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COA Report

A publication of the California Orthopaedic Association

Volume XVIII Issue 1 —— Spring, 2006

Annual Meeting/QME Course
OPAC Activities
2006 Legislative Issues

Richard Santore, M.D. , COA President

Please register for the upcoming COA Annual Meeting/QME Course and Course on Workers' Compensation Medical Treatment, April 20-23, 2006 and reserve a room at the La Costa Resort and Spa. Thanks to the outstanding work of our program chair, Kevin Bozic, MD, MBA, a member of the full-time faculty at UCSF, we have a jam packed array of clinical, health policy, political, legal and Workers' Compensation offerings that will provide something of significant benefit to each and every attendee. The agenda is on Page 4 of this newsletter. One of the true highlights will be the tribute to Bill Tipton and awarding of the William W. Tipton, Jr., M.D. Leadership Award, just before the opening cocktail reception on Friday evening. Pat Tipton will be our guest of honor at the ceremony.

Political update: March 10 is the filing deadline for the November, 2006 statewide elections. In advance of this on January 20, 2006, members of our very active OPAC, COA's Political Action Committee, met privately with Dean Chalios, Executive Director of CALPAC, CMA's Political Action Committee, at the CMA headquarters in Sacramento. In attendance to represent you were Blair Filler (OPAC chair), Ray Jimenez, Steve Hurst, Tim Shannon, Diane Przepiorski, and yours truly. This year, an unprecedented number of open races will occur because the incumbent is ineligible to be reelected due to term limits. Dean reviewed every open seat race in both the Assembly and Senate and gave us important behind-the-scenes information to allow us to target our interviews with candidates and future political activities. COA representatives will meet with 20 candidates prior to the June Primary to discuss their views on issues related to orthopaedic practice.

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Registration Materials …..

COA's 2006 Annual Meeting/QME Course and
New Directions for California's Workers' Compensation Medical Treatment
April 20-23, 2006
La Costa Resort and Spa
Carlsbad, CA (North San Diego County)
Can be found on COA's website: www.coassn.org
Select Annual Meeting/QME Course and follow links or
fax a request to the COA office—916-454-9882.

President's Column (continued from Page 1)

Radiology Issues: Earlier in the day, Diane, Blair Filler and I represented our interests at the semi-annual CMA gathering of the medical specialty societies' Presidents, their Executive Directors, and lobbyists. I had a memorable and terse interaction on the radiologic technician issue and their operation of digital radiographic equipment with my counter part, the President of the California Radiological Society. One area of dispute in this issue is the required training of a technician before they can operate digital equipment. I made what I thought was a helpful suggestion, to support a one-time, 4-hour CME course for limited permitted x-ray techs (XTs) to allow them to safely operate digital x-ray equipment. He seemed to disagree and COA will continue the discussions with the radiologists and other health care providers to resolve this issue. In addition, Tim Shannon and Diane are vigilantly keeping track of any overt or covert attempts by the radiologists to interfere with appropriate and efficient provision of imaging services to patients by orthopaedic surgeons in their offices. We will probably have other battles with the radiologists. They are sponsoring legislation to prohibit physicians from leasing MRI, CT, or PET equipment on a part-time (per click) basis. They say the bill clarifies federal laws, however, we disagree and believe the bill goes further.

Tobacco Tax Initiative: The California Hospital Association has backed off on their original proposal which would have earmarked nearly 95% of the monies raised by the initiative to hospitals and hospital-based physicians and contained totally unacceptable provisions regarding on-call stipends for specialists. The new version, which is trying to qualify for the November general election, includes a $2.60 PER PACK tax on cigarettes, with, as CMA leaders say contains 'something for everyone.' Nonetheless, very little, if anything, trickles down to the on-call specialist and anti-specialist restrictions on stipends remain, though somewhat watered down. Legislative leaders have expressed concern with the initiative as they fear this significant tax on cigarettes will reduce other revenues to the state. We will watch the early polling on this initiative before we decide whether COA should become involved.

Workers' Compensation Utilization Review: The COA Board of Directors is hard at work on measures to counter the unfair and unreasonable denials of authorizations for treatment of injured workers, both due to the unfair manipulation of MPNs and out –of-state utilization reviewers. We continue to believe that these out-of-state reviewers are practicing medicine without a license in California.

Richard Santore, M.D.
President

People in the News

Vernon Tolo, M.D. of Los Angeles will Chair the AAOS 2006 Nominations Committee and **Douglas Jackson, M.D. ,** of Long Beach serves on the Committee. Michelle James, M.D. of Sacramento is an alternative member.

The **2006 OREF Clinical Research Award** has been awarded to **Kevin Bozic, M.D., MBA,** of UC San Francisco, for his paper entitled, "Using Clinical and Economic Outcome Data to Influence Health Policy in the United States."

Tye Ouzounian, M.D. of Tarzana has been appointed to the Practicing Physicians Advisory Council (PPAC). This Council makes recommendations to Congress on physician reimbursement issues. This is the first time that the AAOS has had an appointee to the Council in at least the last 10 years.

Chadwick F. Smith, M.D. of Los Angeles has been elected President of the International Society of Orthopaedic Surgery and Traumatology (SICOT). Dr. Smith is only the second American to be so honored.

It is with regret that we must inform you that **H.M. "Mac" Reynolds, Jr., M.D.** of Oakland, passed away unexpectedly at his home on February 2, 2006 of a heart attack. Dr. Reynolds worked with COA on several issues and was known throughout his community for his work with local young people serving as a team physician for Campolindo High School. He is survived by his wife and two daughters.

New COA Board of Directors
The following orthopaedic surgeons have been elected or re-elected to seats on COA's Board of Directors:

- **Leslie Kim, M.D**., of Daly City was elected to the AAOS Board of Councilors as one of the Councilors representing the Northern California District
- **L. Randall Mohler, M.D.** of San Diego was elected to the AAOS Board of Councilors representing the San Diego District
- **Richard Brown, M.D.** of La Jolla was elected to the Board representing the San Diego District
- **Robert Cash, M.D.** of Modesto was elected to the Board representing the Sequoia District
- **Tye Ouzounian, M.D.** of Tarzana was re-elected to a second term on the Board representing the Los Angeles District
- **Gregory Carlson, M.D.** of Orange was re-elected to a second term on the Board representing the Orange District.
- **David Hak, M.D.** of Sacramento was re-elected to a second term on the Board representing the Sacramento Valley District.
- **Michael Laird, M.D.** of Pismo Beach was re-elected to a second term on the Board representing the Los Padres District.

California Orthopaedic Association
2006 Annual Meeting/QME Course

and an Instructional Course on "New Directions for California's Workers' Compensation Medical Treatment"

April 20-23, 2006
La Costa Resort and Spa
Carlsbad, CA (Northern San Diego County)

COA President: Richard F. Santore, M.D.
Program Chair: Kevin J. Bozic, M.D., MBA

Earn 16.5 Category I CME Credits of which 5 hours will qualify for pain management and end-of-life CME hours and 6 hours of QME CME hours!

An electronic version of the forms contained in the AMA Guides-5th Edition will be available at the meeting. Attendees at this meeting will be the first in the nation to have access to these forms electronically. The AMA developed this new product at the request of COA.

For registration information go to COA's website: www.coassn.org—
click on Annual/ Meeting/QME course or contact the COA office—
Phone: 916-454-9884 — Fax: 916-454-9882— E-Mail: coa1@pacbell.net

AGENDA—COA 2006 Annual Meeting/QME Course/Course on WC Treatment

Thursday, April 20, 2006

New Directions for California's Workers' Compensation Medical Treatment

- The Ideal UR Model of the Future—Does it Exist Now?
- The Pros and Cons of Independent UR—How to Function Effectively Within the System
- Medical Provider Networks in California—Are You In or Out or Don't You Know?
- ACOEM Practice Guidelines – What They Currently Say And When Will They Be Updated?
- Dealing with the Guidelines Clash: Orthopaedic vs. ACOEM—Is It ACOEM or Is It UR?
- Update on Changes in the Workers' Compensation System: E-Billing,
  In-Office Pharmaceuticals—Official Medical Fee Schedule (OMFS) – Physician Services
  Medical-Legal Fee Schedule —Durable Medical Equipment—Outpatient Surgical Facilities
- The Future of QMEs in California .

Friday—Sunday, April 21-23, 2006

2006 Annual Meeting/QME Course

Efficiently Producing a Quality Report Using the AMA Guides – 5th Edition

- Pearls for writing reports involving injuries to:
  The spine The upper extremity The lower extremity Multiple body parts
- Challenges in Assessing Musculoskeletal Impairment Using the AMA Guides—5th Edition - Avoiding the Traps—Common Errors in Report Writing with Sample Reports
- Pre-existing Disease, Pathology, and Their Impact on Apportionment—What is Substantial Evidence? Speculation? Sex Race Age Obesity Smoking Diabetes
- Changes (Increases?) to the Medical-Legal Fee Schedule

Health Policy Update: Implications for Orthopaedic Practice

- Pay-for-Performance Initiatives (P4P): What are they?
- P4P: Government and Private Payer Perspective
- Gainsharing: Hospital Perspective/Office of Inspector General's (OIG) Perspective
- Gainsharing: Structuring Orthopaedic Arrangements to be Covered by Safe Harbors
- Direct-to-Consumer Advertising: Overview and Industry Perspective

Socio-Economic Update: Issues Critical to your Practice

- Strategy to Enact Federal Tort Reform
- Ongoing Threats to In-Office Imaging in California
- AAOS Health Policy Initiatives
- Cultural and Linguistic CME

Contracting 102: Practice Models and Agreements/Payor Contracts

- Basic Issues in Practice Agreements– Buy/Sell/Covenants Not to Compete
- Governance Issues -Orthopaedic Practice - Analyzing Your Current Structure—Are You At Risk?
- How to Organize to Avoid Risk and Litigation
- What Happens When a Partner Leaves, Becomes Disabled, or Dies
- Orthopaedic Practice Models of the Future

Latest Generation of Payor Contract Problems - What is Driving Carriers to Change Their Contract Language

Arthritis in the Young Patient

- Operative and Non-Operative Treatment Options

New Directions in Orthopaedic Pain Management

- Pain Management for THR and TKR: Avoiding IV Narcotics
- Advances in Orthopaedic Pain Management: The Anesthesiologist Perspective

Clinical Update for Orthopaedists Taking ER Call—Including Pain Management of the Orthopaedic Patient

- Open Fracture Management Spanning External Fixation
- Temporizing Pelvic & Acetabular Fractures Hip Fractures: Hemiarthroplasty vs ORIF/IM Nail vs. DHS
- Shoulder Fractures & Fracture Dislocations Wrist Fractures
- Long Bone Fractures: Minimally Invasive Alternatives

State Legislative News

Radiology Bills
Leasing of MRI/CT/PET

AB 2805 (Blakeslee) seeks to prohibit providers from leasing MRI, CT or PET scanning equipment on a part-time basis. We believe the bill would also affect "per-click" arrangements. The California Radiological Society is the sponsor of this bill and they have indicated that the bill will simply clarify existing federal law. They believe that this is an area of potential fraud when the provider receives some financial benefit from referring patients to a specific center for diagnostic services. While kickbacks for making a referral are illegal, we believe that federal law allows part-time leasing arrangements at fair market value. We will be working with the Radiological Society to ensure that the bill restates, but does not expand federal or state law.

Limited Permit X-Ray Technicians

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.

At the request of COA, **Senator Sam Aanestad** has introduced **SB 1670** which would clarify that XTs may operate digital equipment after they have completed continuing education in digital technology and hands-on training. COA will be seeking the support of other health care professionals using XTs.

SB 912 (Ducheny/Runner) - Medi-Cal Cuts

In record time, State Legislators have voted to reverse the 5% cuts to physician fees under the Medi-Cal program. Even though the Governor's Administration had supported the fee cut, faced with unanimous opposition from state legislators, the Governor signed the bill into law. The cuts, implemented as of January 1, 2006 should be reversed by March 1, 2006.

AMA Forms a Physician Task Force on Scope of Practice Issues

With 31 states expected to face legislation that alter or expand the scope of more than 20 allied health professionals this year, the AMA has formed the Scope of Practice Partnership, a coalition of physicians and surgeons, to ensure that quality of care and patient safety is not jeopardized by these efforts. This group of physician specialists will be asking the following questions of the legislation:

- Is there a verifiable need for the requested change?
- What effect will it have on public health and safety?
- What formal education and training support this change, and is there a formal process of accreditation for these teaching institutions?
- Is independent practice advisable, or should collaboration or supervision be required?
- If a bill seeks to bypass licensing or regulatory requirements to allow the requested change, what's the rationale for this, and what effect will it have on patient safety?
- How will regulatory boards interact to evaluate the scope request?
- What is the financial impact and incentives related to this change?

Medicare News

Part D Prescription Drug Benefit

Medicare continues to consolidate information for patients and physicians regarding their Part D Prescription Drug benefit. Their latest effort includes disseminating a fact sheet for physicians which gives them a tool to help streamline the prescribing process. The fact sheet can be found at:

http://www.cms.hhs.gov/MedlearnProducts/downoads/Part_D_Resource_Factsheet.pdf

In addition, other resources for physicians have been consolidated at: www.cms.hhs.gov/center/provider.asp where offices can get access to direct phone numbers to the plan's coverage determination people, as well as copies of model forms that will help speed up the process.

Limits on Physical Therapy Services Are Back

As of January 1, 2006, Medicare has once again capped outpatient rehabilitation services at $1,740 per beneficiary for PT and speech-language pathology with a separate cap of $1,740 for OT. The Medicare therapy limits apply to outpatient therapy services from all settings billing Part B with the exception of outpatient hospital services and hospital emergency rooms. The cap on physical therapy services that was in place several years ago for Medicare patients did not include services rendered in a physician's office. The new cap now includes those services. In addition, Medicare has revised their policy manual to require that PT assistants working in outpatient settings must have graduated from a 2-year college level PTA program approved by the American Physical Therapy Association, or must have 2 years of appropriate experience with a passing score on the State Board examination, prior to December 31, 1977.

New Payment Policy for Imaging Services

The Centers for Medicare and Medicaid Services (CMS) has announced a new payment policy pertaining to imaging services. CMS will now apply the multiple procedure payment reduction to the technical component for certain imaging procedures involving contiguous parts of the body. This reduction will be transitioned in over the next 2 years with a 25% reduction in the technical component in 2006 and a 50% reduction in the technical component in 2007. A list of affected procedures can be found at: http://a257.g.akamaitech.net/7/257/2422/01jan20051800/edocket.access.gpo.gov/2005/pdf/05-15370.pdf

CMS has not deleted the Synvisc medication HCPCS code

The COA office received complaints that the Synvisc medication HCPCS code has been deleted from the HCPCS Manual leaving offices to wonder how sodium hyaluronate products should be billed. The deletion of HCPCS codes J7317 and J7320 was an error. You can continue to bill J7317 and J7320 for these products. Contact the COA office—916-454-9884 if you experience problems billing these codes.

Correct Coding Rules of Interest to Orthopaedic Surgeons

Wrist/Hand/Finger Coding

The August, 2005 *AAOS Bulletin* included information on proper coding and documentation of wrist/hand/finger surgery. To request a copy of the article, fax a request to the COA office—916-454-9882.

AMA CPT Assistant—Issues Opinion on the Removal of Existing Spinal Instrumentation, December, 2005

The **question** posed to the AMA CPT Assistant was: What is the appropriate reporting for removal of existing spinal instrumentation and insertion of new spinal instrumentation at the same and new spinal segments? Should code 22849 be reported for the instrumentation placed at the previous site? Should only the newly instrumented segments be reported using the instrumentation code (22842, 22840)?

Answer: The removal of previously placed spinal instrumentation is reported by code 22855, *Removal of anterior instrumentation,* with modifier 51, *Multiple procedures,* appended. For *CPT 2005*, the introductory notes of the Spinal Instrumentation subsection states, "Codes 22849, 22850, and 22855 are subject to modifier 51 if reported with other definitive procedure(s), including arthrodesis, decompression, and exploration of fusion." The introductory notes further clarify that "code 22849 should not be reported with 22850, 22852, and 22855 at the same spinal levels." Therefore, the newly placed spinal instrumentation is reported to describe the total number of vertebral segments involved. Also, modifier 62 is not appended to spinal instrumentation codes 22840-22848 and 22850-22852.

Workers' Compensation

Apportioning Disability to Causation

By: **Stuart A. Green, M.D.**
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This article represents Dr. Green's opinion of how orthopaedic surgeons can sort out Workers' Compensation apportionment issues and substantiate their calculations if challenged in a deposition. The article is provided to COA members for their information and does not infer that COA has adopted a formal policy on this issue. We thank Dr. Green for sharing his thoughts with COA members.

INTRODUCTION

On April 19, 2004, a cataclysmic earthquake rattled the foundations of California's costly Worker's Compensation system. The upheaval left a new and challenging landscape for those treating and evaluating occupationally injured Californians. The changes have impacted therapeutic parameters, physician treatment choices, disability and impairment determinations, and apportionment (allocation of liability).

Apportioning a medical condition to various sources occurs frequently in medical-legal analysis. A typical example involves lung cancer in a cigarette-smoking asbestos worker. A dispute naturally arises about how much of the claimant's cancer should be ascribed to occupational asbestos exposure and how much was self-inflicted by cigarettes.

Now that the California legislature (in SB899) has determined that apportionment shall be to causation—and in light of the California Workers' Compensation Appeals Board's decision in *Escobedo vs. Marshall's*—California physicians are obligated by statute to apportion all factors that causally contribute to an injured worker's disability and/or impairment with consideration given to pre-existing pathology, prior disability determinations, previous injuries and accidents, and any other factors that, in some measure, contribute to the problem.[12] Moreover, the relative contribution of these factors must be expressed in percentages. This apportionment applies to the monetary award given the "applicant" (an injured worker applying for benefits) after the condition stabilizes and there is a residual compensable medical condition resulting in disability or impairment. (Neither treatment nor the cost of future medical care, nor any rehabilitation costs can be apportioned to non-industrial factors if *any* of the need arises out of a work injury.)

Like it or not, every practitioner in California who treats patients with occupational illnesses or injuries must become acquainted with the various provisions of SB 899 if they want to avoid an endless stream of queries from claims adjustors and lawyers.

Both the law and recent court decisions preclude a physician-evaluator from speculating or guessing on apportionment percentages. Instead, the physician must provide a *medically reasonable* explanation of his or her apportionment determination. As an orthopaedic surgeon who has evaluated more than 15,000 occupationally-injured workers as an agreed-upon (AME) or court-appointed evaluator, I am often pressed—during depositions—to explain why I assigned 60% liability to an employer and 40% to pre-existing arthritis and not the other way around. (Obviously, the party who feels shorted by my apportionment ratio requests the depo.)

After a series of probing questions by attorneys during depositions, I've developed a fair and reasonable scheme to ascribe percentage values for apportioning musculoskeletal injuries. Based on the favorable responses my analysis has received from both sides in disputed matters, I decided to share my method with readers of this publication. In fact, the principles used in assessing apportionment in musculoskeletal injuries can be applied to a wide variety of problems across the spectrum of medicine.

Permanent musculoskeletal disability following most work injuries often involves many causative factors, all interacting with each other. For example, degenerative osteoarthritis (better termed *osteoarthrosis*), whether due to a natural process or an old injury or surgery, along with abnormal mechanical loading or general wear and tear, often contribute to the magnitude and perpetuation of a work injury's consequences.

METHODS

Method of Columns

I determine apportionment by first assuming that causation consists of two columns, each contributing a percentage to the whole, which must add to 100%. One column consists of all *acute* causes while the other column contains the *chronic* causes. (Either one of the columns might be empty.)

Within each column, I envision *sub-units* that must also add to 100%. The sub-units in the *chronic* column usually hold degenerative disorders, chronic medical conditions, and most importantly, cumulative micro-trauma to the body—both occupational and off-the-job. I place a sub-unit in the *acute* column for each *specific* traumatic injury to the body part in question, including those happening both on and off the job. Again, the sub-units must add in value to 100%.

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WC: Apportioning Disability to Causation

By: Stuart A. Green, M.D.

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Apportionment disputes often arise when a specific injury occurs to a body part demonstrating well-established osteoarthrosis on the earliest post-injury imaging studies (or perhaps noted during a medical evaluation *before* that injury).

To make a medically reasonable determination about the relative contribution of the two columns, I first evaluate the magnitude of both the accident's absorbed energy, as well as the amount of deterioration present. All existing trauma classification systems recognize that higher energy injuries results in greater tissue damage than lesser accidents.[9] Thus, a motor vehicle collision at 40 mph is not twice as destructive as a comparable collision at 20 mph but is, instead, fourfold so [$e = mv^2$]. Therefore, a fall from a substantial height will likely cause greater harm than a fall on level ground which, in turn, is likely to be more injurious than simply twisting or getting up from a seated position. Likewise, if the applicant went sprawling or sailing through the air because their feet went out from under them after slipping on oil, the consequences are more likely injurious than a slow-motion event.

The same reasoning can apply to any osteoarthritic disease, even if clinically silent up to the time of an injury. Obviously, a person with advanced osteoarthrosis will be more prone to having permanent consequences to a joint injured during a slip-and-fall than someone who had a structurally sound joint with the identical accident.

Clearly, if there is no or minimal pre-existing pathology nor any history of complaints for that body part, then all (or virtually all) of apportionment comes from the *acute* column. Conversely, advanced pathology in the face of a low-energy "injury" (such as getting up from the seated position or losing ones balance without actually falling) shifts apportionment to the *chronic* column. A medium energy injury superimposed on mild-moderate osteoarthrosis would lead a practitioner to reasonably conclude that both the injury and the arthrosis contributed equally to the applicant's clinical situation.

The same balance might occur with a high-energy injury superimposed on advanced osteoarthrosis, but would not apply to a situation where the injury itself was of low energy but there was no pre-existing pathology. In that case, the acute injury picks up the entire apportionment.

One could argue that trying to apportion disability to a previously asymptomatic condition invites speculation. It's worth remembering, however, that clinicians make reasonable predictions about prognosis with almost every patient that we evaluate. For example, a surgeon who removes a high school football player's knee meniscus is duty-bound to warn the young man to expect some deterioration in joint function ten or fifteen years later—a prognosis that can be favorably modified by giving up certain sports but can also be accelerated by intense activity.

Also, bear this in mind: all of us, as we age, develop some amount of joint deterioration—characterized by small marginal osteophytes, articular cartilage loss, spinal disc space narrowing, and so forth. It's illogical to assume that such changes are abnormal (i.e., pathology) or that they contribute to symptoms or disability. Since such age-related deterioration is *normal* and since the concept of pathology implies something *abnormal*, it's unreasonable to suggest that normal aging processes cause a person's disability absent truly pathologic findings. (Obviously, the identical findings in a younger person is abnormal.) However, aging does produce certain consequences, such as joint stiffness and reduced strength, especially when we get into our 8th and 9th decades. Although few workers are in these age categories, due consideration should be given to this feature of life.

Once I've apportioned disability *between* acute (called *specific* in worker's comp terminology) and chronic causation by creating two columns, I look into each column separately for further analysis.

Method of Hours

First, I assess the chronic column to which I've already assigned a certain overall percentage of causation. To my way of thinking, it's inappropriate to ascribe a percentage of causation to "degenerative osteoarthrosis" without explaining what caused the deterioration. To do so, I use a "method of hours" to compute the contribution of various activities to the wear and tear of body parts.

There are 168 hours in a week (24 x 7) of which the average American spends seven hours per night in bed,[11] for a total of 49 hours. Subtracting 49 from 168 leaves 119 "out of bed" hours, which I round to 120. A person with a 40-hour work-week will therefore spend 80 hours per week off work. Thus, with no other information except the knowledge that a person works 40 hours a week, there exists a 2 to 1 ratio between time off-work and time at-work. Hence, if a person has diffuse

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cervical osteoarthrosis and their at-work activities closely match their off-work endeavors, one could reasonably apportion 67% of an individual's *chronic* column to off-work behavior, and 33% to at-work activities.

The average Californian commutes half an hour a day in each direction.[1] This is a sedentary activity that subtracts five hours from the off-work 80 hours where a person might be weight-bearing, for a total of 75 hours. Likewise, the average person would likely spend two meals a day seated at home or in a commercial eatery, as well as three meals a day for each weekend day off. It is thus reasonable to assign around ten hours to these off work meals, reducing the potential non-work weight-bearing time to 65 hours per week.

According to reliable statistics, the average man in America watches 29 hours of television per week, and the average woman, 32.[6] While I realize that stay-at-home individuals likely spend more hours at this activity than workers, by including such avocational activities such as knitting, crossword puzzles, sitting at one's computer and the like, it would be reasonable to subtract around 25 hours from the off-work activity for sedentary non-occupational endeavors, leaving a total of about 40 hours per week not working but not predictably sitting either.

By the above reasoning, an average person in a job requiring mostly standing and walking, spends about 40 hour per week weight bearing at work and an equal time doing non-sedentary activities off the job. This analysis, with no further information about the level of activities in either place, yields a 50/50 split between work activities and non-work activities. Thus, if a worker spent her off-work time doing similar weight bearing activities as she did at work, that portion of her disability ascribed to degenerative changes caused by cumulative trauma could reasonably be split half and half between non-work and work-activities.

I suspect, however, that most work activity is more taxing on the body than non-work effort, although not always so. Consider, for example, a worker in a completely sedentary job (i.e., telephone operator or dispatcher) who has children at home to care for when not working, who does the family shopping, prepares meals, and cleans the house. These are, for the most part, weight bearing activities. In such a case, an evaluator might reasonably conclude that virtually all cumulative trauma to weight bearing joints of the lower extremities occurred off the job. Thus, apportionment *within* the chronic column would be 0/100 for the work/off-work ratio.

However, if that same individual were a floor salesperson in a department store, the apportionment would be different. In that situation, the person is likely on their feet continuously, dealing with customers, carrying items from storeroom to shelves, and so forth, resulting in a much different apportionment ratio. Generally such work is as injurious, or even more injurious to the body, than off-work activities, yielding, perhaps, a 50/50, 67/33, 75/25 or even an 85/15 work/off-work ratio.

To help with the analysis, I multiple the number of at-work hours by a factor related to the amount of lifting, carrying and other activities on the job. Hanging dry-wall, for instance, involves lifting and carrying 95 lb sheets of material for a portion of the work-day, resulting in a high work-to-off/work ratio. If a worker of normal body habitus spends 15 minutes out of each hour actually lifting and carrying dry-wall, that person could be considered massively obese for 10 hours per week while on the job. (At least that's how his L5 annulus fibrocytes perceive the situation.)

To apportion fairly, one must have a clear picture of an applicant's day-to-day activities both on and off the job. A pre-evaluation questionnaire filled out by the applicant helps. If there is any doubt about the accuracy or truthfulness of the applicant's self-assessment, a formal job analysis may be necessary.

Intense recreational sports—especially those involving running and jumping—should have a multiplying effect on the off-work hours.[3,7] Clearly, it's important to get an accurate history of a claimant's off-work activities to ensure a fair and reasonable analysis. In some cases, the analysis can be quite precise. Running, for instance, causes five times as much mechanical load to the knees as walking. Thus, every hour running can be counted as five hours of non-work weight-bearing, unless running is considered part of the job—to keep fit, for example, as required of firefighters.

Evaluators often apportion a part of causation solely to an applicant's overweight condition. In my opinion, this doesn't make much sense because obese individuals confined to wheelchairs don't develop osteoarthrosis in lower extremity weight bearing joint (although, interestingly enough, they often have such problems in their shoulders). On the other hand, it's unreasonable to disregard obesity altogether. There is, after all, a substantial body of literature connecting obesity to degenerative arthrosis

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with a direct correlation between the magnitude of obesity and the rate of joint deterioration.[2,4,5,10] Because obesity impacts on *all* weight-bearing activities, it stands to reason that a certain percentage of the obesity-associated arthrosis can be ascribed to work-related weight-bearing activities.

I realize some might argue that, had an applicant not been obese, he or she would likely have no arthrosis whatsoever and therefore the degenerative portion of the applicant's disability should be ascribed exclusively to obesity. However, the applicant could contend (with equal validity) that, had he or she not been weight-bearing at work for the past 20 years, there would be much less arthrosis.

Whenever faced with a dispute where each argument had equal validity, I generally split apportionment between the two considerations. Thus, in the column containing the chronic component of apportionment, half could reasonably be assigned to a *weight-bearing sub-unit* (further subdivided into at-work and off-work percentages based on the "method of hours") and half to an *obesity sub-unit*. However, as with apportioning on-work and off-work activities by the number of hours spent and modifying those considerations with information about the magnitude of the relative activities, I often change a 50/50 ratio to match the specifics of the situation. For example, if I learned that the applicant had been morbidly obese since childhood, I would shift apportionment in the direction of the obesity sub-unit, based on evidence in peer-reviewed medical literature dealing with the impact of obesity on osteoarthrosis.[2,10] I would make a comparable shift towards the activity sub-unit (both work-related and off-work), if the applicant's activity warranted such a determination. For example, one overweight woman told me that she walked two miles to and from her job everyday in order to keep her weight down. This made me shift apportionment towards that off-work activity, especially since she had been doing it for a long time.

Work-related Cumulative Trauma

Within the *chronic* column there often exist a cumulative trauma sub-unit that is work related, even if the applicant never filed a cumulative trauma claim. But what if an applicant worked for several different employers during the period of time that their body was being worn down by work activities? If a worker performed essentially the same type work for his or her entire career, then, through a legal principal designed to reduce the number of defendants in a Workers' Compensation claim, the injurious exposure for cumulative work-related trauma is limited to the *last year* of employment and the years before that are disregarded. If an individual has done equally damaging work for more than one employer during the last year of injurious exposure, then each of the employers has a percentage of the industrially-caused cumulative trauma based on what portion of the year the applicant worked on each job.

It might also turn out that the applicant, during the last year of employment, went from a more arduous job to an easier one (or vice versa), spending, say, six months at each place. The evaluator would have to figure out how much more difficult and damaging one job was compared to the other to fairly apportion cumulative trauma between the two employers. For example, if a worker was required to be on their feet continuously at both jobs but in one place lifted 20 pounds, whereas at other job, the lifting was 50 pounds, with everything else being equal, an evaluator could reasonably conclude that each hour at the heavier job was more aggravating than each hour at the lighter job for the industrially-caused cumulative trauma portion of causation. An evaluator could be rather precise in this regard by reasonably considering the 20 lbs or 50 lbs as added body weight, and compute a ratio between the two jobs based on such a concept.

Suppose a worker, for the first 15 years of her career, did particularly heavy work with lots of climbing, lifting, squatting and other activities that damaged her knees. For the past ten years, that same worker has been doing primarily sedentary work as a dispatcher. A reasonable practitioner would likely conclude that virtually the entire occupational cumulative knee trauma is a consequence of an earlier employment and none is the result of the more recent job. The statute of limitations factor rules might preclude the applicant from recovering against the first employer but that's a legal matter that shouldn't influence the evaluator. When making such a determination, however, take into consideration the susceptibility of an already abnormal structure to further injury. The knee, for instance, tends to get loose as the articular cartilage wears out whereas the hip does not. One could argue with equal validity that once the articular cartilage becomes irregular, wear accelerates.[8] The evaluator must consider these issues when apportioning between recent and older events and activities.

Acute Injuries

Quantifying the events in the *acute* column is often difficult, but must be done. Sub-units here include occupational injuries, off-the-job accidents, motor-vehicle collisions, and so forth. Usually, a patient in a non-compensation setting can tell his or her

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doctor which injury was the BIG one—the accident that caused most, if not all, of the current problem. However, when money is at stake, memory frequently becomes distorted, with the compensable injuries taking great prominence in an applicant's telling of their history. The medical records, however, offer hints allowing independent analysis of how much weight to give to each accident in the *acute* column. Several clues help in this assessment: How serious was each accident in terms of velocity of impact, magnitude of lifting episode, length of time off work, amount of treatment, and compensation, if any? (As a general rule, protracted disability often, but not always, suggests a serious problem.) In some instances, especially when time-off-work was not compensated (as happens following most recreational injuries) individuals make great effort to return to work as soon as feasibly possible, whereas in other instances (with compensated time off) a person may have been in no hurry to get back to work. Thus, don't rely too much on time-off-work following an injury to judge its magnitude and contribution to the whole.

Often, an acute injury, especially one that happened a long time ago, has profound influence on the contents of the *chronic* column. For example, consider an old high school football injury that resulted in loss of a cruciate ligament and meniscus. Clearly, degenerative osteoarthrosis of the knee twenty years later can be ascribed to that accident. Or can it?

As with obesity, a damaged weight-bearing joint will not deteriorate unless it experiences load. Had the footballer been confined to a wheelchair after his injury, the knee would not degenerate. This means that the rate of deterioration is governed to some extent, at least, by how much weight bearing was applied. In keeping with the concepts described above, the evaluator must determine how much of the deterioration was caused by work and non-work activities respectively, using the principles outlined above for assessing causation in the chronic column. Indeed, even though the degeneration can be traced directly to an old acute injury, I place that degeneration component in the *chronic* column, sub-attributing it to work and non-work activities. The old football injury itself, however, I leave in the *acute* column. In this manner, I can easily describe in my report causation to specific injuries and separate them from the chronic causes.

Weighing the effect that each injury in the *acute* column has on a body part is challenging, but cannot be avoided in a medical-legal evaluation. Moreover, failure to do so in a reasonable manner may cause a judge to dismiss your entire report, possible grounds for not getting paid for the effort. Luckily, the claimant can help. A good starting point is to ask, "If your pain is worth $100, how much would you attribute to each injury." Clearly, the response is just a guide, but it can help focus the issues. Any discrepancy between the applicant's conclusions and the medical records should be hashed out with the applicant by pointing to specific documents and asking about them. Sometimes the claimant will point to his body and say, "Oh, that pain was there and my pain now is over here."

In general, give due consideration to any statement about such matters the applicant made under oath during a deposition. People being deposed are admonished about the serious penalties for lying and, moreover, they're probably too nervous during a deposition to think clearly enough to fabricate testimony (although exaggeration of symptoms often occurs). Thus, it's reasonable to assume the applicant told the truth and go from there—unless you find a compelling basis for doubt. If so, state your reasons in the report.

In all situations where apportionment to causation is determined by a medical evaluator, there must be sound reasoning behind every decision. The evaluator must explain (in the report) the considerations leading to every apportionment conclusion, lest the judge rule the entire report invalid. If you don't explain your thinking in the report, you may have to do so during a deposition—hardly a comfortable environment for contemplative reflection! Moreover, avoid speculation. With sufficient information and thoughtful analysis, medically reasonable conclusions about apportionment to causation are not that difficult to make.

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News from the Medical Board of California

The following legislation, which affects physicians licensed in California, have been chaptered into law taking effect on January 1, 2006.

AB 1195 (Coto) Requires all continuing medical education courses, on and after July 1, 2006, to include curriculum in the subjects of cultural and linguistic competency. Courses that do not include a direct patient care component have been exempted from this requirement. **At COA's 2006 Annual Meeting/QME Course, we will be including information on cultural and linguistic issues prepared by the AAOS.**

SB 231 (Figueroa) This omnibus Medical Board bill included many provisions including:

1) An increase in physician licensing/renewal fees as of January, 2006 from a cap of $600 to a fixed amount of $790—delinquent and penalty charges also will be increased to $79 and $395 respectively;
2) Clarified existing law that requires physicians to inform the board when they are subject to various court judgments in cases involving death or personal injury caused by negligence, error, or omission in practice;
3) Requires the board to post on its Web site a physician who has been subject to discipline by the board, accusations that are not dismissed or withdrawn and misdemeanor convictions (when they are required to be reported) that are substantially related to the qualifications, functions, or duties of a physician; and
4) Deletes physician cost recovery.

SB 367 (Speier) Enacts the Patient and Provider Protection Act which requires health insurers, who contest or deny a claim, to include in the notice to the healthcare provider the factual and legal basis for each reason to contest or deny the claim. Requires each contract between the insurers and providers to contain provisions requiring a fast, fair, and cost-effective dispute resolution mechanism. Requires by July 1, 2006, the Insurance Commissioner to establish a Web page dedicated to exclusively provide information regarding processing complaints.

SCR 49 (Speier) Creates a panel to study the causes of medication errors and to recommend changes in the healthcare system that would reduce the errors associated with the delivery of prescription and over-the-counter medications to consumers. It requires the panel to convene by October 1, 2005 with a final report to the Legislature by June 1, 2006.

Medical Board Seeks Physician Reviewers

Physician reviewers assist the Board by providing expert reviews and opinions on cases. They may be called upon to testify as the Board's medical expert.

Requirements for participation include:

- Current CA medical license in good standing.
- No prior discipline or accusation pending.
- No complaint history within the last five years.
- Board certification with a minimum of three years of practice in the specialty area.
- Active practice—at least 80 hours a month in direct patient care, clinical activity, or teaching, at least 40 hours of which is in direct patient care or been non-active or retired from practice no more than two years.

Compensation:
$100 per hour for case reviews
$200 an hour for expert testimony

Applications: Found on the MBC website: www.caldocinfo.ca.gov and sent to: Susan Goetzinger—MBC, Expert Review Program, 320 Arden Avenue, #250, Glendale, CA 91203
Phone: 818-551-2129
E-Mail: sgoetzinger@medbd.ca.gov

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Workers' Compensation News

Gallagher Bassett Services—Alert

COA is receiving complaints that Gallagher Bassett Services had an error in their claims processing system which has caused Medical-Legal billings from approximately December, 2005 to March 1, 2006 to be rejected. The ML codes billed were seen as incorrect code numbers and the claim rejected. Orthopaedic surgeons are now receiving the following error message on their EOBs:

> *"The above reference billing for medical related services has been received in our Tucson Medical Bill Processing Center. This billing cannot be processed for payment consideration because of the following reason(s): HCPCS procedure code is invalid/illegible*."

This is obviously an error and, we are told, has been corrected as of March 1, 2006.

In order to be paid on these Medical-Legal claims, you must resubmit the bill and the report or other supporting documentation to:

Gallagher Bassett Services, Inc.
Medical Billing Processing Center
P. O. Box 23812
Tucson, AZ 85734
Phone: 866-324-5585

This applies to any billing under the Medical-Legal Fee Schedule, including supplemental reports. We are investigating whether other billings may have also been incorrectly rejected as a result of these problems. This is a statewide problem as we have received complaints from both Northern and Southern California.

We would urge you to immediately follow-up any unpaid Medical-Legal billings submitted to Gallagher Bassett during this timeframe, demanding interest and penalties if the bill has not been paid in a timely manner.

COA is also bringing this issue to the attention of the Division of Workers' Compensation. Please contact the COA office if you experience additional problems with Gallagher Bassett reprocessing these billings.

Job Placement Announcements/Classified Ads

Practice Opportunity—for a Board Certified/Board Eligible orthopaedic surgeon in Fallon, NV. Fallon is a pleasant, growing community in Northern Nevada., one hour east of Reno. We have a modern 40 bed hospital, nice climate and a variety of outdoor recreation. Excellent opportunity to establish and build a successful practice. Please contact Tami Reid at 775-423-4477.

Transcription—24-hour turnaround. Husband/wife team. Fully automated. 10 years experience. Call Karen or Roy at 775-626-9604 or 707-373-2187.

Podiatrist—trained in a three year Kaiser surgical program wants to join an orthopaedic office. Trained in forefoot and rearfoot surgery as well as assisted in orthopaedic procedures. Also fully trained in podiatric medicine, biomechanics and wound care. Available to start after June 30, 2006. Board eligible, state licensed and DEA already obtained for California. Curriculum vita as well as orthopaedic recommendations and references available upon request.
Contact samsanandaji@yahoo.com or call 818-693-4790 for further information.

Orthopaedic Surgeon—forensic exams only—needs to share office space with an x-ray facility in Beverly Hills or West Hollywood area. Contact: mariana52@sbcglobal.net or call 310-278-7311.

Welcome to COA's Newest Members

Laura A. Alberton, M.D.	La Jolla
David M. Atkin, M.D.	San Francisco
Richard Blanks, M.D.	Fresno
Bruce Bragonier, M.D.	Sebastopol
Elliot R. Carlisle, M.D.	Encino
Wayne Cheng, M.D.	Loma Linda
John G. Costouros, M.D.	Los Gatos
Jeffrey Cummings, M.D.	South Lake Tahoe
Joseph Donnelly, Jr., M.D.	Livermore
Josef E. Gorek, M.D.	Oakland
David R. Gotham, Jr., M.D.	Carmichael
Carlos Guanche, M.D.	Calabasas
Brian D. Hild, M.D.	Riverside
Thomas J. Hopkins, M.D.	Encino
James Huddleston, M.D.	Stanford
John Janda, M.D.	Fresno
Blaine Johnson, M.D.	Sacramento
Kenneth S. Jung, M.D.	Los Angeles
Zafar Kahn, M.D.	Fountain Valley
Orr Limpisvasti, M.D.	Los Angeles
Robert Trigg McClellan, M.D.	San Francisco
Jeffrey Meter, M.D.	San Jose
Mark E. Murphy, M.D.	San Diego
Jonathan J. Myer, M.D.	San Diego
Teodoro Nissen, M.D.	San Francisco
Vahe Panossian, M.D.	Pasadena
Dennis C. Park, M.D.	San Mateo
Robert B. Reisch, M.D.	Pasadena
Michael L. Reyes, M.D.	Daly City
Rolando Roberto, M.D.	Sacramento
Anthony C. Romero, M.D.	Santa Barbara
Anthony Scaduto, M.D.	Los Angeles
Steven S. Shin, M.D.	Playa Vista
Peter R. Silvero, M.D.	Travis
Richard W. Slovek, M.D.	Turlock
Gabriel Soto, M.D.	Grass Valley
Richard M. Thunder, M.D.	La Jolla
Joseph Turk, M.D.	Ventura
John C. Velyvis, M.D.	Rancho Mirage
J. Wellborn, M.D.	Mill Valley
Charles F. Xeller, M.D.	Emeryville
S. Austin Yeargan, M.D.	San Luis Obispo
Erik Zeegen, M.D.	Encino

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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