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September 6, 2013

Marilyn Tavenner, Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
CMS-1600-P
Mail Stop C4-26-05
7500 Security Blvd
Baltimore, MD 21244-1850

RE: CMS-1600-P Medicare Program; Payment Policies Under the Physician Fee Schedule (PFS) and Other Revisions to Part B for CY 2014

Dear Ms. Tavenner,

On behalf of the American Association of Neurological Surgeons (AANS) and Congress of Neurological Surgeons (CNS), we appreciate the opportunity to comment on the above referenced Notice of Proposed Rulemaking (NPRM) published in the *Federal Register* on July 19, 2013. The following comments will focus on the *Physician Compare* website and the Physician Quality Reporting System (PQRS), Medicare Shared Savings, and Value-Based Payment Modifier Programs. Our comments related to the new Qualified Clinical Data Registry and other non-quality related proposals are submitted in separate comment letters.

SUMMARY OF COMMENTS

• **Physician Compare**

- The AANS and CNS are deeply concerned that many data inaccuracies remain in how physicians and group practices are listed and searchable within *Physician Compare*.
- Neurosurgery does not support CMS moving forward with publicly reporting Clinical Group Consumer Assessment of Health Providers and Systems (CG-CAHPS) or any CAHPS surveys.

• **Physician Quality Reporting System**

- We disagree with CMS' proposal requiring physicians to report additional measures (from three to nine measures) to avoid the PQRS payment adjustment in 2016. The AANS and CNS urge CMS to maintain the requirement for physicians to report on three measures within PQRS. We further urge CMS to remove the requirement that these measures must cover at least three of the National Quality Strategy (NQS) domains.
- Because PQRS lacks useful measures for surgeons, maintaining flexibility in the PQRS program is critical for successful participation.
- The AANS and CNS do not support the change in measures groups reporting within the PQRS program.

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- There is no evidence to support expanding the Perioperative Care Measures Group.
 - Neurosurgery believes CMS should merge the PQRS and Value-Based Payment feedback reports, especially since PQRS measures are part of calculating a physician's VBM score.
 - The AANS and CNS do not support CMS' proposal for aligning PQRS and quality measures within the Electronic Health Record (EHR) Incentive Program. We do not believe the proposal eases physicians' – particularly neurosurgeons -- reporting burdens.
- **Value-Based Payment Modifier**
 - The AANS and CNS do not agree with CMS' proposal to increase the amount of money at risk from one percent to two percent in the Value-Based Payment Modifier Program.
 - Neurosurgery believes the 70 percent threshold in the Value-Based Payment Modifier Program is too high and CMS should lower the threshold to 50 percent.
 - The AANS and CNS have serious concerns with CMS' quality tiering methodology. The proposed methodology is weak and is a crude way to determine a physician's quality.
 - Neurosurgery does not support CMS' attribution proposal used to calculate the Medicare Spending Per Beneficiary measure.
 - The development of episode groupers must be transparent and CMS must provide adequate time to validate and test the episodes in real world healthcare settings prior to their application.

DETAILED COMMENTS

Physician Compare

The AANS and CNS have been very involved in working with the Centers for Medicare & Medicaid Services (CMS) during the implementation of the *Physician Compare* website. Physician input is critical to ensuring that this site provides information that is accurate and useful for patients and physicians. We are pleased with CMS' efforts to focus on the use of claims data to help verify physicians' demographic information, as well as to expand the search function related to how physicians and specialties are listed. However, as revealed through further analysis of the redesigned website, we are deeply concerned that many data inaccuracies remain in how physicians and group practices are listed and searchable within the site. As mentioned in previous comments to CMS, the *Physician Compare* website search function and underlying demographics of the data must be accurate before the agency adds any additional performance information.

- **Search Function.** Neurosurgery supports CMS' adoption of a new Intelligent Search Functionality. However, we would like to see the specialty drop-down list re-instated with corrections to how specialties are listed. Our concerns still remain with how neurosurgery is identified as a specialty. If a user types in "neurosurgery", he or she is directed to select names of physicians from family practice, neurology and then neurosurgery – in that order. If one types in "neurosurgeon," the list includes family practice and then neurosurgeons. This simply is not an accurate way to classify our specialty as these groupings are clinically inaccurate, inappropriate and do not help patients find a neurosurgeon when they need one. Providing neurosurgery with its own specialty designation is appropriate as neurosurgery is:

1. A specialty recognized by the American Board of Medical Specialties (ABMS), with its own Board– the American Board of Neurological Surgery;
2. A specialty recognized by the Accreditation Council of Graduate Medical Education (ACGME), with its own Residency Review Committee – the RRC for Neurosurgery;
3. A specialty recognized by CMS on the Medicare provider enrollment form; and
4. A specialty recognized by CMS in the Medicare Physician Fee Schedule -- specialty code designation number 14.

Even worse, when you put in a specific neurosurgeon's name, a link to a list of family physicians comes up. If a user does not take the next step to click on "search by specialty provider", the query brings up zero results. This is extremely confusing to the user and appears as if no neurosurgeons exist within the Medicare program.

In addition, the search function by group practice does not work. For example, if a user does not type in the exact spelling of the group practice, zero results populate in the search. If the practice is not an internal medicine practice, zero results populate in the search even when you click "search by specialty". Also, if one enters a zip code that is close to the group practice's primary address, the group practice does not appear.

- **Demographic Data.** Neurosurgery supports CMS using claims data to further improve the accuracy of a physician's practice location, board certification, and hospital affiliation. However, after careful review of the site, it is obvious that the underlying demographics data continue to remain faulty and incomplete. For example, physicians who are board certified in their field should be so denoted, and an explanation of what "board certified" means should be included on the site.
- **PQRS and GPRO.** The website also provides no real information on the Physician Quality Reporting System (PQRS), Group Practice Reporting Option (GPRO), or Electronic Health Record (EHR) incentive programs, which is confusing to users. There are no disclaimers stating the EHR or PQRS programs are voluntary at the current time. Nor does it inform patients that the failure of physicians or group practices to participate in these incentive programs does not mean that they are poor quality providers. In terms of listing the PQRS GRPO, the website does not educate users on the nuances of GPRO participation and the fact that it does not apply to all physician group practices. The current measures in the GPRO program inhibit specialty group practices from participating because the majority of the measures are primary care and practices must report on all measures; therefore, a neurosurgery practice cannot participate, but shouldn't be viewed in a negative light.
- **Publicly Reporting Patient Experience Data and CAHPS.** Neurosurgery does not support CMS moving forward with publicly reporting Clinical Group Consumer Assessment of Health Providers and Systems (CG-CAHPS) or any CAHPS surveys. It is also inappropriate to require a surgical practice to institute CG-CAHPS in their practice because the questions are not relevant to surgeons. If CMS insists on moving forward with CAHPS, the Surgical-CAHPS (S-CAHPS) is a more appropriate way to measure patient experience data.

The cost to implement CAHPS is also extremely costly and burdensome on a practice, especially a small private practice. Response rates are typically low and based on feedback we have received from providers, patient compliance is very difficult to obtain. The collection of CAHPS data may also lead to survey fatigue by patients due to the fact that CMS requires this in both the Medicare Shared Savings and Inpatient Quality Reporting programs. Patients do not know the difference between a CG-CAHPS survey, Surgical-CAHPS and a Hospital-CAHPS survey.

Furthermore, CMS needs to clarify how practices will be scored on CAHPS. If CMS must move forward, practices should only be measured based on whether or not they have provided patients with a patient experience survey, not based on completed collection rates. A physician should not be held liable or penalized for lack of patient compliance. CMS must recognize that as with all experience surveys, regardless of survey type, opinions vary based on cultural and regional differences.

Finally, as CMS is aware, many practices already collect patient experience data, but not in the CAHPS survey format (e.g., Press-Gainey). Indeed, the American Board of Medical Specialties (ABMS) is considering recognizing multiple different patient experience surveys for the purpose of satisfying Maintenance of Certification (MOC) requirements. CMS should therefore recognize and provide credit to practices that use alternative formats to collect patient experience data.

- **Future Public Reporting Information.** CMS is proposing to have certain measures be reportable by all physicians, and to publicly report the information on these in some manner. The AANS and CNS are very concerned about this proposal. The practice of medicine is not a one-size-fits-all proposition, and we believe that it is a flawed concept for CMS to establish *universal* public reporting measures. There are more relevant and worthwhile information than CAHPS or *Choosing Wisely* for surgeons and their patients. For example, it is much more worthwhile and relevant for surgeons to publicly report on things like patient safety measures, infection rates, shared informed consent/decision-making, and patient education at the time of hospital discharge. In terms of *Choosing Wisely*, it is inappropriate to use the *Choosing Wisely* campaign as a means of measuring physicians. *Choosing Wisely* is a public health service campaign and not a program developed to measure physicians. Furthermore, many of the *Choosing Wisely* topics are already in use within PQRS, such this additional reporting would be redundant. Neurosurgery is happy to work with CMS on developing appropriate measures for use in public reporting that will be useful to Medicare beneficiaries receiving neurosurgical care.

If the purpose of this site is to really educate the public about their health care treatment options significant changes need to be made. We fully understand and appreciate CMS' challenge to manage multiple detailed programs with finite resources and within tight statutory deadlines. However, these problems present substantial risks to patients' health and physicians' valued reputations. Inaccurate presentations of this information can lead to unintended and serious, potentially harmful consequences for both patients and physicians.

Physician Payment, Efficiency, and Quality Improvement—Physician Quality Reporting System

The Physician Quality Reporting System (PQRS), as set forth in sections 1848(a), (k), and (m) of the Social Security Act, is a quality reporting program that provides incentive payments and payment adjustments to eligible professionals based on whether or not they satisfactorily report data on quality measures for covered professional services furnished during a specified reporting period. Participation in PQRS is low, and the AANS and CNS are concerned with a number of CMS' proposals.

- **Changes in Requirements for the 2014 PQRS Incentive and 2016 PQRS Payment Adjustment.** The AANS and CNS appreciate CMS' proposed efforts to maintain flexibility in terms of PQRS reporting, especially since the lack of successful PQRS participation will result in reimbursement cuts in 2015 and 2016. Neurosurgery also supports CMS' proposal to lower the reporting threshold to 50 percent for individual measures. However, we disagree with CMS' proposal requiring physicians to report additional measures (from three to nine measures) to avoid the PQRS payment adjustment in 2016. The AANS and CNS urge CMS to maintain the requirement for physicians to report on three measures within PQRS. We further urge CMS to remove the requirement that these measures must

cover at least three of the National Quality Strategy (NQS) domains. Moving from three to nine measures is a big hurdle, and for many specialties, there are not nine meaningful measures within the program. In addition, for some physicians who only focused on avoiding the penalty in 2013, they will have to go from reporting only one measure successfully, to reporting nine measures successfully. This is a huge leap and an unrealistic expectation of CMS. These new burdensome requirements will not provide physicians enough time to change their reporting infrastructure by January 2014, especially since the final rule is not released until November 2013. Because PQRS lacks useful measures for surgeons, maintaining flexibility in the PQRS program is critical for successful participation.

- **Changes to Measures Group Reporting.** CMS is proposing to modify the definition of measures groups to indicate that a measures group must consist of at least six measures. CMS is also proposing to add additional measures to measures groups that previously contained less than six measures. In addition, the only way to report a measures group is through a registry and it must be reported on 50 percent of the time on applicable patients. Neurosurgery does not support the change in measures group reporting within the PQRS program. There is no evidence to support expanding measures groups by requiring two additional measures to groups with less than six measures. It will also make it much more difficult to meet the threshold, and it will be nearly impossible for Qualified Registries and Qualified Clinical Data Registries to meet this requirement. [*Note:* As stated above, the AANS and CNS have submitted a separate comment letter solely focused on the proposed Qualified Clinical Data Registry requirements. This issue is further discussed in that comment letter.]

One of the only options for neurosurgeons to participate in the PQRS program is through the Perioperative Care Measures Group. For 2014, CMS proposes to add the following three measures:

- Documentation of Current Medications in the Medical Record
- Preventative Care and Screening: Tobacco Use: Screening and Cessation Intervention
- Patient Centered Surgical Risk Assessment and Communication: The Percent of Patients who Underwent Non-Emergency Major Surgery Who Received Preoperative Risk Assessment for Procedure-Specific Postoperative Complications using a Data-Based, Patient-Specific Risk Calculator, and who also Received a Personal Discussion of Risk with the Surgeon

There is no evidence to support expanding the Perioperative Care Measures Group with the above mentioned measures. In fact, the current measures group has been tested and endorsed by the National Quality Forum (NQF) and to now may unilateral changes to the group may render it statistically invalid and/or alter the quality measurement process.

In addition, we do not support the Patient Centered Surgical Risk Assessment and Communication measure. The measure utilizes a tool that was developed by the American College of Surgeons (ACS). There are neurosurgical codes incorporated in the patient risk calculator that do not correspond with the neurosurgical codes included in the perioperative measures. CMS should not assume that if a measure has the word “surgery” in it that it applies to all surgical specialties. Furthermore, this calculator has not been validated for a wide variety of neurosurgical codes. Validity needs to be established before we can conclude the use of this calculator as a necessity for providing “quality” neurosurgical care.

- **Plan for Future PQRS for the 2017 PQRS Payment Adjustment and Beyond.** Within the proposed rule, CMS seeks comments on whether additional hospital Inpatient Quality Reporting

(IQR) measures should be retooled for use in the PQRS to accommodate hospital-based physicians, and whether CMS should attribute the reporting periods and performance results from the hospital IQR program to individual physicians or group practices who elect to have their hospital's performance scores attributed to them. Neurosurgery is supportive of this concept. Many physicians, including neurosurgeons, are participating in the hospital IQR program due to the amount of inpatient procedures they perform in the hospital setting. Allowing physicians to satisfy PQRS by electing to have their hospital's performance scores attributed to them makes sense as it potentially eliminates dual reporting. It also moves towards the goal of aligning quality reporting. We do seek clarification on what constitutes hospital-based based physicians, and what physicians must do to elect to have the hospital's performance attributed to them.

CMS also seeks comments on whether feedback reports within the PQRS and Value-Based Payment modifier (VBPM) should be merged. Neurosurgery believes CMS should merge the PQRS and Value-Based Payment feedback reports, especially since PQRS measures are part of calculating a physician's VBM score.

- **EHR Incentive Program.** The AANS and CNS do not support CMS' proposal for aligning PQRS and quality measures within the Electronic Health Record (EHR) Incentive Program. The proposal does not ease the burden of reporting on physicians, especially neurosurgeons. First, there are a limited number of relevant quality measures within the EHR Incentive Program that are applicable to neurosurgeons. The majority of neurosurgeons report on the Perioperative Care measures, which are not included in the EHR Incentive Program. Therefore, neurosurgeons have to report separate measures to qualify for the EHR Incentive and avoid the PQRS adjustment. Second, the proposed criteria for Qualified Clinical Data Registries (QCDRs) to report quality measures within the EHR Incentive Program are not feasible. Essentially, QCDRs must have the ability to electronically specify their measures, which, as CMS has discovered, is not a simple task and not all quality measures lend themselves to electronic specifications. In addition, QCDRs are forced to go through the meaningful use certification process. True clinical data registries are not EHRs and their purpose is different from an EHR. We are unaware of a clinical data registry going through the meaningful use certification process. Also, we do not believe certification vendors are set up to certify or understand clinical data registries. Finally, requiring QCDRs to go through the certification process will force registries to meet *both* PQRS and meaningful use requirements. Within PQRS, QCDRs will have to meet standards for both certifying the PQRS registry process and the QCDR process. This redundancy must be eliminated and CMS needs to be working towards consolidating, not adding, additional layers of standards for these various programs. [*Note:* as stated above, the AANS and CNS have submitted a separate comment letter solely focused on the proposed Qualified Clinical Data Registry requirements. This issue is further discussed in that comment letter.]

Physician Value-Based Payment Modifier and the Physician Feedback Reporting Program

- **Value-Based Payment Modifier—Payment Adjustment.** Under the Value-Based Payment Modifier (VBPM), physician reimbursement may be adjusted upwards, downwards, or neutral based on whether or not practices meet certain quality and cost metrics. CMS has proposed to increase the amount of payment at risk under the VBPM from one to two percent in CY 2016. We do not agree with CMS' proposal to increase the amount of money at risk from one percent to two percent. 2013 is the first year CMS instituted the VBPM so large group practices are still learning about the VBPM and need time to work out the problems, plus learn from the first year of reporting.

In terms of quality tiering, CMS proposes to make VBPM reporting mandatory for groups of 10 or more physicians. We have concerns with expanding the program to apply to physicians in practices of 10-99 after one year of implementing the VBPM, since it is based on PQRS participation and 2014

is the first year of CMS requiring practices to participate in the full PQRS program. We are, however, supportive of not applying a downward adjustment to groups of 10-99, since it is their first year participating in the VBPM program.

CMS proposes that a group of physicians subject to the CY 2016 modifier avoids the VBPM if at least 70 percent of the individual eligible professionals in the group satisfactorily participate in 2014 PQRS. Neurosurgery believes the 70 percent threshold is too high and CMS should lower the threshold to 50 percent. For a practice that has subspecialists or relies on allied health professionals, such as nurse practitioners or physician assistants, it is very possible that there are no meaningful measures for all the eligible professionals to report on in PQRS or the potential for physicians to unsuccessfully report on PQRS measures. As CMS' experience reports have found, many physicians incorrectly report PQRS measures and this problem may be exacerbated by the new PQRS reporting requirements. If a practice fails the 70 percent threshold, they are subject to both the VBPM and PQRS adjustment.

In terms of identifying physicians subject to the VBPM and 70 percent threshold, CMS proposes to identify groups of physicians subject to the modifier by querying the Provider Enrollment, Chain, and Ownership System (PECOS). We are concerned with this proposal given the ongoing problems with PECOS. Many practices have stated there are errors related to their group practice information within *Physician Compare* or the Quality and Resource Use Reports (QRUR). Either a physician is not attributed to the correct group practice or physicians are attributed who are no longer associated with the practice. This is worrisome given the information posted on *Physician Compare* and QRUR reports are populated from PECOS.

- **Value-Based Payment Modifier—Quality Tiering.** Neurosurgery has serious concerns with CMS' quality tiering methodology. The proposed methodology is weak and a crude way to determine a physician's quality. The majority of physicians only manage a portion of a patient's healthcare expenses. For example, the total per capita cost measure implies that a cardiologist's quality composite is based on the expense of the total hip arthroplasty implant that was implanted by an orthopedic surgeon in that cardiologist's patient. Based on CMS' methodology, the costs are attributed to a cardiologist, which is completely inappropriate.

There are many variables that an individual practitioner has little or no control over, but will affect their performance on this measure. A physician is judged based upon the expense and spending characteristics of other physicians in his or her community, not necessarily by their own efficiency. Furthermore, there should be clear standards for success in reporting quality measures. Simply stating that the bottom 16 percent will always face a downward payment modifier may needlessly penalize providers that otherwise meet quality reporting benchmarks.

The use of a set of chronic conditions to determine per capita costs is problematic as it unevenly rewards and punishes certain physicians. For example, the formula will reward surgeons who do not treat patients with COPD, heart failure, coronary artery disease, and diabetes because they do not expose themselves to these higher cost patients.

We also have concerns with the risk-adjustment used within the measure. Although the risk adjustment model, the CMS Hierarchical Condition Category (HCC) may be generally useful in very large populations (taking into account age, gender, and other demographics), there is no information on its application to those with neurological disease. This model may also not apply to conditions that are treated by neurosurgeons on an inpatient basis. We are not aware whether or not CMS has tested this model specifically with a group of patients with neurological illness. We therefore request that CMS run tests on the HCC model and describe its effect on the reimbursement or coding of a group of test patients from a typical neurosurgical practice with various diagnoses. Without this pilot

testing, it is very difficult to offer constructive feedback on how this risk adjustment methodology will be applied, and how it will affect neurosurgeons or patients with neurosurgical disease. Although, the current cost methodology applies only to a subset of chronic conditions, we anticipate that CMS will expand this measure to most diagnoses, including such as stroke and intracranial hemorrhage, in the near future. For our specialty, it is optimal to see how the cost methodology will apply to these groups in order to offer feedback and educate our members.

We also seek clarification as to why Medicare Part D (prescription drug benefit) is omitted. Outpatient pharmacy expenses contribute to Medicare spending and the health system in general. The omission of prescription medications makes the measure weak and does not provide an appropriate snapshot of patient care.

Additionally, the AANS and CNS do not support CMS' attribution proposal. CMS proposes to attribute an Medicare Spending Per Beneficiary (MSPB) episode to a group of physicians subject to the value-based payment modifier (identified by a single tax identification number), when any eligible professional in the group submits a Medicare Part B claim under the group's TIN for a service rendered during the inpatient hospitalization that is an index admission for the MSPB measure during the performance period for the applicable CY payment adjustment period. The same index admission and MSPB episode could be attributed to more than one group of physicians. Therefore, we believe it is more appropriate for CMS to determine attribution based on a plurality of services, much like it does for Medicare's Shared Savings Program. Our recommended attribution methodology will better align with the practice patterns of surgical specialists.

If CMS decides to move forward with Method One, we request for CMS to conduct an appropriate power analysis to determine how many physicians and how many patients are necessary to develop a meaningful, representative measure based on expected variation in total per capita costs CMS anticipates. There also needs to be a plan in place for groups who do not have an adequate number present to power the analysis.

Finally, we are also concerned with Method One due to sub specialization within neurosurgery. Neurosurgeons that treat subarachnoid hemorrhage or vascular problems have higher costs than neurosurgeons that deal with peripheral nerve and perform elective outpatient services. In sum, the methodology reflects more on patient population served, not surgeon efficiency.

- **Value-Based Payment Modifier- Composite Measures and Score.** CMS proposes to determine a physician's composite based on PQRS measures/reporting, which are proposed to cover the National Quality Strategy domains. It is our understanding the NQS is a set of goals for the entire healthcare system, not for the general individual physician level. Therefore, various domains do not always apply to all specialists, nor are they material to all practices. Also, PQRS measures may not capture physician activity in all of these realms. For example, the AANS and CNS established the ThinkFirst Foundation, a head and spinal cord injury prevention program led by neurosurgeons. ThinkFirst embarked on a public education effort to increase the use of bicycle helmets. This is an example of a neurosurgical population health initiative, the goal of which is to decrease the number of patients with traumatic injury that neurosurgeons see and treat. Unfortunately, there are no PQRS measures for this intervention, despite the fact that these volunteer efforts have a significant impact on the healthcare system.
- **Episode Costs.** Neurosurgery requests that CMS share the results of their initial analysis on refining the VBPM based on episode analysis. As stated in the proposed rule, CMS has developed a CMS prototype episode grouper that, for a limited number of conditions, classifies episodes into three categories: chronic, acute and procedural. The prototype was distributed to only 54 large group

practices. Therefore, if CMS has tested episode costs in these large groups it is incumbent upon CMS to share the results so physicians and specialty organizations can understand the kinds of distributions that are emerging from the tests. This information also needs to be made available for public comment prior to its release and incorporation into payer policy. The limited amount of information we have seen related to episode groupers has been extremely vague and difficult to determine fairness. The development of episodes groupers must be transparent and CMS must provide for adequate time to validate and test the episodes in real world healthcare settings prior to their application. The results of only 54 large group practices is most likely going to skew differently if examined in a large single specialty practice or small physician practice.

CONCLUDING REMARKS

The AANS and CNS appreciate the opportunity to comment on this proposed regulation. We are committed to implementing programs that will improve the value of care provided to Medicare beneficiaries and look forward to working with CMS to make necessary program in all the Medicare quality-related programs. Thank you for your consideration of our comments and in the meantime, if you have any questions or need additional information, please feel free to contact us.

Sincerely,



William T. Couldwell, MD PHD, President
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