

RESOLUTION I- 2026S

Title: Amendment of resolution titles as part of the resolution revision process

Submitted by: Kyle Tuohy MD, Scott Simon MD, on behalf of the Northeast Quadrant

(Primary contact: Kyle Tuohy - ktuohy@pennstatehealth.psu.edu)

WHEREAS, the fundamental construction of the representative assembly centers around the concept of Resolutions from assembly members. The first part is the rationale for the directive and contains all the reasons necessary to justify consideration of the issue by the assembly. The second part is the resolve containing the specific position, belief, or actions proposed by the sponsor. Unfortunately, the rationale is not included in the final publications of accepted resolution, only the resolve clauses; and

WHEREAS, once a resolution is proposed and testimony is heard, it is the role of the Reference Committee to make recommendations on if a resolution should be accepted, rejected, or amended. It is not uncommon for resolutions to be amended in this manner after receiving input from the rest of the CSNS membership, and often times this process improves the quality of the resolution. However, during the amendment process, it is possible that the initial title of the resolution may not completely describe the final version of the text.^{1,2}; and

WHEREAS, there is no formal mention of exactly how a resolution can be amended by the Reference committee and general assembly.³ However, there is a widespread, unofficial understanding that titles of resolutions are not able to be edited or changed after submission, therefore

BE IT RESOLVED, that the CSNS Rules and Regulations be amended to include specific wording on this matter. Specifically, that if a resolution text is amended in any way as part of the general assembly, a motion may be made to also amend the resolution title if it is felt that the title no longer accurately describes the purpose of the resolution. This title amendment must be small and only pertain to the aspects of the resolution text that have been amended.

Fiscal note: 0\$

Prior resolutions: None

References:

1. Resolution II – 2025F: Implementing Periodic Neurotrauma Screenings for Contact-Sport Athletes and Military Personnel
2. Resolution XIX – 2025F: Characterizing Radiation-Related Occupational Hazards and Improving Radiation Safety for Female Neurosurgeons
3. RULES AND REGULATIONS FOR THE OPERATION OF THE COUNCIL OF STATE NEUROSURGICAL SOCIETIES. Council of State Neurosurgical Societies of the American Association of Neurological Surgeons and Congress of Neurological Surgeons. October 2025

Assignments: All Committees

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RESOLUTION II – 2026S

Title: **Establishing a Coding, Reimbursement, and Regulatory Advocacy Training Award**

Submitted by: Clemens M. Schirmer, Luis Tumialan, Anthony Digiorgio, Joshua Rosenow, Kris Kimmell, Edward Vates, Anand Veeravagu, Lauren Foe, Charlotte Pineda, CSNS Coding and Reimbursement Committee

(Primary contact: Clemens Schirmer - cmschirmer@gmail.com)

WHEREAS, neurosurgery’s ability to maintain fair and accurate reimbursement and to protect patient access depends on having a credible, prepared, and durable pipeline of neurosurgeons who can engage effectively in national coding, valuation, and regulatory forums; (1,5-6); and

WHEREAS, despite deep subspecialty clinical expertise across our field, organized neurosurgery faces persistent difficulty developing and sustaining a pipeline of members with expert working knowledge of the coding framework (including code structure, code family design, and code change processes) and the valuation framework (including survey-based evidence development and relativity concepts) necessary to represent neurosurgery effectively in national deliberations; (2-3,6); and

WHEREAS, the RVS Update Committee (RUC) provides an essential multispecialty pathway through which physician societies develop and present evidence-informed recommendations regarding valuation inputs and relativity to inform CMS decisions; (2,5-6); and

WHEREAS, neurosurgery’s representation in these processes must reflect the interests of neurosurgery as a whole—including diverse practice settings, regions, and patient populations—rather than any single subspecialty, local market dynamic, or individual practice interest, in order to preserve credibility, reduce fragmentation, and strengthen the specialty’s national advocacy impact; (2-3,5-6); and

WHEREAS, effective national representation requires not only “knowing the procedure,” but also the ability to translate clinical reality into the shared language and evidentiary expectations of coding, valuation, and federal rulemaking—skills that are learned, mentored, and strengthened through structured training and longitudinal participation; (1-3,5-6); and

WHEREAS, peer-reviewed evidence supports that structured physician professional development programs strengthen leadership capabilities and can accelerate career development into influential roles—supporting the creation of a sustainable cadre of neurosurgeons who can serve organized neurosurgery in CPT, valuation, and CMS-facing advocacy; (7-8); therefore

BE IT RESOLVED, that CSNS shall create the CSNS Coding, Reimbursement, and Regulatory Advocacy Training Award, sponsored by the CSNS Coding and Reimbursement Committee, to identify and support selected CSNS members who seek to develop foundational expertise and serve as future representatives of organized neurosurgery at the AMA CPT and RUC process, and in CMS and payor engagement; and

BE IT FURTHER RESOLVED, that CSNS shall convene (or partner with) an annual in-person training course taught by senior coding, reimbursement, and regulatory faculty, designed to provide awardees a shared, standardized foundation beyond subspecialty domain expertise, including at a minimum:

1. CPT code development and maintenance (applications, evidence expectations, code family)
2. RUC survey principles, time/intensity framing, and valuation presentation fundamentals
3. CMS PFS fundamentals, rulemaking timelines, and effective comment/advocacy mechanics
4. High-level practice expense and malpractice RVU concepts and pitfalls in valuation narratives

5. Professional ethics, conflict-of-interest expectations, and credibility standards for societies ; and

BE IT FURTHER RESOLVED, that the Award shall include recognition by CSNS, funded travel support to attend the training course, and the explicit expectation that awardees are “on-ramped” into organized neurosurgery’s coding/reimbursement and regulatory workstreams.

References

1. Centers for Medicare & Medicaid Services. Physician Fee Schedule (PFS). <https://www.cms.gov/medicare/payment/fee-schedules/physician>
2. American Medical Association. RVS Update Committee (RUC): RVS Update Committee (RUC). <https://www.ama-assn.org/about/rvs-update-committee-ruc/rvs-update-committee-ruc>
3. American Medical Association. Latest CPT Editorial Panel News & Info. <https://www.ama-assn.org/about/cpt-editorial-panel>
4. American Medical Association. Purpose of the CPT coding system & CPT Editorial Panel. <https://www.ama-assn.org/about/cpt-editorial-panel/purpose-cpt-coding-system-cpt-editorial-panel>
5. Federal Register. Medicare and Medicaid Programs; CY 2026 Payment Policies under the Physician Fee Schedule and Other Changes... (Final Rule). <https://www.federalregister.gov/documents/2025/11/05/2025-19787/medicare-and-medicaid-programs-cy-2026-payment-policies-under-the-physician-fee-schedule-and-other>
6. American College of Cardiology. Decoding the CPT RUC. <https://www.acc.org/Tools-and-Practice-Support/Practice-Solutions/Coding-and-Reimbursement/Decoding-the-CPT-RUC>
7. Frich JC, Brewster AL, Cherlin EJ, Bradley EH. Leadership Development Programs for Physicians: A Systematic Review. *J Gen Intern Med.* 2015. (PubMed Central version) <https://pmc.ncbi.nlm.nih.gov/articles/PMC4395611/>
8. Lyons O, George R, Galante J, Kotze K, Firth J. Evidence-based medical leadership development: a systematic review. *BMJ Leader.* 2021. <https://bmjleader.bmj.com/content/5/3/206>

Fiscal Note: \$8000 – see above.

Assignments: All Committees

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RESOLUTION III - 2026S

Title: **Advocating for International Medical Graduates (IMGs) in Neurosurgery Amid Changes to U.S. Visa Policies**

Submitted by: Miguel David Quintero Consuegra, MD

(Primary contact: Miguel David Quintero Consuegra - miguel.quinteroconsuegra@cshs.org)

WHEREAS, the Congress of Neurological Surgeons (CNS) is committed to advancing neurosurgical education, research, patient care, and professional development worldwide; and

WHEREAS, international medical graduates (IMGs) constitute a vital and longstanding component of the United States health care system (1), and within the neurosurgical workforce, contributing substantially to residency training programs, academic productivity (2), innovation, and the delivery of neurosurgical care; and

WHEREAS recent and proposed changes to U.S. immigration policies—including increased restrictions, uncertainty, and delays associated with the H-1B visa program, as well as proposals by the U.S. Department of State to reduce the allowable duration of J-1 visa participation—threaten the stability, recruitment, and retention of IMG neurosurgeons (3,4) ; and

WHEREAS reductions in J-1 visa duration to four years is not aligned with the length and structure of neurosurgical training and fellowship pathways, which requires the standard visa timeframes that has a maximum of 7 years which ensures patient safety, educational integrity, and workforce sustainability; and

WHEREAS, abrupt or restrictive visa policy changes risk unintended consequences including disruption of residency and fellowship training (5), loss of highly qualified neurosurgeons-in-training, increased administrative burden on training programs, and diminished access to neurosurgical care for vulnerable patient populations; and

WHEREAS, neurosurgical training programs accredited in the United States maintain rigorous selection, oversight, and evaluation standards that ensure IMGs meet the same educational, ethical, and professional benchmarks as U.S. medical graduates; and

WHEREAS, equitable treatment of IMGs aligns with the principles of diversity, inclusion, academic excellence, and global collaboration that underpin modern neurosurgery; therefore

BE IT RESOLVED, that the CSNS asks the AANS and CNS to formally recognize and affirm the essential role of international medical graduates in the U.S. neurosurgical workforce and training ecosystem; and

BE IT FURTHER RESOLVED, that the CSNS advocates for immigration and visa policies that are transparent, predictable, and aligned with the realities of neurosurgical education, including preservation of visa durations sufficient to complete residency and fellowship training without unnecessary disruption; and

BE IT FURTHER RESOLVED, that the CSNS in conjunction with the ANNS and the CNS, opposes to reductions in J-1 visa duration that would compromise neurosurgical training continuity, patient care, or academic advancement, and calls for exemptions or specialty-specific considerations reflective of the length and complexity of neurosurgical training; and

BE IT FURTHER RESOLVED, that the CSNS asks the Washington Committee to support the recently bipartisan bill to exempt H-1B visa process fee for physicians; and

BE IT FURTHER RESOLVED, that the CSNS commits to collaboration with the AMA, medical societies, accreditation bodies, and policymakers to communicate the workforce, educational, and patient care implications of restrictive visa policies affecting IMGs; and

BE IT FURTHER RESOLVED, that the CSNS encourages neurosurgical training programs and departments to support IMG trainees through institutional advocacy, legal guidance, and equitable sponsorship practices; and

BE IT FURTHER RESOLVED, that this resolution be disseminated to relevant stakeholders, including federal agencies, legislative bodies, and allied professional organizations, as a statement of the CSNS commitment to fairness, excellence, and global inclusion in neurosurgery.

References

1. William W. Pinsky. The Importance of International Medical Graduates in the United States. *Ann Intern Med.*2017;166:840-841. [Epub 7 March 2017].doi:10.7326/M17-0505
2. Roy JM, Mansoor OMM, Sen S, Segura AC, Ganti RN, Musmar B, Garcia GPR, Henshey B, Patel S, Ranganathan S, El-Hajj VG, Tjoumakaris SI, Gooch MR, Rosenwasser R, Bowers C, Jabbour P. Publication productivity among international medical graduates and U.S. medical graduates in neurosurgery: A comparative assessment using the arms race control score. *Clin Neurol Neurosurg.* 2026 Mar 12;265:109383. doi: 10.1016/j.clineuro.2026.109383. Epub ahead of print. PMID: 41832795.
3. <https://www.aha.org/lettercomment/2025-09-29-aha-comments-dhs-proposed-rule-impacting-j-1-visas>
4. <https://www.aamc.org/news/hospitals-and-health-systems-depend-h-1b-visa-sponsored-physicians-so-what-happens-now>
5. <https://www.nbcnews.com/health/health-news/international-doctors-visa-problems-rcna213710>

Assigned Committee(s):

Workforce

YNRS

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RESOLUTION IV - 2026S

Title: Neurosurgeons are not “providers” – A need for a position statement by Neurosurgical Societies

Submitted by: Callum D Dewar, MD; Mateo Ziu, MD, MBA

(Primary contact: Mateo Ziu - mateo.ziu@gmail.com)

WHEREAS, there has been a universal adoption by healthcare institutions and administrators of the term “provider” to describe physicians as well as other members of the healthcare team; and

WHEREAS, the word provider appears to have been used first in 1965 by Medicare and Medicaid law to refer to providers of services such as suppliers delivering products and services to markets, hospitals or insurance networks, but not for human-to-human interactions; and

WHEREAS, the term "provider" deemphasizes the professional identity of physicians, especially when the term is used to group physicians with other healthcare professionals and practitioners; and

WHEREAS, the term “provider” represents another challenge to ethics and professionalism posed by the corporatization and physician employment in the rise of “medical – industrial complex”; and

WHEREAS, use of term “provider” in reference to physicians and other clinicians detracts and dehumanizes the doctor-patient human relationship, thus diminishing the importance of clinical training and the expertise of the physicians; and

WHEREAS, many other physician organizations have studied the ethical and professional implications of the use of the term “provider” for physicians and introduce positions statements in this regard; therefore

BE IT RESOLVED, that CSNS survey neurosurgeons on their perception of the use of term “provider”, their experiences and their position in that regard; and

BE IT FURTHER RESOLVED, that CSNS ask the AANS/CNS to produce and publicize a position statement on the use of the term “provider” for neurosurgeons; and

BE IT FURTHER RESOLVED, that CSNS asks AANS/CNS to discourage the use of term “provider” for neurosurgeons during meetings, conferences, print and any other forms of media.

Ref.

- 1- Sulmasy LS, et al., Physicians are not providers: The ethical significance of names in Health care: A policy paper from the American college of physicians. Ann Intern Med. 2026 Feb 10, Online ahead of print
- 2- Mangione S, Mandell BF, Post SG. The language game: we are physicians, not providers. Am J Med. 2021;134:1444-1446.
- 3- Goroll AH. Eliminating the term primary care “provider”: consequences of language for the future of primary care. JAMA. 2016;315:1833-1834

Assigned Committee(s):

Medical Practices

Workforce

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RESOLUTION V - 2026S

Title: **Protecting Physician Autonomy and Workforce Stability**

Submitted by: N. Nicole Moayeri, Brian Gantwerker, Ciara Harraher

This resolution has been reviewed and approved by the CSNS Workforce Committee

(Primary contact: N. Nicole Moayeri - nicolemoayeri@gmail.com)

WHEREAS, the Council of State Neurosurgical Societies' mission includes physician advocacy and addressing socioeconomic policies that impact neurosurgical practice; and

WHEREAS, state legislative restrictions on medical practice have created an environment where physicians must consult attorneys before providing evidence-based care, fundamentally undermining physician decision-making authority; and

WHEREAS, the principle of physician autonomy requires that medical decisions be made by qualified physicians using evidence-based medicine, not by legislators or prosecutors; and

WHEREAS, physicians across multiple specialties increasingly face potential criminal prosecution—distinct from civil malpractice liability—for medical decisions made in good faith and consistent with professional standards of care; and

WHEREAS, criminal prosecution differs fundamentally from civil liability in that it carries felony charges, prison sentences, mandatory license revocation, and cannot be insured against through malpractice coverage; and

WHEREAS, data from the Association of American Medical Colleges demonstrates that residency applications have declined by 4.2% overall in states with abortion bans compared to 0.6% in states without restrictions, affecting recruitment across all specialties including neurosurgery;¹ and

WHEREAS, physicians across specialties—including neurosurgeons—treat patients with pregnancy-related complications and must understand the legal landscape when providing emergency care; and

WHEREAS, national organizations, including the American Medical Association and the American College of Surgeons, have affirmed the importance of physician autonomy in patient care and expressed concern about legislative interference in medical decision-making.²; therefore

BE IT RESOLVED, that the Council of State Neurosurgical Societies affirms that physician autonomy and the physician-patient relationship are fundamental to the practice of medicine and that clinical decisions should be guided by professional standards of care and evidence-based medicine, not criminal statutes; and

BE IT FURTHER RESOLVED, that the CSNS requests that the AANS/CNS Washington Committee advocate that lawmakers and policymakers respect neurosurgeons' decision-making process and the physician-patient relationship, and refrain from enacting laws that criminalize neurosurgeons' decision-making or impose criminal penalties on neurosurgeons for providing evidence-based medical care, particularly in the provision of emergency care, which cannot be sought electively in other jurisdictions; and

BE IT FURTHER RESOLVED, that the CSNS requests that the AANS/CNS Executive Committee develop informational resources to guide neurosurgeons practicing in states where criminal statutes may create legal uncertainty, monitor state legislative developments affecting neurosurgical practice autonomy and their impact on neurosurgical workforce recruitment, retention, and patient access to care, and consider the impact of state legislative environments on member participation and healthcare access when planning future organizational meetings and activities; and

BE IT FURTHER RESOLVED, that the CSNS encourages the AANS and CNS to develop a formal position statement affirming physician autonomy and opposing the criminalization of evidence-based medical decision-making in neurosurgery, while recognizing the potential impact of such policies on physician workforce stability.

REFERENCES:

1. Association of American Medical Colleges. “States With Abortion Bans See Continued Decrease in U.S. MD Senior Residency Applicants.” May 2024. Available at: [States With Abortion Bans See Continued Decrease in U.S. MD Senior Residency Applicants | AAMC](#)

2. American College of Surgeons. “ACS Statement on Reproductive Health Legislative Issues.” Updated June 28, 2022. Available at: [ACS Take Position on Reproductive Health](#)

Assigned Committee(s):

- Medico-Legal**
- Medical Practices**
- Workforce**

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RESOLUTION VI - 2026S

Title: **Advocating for a choroid plexus cauterization CPT code**

Submitted by: Michael McDowell, MD, CNS Appointed Delegate

(Primary contact: Michael McDowell - mmcdowell1@pennstatehealth.psu.edu)

WHEREAS, choroid plexus cauterization adds technical complexity, surgical time, and complication risk to endoscopic third ventriculostomy cases for hydrocephalus; and

WHEREAS, no CPT code specific to choroid plexus cauterization exists to fully characterize the additional case complexity or value; therefore

BE IT RESOLVED, the CSNS will petition the Washington Committee to form a coalition including industry partners, the hydrocephalus association, and other interested parties to advocate for the creation of a choroid plexus cauterization specific CPT code with an associated level of reimbursement reasonable for the level of complexity and effort of the procedure.

Dr. McDowell has no conflicts of interests related to this proposal.

Assigned Committee(s):

Coding & Reimbursement

Medical Practices

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RESOLUTION VII - 2026S

Title: **Addressing Exaggeration and Misinformation by Neurosurgeons on Social Media Platforms**

Submitted by: Ernest E. Braxton, MD, MBA, Gregory W. Basil, M.D., Jang W. Yoon, MD, MSc, Muhammad M. Abd-El-Barr MD, PhD, Allan D Levi, MD, PhD on behalf of the Colorado Neurosurgical Society

(Primary contact: Ernest Braxton - ebraxton@vsortho.com)

WHEREAS, the AANS and CNS acknowledge that social media has become a legitimate tool for marketing and in some cases the dissemination of medical information and learning; and

WHEREAS, board-certified neurosurgeons increasingly use social media to comment publicly on surgical techniques, implant selection, and the management decisions of other surgeons; and

WHEREAS, exaggerated, absolute, or misleading statements, such as categorically condemning specific procedures or publicly criticizing other surgeons postoperative films or outcomes without full clinical context, may misinform patients and undermine public trust in the profession; and

WHEREAS, many neurosurgical procedures, have well-established clinical indications supported by peer-reviewed evidence; and

WHEREAS, the public dissemination of incomplete or sensationalized commentary by physicians may contribute to patient confusion, potential delay or cancellation of necessary care, or erosion of collegial respect, and reputational harm to the specialty of neurosurgery; and

WHEREAS, the AANS and CNS maintain Codes of Ethics and Professional Conduct intended to uphold integrity, collegiality, and responsible communication within the specialty; therefore

BE IT RESOLVED, that the CSNS ask the AANS and CNS reaffirm that neurosurgeons communicating on public platforms have an ethical obligation to provide accurate, balanced, and evidence-based information; and

BE IT FURTHER RESOLVED, that the CSNS ask the AANS and CNS develop and disseminate an advisory statement outlining best practices for professional conduct and responsible communication on social media, including guidance on avoiding exaggeration, absolute claims, and public disparagement of reasonable surgical practices; and

BE IT FURTHER RESOLVED, that the CSNS ask the AANS and CNS promote educational resources for members regarding digital professionalism and preservation of public trust in neurosurgery.

Fiscal note: 500 USD

Assigned Committee(s):

Communication and Education

Medical Directors

Medico-Legal

Young Neurosurgeons

Medical Practices

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RESOLUTION VIII - 2026S

Title: Addressing Income-Based Liquidated Damages and Buyout Provisions in Neurosurgical Contracts

Submitted by: Joseph Camarano, MD, Brian Gantwerker, MD, Catherine Mazzola, MD, Laura Stone-McGuire, MD, Bharat Guthikonda, MD, MBA, CSNS Workforce Committee & Medico-Legal Committee

(Primary contact: joseph.camarano@lsuhs.edu)

WHEREAS, As traditional geographic non-compete clauses face increasing scrutiny, physician employment contracts increasingly rely on liquidated damages or “buyout” provisions requiring payment upon departure^{1,2}; and

WHEREAS, Recent state legislation, including Texas Senate Bill 1318, was intended to promote predictability and reduce litigation over what constitutes a reasonable physician buyout, but in doing so permits buyouts tied directly to physician compensation, including caps of up to 100 percent of annual salary and wages^{3,4}; and

WHEREAS, For surgical specialties such as neurosurgery, income-based buyout provisions can functionally codify high and disproportionate financial barriers to mobility that far exceed the actual costs of recruiting and onboarding a replacement physician⁵⁻⁷; and

WHEREAS, Even when ultimate enforceability is uncertain, statutorily sanctioned, high-dollar buyout provisions may limit physician mobility by unfairly leveraging bargaining power in favor of the employer, increasing exit risk for the physician, and discouraging physicians from leaving suboptimal practice environments⁸⁻¹¹; and

WHEREAS, Prior neurosurgical advocacy on physician non-competes and workforce mobility has not specifically addressed income-based liquidated damages or buyout provisions as a distinct and emerging mechanism for restricting neurosurgeon mobility and potentially their trade¹²; therefore

BE IT RESOLVED, That the CSNS ask the AANS and CNS, through the Washington Committee as appropriate, to incorporate income-based liquidated damages and buyout provisions into existing non-compete advocacy by opposing the use of physician income as a measure of reasonableness and supporting limits on buyout obligations tied to direct recruitment and onboarding costs.

Fiscal Note: 0\$

Prior Resolutions:

Resolution III – 2024F

BE IT RESOLVED, that the CSNS conduct a survey that will help assess reasonable noncompete clauses acceptable to neurosurgeons based on geographical location, practice setting, years of experience, and professional or academic rank/title/seniority; and

BE IT FURTHER RESOLVED, that the CSNS report results of this survey in a white paper with the goal of guiding future policy and advocacy efforts.

Resolution X – 2020F

BE IT RESOLVED, that the CSNS performs a systematic review of non-compete agreements pertinent to neurological surgery; and

BE IT FURTHER RESOLVED, that the CSNS develop a course on contract negotiations which includes non-compete agreements.

Resolution XIII – 2018F

BE IT RESOLVED, that CSNS gather data to understand the prevalence and general terms of non-compete clause among practicing neurosurgeons, and

BE IT FURTHER RESOLVED, that CSNS develop education resources for neurosurgeons to understand the different statesTM enforceability of a non-compete clause in a physician contract.

References:

1. Zoe Salzman. Liquidated Damages Clauses in Employment Agreements. *ABA Journal of Labor & Employment Law*. 2020;34(2):239-251.
2. What employed physicians should know about noncompete clauses. American Medical Association. February 21, 2024. Accessed March 8, 2026. <https://www.ama-assn.org/medical-residents/transition-resident-attending/what-employed-physicians-should-know-about>
3. New Healthcare Practitioner Non-Compete Provisions Effective September 1, 2025. Accessed March 8, 2026. <https://www.bradley.com/insights/publications/2025/07/new-healthcare-practitioner-noncompete-provisions-effective-september-1-2025>
4. 89(R) SB 1318 - Committee Report (Unamended) version - Bill Analysis. Accessed March 8, 2026. <https://capitol.texas.gov/tlodocs/89R/analysis/html/SB01318H.htm>
5. Medical Group Management Association. *PROVIDER COMPENSATION AND PRODUCTIVITY DATA REPORT*. Medical Group Management Association; 2024. <https://www.mgma.com/getkaiasset/252744ee-c63b-4a96-9211-8a5d6b908b39/MGMA-2024-Provider-Compensation-Data-Report.pdf>
6. Pappas MA, Stoller JK, Shaker V, Houser J, Misra-Hebert AD, Rothberg MB. Estimating the costs of physician turnover in hospital medicine. *J Hosp Med*. 2022;17(10):803-808. doi:10.1002/jhm.12942
7. PracticeMatch. The Actual Cost to Recruit a Physician in 2024. PracticeMatch. Accessed March 8, 2026. <https://www.practicematch.com/employers/recruitment-articles/the-actual-cost-to-recruit-a-physician-in-2024.cfm>
8. Gill D. Was Research — on Physicians and Noncompete Agreements — Before Its Time? UCLA Anderson Review. December 13, 2023. Accessed March 8, 2026. <https://anderson-review.ucla.edu/was-research-on-physicians-and-noncompete-agreements-before-its-time/>
9. What Happens When Private Equity Firms Sell Medical Practices? | Working Knowledge. Harvard Business School. August 26, 2025. Accessed March 8, 2026. <https://www.library.hbs.edu/working-knowledge/what-happens-when-private-equity-firms-sell-medical-practices>
10. Team S. A practical guide on physician non-compete agreements. Sermo. June 19, 2025. Accessed March 8, 2026. <https://www.sermo.com/resources/physician-non-compete/>
11. Sarva L, Botterbush KS, Sarva S, et al. The Enforceability of Non-Compete Agreements Against Neurosurgeons and Spine Surgeons in the United States: A Review of Outcomes of Previous Litigation and the Current Legal Landscape. *Neurosurgery*. Published online December 24, 2025. doi:10.1227/neu.0000000000003877

12. sandstorm_dev. AANS and CNS Comment on FTC Proposal to Ban Noncompetes. AANS. April 19, 2023. Accessed March 4, 2026. <https://www.aans.org/advocacy/articles/aans-and-cns-comment-on-ftc-proposal-to-ban-noncompetes/>

Assigned Committee(s):

Medico-Legal

Workforce

Medical Directors

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RESOLUTION IX - 2026S

Title: **Assessing the Impact of the CY 2026 Medicare Physician Fee Schedule (MPFS) -2.5% “Efficiency Adjustment” on Neurosurgical Access and Sustainability**

Submitted by: Alexander Greven, Clemens M. Schirmer, Anthony Digiorgio, Charlotte Pineda, Luis M. Tumialán, CSNS Coding and Reimbursement Committee
(Primary contact: Alexander Greven - alexander.greven@commonspirit.org)

WHEREAS, Medicare physician reimbursement has declined in inflation-adjusted terms for more than two decades, and the MPFS does not include an automatic, routine inflationary update mechanism comparable to other Medicare payment systems (1-3); and

WHEREAS, repeated policy-driven changes affecting MPFS payment—including conversion factor adjustments and budget-neutrality mechanics—have occurred during a period in which practice input costs (e.g., staffing, supplies, rent) have risen, increasing financial pressure on physician practices (4-6); and

WHEREAS in the CY 2026 MPFS final rule, CMS finalized an “efficiency adjustment” of –2.5% (derived from the Medicare Economic Index productivity adjustment) that reduces work RVUs and intraservice time for many non-time-based codes, including a wide range of diagnostic and procedural services, thereby disproportionately affecting procedure- and diagnostic-intensive specialties such as neurosurgery (7-9); and

WHEREAS, reductions in physician professional reimbursement—especially when coupled with site-of-service payment differentials—may contribute to accelerated healthcare consolidation, shifts in care delivery to higher-cost hospital-based settings, and higher total spending; and such market changes may threaten stability of specialty coverage, including emergency call coverage, and may worsen access challenges in rural and underserved communities (10-13); and

WHEREAS, organized neurosurgery would benefit from comprehensive national data quantifying the relationship between Medicare physician payment policy changes and neurosurgical practice sustainability, emergency call coverage capacity, and patient access; therefore

BE IT RESOLVED, that the CSNS collaborate with the AANS and CNS to develop a national assessment of the CY 2026 MPFS –2.5% efficiency adjustment and related payment changes on neurosurgical practice models, including at minimum: (1) claims-based modeling of payment impacts by site of service, (2) workforce and practice sustainability survey elements, (3) emergency call coverage impacts (availability, compensation, burden, stability), and (4) rural/underserved access indicators; and

BE IT FURTHER RESOLVED, that findings be synthesized into a policy brief for dissemination to federal legislators and CMS leadership to advocate for sustainable physician payment reform and protect patient access to essential neurosurgical and emergency specialty services.

References

1. AMA – *Medicare physician pay has plummeted since 2001 (inflation-adjusted)*: <https://www.ama-assn.org/practice-management/medicare-medicaid/medicare-physician-pay-has-plummeted-2001-find-out-why>
2. KFF – *What to Know About How Medicare Pays Physicians* (MPFS mechanics; conversion factor context): <https://www.kff.org/medicare/what-to-know-about-how-medicare-pays-physicians/>
3. Committee for a Responsible Federal Budget – *Fixing Medicare Physician Payments* (notes lack of inflation update mechanism): <https://www.crfb.org/papers/fixing-medicare-physician-payments>
4. AMA PDF – *History of Medicare Conversion Factors* (documented CF changes; CY 2026 context): <https://www.ama-assn.org/system/files/cf-history.pdf>
5. MedPAC (June 2025) – *Reforming physician fee schedule updates...* (conversion factor update structure; policy context): https://www.medpac.gov/wp-content/uploads/2025/06/Jun25_Ch1_MedPAC_Report_To_Congress_SEC.pdf
6. MedPAC (March 2024) – *Physician and other health professional services* (input costs/MEI discussion): https://www.medpac.gov/wp-content/uploads/2024/03/Mar24_Ch4_MedPAC_Report_To_Congress_SEC.pdf
7. CMS Fact Sheet – *CY 2026 MPFS Final Rule* (explicit –2.5% efficiency adjustment description): <https://www.cms.gov/newsroom/fact-sheets/calendar-year-cy-2026-medicare-physician-fee-schedule-final-rule-cms-1832-f>
8. Federal Register – *CY 2026 MPFS Final Rule* (regulatory text on efficiency adjustment): <https://www.federalregister.gov/documents/2025/11/05/2025-19787/medicare-and-medicaid-programs-cy-2026-payment-policies-under-the-physician-fee-schedule-and-other>
9. AMA PDF – *2026 MPFS final rule summary/analysis* (notes –2.5% “efficiency adjustment” applied to work RVUs): <https://www.ama-assn.org/system/files/2026-mpfs-final-rule-summary-analysis.pdf>
10. GAO – *Health Care Consolidation: Physician Consolidation Estimates (GAO-25-107450)* (consolidation associated with increased spending/prices; hospital-based setting spending): <https://www.gao.gov/products/gao-25-107450>
11. GAO PDF – *GAO-25-107450 full report*: <https://www.gao.gov/assets/gao-25-107450.pdf>
12. NIH/PMC – Richards et al. (2021) *Treatment consolidation after vertical integration* (evidence integration linked to higher prices/spending in outpatient markets): <https://pmc.ncbi.nlm.nih.gov/articles/PMC8810743/>
13. Axios (2024) – *Docs to see Medicare pay cut nearly 3% next year* (reports concerns re: rural/underserved practice stress from MPFS cuts): <https://www.axios.com/2024/11/04/doctors-medicare-pay-cut-3-percent-2025>

Fiscal Note: none

Prior resolutions: N/A

Assigned Committee(s):

Coding & Reimbursement

Workforce

Medical Practices

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RESOLUTION X - 2026S

Title: Assessment of Reserve Military Neurosurgeons' Ability to Meet Defense Health Agency KSA Readiness Metrics

Submitted by: Devon LeFever MD, Fassil Mesfin MD, Richard Menger MD MPA

(Primary contact: Richard Menger - richard.menger@gmail.com)

WHEREAS, the Defense Health Agency (DHA) mandates Knowledge, Skills, and Abilities (KSA) metrics to measure and maintain surgical readiness for critical wartime specialties, including neurosurgery, using a point-based system derived from case volumes across categories such as cranial (70 points), spine (45 points), peripheral nerve (15 points), endovascular (5 points), and minor procedures (5 points), with an annual threshold of 8,000 points (approximately 667 monthly) to ensure deployability; and

WHEREAS, reserve-component neurosurgeons constitute a vital portion of the military's deployable neurosurgical force, relying primarily on high-volume civilian practices to accumulate KSA points while balancing part-time military obligations, yet face unique administrative, privileging, tracking, and integration challenges; and

WHEREAS, no comprehensive assessment exists of reserve neurosurgeons' current KSA compliance, or perceived impact on deployment readiness and retention; and

WHEREAS, understanding these practice patterns is essential to optimize readiness, reduce administrative burdens, inform policy on case crediting and partnerships, and sustain the reserve neurosurgical workforce amid evolving global threats; therefore

BE IT RESOLVED, that the Council of State Neurosurgical Societies (CSNS) conduct a survey of current reserve military neurosurgeons (Selected Reserve) to assess knowledge of DHA KSA metrics, current ability to meet annual thresholds, barriers encountered (e.g., case logging, privileging, civilian-military data integration); and

BE IT FURTHER RESOLVED, that the CSNS publish a white paper reporting the findings, identifying gaps in KSA attainment and support for reservists.

Fiscal Note: None

Conflict of Interest: Authors are military reserve members, *This is not an official military project, participation is voluntary, and will represent the opinion of the authors only and will not be the opinion of the Department of Defense or United States Navy.*

Prior Resolutions: Multiple active duty military resolutions, no reserve KSA resolutions. This is not an official military project and will represent the opinion of the authors

References:

1. Woodle S, et al. The New Military Neurosurgeon Readiness Metric... (Abstract). Neurosurgery. 2024.

2. Dewar CD, et al. Optimizing Military Neurosurgery Readiness and Validation of the KSA Metric Threshold. (Published 2025).
3. Menger R, et al. Analysis of Factors and Conditions Influencing Military Neurosurgery Recruitment and Retention. World Neurosurg. 2020.
4. Additional DHA/Clinical Readiness Program references as needed.

Assigned Committee(s):

- Medical Practices**
- Neurotrauma & Emergency Neurosurgery**
- Workforce**

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RESOLUTION XI - 2026S

Title: Brain Tumor Alignment of MRI Protocols Throughout MRI Facilities and Insurances

Submitted by: Callum D Dewar, MD; Mateo Ziu, MD, MBA

(Primary contact: Mateo Ziu - mateo.ziu@gmail.com)

WHEREAS, neuro-navigation, tractography imaging protocols and additional sequences have become standard of care for precise neurosurgical treatment of brain tumors.

WHEREAS, a majority of brain MRIs are ordered by non-neurosurgeon practitioners, the subsequent diagnosis of a brain tumor requires urgent neurosurgical referral and expedited additional MRI sequencing to satisfy navigation protocols needed for surgical planning.

WHEREAS, insurance companies have their own criteria for approval of brain MRIs which does not delineate across various sequences needed.

WHEREAS, insurance companies' denial of the brain MRI with the appropriate sequences for neurosurgical planning and intervention causes delay in patient care and countless loss of work hours of medical staff; therefore

BE IT RESOLVED, that CSNS survey neurosurgeons on 1) the MRI sequences that they use for surgical management of brain tumors, 2) the phenomenon of Insurance denials of short interval repeat MRIs if first diagnostic MRI did not include navigation sequences; and

BE IT FURTHER RESOLVED, that AANS and CNS ask CNS and AANS guidelines committee and Tumor section to work with the corresponding committee of the Radiology society to develop standardized guidelines on the sequences necessary to be used by all MRI facilities for diagnosis, surgical planning and treatment of brain tumors.

BE IT FURTHER RESOLVED, that CSNS asks Washington Committee to facilitate communication and negotiations between AANS/CNS and Insurance companies' guideline creation bodies to change their stance and allowing repeat MRIs of brain with the appropriate sequences for timely treatment of patients with brain tumors.

Assigned Committee(s):

Coding & Reimbursement

Medical Practices

Patient Safety

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RESOLUTION XII - 2026S

Title: **Determining Current Perceptions and Involvement of Neurosurgeons in Ambulatory Surgical Centers (ASCs)**

Submitted by: Anisse N. Chaker, MD; Arthur Jenkins, MD; Elad I. Levy, MD, MBA; Mick Perez-Cruet, MD

(Primary contact: Anisse Chaker - achaker1@hfhs.org)

WHEREAS, the current healthcare ecosystem is moving towards increasing surgical operations to outpatient settings when feasible, including neurosurgical operations¹⁻⁶; and

WHEREAS, Ambulatory Surgery Centers (ASCs) represent a place of practice for both academic and private practice neurosurgeons¹⁻⁷; and

WHEREAS, understanding the current state of the neurosurgical ASC practice environment allows for more effective advocacy in current ASC shortcomings that may be facing practicing neurosurgeons and their patients; therefore

BE IT RESOLVED, a survey of neurosurgeons be conducted to assess the current trends of neurosurgical ASC practice and attitudes towards the administrative, legal, or financial aspects involved in expanding their practice to an ASC.

References:

- 1.) Idowu, O. A., Boyajian, H. H., Ramos, E., Shi, L. L., & Lee, M. J. (2017). Trend of spine surgeries in the outpatient hospital setting versus ambulatory surgical center. *Spine*, 42(24), E1429-E1436.
- 2.) Witiw, C. D., Wilson, J. R., Fehlings, M. G., & Traynelis, V. C. (2020). Ambulatory surgical centers: improving quality of operative spine care?. *Global Spine Journal*, 10(1_suppl), 29S-35S.
- 3.) Visconti, M. J., Alentado, V. J., & Potts, E. A. (2025). Outpatient Neurosurgery: ASCs and the Medicolegal Landscape. *Neurosurgery Clinics*, 36(1), 65-71.
- 4.) DeGaetano, A. C., Hess, R. M., Lai, P. M. R., & Levy, E. I. (2025). Evaluating the impact, effectiveness, and success of ambulatory surgery centers: insights and applications for neurosurgical specialization. *Journal of Neurosurgery*, 1(aop), 1-6.
- 5.) Federico, V. P., Nie, J. W., Sachdev, D., Hartman, T. J., Trevino, N., Gabriel, S., ... & Phillips, F. M. (2023). Medicare procedural costs in ambulatory surgery centers versus hospital outpatient departments for spine surgeries. *Journal of Neurosurgery: Spine*, 40(1), 115-120.
- 6.) Steadman, P. E., & Bernstein, M. (2026). Outpatient Surgery in Neuro-Oncology—Advancing Patient Access and Care. *Current Oncology*, 33(1), 40.
- 7.) Lai, P. M. R., Mullin, J. P., Berger, A., Moreland, D. B., & Levy, E. I. (2024). Neurosurgical training requires embracing ambulatory surgery centers. *Neurosurgery*, 95(4), 725-727.

Fiscal Note: None

Prior Resolutions: Resolution V-2019F - Prevalence of Ambulatory Surgery Centers in Neurosurgery Practice. Though related to ASCs, our proposed resolution would offer a more nuanced assessment of

current Neurosurgeon's involvement and perceptions of ASCs to determine potential needs in advocacy for surgeons and patients in their access to outpatient neurosurgical care.

Assigned Committee(s):

Medical Practices

Workforce

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RESOLUTION XIII - 2026S

Title: Survey to Determine Training of Neurosurgical Residents in the Ambulatory Surgical Center (ASC) Setting

Submitted by: Anisse N. Chaker, MD; Arthur Jenkins, MD; Elad I. Levy, MD, MBA; Mick Perez-Cruet, MD

(Primary contact: Anisse Chaker - achaker1@hfhs.org)

WHEREAS, ambulatory surgery centers (ASC) and outpatient surgical facilities are a critical part of the health care ecosystem and a place of practice for neurosurgeons ranging from academic to private practices¹⁻⁵; and

WHEREAS, the training of neurosurgery residents has evolved over the last century from a few major teaching hospitals to 117 programs both a mix of academic and private practices¹; and

WHEREAS, the role of neurosurgical residents in the outpatient surgical environment remains limited; therefore

BE IT RESOLVED, a survey of neurosurgery residency program directors be conducted to determine the current exposure neurosurgery residents have to ASCs, as well as the current opinion of program directors in involving ASCs in resident training as program directors.

References:

- 1.) Lai, P. M. R., Mullin, J. P., Berger, A., Moreland, D. B., & Levy, E. I. (2024). Neurosurgical training requires embracing ambulatory surgery centers. *Neurosurgery*, 95(4), 725-727.
- 2.) Idowu, O. A., Boyajian, H. H., Ramos, E., Shi, L. L., & Lee, M. J. (2017). Trend of spine surgeries in the outpatient hospital setting versus ambulatory surgical center. *Spine*, 42(24), E1429-E1436.
- 3.) Witiw, C. D., Wilson, J. R., Fehlings, M. G., & Traynelis, V. C. (2020). Ambulatory surgical centers: improving quality of operative spine care?. *Global Spine Journal*, 10(1_suppl), 29S-35S.
- 4.) Visconti, M. J., Alentado, V. J., & Potts, E. A. (2025). Outpatient Neurosurgery: ASCs and the Medicolegal Landscape. *Neurosurgery Clinics*, 36(1), 65-71.

Fiscal Note: None

Prior Resolutions: Resolution V-2019F - Prevalence of Ambulatory Surgery Centers in Neurosurgery Practice. Though this prior resolution was related to ASCs, our proposed resolution focuses on understanding Neurosurgical trainees' involvement with ASCs and Program Directors' attitudes towards training in ASCs specifically.

Assigned Committee(s):

- Communication and Education**
- Medical Practices**
- Workforce**
- YNRS**

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RESOLUTION XIV - 2026S

Title: Transition of care practice patterns for pediatric to adult neurosurgical oncology care for Pediatric Brain Tumor Survivors

Submitted by: Kyle Tuohy MD, David Bailey MD, Seth Rosenberry, Elias Rizk MD, PhD, Michael McDowell MD, Brad Zacharia MD, Michael Glantz MD, PhD, Scott Simon MD

(primary contact: Kyle Tuohy - ktuohy@pennstatehealth.psu.edu)

WHEREAS, the American Academy for Pediatrics has issued recommendation for the transition from child to adult, to be implemented and adapted to the different fields of child-oriented care.¹ Neurology has also looked into the breadth of this problem in their field.¹ Within neurosurgery, there are several childhood conditions with long-term sequelae that persist into adulthood and require ongoing treatment or surveillance.³ Some of the more common conditions are those diagnosed and managed initial as a child, such as spina bifida and hydrocephalus⁴⁻⁶ : and

WHEREAS, survival rates for pediatric brain tumors continue to improve with advances in treatment. As a result, many of these have also turned into conditions that need to be managed into adulthood. As a result, our field faces a growing challenge: ensuring a seamless transition from pediatric to adult neurosurgical oncology care; and

WHEREAS, Various models for optimal care transition have been previously described.⁷ Many of this prior literature focuses on specific disease groups such as neurofibromatosis or tuberous sclerosis, but less has been studied on patients without systemic congenital disorder who may not have a robust multidisciplinary team available to them. Furthermore, although these studies provide single institutional experience with a given transition model, it is unclear to what extent these transitions are being employed across the country; therefore

BE IT RESOLVED, that the CSNS develop and disseminate a survey to practicing neurosurgeons who treat pediatric or adult patients with brain tumors. The goals of which being to characterize current practices and existing models for transitioning pediatric neuro-oncology patients to adult neurosurgical care in the United States, identify perceived barriers to successful transition from both the pediatric (sender) and adult (receiver) perspectives, and assess the prevalence of structured transition programs vs. ad hoc transfers; and

BE IT FURTHER RESOLVED, that the results of the survey be compiled and disseminated to the CSNS as an oral presentation with the goal of developing and publishing best practice guidelines and facilitating implementation of structured transition programs within neurosurgical oncology.

Prior resolutions: None

Fiscal note: 0\$

References:

1. American Academy of Pediatrics (2002) A consensus statement on health care transitions for young adults with special health care needs. *Pediatrics* 100: 1304–1306
2. Tuffrey C, Pearce A (2003) Transition from pediatric to adult neurological services for young people with chronic neurological problems. *J Neurol Neurosurg Psychiatr* 74: 1011–1013

3. Lohkamp, L., Nguyen, R., & Greenfield, J. P. (2024). Challenges and opportunities in neurosurgical care transition. *Neurosurgical Focus*, 57(2), E17. <https://doi.org/10.3171/2024.5.FOCUS24281>
4. Anderson, M. G., Mannam, P., Leclair, N. K., Martin, J. E., Bookland, M. J., Kelley, B. J., Kureshi, I. U., & Hersh, D. S. (2024). Healthcare transition in pediatric neurosurgery: lessons learned from a pilot program for patients with hydrocephalus and spina bifida. *Neurosurgical Focus*, 57(2), E10. <https://doi.org/10.3171/2024.5.FOCUS24214>
5. Simon TD, Lamb S, Murphy NA, Hom B, Walker ML, Clark EB. Who will care for me next? Transitioning to adulthood with hydrocephalus. *Pediatrics*. 2009;124(5):1431-1437. doi:10.1542/peds.2008-3834
6. Johnson A, Marks J, Little J. A Pilot Project: Improving the Transition Care Process for Neurosurgical Adolescent Patients with Indwelling Shunts to Adult Care. *J Pediatr Nurs*. 2021 Sep-Oct;60:164-167. doi: 10.1016/j.pedn.2021.05.003. Epub 2021 May 13. PMID: 33992915.
7. Ebel F, Greuter L, Guzman R, Soleman J. Transitional Care in Pediatric Brain Tumor Patients: A Systematic Literature Review. *Children*. 2022; 9(4):501. <https://doi.org/10.3390/children9040501>

Assigned Committee(s):

Communication and Education

Medical Practices

Patient Safety

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RESOLUTION XV - 2026S

Title: **Strengthening Management Practices in Penetrating Traumatic Brain Injury**

Submitted by: Elias Geist MD, Callum Dewar MD, Bradley Dengler MD, Kristopher Hooten MD

(Primary contact: Elias Geist - eli.geist14@gmail.com)

WHEREAS, penetrating traumatic brain injury (pTBI) carries significant morbidity and mortality in both the civilian and military populations,^{1,2} underscoring the need for a prompt, protocolized approach for pTBI patients; and

WHEREAS, the recently published second edition of the Brain Trauma Foundation (BTF) Guidelines for the Management of Penetrating Traumatic Brain Injury³ provides updated treatment strategies for pTBI patients, the adaptation of these guidelines remains variable, and, given the relative paucity of available high-quality, large-volume studies investigating pTBI management, the guidelines rely heavily on expert consensus, rather than evidence-based recommendations; therefore

BE IT RESOLVED, that the CSNS conduct a national survey to assess pTBI treatment patterns, including adherence to current guidelines; and

BE IT FURTHER RESOLVED, that the results of the survey be published in a white paper and used, in collaboration with the AANS, CNS, and BTF, to guide and advocate for future, multicenter studies on pTBI management, including prospective research where feasible and ethical.

Fiscal note: none

References:

1. Shackelford SA, Del Junco DJ, Reade MC, et al. Association of time to craniectomy with survival in patients with severe combat-related brain injury. *Neurosurgical Focus*. 2018;45(6):E2. doi:10.3171/2018.9.FOCUS18404
2. Deng H, Yue JK, Winkler EA, Dhall SS, Manley GT, Tarapore PE. Adult Firearm-Related Traumatic Brain Injury in United States Trauma Centers. *Journal of Neurotrauma*. 2019;36(2):322-337. doi:10.1089/neu.2017.5591
3. Bell RS, Selph S, Ghajar J, et al. Brain Trauma Foundation Guidelines for the Management of Penetrating Traumatic Brain Injury, Second Edition. *Neurosurgery*. 2026;98(3S):S6-S164. doi:10.1227/neu.0000000000003738

Assigned Committee(s):

Communication and Education

Medical Practices

Neurotrauma and Emergency Neurosurgeons

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RESOLUTION XVI - 2026S

Title: **Opposing the Selective Use of Weak or Incomplete Evidence by Insurance Carriers to Deny Medically Necessary Neurosurgical Care**

Submitted by: Ernest E. Braxton, MD, MBA, Brian R. Gantwerker,
Anisse N. Chaker, MD, Luis M. Tumialán, MD on behalf of Colorado Neurosurgical Society and the Medico-Legal Committee
(Primary contact: Ernest Braxton - ebraxton@vsortho.com)

WHEREAS, private insurance carriers increasingly cite selective or methodologically weak studies to justify denial of coverage for neurosurgical procedures, including but not limited to minimally invasive spine surgery, motion preservation technologies, biologics, and emerging outpatient techniques; and

WHEREAS, the selective citation of limited, underpowered, or outdated studies, while ignoring higher-quality evidence, real-world registry data, and specialty society guidelines undermines evidence-based medicine; and

WHEREAS, inappropriate denials of medically necessary neurosurgical care may delay treatment, increase patient suffering, contribute to neurologic deterioration, and ultimately increase overall healthcare costs; and

WHEREAS, neurosurgeons have an ethical obligation to advocate for policies that promote accurate interpretation of scientific literature and protect patient access to appropriate care; therefore

BE IT RESOLVED, that the appropriate joint section of the AANS and CNS formally challenge the use of low-quality or incomplete evidence by insurance carriers to deny medically necessary neurosurgical procedures; and request the Washington Committee to engage in active advocacy work in this regard, and

BE IT FURTHER RESOLVED, that the AANS and CNS develop and publish a white paper outlining standards for appropriate evidentiary review in payer medical policy determinations, including transparency in methodology and balanced appraisal of available data; and

BE IT FURTHER RESOLVED, the Section on Disorders of the Spine and Peripheral Nerves of the AANS and CNS develop standards for appropriate evidentiary review for payers whose patients with spinal issues are under the care of qualified neurosurgeons and be transparent in the methodology of their derivation and application coverage policies.

Fiscal Note: 100 USD

Assigned Committee(s):

- Coding and Reimbursement**
- Medico-Legal**
- Medical Practices**

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RESOLUTION XVII - 2026S

Title: **Neurosurgery Support for Folic Acid Fortification of Corn Masa Flour to Prevent Neural Tube Defects**

Authors: Megan EH Still MD, Laila Mohammad MD, Michael Feldman MD

(Primary Contact: Megan Still - megan.still@ufl.edu)

WHEREAS, neural tube defects (NTDs), including spina bifida and anencephaly, represent some of the most common and severe congenital anomalies in the United States, often leading to lifelong neurologic morbidity, substantial healthcare costs, and significant psychosocial impact on patients and families¹⁻³; and

WHEREAS, robust evidence demonstrates that adequate periconceptional folic acid intake substantially reduces the incidence of neural tube defects, forming the basis for longstanding folic acid fortification policies and ongoing efforts to broaden fortification to additional dietary staples to maximize preventative impact⁴⁻⁶; and

WHEREAS, Hispanic/Latino populations in the United States continue to experience disproportionately elevated rates of neural tube defects⁷, in part due to lower folic acid intake from high reliance on corn masa-based foods excluded from fortification mandates^{2,8,9}; and

WHEREAS, multiple states including Alabama (House Bill 384¹⁰), California (Assembly Bill 1830¹¹), Georgia (Senate Bill 278¹²), and Oklahoma (House Bill 1912, the *Corn Masa Nutrition Enhancement Act*)¹³ are taking action to mandate folic acid fortification of corn masa flour and wet corn masa products, reflecting broadening momentum toward addressing this preventive public health need; and

WHEREAS, neurosurgeons, by virtue of their clinical expertise and routine care of patients with spina bifida and other neural tube defects, have a unique professional, ethical, and advocacy responsibility and are uniquely positioned to champion prevention-focused public health policies that reduce the burden of preventable neurosurgical diseases; therefore

BE IT RESOLVED, that the Congress of State Neurosurgical Societies (CSNS) formally recognizes folic acid fortification of corn masa flour and corn masa products as an effective and evidence-based strategy to reduce the incidence of neural tube defects and associated neurosurgical morbidity in the United States; and

BE IT FURTHER RESOLVED, that CSNS encourage its parent organizations, the American Association of Neurological Surgeons (AANS) and the Congress of Neurological Surgeons (CNS), to adopt or endorse a formal position statement supporting state and federal efforts to expand folic acid fortification policies to include corn masa flour and related products; and

BE IT FURTHER RESOLVED, that CSNS request the AANS/CNS Washington Committee include advocacy for corn masa flour fortification with folic acid in its legislative and regulatory priorities,

including support for state legislation and regulatory actions that advance mandatory or expanded fortification policies; and

BE IT FURTHER RESOLVED, that CSNS develop, curate, and disseminate advocacy resources for state neurosurgical societies—including educational materials, policy briefs, talking points, and legislative guidance—to support informed neurosurgeon engagement in state-level legislative and regulatory efforts related to folic acid fortification of corn masa flour and products; and

BE IT FURTHER RESOLVED, that CSNS support educational efforts directed toward neurosurgeons, trainees, policymakers, and the public regarding the role of nutrition-based prevention strategies, including folic acid fortification, in reducing the burden of congenital neurosurgical disease.

References

1. Kancherla V. Neural tube defects: a review of global prevalence, causes, and primary prevention. *Childs Nerv Syst.* 2023;39(7):1703-1710. doi:10.1007/s00381-023-05910-7
2. Williams J, Mai CT, Mulinare J, et al. Updated estimates of neural tube defects prevented by mandatory folic Acid fortification - United States, 1995-2011. *MMWR Morb Mortal Wkly Rep.* 2015;64(1):1-5.
3. Rofail D, Maguire L, Kissner M, Colligs A, Abetz-Webb L. A review of the social, psychological, and economic burdens experienced by people with spina bifida and their caregivers. *Neurol Ther.* 2013;2(1-2):1-12. doi:10.1007/s40120-013-0007-0
4. Viswanathan M, Treiman KA, Doto JK, Middleton JC, Coker-Schwimmer EJ, Nicholson WK. *Folic Acid Supplementation: An Evidence Review for the U.S. Preventive Services Task Force.* Agency for Healthcare Research and Quality (US); 2017. Accessed January 4, 2024. <http://www.ncbi.nlm.nih.gov/books/NBK410113/>
5. Caceres A, Blount JP. Preventing spina bifida through folate fortification: a labor of love. *Childs Nerv Syst.* 2023;39(7):1695-1697. doi:10.1007/s00381-023-05948-7
6. Atta CAM, Fiest KM, Frolkis AD, et al. Global Birth Prevalence of Spina Bifida by Folic Acid Fortification Status: A Systematic Review and Meta-Analysis. *Am J Public Health.* 2016;106(1):e24-e34. doi:10.2105/AJPH.2015.302902
7. Mai CT, Evans J, Alverson CJ, et al. Changes in Spina Bifida Lesion Level after Folic Acid Fortification in the US. *J Pediatr.* 2022;249:59-66.e1. doi:10.1016/j.jpeds.2022.06.023
8. Kancherla V, Averbach H, Oakley GP. Nation-wide failure of voluntary folic acid fortification of corn masa flour and tortillas with folic acid. *Birth Defects Res.* 2019;111(11):672-675. doi:10.1002/bdr2.1518
9. Flores AL, Cordero AM, Dunn M, et al. Adding folic acid to corn Masa flour: Partnering to improve pregnancy outcomes and reduce health disparities. *Prev Med.* 2018;106:26-30. doi:10.1016/j.ypmed.2017.11.003
10. Feldman MJ, Hereford WJ, Gaskin R, et al. Fortify Alabama: Corn Masa Fortification for Spina Bifida Prevention. *Pediatrics.* 2026;157(2):e2025073306. doi:10.1542/peds.2025-073306

11. AB 1830- CHAPTERED. Accessed February 12, 2026.
https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202320240AB1830
12. Georgia SB278 | 2025-2026 | Regular Session. LegiScan. Accessed February 12, 2026.
<https://legiscan.com/GA/bill/SB278/2025>
13. Bill Information. Accessed February 12, 2026.
<https://www.oklegislature.gov/BillInfo.aspx?Bill=HB1912&Session=2500>

Assigned Committee(s):

Communication and Education

Medical Practices

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RESOLUTION XVIII - 2026S

Title: Evaluating Site-of-Service Reimbursement Disparities and Their Impact on Neurosurgical Care Delivery

Submitted by: Jessica K. Campos, MD; Anthony M. DiGiorgio, DO, MHA; Namath S. Hussain, MD, MBA; Brian R. Gantwerker, MD

(Primary contact: Jessica Campos - camposjk@uci.edu)

WHEREAS, increasing consolidation of hospital systems has resulted in vertical integration of neurosurgical practices; and

WHEREAS, site-of-service reimbursement differentials incentivize the migration of neurosurgical care from independent and ambulatory settings to hospital-owned facilities; and

WHEREAS, these reimbursement disparities may contribute to increased healthcare costs without clear improvements in quality or patient outcomes; and

WHEREAS, such shifts may impact the viability of independent neurosurgical practice and influence patient access to high-value care settings; therefore

BE IT RESOLVED, that the Council of State Neurosurgical Societies (CSNS) request that the AANS/CNS Washington Committee, in collaboration with the CSNS, perform a structured review of existing policy analyses and publicly available data regarding site-of-service reimbursement differentials to evaluate their impact on neurosurgical practice environments, healthcare costs, and patient access; and

BE IT FURTHER RESOLVED, that these findings be synthesized into a white paper to inform advocacy efforts supporting equitable and value-based reimbursement policies across care settings.

Fiscal Note: Minimal (staff and committee time; <\$100)

The authors have no financial disclosures.

Assigned Committee(s):

Coding and Reimbursement

Medical Practices

Medico-Legal

Patient Safety

Medical Directors

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