan of PCORI. Sponsored by the PIPC, the roundtable focused on ways to ensure that patients and physicians have input into the processes, strategic research agenda and individual project decisions of PCORI. Additionally, the roundtable considered issues related to CER in spine and discussed the importance of seeking patient centricity in the diagnosis and treatment of patients with spinal disorders.

Based on an AANS and CNS proposal, neurosurgery was selected to participate in a PCORI forum last December to help shape their agenda, entitled “What Should PCORI Study?” Zachary Litvack, MD represented neurosurgery at the forum and our proposals dealing with developing and determining the best validated patient outcomes measurements, shared decision making and funding research related to defining valid outcome measurements were well received.

In March, PCORI conducted a workgroup meeting to discuss, “Treatment Options for Back Pain”. The aim of the multi-stakeholder group was to advise PCORI on highest priorities of funding within this topic. “Treatment Options for Back Pain” is one of five focused funding areas for which RFAs will be announced this Spring. Individuals at this roundtable meeting included representatives of osteopathic medicine, health services researcher, anesthesia pain management, employers, physical therapy, radiology, the NIH, occupational therapy, chiropractic care, and patient advocates. Matt McGirt, MD and Joseph Weistroffer, MD (AAOS) were the only surgeon representatives. The session was moderated by Paul Shekelle, MD, PhD, Director of RAND and Quality Improvement at UCLA.

After an all-day meeting, five areas emerged (which seemed almost predetermined by PCORI): 1. Methods for classifying patients for treatment planning; 2. Effectiveness of treatment options; 3. Relapse prevention and self-management; 4. Prioritizing Outcomes and; 5. Healthcare Systems

Dr. McGirt made a strong argument that it would be a mistake to ignore several areas surrounding lumbar surgery in PCORI low back pain funding priorities. He highlighted that despite the competing effectiveness and decision making that patients undergo for alternative treatments early during their presentation of back pain (which was most of the meetings focus), a substantial number receive and fail non-invasive medical treatments and present for consideration of surgical intervention. This surgical phase is the most costly, involves the most risk taking, is irreversible, and MUST be studied. He highlighted the feasibility and utility of longitudinal outcomes registries to capture the patient experience throughout an extended episode of back care, to identify prognostic patient-level factors to refine surgical indications, and to develop informed and shared decision aids. He also highlighted the rapidly rising utilization of fusion and the need to fund comparative effectiveness of this intervention, etc. Joseph Weistroffer (AAOS) was highly supportive.

In sum, neurosurgery was successful in narrowing category #2 (Effectiveness of treatment options) to three high focus treatments in: opioids, spinal injections, and surgery/fusion. In category #5 (Healthcare Systems), neurosurgery was successful in getting the use of outcomes registries to inform patient

decision making listed as a priority. The PCORI board of governors will meet to vote and refine the list of priorities.

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 National Neurosurgery Quality and Outcomes Database (N^2QOD). NPA has partnered with the Vanderbilt Institute for Medicine and Public Health (VIMPH) to provide an online data-entry system and to perform back-end statistical analysis of the data and provide individualized feedback reports to practices. To date, 31 groups have signed contracts to participate in the initial N^2QOD spine module. Nearly 40 have gone through IRB review. Additional plans are in the works to develop more subspecialty modules and an "essentials" module to encourage more physicians to participate in this initiative. NPA leaders and Washington Office staff are working to position the NPA as a one-stop portal for purposes of MOC, PQRS and quality reporting. We are developing a plan for interfacing with key stakeholders (i.e., third party payers, employers, government officials). To this end, we have met with representatives from HHS, CMS, ONC, OCRP, NQF, United Healthcare, Pacific Business Group and others. The hope is to broaden our efforts with other major insurance companies and purchasers.

BCBSA Blue Distinction Program

Over the last year, the BCBSA worked with various stakeholders to develop a Blue Distinction Program for Spine Surgery to recognize what it deems high quality spine surgery facilities. In late 2010, the AANS and CNS were also asked to assist the BCBSA with updating its Blue Distinction Program for Rare and Complex Cancers. We continue to interface with BCBSA to educate them about the N^2QOD as a means of identifying neurosurgeons to quality for distinction. Unfortunately, it its latest iteration of the program for spine, BCBSA did not include participation in N^2QOD as a mechanism for neurosurgeons to achieve distinction.

ABIM *Choosing Wisely* Campaign

In an effort to address overuse of testing, the American Board of Internal Medicine Foundation launched the *Choosing Wisely* campaign in the spring of 2012. *Choosing Wisely* is part of a multi-year effort to help physicians be better stewards of finite health care resources. Originally conceived and piloted by the National Physicians Alliance through a Putting the Charter into Practice grant, nine medical specialty organizations, along with Consumer Reports, have identified five tests or procedures commonly used in their field, whose necessity should be questioned and discussed. The campaign is now going through a second phase and a total of 26 specialties have signed on and identified additional areas of overuse. The AANS and CNS have been invited to participate in this campaign and we are currently reviewing appropriate areas for this campaign. Most recently, the CV section provided input to the American Academy of Neurology on their *Choosing Wisely* items. For more information go to: http://bit.ly/Kqr7j8

Quality Improvement Organizations

The AANS and CNS continue to actively participate in a number of quality improvement organizations, including the Physician Consortium for Performance Improvement, Surgical Quality Alliance, and National Quality Forum. It has been decided to terminate our participation with AQA, due to their lack of relevance and value. Projects include:

- Perioperative measure set
- Efficiency and overuse measures, including imaging
- Fostering use of clinical registries
- Regionalized emergency care
- Stroke measure set
- Measure Application Partnership (MAP)
- Measures for use by CMS in payment systems
- Consumer assessment of healthcare providers and systems (CAHPS) for surgery.

- Physician profiling and public reporting

We have also recently nominated a number of neurosurgeons to participate on several quality-related projects, including:

- John Ratliff, MD was nominated, but not chosen for the NQF Cost and Resource Use Steering Committee. This project focuses on evaluating and endorsing cost and resource use measures
- Shelly D. Timmons, MD was appointed to the NQF Phase II Regionalized Emergency Medical Care Services (REMCS) Taskforce. The taskforce is responsible for providing guidance to measure developers on the Office of Assistance Secretary for Preparedness and Response's prioritized areas of ED crowding, including a specific focus on boarding and diversion, emergency preparedness, and surge capacity.
- Michael G. Kaplitt, MD was appointed to the NQF Neurology Endorsement Project. He is the sole neurosurgeon on the panel. The panel is responsible for re-evaluating existing neurology measures and reviewing new measures. Measures under review relate to stroke, Parkinson's, and epilepsy. CMS put forward two stroke readmission and mortality measures and due to weak evidence they were voted down. Neurosurgery was not supportive of the measures.
- Jeffrey W. Cozzens, M.D., FACS, was recently selected as an expert panelist to serve on an Agency for Healthcare Research and Quality (AHRQ) ICD-10-CM/PCS Quality Indicators (QI) Neurology Group. The workgroup process will lead to recommendations regarding how the existing AHRQ QIs should be re-specified using ICD–10–CM/PCS codes, retaining the original clinical intent of each indicator while taking advantage of the greater specificity of ICD–10–CM/PCS to improve the indicator's validity.
- John K. Ratliff, MD, FACS to the Physician Consortium for Performance Improvement (PCPI) Medicare Episode Grouper: Musculoskeletal-Orthopedics Work Group.

Joint Commission Stroke Certification

On Jan. 28, 2013, the American Academy of Neurology (AANS), American Association of Neurological Surgeons (AANS), American Board of Neurological Surgeons (ABNS), Congress of Neurological Surgeons (CNS), AANS/CNS Joint Cerebrovascular Section, Society of Neurointerventional Surgery (SNIS), Society of Neurological Surgeons (SNS), and the Society of Vascular and Interventional Neurology (SVIN) sent the Joint Commission an additional letter regarding the JC's standards for Comprehensive Stroke Centers (CSC). The group made the following recommendations to the current CSC requirements:

For aneurysmal subarachnoid hemorrhage care:

1. We recommend that the number for procedures for intracranial aneurysms be increased to ≥30, with a minimum of 10 microsurgical clipping and 20 endovascular coiling procedures at each CSC. It is imperative that centers demonstrate that they are capable of adequately treating aneurysms with BOTH clipping and coiling approaches on a 24/7 basis.
2. We recommendations adoption of the AHA/ASA guidelines which support demonstrating care of ≥35 patients annually with aneurysmal subarachnoid hemorrhage.

For acute ischemic stroke:

1. We recommend a minimum number of endovascular cerebral (extracranial and/or intracranial) procedures for patients with ischemic stroke; based upon consensus and emerging data, at least 10 endovascular ischemic stroke cases every year should be adopted as a criterion to qualify for comprehensive stroke center certification. This capability must be available on a 24/7 basis at a CSC.

Representatives from the group met with Jean Range from the JC during the Brain Attack Coalition meeting.

GUIDELINES

Current Committee Members

Tim Ryken, MD, Chair
Sepideh Amin-Hanjani, MD,
Co Vice-Chair Kevin Cockroft, MD, Co Vice-Chair
Steven Kalkanis, MD, Co Vice-Chair

P. David Adelson, MD (Past JGC Co-Chair)
Peter Angevine, MD (CV Section)
Thank Brooks, MD (Spine)
Jeff Bruce, MD (Tumor Section)
Steve Casha, MD (Tumor Section)
Sean Christie, MD (Spine Section)
Jeff Cozzens, MD (CRC)
Aaron Filler, MD (Peripheral Nerve)
Ann Flannery, MD (Pediatric Section)
Sarah Gaskill (Pediatric Section)
Isabelle Germano, MD (Tumor Section)
Gregory Hawryluk, MD (Trauma Section)
Dan Hoh, MD (Spine)
Brian Hoh, MD (CS Section)
Kathryn Holloway, MD (Stereotactic Section)
Steve Hwang, MD (Spine)
Jack Jallo, MD (Trauma Section)
Terrence Julien, MD (Tumor Section)
John Kestle, MD (AANS Appointee/Peds)
Alex Khalessi, MD (CV Section)
Abhaya Kulkarni, MD (AANS Appointee/Peds)
Sean Lavine, MD (CV Section)
Elad Levy, MD (CV Section)
Mark Linskey, MD (Past JGC Chair)
Zachary Litvack, MD
William Mack, MD (CV Section)
Christopher Madden, MD (Trauma)
Cathy Mazzola, MD (Pediatric Section)
Tood McCall, MD
J. Mocco (CV Section)
Jeffrey Olson, (Tumor Section)
John O'Toole (Spine Section)
Chirag Patil (Tumor Section)
Julie Pilitsis, MD (Pain/Stereotactic Section)
J. Adair Prall, MD (Trauma Section)
Patricia B. Raksin, MD (Trauma Section)
Daniel K. Resnick, MD (Spine Section)
Josh Rosenow, MD (Pain/Stereotactic Section)
John Shin, MD (Spine)
Konstantin Slavin, MD (Stereotactic Section)
Martina Stippler, MD (Trauma Section)
Krystal Tomei, MD (CNS Appointee)
Marjorie Wang, MD (Spine Section)
Monica Wehby, MD (CSNS Appointee)
Chris Winfree, MD (Pain Section)
Christopher Zacko , MD (Trauma Section)
Gabriel Zada, MD (Tumor Section)
Gregory Zipfel, MD (CV Section)

Consultant:
Beverly Walters, MD

Staff Liaisons:
Laura Mitchell
Koryn Rubin

Administrative Issues

As of January 1, 2012, Tim Ryken assumed the position of JGC Chair. The following individuals will serve as Co Vice-Chairs: Sepideh Amin-Hanjani, Kevin Cockroft, and Steve Kalkanis. Additionally, the CNS has hired a new guidelines manager, Laura Mitchell. The JGC also now has its own CNS-hosted website at: http://www.cns.org/advocacy/jgc/default.aspx.

IOM Committee on Developing Trustworthy Clinical Practice Guidelines

In March 2011, the Institute of Medicine's (IOM), as commissioned by Congress as part of the Medicare Improvement for Patients and Providers Act of 2008, released a report titled, "Clinical Practice Guidelines We Can Trust." Mark Linskey and Koryn Rubin have participated on the Council of Medical Specialty Societies (CMSS) Clinical Practice Guideline (CPG) Component Group, which has been working to develop a response to the IOM's standards for guidelines. The CMSS hosted a call in March, 2012 to discuss the suggestions and comments provided by varying organizations and subspecialty groups regarding the set of "Principles for the Development of Specialty Society Clinical Guidelines." The CMSS issued the publication of the finalized principles in January 2013. [See link: http://bit.ly/YhdG6W]

CNS Guidelines Committee

In April, 2012, the CNS created a Guidelines Committee and appointed Steven Kalkanis as the Guidelines Committee Chair. This committee will facilitate interaction with the AANS/CNS Joint Sections and CNS Guidelines personnel to continue creating high quality evidence-based guidelines.

The CNS Guidelines Committee provides varying levels of support to sponsoring sections such as refining an initial guideline topic, creating a multidisciplinary taskforce group, evidence tables development, librarian and methodological support, grading criteria for levels of evidence and recommendation, assistance with writing, peer review by the AANS/CNS Joint Guidelines Committee, publication logistics/liaison with Neurosurgery®. Additional information regarding initial planning and development of evidence-based guidelines can be located at: http://www.cns.org/guidelines/

Neurovascular Coalition

The American Association of Neurology (AAN) recently reached out to neurosurgery to re-join the Neurovascular Coalition. The coalition previously fell apart due to conflicting viewpoints from member groups. A group met in February to discuss reinitiating this effort, and the organizations agreed that it was a good idea, but that going forward the coalition would be neuro-based. The members will include:

- American Academy of Neurology
- AANS/CNS Cerebrovascular Section
- American Society of Neuroradiology
- Society of NeuroInterventional Surgery
- Society of Vascular and Interventional Neurology

The group also tentatively decided to rename the coalition the "CerebroVascular Coalition." Each organization will have a representative, who will serve as the point person to the coalition. Kevin Cockroft, MD and Nick Bambakidis, MD will serve in this role. Washington Office staff will provide additional support.

The mission of the Coalition is to ensure excellence in medical education, training, and research related to vascular conditions affecting the central nervous system and thus promote high-quality patient care. The Coalition also provides expert advice on health care policy in order to advance the diagnosis, prevention and treatment of vascular disorders

Current and Completed Projects

- **Cerebrovascular**
  - AHA Stroke Projects. There are several AHA guidelines and scientific statements of interest to neurosurgery that recently have been, or soon will be, updated. These include: Secondary Stroke Prevention, Intracerebral Hemorrhage, Subarachnoid Hemorrhage, Management of Acute Stroke and Primary Stroke Prevention.
  - Early Management of Patients With Acute Ischemic Stroke
  - Cerebral Venous Thrombosis
  - Definition of Stroke
  - Palliative and End of Live Care in Stroke (Scientific Statement)
  - Evaluation and Management of Malignant Infarcts
  - Risk of Cervical Arterial Dissection after Chiropractic manipulation (Scientific Statement)
  - Management of Cerebral & Cerebellar Infarction with Swelling
  - Cervical Dissection and Palliative Care (Scientific Statement)
- **Spine/Peripheral Nerve**
  - Guidelines for the Surgical Management of Cervical Degenerative Disease
  - Position Statement on Percutaneous Vertebral Augmentation
  - Treatment of Osteoporotic Spinal Compression Fractures

- Cervical and Thoracic Spine Disorders Guideline
- AAOS/ADA Antibiotic Prophylaxis for Bacteremia in Patients with Total Joint Replacements Guideline
- Lumbar Fusion Guideline
- Cervical Spine Trauma Guideline
- AAOS Guideline on Diagnosis of Carpal Tunnel Syndrome

- **Trauma**

  - Thoraco-Lumbar Trauma Guideline
  - Traumatic Brain Injury
  - Transfer of Patients with Traumatic Brain Injury
  - Management of Coagulopathy and DVT Prophylaxis in TBI Patients
  - The Role of the Neurosurgeon in the ICU
  - American College of Occupational and Environmental Medicine (ACOEM) chapter on traumatic brain injury within its evidence-based Occupational Medicine Practice Guideline

- **Tumor**

  - Guidelines for the Treatment of Newly Diagnosed Glioblastoma
  - Metastatic Brain Tumor Guidelines
  - ASTRO Guideline on Radiotherapeutic and Surgical Management for Brain Metastases
  - Metastatic Spinal Tumor Guideline
  - Management of Progressive Glioblastoma
  - Non-Functioning Pituitary Adenoma Guideline
  - Low-Grade Glioma

- **Stereotactic/Functional**. This Section is currently in the process of prioritizing topics for guideline development, including Surgery for Epilepsy and retackling the Movement Disorder Guideline. In addition, the CNS Guidelines Committee and staff are currently formulating a multidisciplinary taskforce to develop a Deep Brain Stimulation Guideline for patients with Obsessive Compulsive Disorder.

- **Pediatrics**

  - Hydrocephalus

- **Pain**. This Section is interested in collaborating with the Spine Section to begin developing a guideline on spinal cord stimulation.

Cross-Sectional Projects

  - Appropriateness Criteria for Diagnostic Imaging
  - CSNS Brain Death Guidelines

Emergency Neurosurgical Services Update

Legislative Activities

- **Pandemic and All-Hazards Preparedness Act (PAHPA) Signed Into Law**. On Jan. 18, Rep. Mike Rogers (R-MI) reintroduced Pandemic and All-Hazards Preparedness Reauthorization Act (PAHPA) of 2013 (H.R. 307). The bill was immediately placed on the suspension calendar for Tuesday, Jan. 21 and passed 395-29. On Feb. 7, Sen. Richard Burr (R-NC) introduced companion legislation, S. 242 that was passed by unanimous consent on Feb. 27. The differences in the two bills were then easily resolved and presented to the President for his signature on March 13. It is now Public Law (PL) 113-005. Supported by the AANS and CNS, this law contains several provisions that our organizations strongly advocated for inclusion including:

  - Strategies for preparedness and response during public health emergencies;
  - A national strategy for establishing an effective and prepared public health workforce;
  - Integrating public health and public and private medical capabilities with first responder systems;
  - Increasing preparedness, response capabilities and surge capacity of hospitals, other health care facilities and ambulatory care facilities and trauma care, critical care and emergency medical service systems including related availability, accessibility, and coordination; and
  - Coordinated medical triage and evacuation to appropriate medical institutions based on patient medical need, taking into account regionalized systems of care.

- **EMTALA-Related Medical Liability Protection Legislation Re-Introduced.** Working with other Trauma Coalition members, AANS/CNS was once again successful in having legislation introduced that would provide medical liability protections to all physicians that provide EMTALA-related emergency care. This would include physicians who initially see the patient upon arrival at an emergency department to physicians who provide stabilization and post-stabilization services, including surgery. The bill would provide protection by moving these physicians under the protection of the Federal Tort Claims Act.

  H.R. 36, the Health Care Safety Net Enhancement Act of 2013, was introduced by Reps. Charlie Dent (R-PA) and Pete Sessions (R-TX) on the first day of the 113th Congress, January 3, 2013. The bill currently has 42 co-sponsors, including four democrats. Trauma Coalition members are actively looking for a Senate champion to introduce companion legislation.

- **Senate Judiciary Holds Hearing on "Proposals for Reducing Gun Violence".** On Tuesday, Feb. 12, the day of President Obama's first State of the Union address of his second term, the Senate Judiciary Subcommittee on the Constitution, Civil Rights, and Human Rights held a hearing to discuss proposals for reducing gun violence in America. Sen. Dick Durbin (D-IL), Senate Assistant Majority Leader and Subcommittee Chairman organized the hearing to discuss whether proposals such as universal gun background checks, limits on ammunition magazine capacity, tougher gun trafficking laws, and restrictions on military-style assault weapons are consistent with the Second Amendment and whether they burden law-abiding gun owners. The hearing also explored whether these proposals will help better protect children and communities from gun violence. The original federal assault weapons ban expired in 2004, but new weapons ban legislation was recently introduced by Sen. Dianne Feinstein (D-CA). S. 150, the Assault Weapons Ban of 2013 would ban the import, sale, manufacture, transfer, or possession of a semiautomatic assault weapons.

  On the other side of the debate, the CEO of the National Rifle Association said the nation's mental health system is broken and called for a study into the "the full range of mental health issues, from early detection and treatment, to civil commitment laws, to privacy laws that needlessly prevent mental health records from being included in the National Instant Criminal Background Check

System." Senator John Cornyn (R-TX) said that background-check legislation should be "updated to screen out the growing number of people who are subjected to court-ordered outpatient mental-health treatment." Apparently a bipartisan group of senators are drafting legislation that would include mental health records in background checks.

The Washington Committee is working with the Trauma Section to draft statement on firearms safety, advocating for education and prevention, without getting into the specifics related to background checks, weapons' ban, etc.

- **Field EMS Bill Supported by AANS/CNS**. As previously reported, H.R. 3144, the Field EMS Quality, Innovation and Cost-Effectiveness Improvement Act, was introduced by Reps. Tim Walz (D-MN) and Sue Myrick (R-NC) and supported by AANS/CNS in the 112th Congress. The bill would provide a path first identified by the IOM's landmark 2006 report, *Emergency Medical Services: At the Crossroads*. Among IOM's recommendations addressed in H.R. 3144 is the establishment of a primary federal agency for EMS and trauma. Unfortunately Rep. Myrick retired and due to political pressure from the fire fighters association, Rep. Walz has decided to pull his support. So, we have identified a new champion for this legislation and Rep. Larry Bucshon, MD (R-IN) introduced H.R. 809 in the 113th Congress.

Other

- **GAO Report Released on Trauma-EMS.** After an extensive and persuasive lobbying effort by the AANS/CNS and other trauma-EMS interested organizations, in Jan. 2012, Reps. Fred Upton (R-MI) and Henry Waxman (D-CA), the Chairman and Ranking Member respectively, of the U.S. House Energy & Commerce Committee directed the Government Accountability Office (GAO) to conduct a study on the availability, capacity and preparedness of health systems to provide surge capacity to address public health emergencies.

  The report, *National Preparedness; Improvements Needed for Measuring Awardee Performance in Meeting Medical and Public Health Preparedness Goals*, was finally released on March 22, 2013. Unfortunately, it does not directly address the main focus of the original study request letter questions, but instead focused on the Hospital Preparedness Program (HPP) and the Public Health Emergency Preparedness (PHEP) program awardees and the progress they have made towards carrying out the required activities of these grants. While the impact of these federal grants programs was part of the initial GAO report request, we are disappointed that due to a lack of available information, several study requests were not taken into account, specifically in regard to emergency and trauma care systems. To see the report, please go to http://www.gao.gov/mobile/products/GAO-13-278.

  AANS/CNS staff will meet with other interested groups to go through the report to develop next steps to follow up with this report. While at first glance it doesn't appear to provide any specific data for us to use, we are hopeful that we will be able to work with HHS and ASPR to change and enhance the current performance targets of these grants in order to achieve better public health preparedness.

- **IOM Committee on Sports-Related Concussions in Youth.** The Institute of Medicine has formed a committee to study sports concussions in youth, holding its first session on Jan. 7, 2013. The committee, formed at the request of two senators – Jay Rockefeller (D-WV) and Tom Udall (D-NM) -- is reviewing current science on concussions and will issue a report with findings and recommendations by early 2014. The report will include findings on the effects of head impacts on the brain, risk factors for sports concussions, different diagnostic tools and the effectiveness of protective equipment, among other things. The AANS and CNS had nominated Geoff Manley, MD to serve on the committee, but unfortunately because he had served on the American Academy of Neurology's guidelines committee reviewing this topic, he was disqualified from serving on the panel. IOM staff has assured us that we will have an opportunity to provide input. Further information about the effort is available at: http://bit.ly/ZD0Mp5.

- **IOM Hosts Workshop on Sports-Related Concussions in Youth.** On Feb. 25, the IOM Committee on Sports-Related Concussions in Youth hosted a workshop to hear testimony from several stakeholder groups, including physicians, school officials, coaches, sports officials, military representatives, and equipment manufacturers. The purpose of this workshop was to provide committee members with information on current strategies for the reduction of sports-related concussion in youth, the diagnosis and management of concussion in youth, and the interface between medical and educational systems in managing concussed athletes' return to school.

  Panelists from varied backgrounds and experiences provided the committee with recommendations regarding evaluation, education and training, increased awareness, coordination, and communication. Everyone from parents, teachers, coaches, officials, players, etc. must be part of a prepared system that goes into effect as soon as any type of head injury occurs to ensure that a child's health is not compromised. From the "field of injury" to recovery, there are many coordinated steps that all adults in a child's life must be made aware of and made to follow.

  Established last year, this committee has been charged to conduct a study and prepare a report on sports-related concussions in youth, from elementary school through young adulthood, including military personnel and their dependents. The committee is reviewing available literature on concussions, in the context of developmental neurobiology, in terms of their causes, relationships to hits to the head or body during sports, effectiveness of protective devices and equipment, screening and diagnosis, treatment and management and long-term consequences.

- **Staff Meets with National Institute of Neurological Disorders and Stroke (NINDS) at NIH.** On January 4, as part of the National Coalition for Heart Disease and Stroke, AANS/CNS staff met with several NIH personnel, including Story Landis, Ph.D., director of the NIH National Institute of Neurological Disorders and Stroke (NINDS), to receive an update on current research programs currently under way at NINDS.

  Most importantly, the Stroke Progress Review Group has recently narrowed down over 150 recommendations to nine, with three each in three separate categories: prevention, treatment, and recovery. For more information, go to http://1.usa.gov/YsA4wp Also, the Neurological Emergencies Treatment Trials (NETT), which is comprised of several stakeholder (neurosurgeons, emergency physicians, etc.) has found significant evidence of therapies that have improved patient outcomes and will continue to fund these trials. Information can be found at: http://1.usa.gov/YsA9jS. The biggest hurdle facing the NINDS right now is lack of funding. There is significant concern that there is not enough money to fund all the research they have planned, specifically the Stroke Progress Review Group recommendations, among others. For more information on other research programs that NINDS is currently funding, please go to the following website: http://1.usa.gov/XVvd2L.

Medical Liability Reform Update

Health Coalition on Liability and Access

The Health Coalition on Liability and Access, of which Katie Orrico is Vice Chair and Chair of its Legislative Committee, has planned for an active year. Information about HCLA and the *Protect Patients Now* initiative is available at http://bit.ly/114rbdH. HCLA's Legislative Agenda includes the following:

- Maintaining support for the HEALTH Act as the fundamental basis of proven medical liability reform. The HEALTH Act has a hard $250,000 cap.
- Adopting additional reforms -- liability protections for volunteers, pretrial screening, certificate of merit, expert witness, protection for physicians following practice guidelines -- to complement the HEALTH Act and which may garner bipartisan support.
- Promoting modifications to the ACA including: Amending the medical liability reform demonstration project language and adding new language stating that nothing in the Act shall create new causes of action.
- Monitoring efforts to repeal the antitrust exemption for medical liability insurers.

Congressional Activities

Efforts to reform the medical legal system have gotten off to a slow start in the 113th Congress. Rep. Phil Gingrey, MD (R-GA) is expected to reintroduce the HEALTH Act later this spring. In addition, he will soon introduce the Standard of Care Protection Act, which makes it clear that nothing in the ACA or Medicare creates a national standard of care. There is some concern that quality reporting and other similar mandates will be used to argue that physicians who do not successfully comply with these payment programs have also failed to meet the standard of care.

In the Senate, Sen. Rob Portman (R-OH) has introduced S. 44, the Medical Care Access Protection Act of 2013, which adopts a "stacked cap" approach, similar to that in place in Texas. It has one cosponsor. Sen. Roy Blunt (R-MO) is expected to introduce the HEALTH Act.

Federal Rules Initiative

The AANS and CNS, along with the AMA and a handful of other medical specialties, have been working with Professors Kenneth Lazarus and Paul Rothstein of Georgetown University Law Center on the Federal Rules Initiative Group. This initiative is an effort to protect the litigating interests of physicians. Amendments to the Federal Rules impact federal court cases and also generally serve as a model for state rule enactments. Recent changes were made governing the discovery of expert testimony and the utilization of summary judgment remedies.

State Activities

- **Oregon.** The Oregon legislature passed S.B. 483, a bill to establish an early discussion and resolution (EDC) process within the Oregon Patient Safety Commission (Commission). This voluntary process is intended to facilitate open communication about all outcomes of care, including serious events, between the provider, health care facility and the patient. Pursuant to the bill, when an adverse health care incident occurs, the patient, health care provider or health care facility where the incident occurred may file a notice of adverse health care incident with the Commission. This notice triggers discussion of the health care incident and, if appropriate, an offer of compensation. If discussion does not result in the resolution of the claim, the bill gives the parties the option of participating in Commission-facilitated mediation. The entire process is voluntary. S.B. 483 is the result of negotiations between the Oregon Medical Association and Oregon trial bar, at the direction of Oregon Governor John Kitzhaber. The governor, an emergency room physician, has made medical liability reform one of his top priorities.

- **Mississippi.** On Feb. 27, the U.S. Court of Appeals for the Fifth Circuit in *Learmonth v. Sears, Roebuck & Co.* upheld Mississippi's $1 million limit on noneconomic damages in personal injury cases. Mississippi's separate $500,000 limit on noneconomic damages in medical malpractice cases was not at issue.

- **Arizona.** March 12, Arizona's Supreme Court unanimously upheld state law that reasonably requires medical liability plaintiffs to adduce expert testimony in support of their claims from physicians practicing within the same medical specialty as defendant physicians. The high court ruling acknowledged that the expert witness "requirement makes it more difficult to file medical-malpractice suits but is not unconstitutional because the requirement doesn't flatly prevent plaintiffs from having their day in court."

Physician Industry Relations

- **Sunshine Act Final Rule.** On February 1, 2013, CMS issued the final regulations implementing the Physician Sunshine Act, which requires drug and medical device companies to publicly disclose their financial relationships with physicians. According to the final rule, CMS will publicly available payments or other transfers of value -- including gifts, consulting fees, research activities, speaking fees, meals and travel -- from manufacturers of drug, device, biologic and medical supply covered by Medicare, Medicaid and the Children's Health Insurance Program which require a prescription, for drugs and biologics, or FDA premarket approval or notification, for devices. In addition, CMS will also make information publicly available about physicians' or immediate family members' ownership or investment interests in applicable manufacturers and group purchasing organizations. A copy of the final regulation is on the web at http://1.usa.gov/YzPU4Z. Below are some key topics of interest to the AANS and CNS.

  - Reporting and Data**.** Under the final rule, industry and applicable group purchasing organizations will have to start collecting data on their financial relationships with physicians Aug. 1 and report the data for August through the end of 2013 to CMS by March 31, 2014. CMS will release the data on a public website by Sept. 30, 2014, according to the agency. Physicians will have an additional 15 days to resolve any disputes about the information before it is published publicly following a 45-day review and correction period. The agency says the additional time was added in response to public comments requesting additional time to resolve disputes initiated late in the 45-day review period. Physicians will be notified of the information using an online posting and through notifications on CMS' list-serves, and any dispute will be resolved directly between the doctor and the manufacturer or GPO, the rule states.

  - CME. Importantly for the AANS, CNS and other medical organizations sponsoring CME, the final rule limits the reporting requirements for continuing medical education, excluding accredited CME activities that meet the definition of “indirect payments” from the law. As stated in the section on indirect payments or other transfers of value, the CMS does not intend to capture the attendees at accredited or certified continuing education events whose fees have been subsidized through the CME organization by an applicable manufacturer (as opposed to payments for speakers at such events); however, we believe that any travel or meals provided by an applicable manufacturer to specified covered recipients associated with these events must be reported under the appropriate nature of payment categories.

    Additionally, an indirect payment made to a speaker at a continuing education program is not an indirect payment or other transfer of value for the purposes of this rule and, therefore, does not need to be reported, when all of the following conditions are met: (1) the program meets the accreditation or certification requirements and standards of the ACCME, AOA, AMA, AAFP or ADA CERP; (2) the applicable manufacturer does not select the covered recipient speaker nor does it provide the third party vendor with a distinct, identifiable set of individuals to be considered as speakers for the accredited or certified continuing education program; and (3) the applicable manufacturer does not directly pay the covered recipient speaker. However, with regard to unaccredited and non-certified education, CMS believes that since this type of education program does not require the same safeguards as an accredited and certified program, payments or transfers of value should be reported as required for any other payment or other transfer of value. Thus the final rule appears to recognize the adequacy of current protections against inappropriate bias in CME, and makes clear that industry should not be discouraged from underwriting accredited CME activities.

- State and Local Law Preemption. Finally, the regulation preempts any State or local laws requiring reporting of the same types of information regarding payments or other transfers of value made by applicable manufacturers to covered recipients; thereby negating the need to file multiple reports.

- **Massachusetts Relaxes Ban on Manufacturer Gifts to Physicians.** On Nov. 21, 2012, the Massachusetts Public Health Council (PHC) approved the final regulatory amendments, effective Dec. 7, 2012, implementing the Pharmaceutical and Medical Device Manufacturer Conduct Law, which was amended by Gov. Deval Patrick in July 2012. The new regulations allow manufacturers to provide modest meals and refreshments to Massachusetts healthcare practitioners and to reimburse training expenses without a written purchase contract. Further, the PHC clarified that, while some disclosure requirements overlap with the federal Sunshine Act, others unique to Massachusetts remain. More information on the amendments to the regulations, known as the Marketing Code of Conduct, is available at http://1.usa.gov/WcycVT.

- **Partners for Healthy Dialogues.** The AANS and CNS are participating in PhRMA's "Partners for Health Dialogues" public education campaign. The Partners for Healthy Dialogues initiative is a collaboration between health care provider organizations and biopharmaceutical organizations to demonstrate the value of interactions between physicians and biopharmaceutical companies, from better patient care to advancing medical innovation. Drs. Robert Harbaugh, Steve Kalkanis and Aviva Abosch are serving as the official AANS/CNS liaisons and neurosurgery's spokespeople for this initiative. Details of the campaign are available at: http://bit.ly/YNDl6G.

Congressional Activity

- **Senate Device Industry Tax Repeal.** On March 21, 2012, the Senate passed an amendment to the Senate Budget Resolution, S. Con. Res 8, offered by Sens. Orrin Hatch (R-UT) and Amy Klobuchar (D-MN). The amendment would repeal the 2.3 percent excise tax levied on the sales of medical devices. This tax was included in the Patient Protection and Affordable Care Act. The bipartisan amendment overwhelmingly passed by a margin of 79-20, with 33 Democrats and one Independent joining all Republican senators in support of the measure. Repealing the medical device tax is one of neurosurgery's legislative priorities and AANS and CNS will has been and continue to collaborate with AdvaMed, which is leading the Device Tax Repeal Coalition, to seek the adoption of legislation that overturns the tax.

  Because Congressional budget resolutions are not law, but merely blueprints for each chamber to use in setting detailed budget priorities, the amendment is nonbinding and will not become law. However, it has symbolic repercussions as an overwhelming number of Democrats are now on record as opposing this tax, which went into effect in January. Assuming none of the amendment's backers rescind their support, Sens. Hatch and Klobuchar now have more than enough support to surpass the 60 votes needed to repeal the tax on another bill in the future. Both are the lead sponsors of S. 232, the Medical Device Access and Innovation Protection Act, which would repeal the device tax and currently has 29 cosponsors. Reps. Eric Paulsen (R-MN) and Ron Kind (D-WI) have introduced a companion measure in the House, H.R. 523, the Protect Medical Innovation Act This bill passed the House of Representatives in the last Congress and currently has 212 cosponsors, 6 shy of the 218 needed to pass the bill. Repealing the tax would cost $29 billion over a 10-year period.

- **House Energy and Commerce FDA Agenda.** The Chairman of the House Energy and Commerce Committee, Rep. Fred Upton (R-MI), and the Health Subcommittee Chairman, Joe Pitts (R-PA), recently released a list of five "policy concepts" they said were priorities for the 113th Congress. They include: keeping mobile medical applications and other health technology free from pre-market approval requirements and the PPACA medical device tax (at a recent hearing FDA officials stated they have no plans to regulate consumer smart-phones and tablet computers as medical devices and would not consider mobile platform manufacturers or medical apps distributors, such as the iTunes App store or the Android market, to be medical device manufacturers); empowering the critically ill to structure their own treatment and clarify the use of off-label drugs; reauthorizing the animal drug and

animal generic drug user fee legislation; encouraging the development of antibiotics; creating a workable framework for tracking drugs through the supply chain; and creating an FDA board of directors to assess the FDA's performance and to make recommendations for improvement.

Food and Drug Administration Activities

- **FDA Proposes Fees for Compounding Pharmacies.** In the aftermath of the meningitis outbreak that killed 50 people and injured hundreds from spinal injections produced by a Massachusetts compounding pharmacy, FDA Commissioner Margaret Hamburg has proposed charging compounding pharmacies fees to pay for FDA oversight. She called on Congress to pass legislation to provided increased resources to monitor them. More information is available at: http://1.usa.gov/ZW3enn

- **Neurological Devices Moved to New Division**. The FDA Center for Devices and Radiological Health (CDRH) Office of Device Evaluation (ODE) has been reorganized. There are two new divisions—the Division of Surgical Devices and the Division of Neurological and Physical Medicine Devices. The stated goal of the reorganization is to reduce manager to staff ratios and better align product areas, as well as accommodate the new employees that will be coming in to ODE as a result of changes implemented by the Medical Device User Fee Act (MDUFA) provisions of the Food and Drug Safety and Innovation Act (FDASIA), signed into law in July 2012.

  Acting Director of the new Division of Neurological and Physical Medicine Devices is Victor Krauthamer, PhD. Dr. Krauthamer's training was in neuroscience, behavior and electrophysiology. He received his B.S. degree from the City College of New York and his PhD degree from the State University of New York at Buffalo. He did postdoctoral research at the New York Medical College on multichannel optical recording from neurons and has held a faculty position at Nova-Southeastern University in Florida. Before the recent CDHR reorganization, Dr. Krauthamer was a research scientist and Director of the Division of Physics, overseeing programs in biophysics, electromagnetics, optics and human factors as related to medical devices. More information about the new FDA CDRH organization structure is on the web at: http://1.usa.gov/12XLEyN.

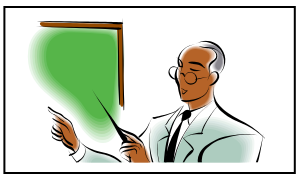
- **FDA Neurological Devices Panel for Neurostimulator for Epilepsy.** On Feb. 22, 2013, the FDA Neurological Devices Panel met to discuss, make recommendations and vote on information regarding the premarket approval application (PMA) for the NeuroPace RNS System sponsored by NeuroPace, Inc. The RNS System is indicated for use as an adjunctive therapy in reducing the frequency of seizures in individuals 18 years of age or older with partial onset seizures from no more than two foci that are refractory to two or more antiepileptic medications. CNS Executive Committee member, Ashwini Sharan, MD, presented information on behalf of the AANS, CNS and the American Society for Stereotactic and Functional Neurosurgery (ASSFN) discussing the patient population who may benefit from the device. The societies submitted written comments. More information on the panel meeting is available on the FDA website at: http://1.usa.gov/15Krc8S

- **Neurologic Devices Panel for NeuroFlo Catheter.** The FDA Neurological Devices Panel met on Dec. 10, 2012 (postponed from Nov. 1, 2012) to discuss current knowledge of the safety and effectiveness of the NeuroFlo Catheter for use in patients with acute ischemic stroke within 14 hours of symptom onset. The NeuroFlo Catheter is a 7 French multi-lumen device with two balloons mounted near the distal tip. The balloons can be inflated independently to occlude flow in the selected vessels. When used in the descending aorta of acute ischemic stroke patients, balloon inflation is intended to result in diversion of cardiac output to the upper torso and core organs. The NeuroFlo Catheter was approved under a Humanitarian Device Exemption (HDE) for the treatment of cerebral ischemia resulting from symptomatic vasospasms. Additionally, FloControl (a catheter that is physically identical to NeuroFlo) received previous marketing clearance for selectively stopping or controlling blood flow in the peripheral vasculature, which includes the descending aorta. The Panel discussion focused on the safety and effectiveness results and conclusions of the Safety and Efficacy of NeuroFlo Technology in Ischemic Stroke (SENTIS) trial. The non-voting panel provided expert scientific, statistical and clinical opinion on the risks and benefits of this device based on the available preclinical, clinical and postmarket data. Neurosurgeons on the panel included Earl R. Dorsey, MD,

MBA from Johns Hopkins University and Lynda Yang, D, PhD from the University of Michigan. More information is available at: http://1.usa.gov/XCWuuG

- **Network of Experts**. Since entering into a "Network of Experts" agreement with the FDA in the fall of 2012, the AANS and CNS have been called on by the agency several times to provide neurosurgical expertise. Recent requests have included clot retrievers and shunts. Specific details are covered by a confidentiality agreement. More information on the program is available on the FDA website at: http://1.usa.gov/TX2ZIa.

- **Spine Devices Forum**. On March 13, 2013, the North American Spine Society (NASS) hosted a multi-specialty FDA/Specialty Society Devices Forum. Charles Sansur, MD, and Washington Office staff attended the meeting on behalf of AANS and CNS. The meeting included a review of the drug and device approval processes, an overview of the relationship between FDA approval and reimbursement, an update on the spinal meningitis outbreak from spinal injections, and FDA recommendations for pain medications containing hydrocodone. NASS has proposed a second meeting for Aug. 2013 but a date has not yet been determined.



Neurosurgical Education and Training

IOM Study on Governance and Financing of Graduate Medical Education

Pursuant to a Congressional request in December 2011, the Institute of Medicine has embarked on a review of the GME system. An IOM committee will: (1) assess current regulation, financing, content, governance, and organization of U.S. graduate medical education (GME) and (2) recommend how to modify GME to produce a physician workforce for a 21st century U.S. health care system that provides high quality preventive, acute, and chronic care, and meets the needs of an aging and more diverse population. The study began June 1, 2012 and will conclude 16 months from this date.

The IOM has held a number of meetings, and Ralph Dacey, MD testified on behalf of organized neurosurgery testified at a December public hearing, and the AANS ,CNS, ABNS and SNS submitted a detailed paper to the IOM. A copy of the statement is available here: http://bit.ly/UjqyqZ. In our statement we recommended the following:

- Need more primary care ***and*** specialists
- Expand GME funding to fully cover all years of training
- Eliminate GME funding caps
- Establish an all-payer fund for GME
- Maintain funding for children's hospital GME
- Maintain the ACGME as entity overseeing GME

We will continue to interface with the IOM and others about this project and topic to help ensure that any recommendations are not detrimental to neurosurgical training and education. Information about the study is available at: http://bit.ly/HMpyZf.

Legislation

- **AAMC Holds GME Briefing.** On Feb. 21, the Association of American Medical Colleges (AAMC) hosted a briefing for physician organizations to discuss the future of Medicare GME funding, the challenges physicians face in the deficit reduction debate, and the potential impact on physician training. Led by Atul Grover, M.D., Ph.D., AAMC's Chief Public Policy Officer, organizations were updated on the current physician shortage crisis and the legislative efforts the AAMC are spearheading in the 113th Congress. While most of the physician shortage dialogue has been focused on primary care, Dr. Grover highlighted that the projected shortages for specialty care physicians are just as acute -- 65,800 shortage for primary care vs. 64,800 for specialists.

- **Alliance of Specialty Medicine Roundtable Briefing.** On March 19, the Alliance of Specialty Medicine held a roundtable briefing entitled: Ensuring an Adequate Specialty Physician Workforce for the 21st Century. Neurosurgeons attending on behalf of the AANS and CNS included John Wilson, MD, Ann Stroink, MD, Bob Harbaugh, MD and Krystal Tomei, MD. Speakers at the briefing included:

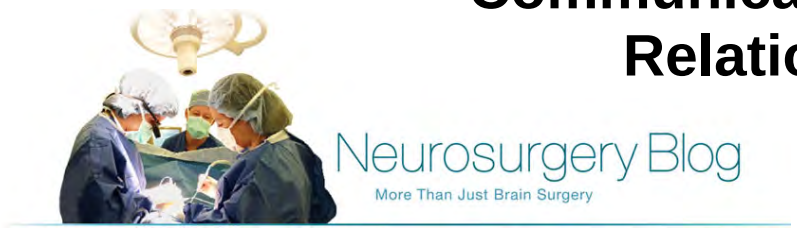
  - Atul Grover, MD, PhD, Chief Public Policy Office, Association of American Medical Colleges
  - Roger Herdman, MD, Director, Board on Health Care Services, Institute of Medicine
  - Congressional Staff Panel:
    - Margie Almanza, Rep. Aaron Schock (R-IL-18)
    - Remy Brim, PhD, Rep. Allyson Schwartz (D-PA-13)
    - Meghan Taira, Senator Charles Schumer (D-NY)
    - Sasha Albohm, Senator Bill Nelson (D-FL)
  - Honorable Aaron Schock (R-IL-18)

- **Legislation to Provide Additional Residency Slots Re-Introduced in the House and Senate.** On March 14, Reps. Aaron Schock (R-IL) and Allyson Schwartz (D-PA) re-introduced H.R. 1201, the

Training Tomorrow's Doctors Today Act. Capped in 1997 by the Balance Budget Act, this legislation would increase the number of Medicare supported residency positions by 3,000 each year for the next five years for a total of 15,000 new residency slots. One-half of these positions are required to be used for shortage specialty residency programs, of which neurosurgery qualifies. The bill currently has 10 co-sponsors.

Additionally, S. 577, the Resident Physician Shortage Reduction Act, was also introduced on March 14 in the Senate by Sens. Bill Nelson (D-FL) and Charles Schumer (D-NY) and has three co-sponsors. The companion bill, H.R. 1180, was introduced in the House by Reps. Joseph Crowley (D-NY) and Michael Grimm (R-NY). These bills also provide for an additional 3,000 residency slots for the next five years with half going to specialty shortage slots.

Communications and Public Relations Update



Administrative Issues

The goal of the Communications and Public Relations (CPR) Committee is to provide a strategic, formalized process to coordinate and prioritize Washington Committee/Office communications and public relations efforts.

- **Committee Members**

Monica Wehby, MD, Chair

Cory Adamson, MD (Young Neurosurgeons)
Peter Angevine, MD (Coding and Reimbursement)
Tony Asher, MD (NeuroPoint Alliance)
Rick Boop, MD (Journal of Neurosurgery)
Sander Connelly, MD (Neurosurgery)
William Curry, MD (Tumor Section)
Art Day, MD (Society of Neurological Surgeons)
Rick Fessler, MD (Drugs and Devices Committee)
James Harrop, MD (CNS Quarterly)
Jason Hauptman, MD (CSNS Resident Fellow)
Kathryn Holloway, MD (Stereotactic Section)
Rashid M. Janjua, MD
Jack Knightly, MD (QIW)
Alon Mogilner, MD (Pain Section)
David Okonkwo, MD (Trauma Section)
Corey Raffel, MD (Pediatric Section)
Brian Ragel, MD (CNS)
Clemens Schirmer, MD, PhD
Gary Simonds, MD (CSNS)
Mike Steinmetz, MD (Spine Section)
Brian Subach, MD (AANS)
Shelly Timmons, MD (Emergency NS Task Force)
Craig Van der Veer, MD (NeurosurgeryPAC)
Christopher Winfree, MD (Guidelines Committee)

Staff Liaison:
Alison Dye, Sr. Manager for Communications

Ex-Officio:
John Wilson, MD (WC, Chair)
Mitch Berger, MD (AANS President)
Ali Rezai, MD (CNS President)

- **Washington Office Begins Process to Form Blog Editorial Board.** The CPR met at the CNS Annual Meeting in Chicago and approved the development of a Neurosurgery Blog editorial board. This board will consist of 6-10 members who will meet on a quarterly basis to review the latest news and opinion trends and to discuss what the blog should say on a range of issues relating to neurosurgery. The primary functions of the blog editorial board will include:
  - Writing guest editorial blog posts
  - Commenting on special issues include blog posts
  - Serving as high-volume reviewers of submitted articles
  - Committee liaisons identifying potential blog content from various sections

Communication Activities

- **Neurosurgery Blog Gets Top Blog Nod from Online Surgical Technician Courses.** In December, the AANS/CNS Neurosurgery Blog was named the fourth top spine neurosurgery blog for 2012 by the folks at Online Surgical Technician Courses which was an amazing feat given the fact we haven't yet had our official blog launch.

Each week, Neurosurgery Blog is updated on a regular basis and reports on how healthcare policy affects patients, physicians and medical practice and to illustrate that the art and science of neurosurgery encompasses much more than brain surgery. As of March 20, 2013, we have disseminated 39 blog posts on topics including the SGR, the Independent Payment Advisory Board (IPAB), medical liability reform, and health reform in general. We invite you to visit the blog and subscribe to it, as well as connect with us on our various social media platforms list below, so that you can keep your pulse on the many health-policy activities happening in the nation's capital.

- Neurosurgery Blog: More Than Just Brain Surgery - www.neurosurgeryblog.org
- Neurosurgery's Twitter Feed: @Neurosurgery – https://twitter.com/neurosurgery
- Neurosurgery's Facebook Page – http://bit.ly/NeuroFacebook
- Neurosurgery's LinkedIn Group http://bit.ly/NeuroLinkedIn

- **Reaching Key Health Policy Influencers Online**. Neurosurgery's Washington office continues to use social media platforms to expand the reach of its message by reaching key health policy influencers online. Our new media tools serve as a conduit to deliver two types of communiqués: (1) neurosurgery's positions on key health policy issues, and (2) news about neurosurgery that could range from op-eds to endeavors in new medical innovations to bring greater attention to the achievements of, and issues facing, the AANS and CNS. More specifically, we have engaged on Twitter with individuals such as:

  - U.S. House Representatives:
    - Speaker of the U.S. House John Boehner (R-OH-8)
    - Kevin McCarthy, Majority Whip of the U.S. House (R-CA-22)
    - Jim Bridenstine (R-OK-1)
    - Michael Burgess (R-TX-26)
    - Rodney Davis (R-IL-13)
    - Charlie Dent (R-PA-15)
    - Jim Matheson (D-UT-2)
    - Markwayne Mullin (R-OK-2)
    - Rep. Phil Roe (R-TN-1)
    - Aaron Schock (R-IL-18)
    - Pete Sessions (R-TX-32)
    - Pat Tiberi (R-OH-12)
  - Senators:
    - Mark Kirk (R-IL)
    - Jeff Merkley (D-OR)
  - Hill Staff:
    - Tiffany McGuffee, Communications Director for Rep. Phil Roe
    - Jessica Sandlin, Press Secretary for Sen. John Cornyn
    - Jay Khosla, Policy Director for the Senate Finance Committee
  - Health Media:
    - Jennifer Haberkorn and Jason Millman, prominent health reporters for Politico
    - USA Today health reporter, Liz Szabo
    - Scott Hensley, writer and editor for Shots, NPR's health blog
    - The Hill's Healthwatch Blog and Congress Blog
    - Maggie Fox, Senior health writer at NBC News
    - American medical News reporter, Charles Fiegl
    - Matthew Cooper, Editor, National Journal Daily

- **Traditional Media Outreach.** In addition to aforementioned new media efforts, the DC office will continue to implement traditional media/communication efforts including Op Eds, letters to the editor, radio "tours" and desk side briefings with reporters. Since December, we have been able to generate

media hits in the following outlets: Bureau of National Affairs (BNA), Health Leaders Media, Inside Health Policy, MedPage Today, medwire News, NBC News, and Politico. In the past year, the Washington Office has generated 39 traditional media hits reaching a circulation of nearly 2.5 million.

- **Member Outreach.** The AANS and CNS have continued to expand communication with our members by disseminating a monthly DC e-newsletter to better inform them of key health policy activities happening in Washington. To date, we have we have produced thirteen "Neurosurgeons Taking Action" newsletters, which reach a distribution list of 10,350 individuals and covered a variety of topics including the Independent Payment Advisory Board (IPAB), sequestration cuts, replacing the sustainable growth rate (SGR) formula, and a host of other topics of concern to organized neurosurgery. Accessing past issues is easy as they are archived directly on the AANS website and are available at: http://bit.ly/MgL646.

  Please note, "Neurosurgeons Taking Action" is technically an AANS publication because it also includes information regarding NeurosurgeryPAC and given the CNS' tax status it would be illegal for it to be a jointly sponsored endeavor. That said, in an effort to get key health policy information out to a broader audience, beginning this year the CNS began disseminating all non-NeurosurgeryPAC information via its "In the Loupe with the CNS" newsletter. Additionally, the DC office continues to provide content for AANS and CNS newsletters and publications and regularly submits items to AANS and CNS for website postings.

- **AANS Website Update.** Currently, the Washington Office communications staff is working with the AANS headquarters staff to update the legislative activities pages of the AANS website. Amongst other things, changes will entail a complete revamp of the Washington Office section on the AANS website including archiving old materials by year and only having 2013 content on the main pages, renaming and adding new navigation sidebars to better reflect our activities, adding links to our blog and social media platforms, and enhancing our pages with key links and introductory copy to provide viewers with context as to what each page offers. Once this project is completed, we will send out a notice in our monthly e-newsletter communications.

- **Coalition Efforts**

  - The Alliance of Specialty Medicine and Health Coalition on Liability and Access. The AANS and CNS have continued to work closely with other healthcare organizations, including the Alliance of Specialty Medicine (Alliance), the Health Coalition on Liability and Access (HCLA) to provide assistance in promoting those organizations and/or their health policy and advocacy to the media. Past Washington Committee Chairman, Alex Valadka, serves as the spokesperson for the Alliance and is also called on by HCLA to speak on the topic of medical liability reform.

    In past three months, working with these groups, we have been able to generate media hits in the following outlets: American Medical news, CQ Healthbeat, FierceHealthcare, Inside Health Policy, Modern Healthcare Magazine, Modern Physician, Roll Call and The Hill. One of these aforementioned hits appeared in Roll Call Newspaper (Capitol Hill's paper of record) when they published a Guest Opinion piece featuring the Alliance and Dr. Valadka. The article, "Doctors: We Gave at the Office, and Then Some" addressed the idea that preventing the pending SGR cuts isn't the only reimbursement challenge that physicians face and more physician cuts will hurt patients. Another piece worth spotlighting was published in the American Medical News and featured John Wilson, chair of the AANS/CNS Washington Committee. The story, "Lawmakers Warned Primary Care Can't Absorb ACA Expansions" tackled the topic that it's not just primary care facing a shortage and more attention needs to be given to the fact that specialty doctors are also facing shortages.

  - Drs. Harbaugh, Kalkanis and Abosch Serving as Spokespersons for Partners for Healthy Dialogues Campaign**.** The AANS and CNS have joined the new "Partners for Healthy Dialogues" campaign, an initiative aimed at educating physicians and patients about the Sunshine Act and the benefits of appropriate industry and physician interaction and collaboration. In their roles, they

will serve as media spokespeople and will on occasion speak to other organizations including non-media audiences about this effort. More information is available at: http://bit.ly/YNDl6G.

- Neurosurgery Serves on the PAC's Social Media Advisory Board. Starting in 2013 organized neurosurgery will serve on the Public Affairs Council's social media advisory board. The council is a nonpartisan, nonpolitical association for public affairs professionals and has more than 600 member companies and associations who work together to enhance the value and professionalism of the public affairs practice. In this new role, we will help shape the PAC social media program and speak at during conferences throughout the year. Not only will this allow us to expand our own audience, but it will grant us the opportunity to engage with other leaders who are actively participating in the digital advocacy space.

Making Progress

In just the first year of operation, neurosurgery has seen a significant expansion of its digital media outreach. This new highly effective online echo chamber, allows us the ability to share neurosurgery news and AANS/CNS health policy positions to a growing audience of healthcare media and key policy influencers in a very rapid manner. Listed below are some key metrics pertaining to neurosurgery's digital media efforts:

- From March 15, 2012 to March 15, 2013, Neurosurgery's Twitter has "touched" 3,487,590 million twitter users with its communications.
- From Sept. 15, 2012 to March 15, 2013, Neurosurgery generated 12,222 hits via its bit.ly links.
- From Sept. 10, 2012 to March 15, 2013, Neurosurgery Blog has garnered 8,997 hits.
- From Oct. 15, 2012 to March 15, 2013, Neurosurgery's Facebook page has "touched" 59,178 Facebook users with its communications.
- From Oct. 15, 2012 to March 15, 2013, Neurosurgery's LinkedIn Group has "touched" 7,913 LinkedIn users with its communications.