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COA Report

A publication of the California Orthopaedic Association

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Medicare:
Just Walk Away

Most California orthopaedists have read the recent issue of, "Orthopaedics Today" which detailed that the Medicare reduction in payments will be 5.1% as of January 1, 2007. With respect to orthopaedics overall, it is estimated there will be an 8% reduction in fees. The article also predicted a 10% reduction in the reimbursement for total hip replacement, a 21% reduction for total knee replacement, and an 18% decrease in reimbursement for the care of hip fractures. There were no comments on proposed reductions to spine codes, but I would anticipate reductions are planned for these codes as well. Despite efforts by various organizations to overturn these reductions, the message from Congress was,

"Sorry, we don't have the time, but we'll get it done in the 'lame duck' session."

Larry Herron, M.D., President

The Congressional leadership was willing to just walk away and start campaigning without dealing with the impending cuts. These cuts will likely go into effect in January, and could be in place in 2007 for several months before Congress may retroactively reverse them, as they have in the past. There are, of course, no guarantees that Congress will act. Members of Congress continue to believe that doctors will just accept this reduction and "roll over on this."

(Continued on Page 2)

GOOD NEWS—COA-Sponsored SB 1670

Has passed the Legislature and was signed into law—effective January 1, 2007.

See Page 5 of this newsletter for additional information on this bill.

COA/AAOS Pain Management Course

Orthopaedic Surgeons are required to attend a minimum of 12 hours of Category 1 CME in pain management and/or end-of-life issues by December 31, 2006. This is a one time requirement as a condition of the renewal of your medical license.

If you have not yet obtained these required pain management hours or if you want to learn more about treating orthopaedic pain, attend a joint COA/AAOS course entitled,

"Treatable Causes of Chronic Orthopaedic Pain "
Saturday, December 9, 2006
Crowne Plaza Hotel—Los Angeles

A registration form is included in this newsletter or you can call COA—916-454-9884 to register.

President's Column (continued from Page 1)

Congress also wants to impose pay-for-performance and quality reporting as an unfunded mandate along with the decrease in payment. At present, 93% of physicians participate fully in Medicare without restricting patient access. Congress is treating physicians badly and in an irresponsible manner. When questioned as to when Congress will quit cutting Medicare reimbursement, Congressman Pete Stark stated in the past, "when you stop seeing the patients." The actions of Congress this time, I believe, will result in decreased patient access and reenforces the message that physicians must quit or markedly decrease their participation in the Medicare program before members of Congress will correct the problems in the system.

Several proposals have been suggested to address the Medicare reimbursement problem. Congressman Bill Thomas from California and outgoing Republican Chair of the Ways and Means Committee, has suggested that the 5% decrease should be converted to a 2% increase for those doctors willing to "report on quality," i.e., pay-for-performance. Those who choose not to participate, will have their reimbursement frozen.

Congressman Joe Barton, Republican from Texas, proposes a 3-year freeze in Medicare decreases in exchange for a pay-for-performance program to be instituted in January, 2008. This obviously represents an unfunded mandate and does not allow reimbursements to address inflation at all.

Finally, Congresswoman Nancy Johnson from Connecticut, has proposed a 1% increase for 2007 and an additional 1.5% increase for physicians who participate in "physician-friendly reporting systems." These are to be designed and implemented by mid 2007 and will require quality and utilization review components. The utilization review components are to be designed and implemented by state medical societies or the state Medicare fiscal intermediary. She would also create, "the intent of Congress" to eliminate the sustainable growth rate (SGR), without specifying the date it would actually happen.

Physicians locally have previously addressed Medicare reimbursement inadequacies in a variety of manners. One neurosurgeon will see only one new Medicare patient a month. He states that he sees his share of Medicare patients through the emergency room and cannot subsidize the system further in his office. Another neurosurgeon routinely informs Medicare patients that they are too old for surgery, thereby he does not have to accept inadequate Medicare reimbursement for surgical services and allows his surgical time to be devoted to patients with other coverage at a significantly higher rate. Many Medicare patients locally are unable to find primary care physicians accepting Medicare.

The COA performed a study on practice costs several years ago. The study found that it costs a California orthopaedist, on average, $45 for a follow-up visit. This is more than Medicare currently reimburses for a follow-up visit in San Luis Obispo, partly because of the geographic adjustment (GPCI) which has rated this county as rural Area 99—the lowest reimbursement in the state—and reimburses doctors in this county at the same rate as rural Mississippi.

Personally, I am strongly considering dropping out of Medicare completely. Otherwise, I will be forced to severely ration the number of patients that I see. I am unable to financially subsidize the system further. Congress only responds to a crisis. Unless Medicare patients are unable to obtain care, Congress will continue to decrease physician reimbursement.

Larry D. Herron, M.D.
President

People in the News

Paul D. Burton, DO of Redlands has been elected to the AAOS Board of Councilors representing the Inland Empire District. He replaces Gary Frykman, M.D. who has reached his maximum term on the Board.

Thomas Barber, M.D. of Oakland has been re-elected to a second three year term on the AAOS Board of Councilors as one of the Councilors representing the Northern California District.

Robert O'Hollaren, M.D. of Ventura has been re-elected to a second three-year term on the AAOS Board of Councilors representing the Los Padres District.

Ramon Jimenez, M.D. of Monterey received the **Physician Recognition Award** annually awarded by the Medical Board of California for his lifelong work with the underserved population in the Central Valley of California and in Mexico.

5K Winners at COA's Annual Meeting included:
Women's—Kirsten Winter of Stockton; and,
Men's—Alexander Davis, M.D. from Modesto.

Classified Ad

Department of Managed Health Care

Following an Executive Order from Governor Arnold Schwarzenegger, the California Department of Managed Health Care is proposing several regulations which will prohibit non-contracted emergency room providers from billing patients they treat in the emergency room for amounts that are not paid by their health plan. In addition, the regulations propose a dispute resolution mechanism to resolve billing disputes and expands the existing Gould criteria for determining appropriate reimbursement rates. COA has joined with CMA and other medical specialty organizations in opposing the regulations and orthopaedic surgeons have testified at the hearings.

Orthopaedic surgeon, Ralph DiLibero, M.D., President of the Los Angeles County Medical Association and member of COA's Board of Directors, offers the following comments on these regulations.

A Lesson Learned From Our Colleagues In Healthcare Delivery

The newly elected president of the CMA, Dr. Brian Day, has an "illegal" medical practice? He, like me, is an orthopaedic surgeon and practices according to his training, experience and qualifications, but his surgical practice has been termed "illegal" by administrative physician bureaucrats even though such terminology runs contrary to a supreme court judicial decision. Dr. Day represents 63,000 physicians in the CMA and his election campaign was wrought with difficulties, but he overcame those obstacles and soundly defeated opponent bureaucratic physicians in an open election for president of the CMA.

The CMA that I am referring to is not the California Medical Association, but the Canadian Medical Association. I now see your faces appear not so confused about that 63,000 membership figure.

Dr. Brian Day was trained in the socialistic milieu of Liverpool and now practices out of his private surgical center in Vancouver, Canada. A judicial decision from Canada's Supreme Court in Quebec last year determined that the Canadian government did not have the right to restrict access to medical care by forbidding citizens from buying private medical insurance. That decision from Canadian justices clearly stated, **"Access to waiting lists is not access to health care."**

In California, the percentage of people without insurance continues to increase, while the percentage of people with job-based insurance continues to decrease. However, that is not as much concern as is the increasing number of people with incomplete or inadequate insurance. I quote the Canadian justices once again and now in reference to the situation right here in California, **"Access to waiting lists is not access to health care."**

Now, our California Governor has ordered regulations to be enacted to ban balance billing. This runs contrary to the California judicial system.

The ill-advised order to prevent physicians from billing for the unpaid balance of a fair and reasonable medical fee is illegal according to three rulings from the California courts:

The "Bell", or Dr. Bell vs. Blue Cross decision pronounced balance billing legal as a matter of common law. When a physician delivers healthcare to a patient, there is an implied contract with that patient for that healthcare. Physicians have the right to participate as professionals in an open market economy of a free society and have the right to bill patients, or corporate Risk Bearing Organizations (RBO)s, or both for the balance of their reasonable and legitimate bill.

The matter of a true fair and reasonable fee was also addressed in the California courts. Through a Workers' Compensation case, the "Gould" decision defined precise criteria to be used in determining a just fee. Specifically, Medicare and Medi-Cal schedules were deemed not to be fair-market value criteria.

In "Prospect vs Northridge Emergency Group et al" or the "Prospect" case, Prospect claimed that a statute (1379 (b) of the California Health and Safety code) required a RBO corporation to act as an exclusive remedy for the balance of a physician's bill. The court ruling upheld the right of physicians to bill a patient, a RBO, or both for the balance of the physician's fair and reasonable fee and specifically referred to the Gould criteria as a method to determine the dollar amount for that just and legal billing charge.

(Continued on Page 4)

Department of Managed Health Care (continued from Page 3)

Don't be fooled, this controversy is not a physician-consumer battle; this irresponsible emergency regulation is the result of RBOs only partially fulfilling the contractual needs of their contracted patients. Also, and because of antitrust restrictions, physicians are not able to negotiate worthwhile contracts with corporate RBO oligopolies.

The Los Angeles County Medical Association has no sympathy for gouging or unreasonable fee billings; LACMA's only concern is for usual, customary, and reasonable fee billings; such legitimate billings should be paid in full, without an unpaid balance.

Before being sold to our patients, insurance policies should be reviewed by the California Department of Managed Health Care (DMHC). There should be no carve out for any special type of RBO. The DMHC should not allow an insurance policy to be issued in the state of California unless the RBO provides for three things:

1. **Adequate medical coverage for all types of medically necessary healthcare treatments.**
2. **A comprehensive and accurate up-to-date physician network that includes all medical specialties.**
3. **Sufficient financial reserves set aside for full payment of legitimate, non-contracted and contracted physician billings.**

Those three requirements should serve as prerequisites, for such expectation in insurance coverage is what patients and physicians alike want and expect the DMHC to assure.

In no way am I suggesting any carve out for any type of risk-bearing organization. All insurance corporations should have an up-to-date accurate and comprehensive physician network, sufficient reserves to pay non-contracted physicians, and coverage for patients that include all medically necessary healthcare treatments.

Additionally, let it be known that a portion of a patient's paid premium is routinely put aside by insurance corporations to allow for non-contracted emergency healthcare, and that that reserve set of funds is often simply held back and not used to pay the balance of a non-contracted physician's usual, customary, and reasonable billing. Those funds often find their way onto the profit line of stockholder statements.

(Furthermore, we are too often dealing within a reimbursement system that is resource-based. The inadequacy of the system is no excuse for incomplete reimbursement when healthcare is dearly needed. The resource base should be expanded to provide for an increasing number of necessary services to an increasing number of patients in true need of healthcare delivery.)

LACMA, the Los Angeles County Medical Association, is urging that the regulations focus on and treat the underlying disease infesting healthcare delivery, rather than focus on placating just one of the symptoms -- balance billing.

We physicians know well that treating only the symptoms of a pathological process will allow the disease to fester and produce even more debilitating symptoms. By not treating the cause of the healthcare delivery problem, our patients will suffer from a greater number and more severe symptoms. **Our patients don't want and don't deserve future reduced emergency room physician coverage, future closure of emergency treatment facilities, and future closure of hospitals, all of which amount to an increase in access waiting lines and a decrease in access to healthcare delivery.** Healthcare insurance should adequately cover needed services rendered.

True healthcare insurance should not be a form of cheap, inadequate, and phony "underinsurance" that constantly modifies valid billings with payment delays, payment deductions, and payment denials. When a patient gets insured -- through a self-pay, work benefit, or governmental program -- that patient assumes and expects that the provided insurance policy will cover all legitimate costs without excessive co-pays or excessive balance billings that the patient is legally forced to pay. That is not an unreasonable expectation. LACMA urges our governor to cure the disease in our healthcare delivery system, and not simply treat a symptom.

If the federal government of Canada does not have the right to limit a citizen's right to healthcare delivery access, then why in the world would anyone in California allow insurance corporations to take away our patients' right to the same?

Ralph J. Di Libero, M.D.
President , Los Angeles County Medical Association
Member, COA's Board of Directors

Legislative Update

Good News . . .
COA-Sponsored SB 1670 Is Signed Into Law
Effective January 1, 2007

Limited Permit X-Ray Technicians—Operate Digital X-Ray Equipment

Radiologic Health Branch (RHB) regulations currently prohibit limited permit x-ray technicians (XTs) from operating digital x-ray equipment. This has caused problems and confusion as orthopaedists convert their analog x-ray equipment to computed radiographic equipment (CR) or install digital radiographic equipment (DR) in their offices. The RHB has been reluctant to remove this prohibition without assurance that XTs are well-trained in the operation of digital equipment. Currently the hands-on training is provided by the vendors when the equipment is installed.

We are pleased to report that COA-sponsored **SB 1670** authored by **Senator Sam Aanestad of Grass Valley** has been signed into law and clarifies that XTs may operate digital equipment after they have completed 20 hours of continuing education in digital radiographic technology. The bill goes into effect January 1, 2007.

COA is in the process of working with XT schools and other experts in digital radiographic technology to identify or create a 20-hour course to meet these educational requirements. Once completed, the XT will be able to operate digital x-ray equipment.

In addition, SB 1670 requires XT schools to build into their curriculum, 20 hours of education in digital radiography so that newly graduated XTs will have had this training and requires both XTs and certified radiology technologists (CRTs) to attend continuing education courses in digital radiographic technology. The specific number of hours to be determined by the Radiologic Health Branch.

COA **thanks Senator Aanestad** for his dedication and support of this worthwhile issue.

Other Legislation of Interest

SB 736 (Speier) - Diagnostic Imaging Services

Late in the Legislative Session, SB 736 was gutted and amended to prohibit physicians from billing for the technical component of diagnostic services that were not rendered by the physician. This was intended to prohibit the referring physician from billing for the technical service if he/she did not perform the service. It would have affected current lease arrangements where the physician is billing for both the technical and professional component of the service.

COA opposed the bill for several reasons:

1. The bill was amended late in the session and had not been heard by other policy committees.
2. There is already federal and state law defining appropriate lease arrangements. Current definitions do not prohibit physicians from billing both services.
3. It was unclear what impact this bill would have had on existing laws and whether it would have a negative impact on legitimate lease arrangements.

Due to opposition from COA and the California Medical Association, the bill died. It is expected that the California Radiologic Society, the sponsors of the bill, will reintroduce the bill in the next legislative session.

COA has prepared a summary of these and other legislative/regulatory issues in which we have been involved during the 2005-2006 Legislative Session.
You can find the summary on COA's website at:
http://www.coassn.org/wrap-up%202005-06.pdf

Eighty-Six Prop 86

By: Ralph Di Libero, MD
LACMA President

It sounds like motherhood and apple pie: Raise taxes on cigarette smokers by $2.60 per pack (13 cents per cigarette) to fund a variety of health-related programs. It's a freebie because the only people paying the tax would be the 14% of Californians who smoke. What could be better?

Unfortunately, as the old saying goes, "If something sounds too good to be true, it probably is." Proposition 86 contains a number of serious flaws and deserves a NO vote this November.

Proposition 86 is not what it seems. It's a tobacco tax where only 10% of the measure's revenue is dedicated toward smoking cessation programs. Fully 40% of the revenues collected, the largest allocation of any in the initiative, goes directly to hospital corporations. To make matters worse, Proposition 86 contains a poison pill that exempts hospital corporations from vital federal and state anti-trust laws – a provision that doctors oppose because it is bad for our patients and would ultimately hurt the public at large.

Prop. 86 would allow hospital corporations to share business information in order to develop plans for providing emergency or specialty medical services. While this may also sound appealing, this exemption is entirely too broad and would result in hospitals having *carte blanche* to share information for any reason, including anti-trust behavior that, today, is illegal.

Anti-trust laws exist to protect consumers from monopolistic behavior. Among other possible negative consequences, the hospital corporations' anti-trust power grab would give them monopoly power to dictate the manner in which doctors treat their patients. The measure would allow hospital bureaucrats to set work schedules and fix prices for services. This unchecked power by hospital corporations would force physicians to abandon certain emergency medical care systems. Deregulated monopolistic behavior by hospital corporations would, ultimately, reduce healthcare quality in California.

For example, if Prop. 86 passes, hospitals could agree to restrict healthcare to only certain types of patients and allow only certain medical specialties to practice in a given hospital. Patients might have to travel long distances to get certain types of healthcare….in traffic-impacted Southern California, this is a big deal.

Why is this anti-trust exemption such a big deal? It represents a dramatic power swing that would place too much control in the hands of hospital corporation bureaucrats.

Additionally, physicians would work at the sole discretion of hospital corporations, unable to negotiate mandated stipends for their good, fair, and worthy work efforts. The many hidden costs and labor-intensive duties of a specialist being on call could be ignored. Geographic emergency call patterns would naturally change. If physicians become indentured workers, subservient to a dominant hospital corporate influence, then physician practice patterns would eventually change and, ultimately, patients in need of emergency care would feel abandoned.

The tricky issue facing physicians is that the programs outlined in Proposition 86 present good ideas to improve healthcare access, especially for children. But, sneak in a small, but far-from-innocent anti-trust exemption for hospital corporations, and Prop. 86 goes from being desirable to totally unworkable.

Some medical practice mode groups and specialty practice groups such as COA, as well as county medical associations from Los Angeles, Monterey, Alameda, and Santa Clara counties are all opposed to this measure.

As a representative of a large medical association, I ask patients and voters to not be fooled. Physicians are anxious to and always will work to promote public awareness concerning the evils of tobacco use and cigarette smoking. But, this irresponsible proposition is an effort by hospital corporations to cancel contracts and alter obligations to the state and people of California.

Despite our support for reducing tobacco use, we cannot support a measure that would endanger the availability of emergency and specialty medical services for our patients in California and would firmly entrench a hospital bureaucrat in between the doctor-patient relationship. Prop. 86 deserves a NO vote on November 7th.

COA Joins Dr. DiLibero in urging orthopaedic surgeons to vote NO on Prop 86.

Orthopaedic Office Managers Work to Expand BONES

BONES, an organization for orthopaedic practice managers, is working to expand their membership throughout California. COA is assisting them in these efforts as they are an invaluable resource for COA when we are working on legislative and regulatory issues that involve coding and/or billing issues.

Please bring this letter and the California C-BONES application found on Page 8 of this newsletter to the attention of your practice manager and encourage him/her to become a BONES member.

TO: Orthopaedic Practice Managers

RE: California BONES (C-BONES)

We have much in common given that we work for orthopaedic surgeons and one of those common elements currently looming large is an extremely challenging business environment. And it does not appear that this environment will change in our favor any time soon. Just to mention a few issues that immediately come to mind:

- Carrier reimbursements remain stagnant or are declining;
- While the federal government enthusiastically encourages physicians to convert to electronic medical records, physician enthusiasm is routinely tepid with budgets already strained;
- The struggles of the California Workers' Compensation system; and,
- The growing uninsured population.

We all feel the same pain. With this thought in mind a number of orthopaedic practice managers met in Sacramento in June with Diane Przepiorski, Executive Director of the California Orthopaedic Association, to discuss the potential benefits to be gained by providing orthopaedic practice managers an opportunity to interact. It was unanimously agreed that practices and their managers could benefit greatly from such a network. To that end, two approaches are being pursued; local meetings and a state meeting.

The state has been divided into 9 regions: Northern California, Bay area, Sacramento Valley, Sequoia (Central Valley), Los Padres, Los Angeles, Inland Empire, Orange, and San Diego. A regional coordinator has been appointed for each region. They will be setting up local meetings.

Also, a state meeting will be held in conjunction with COA's 2007 Annual Meeting/QME Course on Friday, April 13 in the afternoon at the Portola Plaza Hotel in Monterey.

Please complete the California C-BONES application found on Page 8 of this newsletter and return it to the COA office—5380 Elvas Ave., #221, Sacramento, 98519 or Fax: 916-454-9882 at your earliest convenience to make sure that you are notified of these meetings.
There is no membership fee.

Thank you in advance for your interest in this important organization.

California C-Bones Application

Name:					
Name of practice:					
Mailing Address:					
Phone No.:	( ) -	Ext.	Fax No.:	( ) -	
E-Mail Address:					
Number of physicians in practice:					
Does your practice employ: (select all that apply)	Physician Assistant Orthopedic Physician Assistant Nurse Practitioner Registered Nurse First Assist Registered Nurse Surgical Assistant		Orthopedic Technologist Radiological Technologist Physical Therapist Hand Therapist Occupational Therapist		
Ancillaries:	X-Ray Digital Analog MRI Extremity Full Body Bone Density Physical Therapy CT Other:				
In-house Billing and Transcription:	In-house Transcription: Yes No In House Billing and Collections: Yes No Practice management System: Yes No PMS Name: Electronic Medical Record: Yes No EMR System Name:				
Anything you do as a manager that sets you apart from other groups:					
Any topics you would like to discuss at meetings statewide??					
Special Interest:					
Physician Name:			Subspecialty		
Physician Name:			Subspecialty		
Physician Name:			Subspecialty		
Physician Name:			Subspecialty		
Physician Name:			Subspecialty		

Complete and return the application to COA: 5380 Elvas Ave., #221, Sacramento, 95819 Fax: 916-454-9882

Worker' Compensation—Patients Are Being Harmed by Delays in Treatment

Below is an excerpt from an October 19, 2006 LA Times article recounting the plight of two injured workers, Mary Stone and Fred Payne, who have been harmed as a result of their treating physicians being unable to obtain authorization for treatments they believe are medically necessary. COA has been collecting similar examples of utilization review problems and have been informing DWC of these problems.

latimes.com Los Angeles Times

Workers' Comp Gains Haven't Eased the Pain of Tough Cases

SACRAMENTO — Two years after California overhauled its workers' compensation program, costs paid by employers have been sliced in half and profits for insurers have soared. But employees injured on the job say they are paying a heavy price. The sweeping changes — pushed by Gov. Arnold Schwarzenegger and passed by the Legislature in 2004 — were intended to rein in a program that was described as rife with fraud and had become the most expensive in the nation, discouraging some businesses from moving to or staying in the state. Even as the number of claims has plummeted — by 28% in the last two years — appeals of claim denials are up. Requests for hearings rose 7.6% to 73,513 in the second quarter of this year, compared with the fourth quarter of 2003, according to state statistics. Medical care and disability payments by insurers to injured workers fell an estimated 37% from 2003 to 2005. Physicians, labor union officials, advocates for injured workers and even some workers' comp officials are wondering whether the changes went too far. Under the new law, services and disability payments for many injured workers were cut, opportunities for rehabilitation were trimmed, and insurance companies received more power to scrutinize and reject doctor recommendations. That review process is at the heart of many complaints. "Every little request is a battle, and the patient is worse for the wear," said Dr. Paul Slosar, a spine surgeon and associate director of a Daly City medical group specializing in back injuries. "The delays are 10 times worse than anything I was dealing with three or four years ago because everything is being challenged."

A Lesson for Mary Stone Mary Stone of Yorba Linda agrees. The former assistant principal at Anaheim's Western High School was assaulted and seriously injured while working late in her office in 2003. Stone blames the new system for denying her the care her doctor recommended. As a result, she said, she was forced to give up her career. She waited more than a year to get approval for surgery on her right shoulder. After the operation and the denial of a request for postoperative physical therapy, her shoulder locked in its socket. Unable to return to work, she lost her job. "I'm more disabled than the day I left work," Stone said.

Mary Stone loved being an educator. The school administrator, then 44, had just earned a doctoral degree in education and helped lead a drive to boost her students' test scores. While she was working alone the night of April 30, 2003, Stone's career crashed. An assailant crept into the school office and threw her to the floor. She severely injured her right shoulder and hand. Over the last 3 1/2 years, Stone has been seen by more than half a dozen physicians and specialists; undergone surgery and other medical procedures; received numerous MRIs, X-rays and diagnostic tests; and been probed and questioned by medical-legal evaluators. On the day after being attacked at work, she was examined by her personal physician, and X-rays showed no broken bones. So Stone continued going to work, taking analgesics and receiving limited physical therapy, despite growing pain. After waiting more than a year for authorization from the insurance company, she underwent surgery on her right shoulder. But her condition deteriorated, she said, after the school district's insurance administrator approved only two weeks of postoperative physical therapy. Her doctor's request for "additional therapy and referral to a neurologist" also was denied by the insurance administrator. Over the next 18 months, Stone was in constant pain, she said. "I was sitting at home atrophying," she said. In the meantime, she lost her job after the insurance company concluded that she was permanently disabled Steve Lansford, an attorney for Stone's self-insured employer, the Anaheim Union High School District, said Stone wasn't denied needed care. "All medical treatment requested by her physicians has been authorized in a timely and appropriate manner," he said. In an April 11 report, Dr. David L. Wood, a medical examiner approved by attorneys for Stone and the school district, said he would not oppose a recommendation by Stone's neurosurgeon for another operation. "She does have marked loss of range of motion, and re-operating on the shoulder should be available to her," Wood wrote. The insurer has asked for a second evaluation from him. Stone is hoping she still can be helped. And she is appealing to a workers' comp judge to review her case and order an operation.

Fred Payne's Plight—Unlike Stone, who was hurt by a sudden, traumatic incident, Fred Payne's injury was a result of years of repetitive movements. He regularly sat for as much as four hours straight, talking on the phone and typing at a keyboard as a technical support worker at United Parcel Service in Santa Maria. But as time passed, Payne said, his "neck became stiffer and stiffer and my shoulders got more painful." A company doctor treated him with physical therapy and muscle relaxants. But neither worked. In February 2005, the doctor ordered Payne, 50, to stop working. "I couldn't sit for three or four minutes without extreme pain," he said. Since then, Payne lost his $13.75-an-hour job and fell $20,000 into debt. He divorced, put his house on the market and began paying $150 a month in child support. The $207 a week he gets in temporary-disability benefits doesn't begin to cover his living expenses, he says. Now, 22 months after filing his workers' compensation claim, Payne says he's being denied the medical treatment he needs to return to a relatively normal life and hold down a job. Moreover, his employers' insurance company turned down his doctors' request for surgery and declined to authorize further medical appointments, pain medicine or physical therapy. A spokesman for the insurance company, Liberty Mutual Group, declined to comment on Payne's case, noting that it remained in litigation. Payne's neurosurgeon, Dr. Phillip Kissel, wrote Liberty Mutual that he was "in direct disagreement" with the insurer's denial of a recommendation for surgery. He criticized "the obstructive nature of your company's decision." Payne is despondent. "They could give me a half a million bucks," he said, "and it would not be worth this pain."

(continued on Page 11)

Workers' Compensation News

COA Develops a Resource Center—to assist members in performing evaluations utilizing the AMA Guides-5th Edition. The following Resource Center can be found at **COA's website:** www.coassn.org

Resource Center

The COA provides its members with this Resource Center to identify organizations that can assist them in performing evaluations utilizing the AMA Guides –5th Edition.
By being listed in this center, it in no way implies a COA-endorsement of the service.
Click on the logo of each vendor to visit their vendor site and to obtain more information on their services.

Brigham & Associates

Brigham and Associates, Inc. is a unique solution to permanent impairment evaluation. Their focus is assessing impairment according to the AMA Guides to the Evaluation of Permanent Impairment and the complex issues often associated with Workers' Compensation, personal injury, automobile casualty, Longshore and Harbor Workers', and long term disability cases. Clients include attorneys (defense and plaintiff), insurers, corporations, non-profit entities, governmental agencies, and health care providers. Their mission is to be the international leader in the field of high quality impairment and independent medical review.

Please call: 1-888-262-1202 www.impairment.com

EME International

EME International is a leader in the impairment evaluation industry, developing software, certification, services and seminars for physicians and carriers all around the issue of Impairment Ratings. Services that will assist physicians in the use of the AMA Guides—their evaluations and report writing include:

- WholePerson Premiere 5 Impariment Rating Software
- IR Forum to ask questions pertaining to impairment ratings with answers within 24-48 hours
- IR Report Help

COA members receive a discount on their services.

Please call: 1-800-639-1233 www.wholepersontech.com

CMRS Comprehensive Medical Reporting Services — Reliable, Timely Impairment Ratings

Our trained, experienced staff will provide a comprehensive and detailed AMA impairment rating per the AMA Guides to the Evaluation of Permanent Impairment, 5th Edition. Simply complete the examination with all necessary AMA measurements, forward your dictated report, and we will do the rest. We will review all findings and relevant information (diagnostics, operative reports) and apply the criteria in the Guides in the most appropriate manner. We will compose an impairment rating complete with supporting rationale, and return this with a copy to your transcriptionist to be inserted into your report.

Please call 1-619-528-8300 www.cmrs.biz

AAEME American Academy of Expert Medical Evaluators

COA members can submit questions to EME International IR Forum to receive expert advice from physicians knowledgeable in the AMA Guides.

Responses will be received within 24-48 hours.

The responses will be sent directly back to you and will be published in COA's quarterly newsletter.

Click below to submit a question.

SUBMIT QUESTIONS

Workers' Compensation News

DWC Medical Director Meets With Orthopaedic Groups

In response to complaints from our members regarding inappropriate treatment denials and delays in treatment, COA has invited Anne Searcy, M.D., DWC's Medical Director, to meet with orthopaedic groups throughout California to hear first-hand about the problems they are experiencing. To date, Dr. Searcy has met with orthopaedic groups in the Inland Empire and is scheduled to meet with groups in the Ventura area on October 24. The next meeting will be scheduled in the Sacramento area.

These meetings have been very helpful to assist Dr. Searcy in understanding the depth of the physicians' frustration with the existing utilization review system. Orthopaedists have told Dr. Searcy how helpless they feel in being able to help their patients. Dr. Searcy has heard their concerns and suggested some remedies. We appreciate her willingness to attend these meetings and address these issues with our members.

Work on Updating the OMFS to Begin Soon

Carrie Nevans, acting Director of the Division of Workers' Compensation, indicated at a California Workers' Compensation Forum, that work on updating the Official Medical Fee Schedule for physicians services will begin in approximately 2 months. The Division had previously announced their interest in adopting Medicare's Resource Based Relative Value Scale (RBRVS), but unlike earlier proposals, the DWC is now not insisting on a revenue-neutral transition. A revenue neutral transition would have meant that fees paid to specialists would have been reduced in order to increase fees for Evaluation and Management services. Ms. Nevans said that Governor Schwarzenegger recognizes that physicians' fees need to be increased.

This is very good news and illustrates that the Division is concerned that physicians may be dropping out of the system as a result of the recent reforms and low reimbursement rates. COA will continue to work with the Division on this transition.

CSIMS Alerts Members That QME Reports are Being Retroactively Reviewed

Members of the California Society of Industrial Medicine and Surgery have received an alert indicating that QME reports are being retroactively reviewed and their impairment ratings changed. They indicated that the stated purpose of the review is to obtain more "accurate" ratings. CSIMS has complained to DWC about this trend.

It is their belief that, "if an evaluating physician prepares a supplemental report that discusses the contents of an outside third party review, the evaluating physician might inadvertently place that third party opinion "on the record." In addition, if the "expert's" review has not been served on the applicant, the evaluator may also be guilty of *ex parte* communication." **Please let COA know if your QME Reports are being retroactively reviewed and supplemental reports issued.**

DWC Adds Doctors to Staff

The Division of Workers' Compenation has hired three physicians to curb abuses in utilization review, review reports by qualified medical evaluators and continue educational efforts to improve evaluations utilizing the AMA Guides, and to provide input into refining the medical treatment guidelines.

They are:

- Avrum Gratch, M.D., orthopaedic surgeon from the San Francisco area.
  Dr. Gratch will work full-time to oversee utilization review issues.
- Paul Wakim, DO, an osteopath from Huntington Beach. Dr. Wakim is on COA's Workers' Compensation Committee. Dr. Wakim will review reports by QMEs and work to educate them on performing evaluations utilizing the AMA Guides.
- Bowen Wong, M.D., a neurologist from Oakland. Dr. Wong's will be working to refine the treatment guidelines.

Rating Bureau Projects Loss Ratios Down 31% in California

Workers' Compensation rates charged to California employers in the first half of 2006 dropped 42% from their peak in late 2003. The rating bureau said in its latest summary of insurer experience that average premiums in California dropped to $3.75 per $100 of payroll, down from $6.37 in the second half of 2003. If the projection proves accurate, carriers will earn 45 cents of profit on each dollar of premium they collected in 2005, not including income from investments.

Workers' Comp Gains Haven't Eased the Pain of Tough Cases (continued from Page 9)

Outlook for Change

As Stone, Payne and other injured workers wait, often in pain, for their cases to be heard by a judge, the Schwarzenegger administration has been slow to gauge how the new law is affecting injured workers. Although studies have been completed calculating the savings for business, the state has conducted little research into the quality of medical care being delivered to injured employees. "It doesn't seem like the people who can do the study or who can afford to have the study done are interested in doing it," said Frank Neuhauser, a UC Berkeley researcher specializing in workers' comp. Insurers and many employers contend that they lack sufficient evidence to justify tinkering with the success of the 2004 workers' comp law. "We can't make major policy decisions based on anecdotes," said Nicole Mahrt, a spokeswoman for the Sacramento office of the American Insurance Assn., an industry lobbying group. For his part, the governor has promised to revisit some parts of the workers' comp overhaul if an administration analysis due at the end of the year should find that "seriously injured workers are falling through the cracks." Schwarzenegger has opposed virtually all proposed changes in the law. On Sept. 19, he vetoed a bill sponsored by Democrats in the Legislature that would have doubled the cost of permanent-disability benefits. "I will continue to defend the workers' compensation reforms," the governor said.

The workers' comp issue, though red-hot during the 2003 recall campaign, hasn't had much of an airing this election season. Schwarzenegger vows to hold the line against significant changes. His Democratic opponent, state Treasurer Phil Angelides, said that if elected he might adjust parts of the overhaul. Officials in the Schwarzenegger administration are writing regulations that they hope will cut down on abuses. Among the ideas being discussed: slapping large fines on insurers that unfairly delay or deny care. The Schwarzenegger administration needs to move quickly to fine-tune the system, said Thomas Rankin, former president of the California Labor Federation. "They are stalling while the workers are suffering," he said. "The ones for whom the system was designed are the ones getting the short end of the stick."

Welcome to COA's Newest Members

Ravi S. Bains, M.D.	Oakland
Charles S. Brenner, M.D.	Ventura
Frank Chen, M.D.	Palo Alto
Rakesh Donthineni-Rao	Sacramento
Sara L. Edwards, M.D.	Oakland
Christian Foglar, M.D.	Los Gatos
Peter Gerbino, M.D.	Monterey
Masoud Ghalambor, M.D.	Sacramento
Jeffrey Holmes, M.D.	San Jose
John Kelly, M.D.	Newport Beach
Nicholas Komas, M.D.	Chico
Lawrence Mozan, M.D.	Long Beach
Thomas Peatman, M.D.	Oakland
Taryn Vu-Rose, M.D.	Beverly Hills
Lytton Williams, M.D.	Los Angeles
Amy Williams-Black, M.D.	Sacramento
Edward H. Yian, M.D.	Huntington Beach

If these orthopaedic surgeons practice in your community, please welcome them to COA and urge them to become involved in the Association—
COA is an effective organization <u>because</u> of the involvement of its members.

MOVING?

Please notify COA promptly if you are moving.

Name: _____

New
Address: _____

City/ST/Zip

_____

Phone: _____

Fax: _____

E-Mail:_____

Mail to: COA, 5380 Elvas Ave., #221,
Sacramento, CA 95819

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