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COA Report

A publication of the California Orthopaedic Association

Volume XVIII Issue 2 —— Summer, 2006

Medical Provider Networks (MPN):
A Good Idea Gone Bad

Recently when I was downtown, I was stopped by a patient whom I had seen in consultation for a Workers' Compensation carrier for a lumbar disc herniation. At that time, I advised that he undergo lumbar laminectomy and discectomy as conservative care had failed. The carrier was informed that I would provide that service if reimbursement was at the Official Medical Fee Schedule (OMFS) rates.

That was the last time I saw the patient. In the interim, he was referred to a surgeon in the carrier's Medical Provider Network who accepts discounted rates for treating injured workers. The patient's care has been "delayed" for approximately 6 months by multiple "injection procedures," which were performed at the surgeon's surgicenter. Additionally, the patient has been seen every 2 weeks by the surgeon's physician assistant, at which time he received multiple medications dispensed out of the surgeon's office on essentially every visit. Finally, the advised laminectomy and discectomy was performed approximately 6 months later.

In an attempt to save $200 or $300 by not reimbursing reasonable rates reflected in the OMFS when this patient was seen by myself originally, the patient now has his temporary total disability extended at least 6 months. Additionally, there were multiple facility fees for the "injection procedures," not to mention the fee of the anesthesiologist who performed these

(Continued on Page 2)

Larry Herron, M.D., President (left) presents Richard Santore, M.D. (right) with an appreciation plaque for his COA service.

New Medical-Legal Fee Schedule— effective July 1, 2006

See Page 3 of this newsletter for a summary of the changes.

COA 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
Los Angeles Area

A registration form is on Page 15 of this newsletter or call COA—916-454-9884 to register.

President's Column (continued from Page 1)

procedures. Six months of in-office pharmacology fees were probably very significant as well; not the least of which is that this patient's increased morbidity was secondary to prolongation of his suffering until his ultimate surgery. Whether or not the loss of the 3-6 month "golden period" decreased his statistical chance of a good or better surgical outcome is debatable.

This delay and "shopping" for the lowest cost surgeons does nothing to ensure quality care for injured workers.

The original goal of medical provider networks was to give the carrier/self-insured employer control of the patient so that they could get them to physicians known to be "nonabusers" of the Workers' Compensation system. Instead, many of those physicians have declined to participate as carriers or their agents try to force them to accept reduced reimbursement rates. In the above example, the desire of the Workers' Compensation carrier to "save" $200 or $300 led to probably greater than $100,000 of additional costs to the carrier and ultimately the employer. Insurer greed has led to a "penny wise, pound foolish" approach to the care of many Workers' Compensation patients. In terms of unintended consequences, the medical provider networks have apparently become exactly what they were designed to avoid in the first place.

Larry D. Herron, M.D.
President

People in the News

DWC Medical Director
Anne Searcy, M.D. has been appointed the Medical Director of the Division of Workers' Compensation. COA has worked with Dr. Searcy for many years and she has always been very accessible and listens to physicians' concerns. We look forward to continuing to work with her as the DWC Medical Director.

New Governor's Point Person on Workers' Compensation Issues
Michael Prosio, the former undersecretary for legislation and enforcement at the Labor and Workforce Development Agency will be taking over as deputy legislative secretary and Workers' Compensation advisor to the Governor. Prosio takes over from Moira Topp who has gone to work for the California Chamber of Commerce.

Classified Ad

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

Winners at COA's 2006 Annual Meeting/QME Course

Grand Prize Winner

Complimentary registration and 2 night stay—COA 2007 Annual Meeting at the Portola Plaza in Monterey—
Richard Santore, M.D.

Other Winners:
COA 2007 Annual Meeting
Upgrade to a Suite—Max Moses, M.D.
Complimentary registration—Alfred Kuo, M.D.

Compliments of Cardinal Pharmaceutical
Golf Clubs—Jerry Morris, M.D. and James Cookson, M.D.

Compliments of Acordia
DVD Player—George Westin, Jr., M.D.
iPOD Nano—M. Sabri, M.D. and John Kayvanfar, M.D.

Compliments of Southwood Pharmaceuticals
iPOD Bose speakers—Christopher Wills, M.D.

Compliments of Ortho Art oscopy
Orthopaedic Artwork—Donald Ball, M.D.

Compliments of Plus Orthopaedics
Orthopaedic Artwork—James Lilley, M.D.

Compliments of Senex Group
Golf Shirts—Leisure Yu, M.D., James Loddengaard, M.D.
Ismael Silva, M.D. and Dennis Rhyne, M.D.
Calloway Golf Balls—Bruce Brown, M.D.

Compliments of HNP Pharmaceuticals
iPOD Shuffle—Ernest Miller, M.D.

Compliments of COA
Western Digital -320 gb External Hard Drive—Jack Lang, M.D.
Flash Drive—2 gb—Liz Stark, M.D.

Golf Tournament Winners

First Place—John Garbino, Mark Hellner, Wellington Hsu
Second Place—Bill Bowman, Hose Kim, Ed Bestard, Tom Ming
Longest Drive—Men's—Michael Klassen
Women's—Sara Gardner
Closest to the Pin—Tom Ming

Thanks to the exhibitors for sponsoring these gifts.

Workers' Compensation News

Medical-Legal Fee Schedule Changed as of July 1, 2006

Good News—25% Increase for Medical-Legal Evaluations

The Division of Workers' Compensation has approved changes to the Medical-Legal Fee Schedule, discussed at COA's 2006 QME Course, which provides for an across-the board **25% increase** in reimbursement as of **July 1, 2006**.

This increase will apply to all medical-legal evaluations where the evaluation occurs on or after the effective date, supplemental reports requested on or after the effective date, or medical-legal testimony provided on or after the effective date.

This increase came about only after COA and other health organizations opposed an earlier version of the regulations which would have reduced reimbursement for orthopaedic evaluations. Employers, having trouble gaining timely access to QMEs/QMEs, also supported the increase.

Highlights of the changes to the Medical-Legal Fee Schedule include:

- 25% across-the-board increase in reimbursement—the multiplier is increased from $10 to $12.50.
- Changes in the complexity factors for ML-103—Complexity factors have been added to: 1) address the issue of apportionment of multiple injuries, employers, or body systems; and, 2) to address the issue of denial or modification of treatment by the claims administrator following utilization review.
- Creation of new codes: ML-105 for medical-legal testimony; and,
ML-106 for supplemental evaluations.
- Adds a definition for "Medical Research" and clarifies that medical research does not include reading or reading about the AMA Guides or the ACOEM treatment guidelines.
- Clarifies that the fee for the medical-legal evaluation includes the history and physical examination and typing and transcription services, and other overhead expenses.

A copy of the new Medical-Legal Fee Schedule can be found on the DWC website:

http://www.dir.ca.gov/DWC/DWCPropRegs/MedicalLegalFeeSchedule_Regulations/MedicalLegalFeeSchedule_regulations.htm

If you are unable to download the fee schedule on-line, fax a request to the COA office—916-454-9882 and we will fax you a copy of the fee schedule.

COA's Annual Meeting/QME Course

Congratulations to Kevin Bozic, M.D., MBA, Program Chair of the 2006 Annual Meeting, Peter Mandell, M.D., Chair of the 2006 QME Course, and Glenn Pfeffer, M.D., Chair of the Course on Workers' Compensation Medical Treatment Issues for putting together courses that drew record attendance at the La Costa Resort in Carlsbad, April 21-23, 2006.

New COA Officers Elected

The following new COA 2006-2007 officers were elected:

Larry D. Herron, M.D. of San Luis Obispo

James Caillouette, M.D. of Newport Beach

Mark Wellisch, M.D. of Encino

Glenn B. Pfeffer, M.D. of Los Angeles

Blair Filler, M.D. of Los Angeles (above center) receives the first William W. Tipton, Jr., M.D., Leadership Award for his years of dedicated service to orthopaedics on the state and national level. Dr. Filler is one of the Founders' of COA. The award was presented by Larry Herron, M.D. (left) and Richard Santore, M.D. (right).

Attendees enjoy the La Costa Resort.

A **Special Thank You** to **Charles Touton, M.D.** of Fresno for being COA's "official photographer" and taking these photos at COA's Annual Meeting.

Residents receive awards for outstanding research

Afshin Khalafi, M.D., UC Davis (left) receives the OREF Resident Award.

Wellington Hsu, M.D., UCLA (left) receives the Orthopaedic Hospital Resident Award.

Catherine Robertson, M.D., UC San Diego (left) receives the Depuy Resident Award.

Adrian Hinman M.D., M.D., UC San Francisco (left) receives the Lloyd W. Taylor, M.D. Resident Award. Program Chair, Kevin Bozic, M.D., MBA (right) presented the awards.

Federal Workers' Compensation System

U.S. Department of Labor and other Carriers
Ways To Streamline Authorizations for Medical Services and Payment of Claims

In September, 2003, the U.S. Department of Labor (DOL) implemented a new process for providers to obtain authorization for medical treatment services for federal employees injured on-the-job and for the subsequent submission of the claims for payment. This new process represented significant changes, even to the point of requiring providers to re-enroll in the system if they wanted to continue to treat federal employees. Affiliated Computer Services (ACS) was selected as the intermediary to administer this new system.

When the system was implemented, there were many problems in both obtaining authorization for services and delays in payment. Virginia Miller, M.D., the Medical Director of the OWCP Medical Fee Schedule (the federal Workers' Compensation Fee Schedule), has been committed to an ongoing working relationship with providers to resolve these system problems and to put in place a more effective and efficient system.

COA representatives met with Dr. Miller in May, 2006 when our delegation was in Washington, D.C. at the National Orthopaedic Leadership Conference. Dr. Miller confirmed that their system has made some major improvements, but she went on to identify several areas in which they needed the help of providers to improve communication with ACS reviewers to improve the authorization process and speed up the claims processing.

We discussed the following areas:

Identifying the Anatomical Part Injured
In their request for authorization, providers use medical terms to describe the anatomical area injured. For example, they state that the injury was to the "clavicle" or to the "scapula." Unfortunately, at times, the ACS staff does not understand these terms and realize that this was a shoulder injury.

Dr. Miller felt that it would be immensely helpful and would speed up the authorization of medical services, if the **provider stated in the beginning of their authorization request that this is a shoulder injury involving the clavicle, etc. It is also recommended that you avoid using the unlisted or unspecified anatomical ICD-9 codes.** This will help the reviewing staff target the right group of "treatment suites" for the injury and will speed up the authorization requests.

Treatment Suites
This new OWCP system is based on "Treatment Suites," a list of commonly billed CPT codes for each ICD-9 code. Codes listed in the treatment suites are generally approved and/or paid with little delay. However, if the CPT code is not included in the treatment suite for the particular ICD-9 code billed, delays result as the ASC attempts to determine whether the service was medically indicated.

Some times, the delays result because the ASC is not aware of other complications with the patient that may not be evident by the ICD-9 code billed. Complications such as the patient has an infection, has circulatory problems, needs ongoing drug therapy, or has had other medical history affecting their treatment regimen (e.g., psychological trauma, heart or other major surgery, etc.). These conditions can add legitimate complexity to the case, justify additional medical services and precautions, but is not apparent to ACS as they are reviewing the authorization request.

In addition to billing the ICD-9 code, it is recommended that providers also include "V Codes" to identify other complications of treating the patient.

This allows ASC to access other "treatment suites" in their system to help justify the service(s) requested. This will also speed up the authorization and/or payment process.

We would urge our members to implement these procedures for all authorization requests for medical services and/or on claims for payment for all carriers. If the federal Workers' Compensation reviewers are having these problems, it is likely that other carriers have the same issues.

(Continued on Page 8)

Medicare News

CMS Recovery Audit Contract (RAC) Initiative

California, Florida, and New York were selected for pilot RAC audits due to their high volume of Medicare expenditures. On January 11, 2005, the Centers for Medicare and Medicaid Services (CMS) announced the Recovery Audit Contract Initiative. This is three-tiered review process:

- The first level involves Part A (hospital/facilities) Diagnosis-Related Group (DRG) reviews. California hospitals/facilities started to see requests for medical records in October, 2005.
- The second level involves overpayments in either Part A or Part B—physician services—by identifying overpayments that do not meet Medicare requirements. **National Heritage Insurance Company (NHIC)**, the fiscal intermediary in California, reports that they are starting to see information from the RAC identifying overpayments. The reviews are initially focusing on duplicate payments. **NHIC is in the beginning stages of sending out repayment demand letters to providers in California.** Providers may request a redetermination (appeal) through the overpayment process and must submit sufficient documentation to support that the payments are not duplicate. The audits can review claims dating back to 2002.

  NHIC indicates that duplicate billing is the #1 claim submission error in California.
  The rate of duplicate billings in California by specialty is as follows:

Specialty	Rate
- Urology	7.9%
- Orthopaedic Surgery	6.7%
- Physical Therapists in Private Practice	6.5%
- Family Practice	5.4%
- Internal Medicine	5.2%
- Cardiology	4.4%
- Ophthalmology	4.4%
- Diagnostic Radiology	3.1%
- Clinical Laboratories	2.6%

- The last level of review involves requesting the actual medical records for Part B services.

NHIC has posted an article, "How to Avoid Duplicate Claim Denials" on their website. It provides practical tips to help you avoid duplicate denials. http://www.medicarenhic.com/cal_prov/articles/dupclmdenials_0825.htm
One of the major causes of duplicate denials is resubmitting previously paid or denied claims over and over. If your claim was paid or denied, and you are not satisfied with the decision, exercise your appeal rights. Constant resubmission of the same claim will not get you payment, and may cause you to miss the time limit for requesting an appeal. You only have 120 days from the date on the remittance advice of the *first* decision made on your claim, not the resubmitted claim that was denied as a duplicate, to appeal.

The Alliance of Specialty Medicine (of which AAOS is a member) sent a letter to CMS in March, 2006 outlining some problems that they identified with the program. It is unclear whether changes to the program have been implemented as a result of this letter. Please report to COA any problems that you might experience should you receive demand letters for repayment. COA will transmit them to the Alliance.

Top Ten Claim Submission Errors

1. Duplicate Claims.
2. The need for this service was not supported on this claim.
3. Medicare eligibility not in effect when services were received.
4. Service denied/reduced because this service is not paid separately.
5. Medicare is secondary payer on this claim.
6. This service is part of another service done at the same time.
7. Not payable, service part of another service performed on the same day.
8. Service not considered. Requested information was not received.
9. This item or service is not covered by Medicare.
10. This charge is included in the surgical fee.

Orthopaedic Surgeons Get Involved in the Primary Election

Thirty-six of the 80 State Assembly seats and 12 of the 20 state Senate seats are up for election this year. In addition, many elected officials are running for other state office, including the constitutional offices of Attorney General, Lt. Governor, and Insurance Commissioner. This presents a tremendous opportunity for COA to meet with these individuals and educate them on issues key to orthopaedic surgeons and their patients.

Thanks to the involvement of COA members, prior to the 2006 Primary Election, COA's Political Action Committee (OPAC) interviewed candidates in 20 open Assembly and Senate seats and other incumbent legislators who have been our friends in the past. OPAC ended up supporting 19 of these individuals, 16 of whom won their Primary race. District fundraising events were also held in Stockton and San Diego organized by local orthopaedic surgeons, Roland Winter, M.D. and Stephen Shoemaker, M.D. respectively. Both events received broad local support from other orthopaedic surgeons in the area.

Elected officials appreciate this support and the opportunity to meet local orthopaedic surgeons and their spouses.

Your PAC contributions make these activities possible.
Thank you for your ongoing support of COA's state orthopaedic PAC.

If you would like to participate in future political activities and/or are acquainted with elected officials, please let us know by completing and returning the below form indicating that interest. We would also urge you to send in a contribution to OPAC and the AAOS National Orthopaedic PAC. The AAOS National Orthopaedic PAC supports federal candidates.

- -

Legislative Response Form

___ Yes, I want to get involved in state and federal issues.
I am acquainted with or would like to get to know the following state or federal legislators:

_______________________________ _______________________________

____ Enclosed is a contribution to:

___ COA's state orthopaedic PAC ($100 is recommended, but any amount is appreciated)
Make check payable to "California Orthopaedic Association" or list credit card number below.

___ AAOS federal orthopaedic PAC ($100 is recommended, but any amount is appreciated)
This must be a separate check made payable to "The Orthopaedic PAC" or list credit card number below.

Mail both checks to the California Orthopaedic Association, 5380 Elvas Ave., #221, Sacramento, CA 95819.

Please charge: $________ for the COA State PAC and $ ______ for the AAOS Federal PAC

Visa or Mastercard # ______________________________ Expiration date: ___________

Your Name: ______________________________ Phone Number: ____________________
(please print)

THANK YOU FOR YOUR SUPPORT.

Federal Workers' Compensation System

(continued from Page 5)

Other reminders for providers regarding the OCWP Fee Schedule:

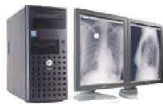
1. The current OWCP Fee Schedule is online and can be downloaded at: http://www.dol.gov/esa/owcp_org.htm
2. Whenever you treat an injured worker, check the ACS website (http://owcp.dol.acs-inc.com) click on FECA provider - to see if the procedure(s) require authorization.
   Level 1 – procedures do not require authorization (e.g., Evaluation and Management services, diagnostic tests, and lab work)
   Level 2 – procedures can be authorized by ACS – often over the phone (866-335-8319, Monday-Friday, 8 am – 8pm, EST) Requests can also be faxed to ACS at 800-215-4901.
   Level 3 and 4 – procedures require authorization by a claims examiner – initiated through a written request from the provider faxed to ACS at 800-215-4901. The written request must include
   - Claimant name
   - Claimant case number – on each page faxed
   - CPT or HCPCS codes on which you are requesting authorization
   - Specific body part to be treated
   - Requested date of service
   - Appropriate supporting documentation of the need for the procedure
   - Provider name
   - ACS Provider number
   - Previous diagnosis/ICD9 number if known and new diagnosis/ICD9 number

   ACS will send a written response if the service is approved. If the service requested is an uncovered service, ACS will also notify you of this in writing. Generally the response should be received within 30 days of the request.

   ACS cannot deny covered services. Only the claims examiners in the district office can deny a covered service. It is not critical to speak with the same claims examiner each time you call on a particular case. All claims examiners have access to all of the medical information and records and should be able to assist you.

3. Providers can check the status of medical authorizations or payment of a claim at the ACS website – http://owcp.dol.acs-inc.com Select – FECA provider.

If you are unable to resolve billing problems through ACS, contact Raquel Ramirez at the Department of Labor's District Office at 415-848-6783.



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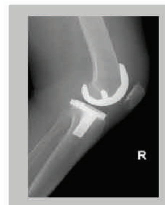

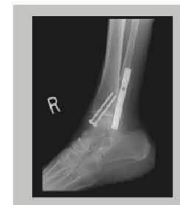

COMPLETE X-RAY SYSTEM SALES & SERVICE

Workers' Compensation News

DWC Addresses Complaints About Inappropriate Utilization Review Programs and Denials—Propose Fines and Penalties

The Division of Workers' Compensation (DWC) will be holding a hearing on their Utilization Review Enforcement regulations on June 29, 2006. The regulations propose a schedule of fines and penalties for Workers' Compensation carriers and self-insured employers who, among other things, do not implement an acceptable utilization review program, use unqualified reviewers, or unreasonably delay treatment decisions.

For example, the regulations propose a $5,000 fine if:
1) a request for authorization of services is denied solely on the basis that the treatment is not addressed by ACOEM; or,
2) if a person other than a reviewer, as defined by Labor Code 9792.6 makes a decision to delay, modify, or deny a treatment authorization request; or
3) the carrier/self-insured employer fails to authorize and to provide all medical treatment consistent with Labor Code Section 5307.27 or the ACOEM practice guidelines until either the claim is accepted or rejected, etc.

There are lesser fines for other violations such as: 1) the claims administrator fails to include required items in their decisions, or 2) for the failure to make decisions in a timely fashion, etc. COA is hopeful that these new fines and penalties will help rein in utilization review practices that have delayed and denied appropriate medical treatment and created hassles for the treating physicians.

To assist the DWC in collecting information on possible UR violations, COA has developed a UR Complaint Form for our members. This form focuses on collecting data in the following areas:

1. UR reviews by inappropriate reviewers—individuals who are not knowledgeable in the procedure requested.
2. UR decisions being made solely on the fact that the treatment is not addressed by the ACOEM guidelines.
3. Inability to contact reviewers to discuss their treatment decisions.
4. UR reviewers not being sent the complete medical record of the injured worker so that appropriate decisions can be made.
5. Patient harm that was caused by treatment delays.
6. Inability of specialist to perform follow-up care after a surgical procedure because the carrier/self-insured employer fails to authorize the follow-up visits or diagnostic tests.
7. Inability to obtain authorization for post-surgical rehabilitation.

The COA-developed DWC UR Complaint Form can be found on Page 10 of this newsletter.

If you are having problems, obtaining authorization for medical treatment, tell us about your experiences by completing the UR Complaint Form detailing each problem. COA will compile the complaints and forward them to DWC for their consideration. Thank you in advance for your help in documenting these complaints.

Utilization Review Complaint Form

______________________	______________________	______________________
Claims Administrator	Carrier	Name of Injured Worker
Name of UR Reviewer	UR Company	Claim Number
Employer	Date of Injury	Date Medical Services Requested

Date(s) of Subsequent Requests ____________________ ☐ No Response ☐ Response Date: ___________

Appealed: ☐ Yes ☐ No Date: ___________________

Describe Medical Treatment/Diagnostic Tests Requested

____

____

____

Complaint: (check as many as apply)
(please print)

_____ Denial/modification of services made by an non-physician _____ a physician not familiar with the procedure _____

Describe situation:____

____

_____ UR decisions based solely on the fact that the treatment is not addressed by the ACOEM Practice Guidelines.

_____ UR decisions were not timely. It took _______ days to receive decision.

_____ Inability to contact reviewers to discuss treatment decisions – reviewers are not available at specified time or they fail to provide a minimum of 4 hours period for contacting the reviewer: ☐ Yes ☐ No

Describe situation: ____

____

_____ UR reviewers call after CA business hours—List time physician was called ______________________

_____ UR reviewers not sent the pertinent medical record of the patient. Medical records faxed by physician ☐ Yes ☐ No

_____ Requested services denied for lack of information, but the reviewer did not request additional information.

——-- Unreasonable demands for justification for medical services(s) requested—Describe demand: ___________________

____

_____ Inability to perform follow-up care after a surgical procedure because the carrier/self-insured employer fails to authorize the follow-up visits or diagnostic tests—Describe situation: ______________________

____

_____ Inability to get approval for post-surgical rehabilitation services.

_____ Payment denied even though service was authorized.

_____ Patient harm caused by treatment delays—describe harm—or other complaint: ______________________

____

____

Physician Name: ______________________ Contact Person: ______________________

Phone: ______________ Fax: ______________ E-Mail: ______________________

Send the completed form to COA—5380 Elvas Ave., #221, Sacramento, CA 95819.
Include documentation of your complaint with the form.

Workers' Compensation News

DWC Works to Remove the $100 Lien Filing Fee

As part of the Budget discussions, the Division of Workers' Compensation has asked that the $100 lien filing fee be removed on medical treatment and medical-legal bills. The fee has become an administrative problem for the Division as well as a deterrent to physicians in filing liens. The change could become effective as early as July 1 if the Budget is passed on time.

DWC/UCLA Study on Access to Medical Care

The Division of Workers' Compensation has commissioned the UCLA Center for Health Policy to conduct a study of 1,200 injured workers, 1,200 medical providers, and Workers' Compensation carriers and self-insured employers to obtain their input on whether problems with access to medical care have resulted due to the Workers' Compensation reforms. DWC Medical Director, Dr. Anne Searcy says, "The information we gather will tell us whether workers injured in California have access to quality care. It's vital that injured workers and physicians selected for the study participate because their responses will help us make decisions on important issues."

If you are selected for the survey, we would urge you to participate.

DWC Issues Newsline Reminding Claims Administrators of their Payment Obligation for Medical Treatment Provided to Injured Workers

The DWC has received reports that Workers' Compensation claims administrators are refusing to pay for medical treatment provided by physicians or facilities to which injured employees were referred by their employers. Often in these cases, the employer has referred the injured employee to a physician or clinic that is not part of the insurer's medical provider network. In some instances, the medical treatment that was authorized through the utilization review process has been provided and the claims administrator subsequently determines the physician who provided the treatment is not part of the MPN.

The DWC Newsline states that if medical treatment has been authorized by either the employer or insurer, it must be paid for in a timely manner, even if it is later determined the treatment authorization was made to a provider outside the medical provider network. Fax a request to the COA office if you would like a complete copy of the DWC Newsline: COA—916-454-9882.

Adjustments to the DMEPOS Medical Fee Schedule Posted on DWC Web Site

The DWC has posted an adjustment to the Durable Medical Equipment, Prosthetics, Orthotics, and Supplies section of the Official Medical Fee Schedule to conform to changes in the Medicare payment system as required by Labor Code Section 5307.1. The effective date of the change is July 1, 2006.

DWC Posts Information on Reporting Suspected Medical Care Provider Fraud

The law requires any insurer, self-insured employer, third-party administrator, workers' compensation administrative law judge, audit unit, attorney, or other person that believes a fraudulent claim has been made by any person or entity to report the suspected fraud to the administrative director of the DWC. DWC has developed protocols, in cooperation with the California Department of Insurance and the Department of Justice, for reporting suspected fraud. Information on submitting information can be found on DWC's web site:
http://www.dir.ca.gov/dwc/MedicalCareProvider/MedicalCareProviderLC3823.htm

DWC Posts Regs on Repackaged Medications

The DWC has posted regulations which are intended to close a loophole allowing repackaged drugs, dispensed from physician offices, to be paid at higher rates than if the medication was dispensed from a pharmacy. The regulations propose the following pharmaceutical fee schedule:

1) The maximum reasonable fee for pharmacy services is 100% of the Medi-Cal rates.
2) If the National Drug Code (NDC) for the drug is not in the Medi-Cal database and the NDC for the underlying drug product from the original manufacturer appears in the Medi-Cal database, then the maximum reimbursement shall be the NDC for the underlying drug product from the original manufacturer, calculated on a per unit basis.
3) If the NDC for the drug product is not in the Medi-Cal database and the NDC for the underlying drug product from the original manufacturer is also not in the Medi-Cal database, then the reimbursement shall be the AWP of the lowest priced therapeutically equivalent drug minus 17%, calculated on a per unit basis.

A $7.25 dispensing fee is allowed; $8.00 if the patient is in a skilled nursing facility. The ability for a physician to dispense medications from their office remains. COA has submitted comments indicating that injured workers should be able to choose where they receive their medications.

If you are dispensing medications from your office, we remind you that you are required under Business and Professions Code 4170 to provide the patient with a written disclosure that they have a choice between obtaining the prescription from the dispensing prescriber or a pharmacy.

To help ensure payment, we would strongly recommend that you have the injured worker sign a statement acknowledging the disclosure and electing to receive the medication from you.

An Orthopaedic Surgeon's Thoughts on the Workers' Compensation Utilization Review Quandry

By: F. Ray Nickel, M.D., Ventura

COA has been actively considering how to deal with inappropriate utilization review (UR) activity. In that process, discussion has been held about the potential benefits of meeting with state legislators and insurance representatives and making them aware of the problem. Unless it is a statewide effort involving the collection of hundreds of UR examples, I am pessimistic regarding the efficacy of such an activity. If we have such a meeting, the focus is going to be on the individual cases that we have sent, not the system. The insurance people will ask for the date/time/person addressed and other factual data. The insurance representatives will express their sorrow over these individual cases, a lack of knowledge of the people and procedures that resulted in the denial of care, a categorical denial of a systematized process to limit care and a promise to "look into it." The legislator will be left with the impression that a few doctors are having a few problems with a few carriers and a good feeling that he/she did his representative duty to bring the parties together. Problem solved.

Nothing else will happen because the ACOEM Guidelines are being used in a systematized manner to delay and deny care and it's all about money. SB 899 references care that a reasonable person would find appropriate as a justification for treatment. The ACOEM Guidelines are mentioned later as presumed correct, but the wording of the bill was obviously an attempt to use logical reasoning and commonly accepted methods of treatment as the standard, not the guidelines. The guidelines were added as a reference standard for such logical reasoning and methods, not as the gold standard. Unfortunately, by using the "presumptive" descriptor, the guidelines have become the tool which institutionalizes denial of care. Much has been made of the absence of orthopedic input into the guidelines, but such discussion misses the point. There is little which is truly inappropriate within the guidelines as long as it is understood that they are indeed guidelines for initial treatment in an occupational medicine clinic or similar situation and are not a law to be applied to subspecialty care.

Unfortunately, the insurance companies have no incentive to change because denying care adds to their income. Care that is delayed, awaiting a response from the reviewing companies, makes interest on the money held. A certain percentage of the requests for care which are denied are not being resubmitted. They save money. Of the cases which are appealed, they make money while the appeals process is taking place. A significant percentage of those which are appealed are again denied. They make money because of the denial and even if a second appeal is submitted, they make money on the interest. Even if they eventually decide to yield on the requested service, it doesn't cost them any more than had they authorized it in the first place. Although TTD payments may decrease the money saved, the net result of the denial process is a net increase in income for the company. There is nothing wrong with the need to be profitable, and there are many people who work within the system to obtain good care for their injured workers. However, it needs to be understood that although patient care is the nature of their business, the corporate goal is profitability and the current system permits the denial and delay of care. If this were not financially beneficial, there would be a hue and cry from the carriers regarding the inappropriate application of 899. I am unaware of any such protest.

Procedurally, if I request a particular test, the insurance company will theoretically pay another doctor to review my request. From my experiences. My impression is that, in actuality, they pay a company who has a non-MD do an initial extraction of the data from the chart notes that are available to them at the time, references this extraction to the ACOEM Guidelines with a recommended response and forwards this to an MD. This MD may or may not be licensed in this state, is unlikely to be a board-certified orthopedic surgeon and is highly unlikely to have been fellowship trained in my area. The use of the term "peer reviewer" therefore is highly questionable. This MD makes an evaluation of the non-MD summary, checks the box agree/disagree and then sends it back to the non-MD who generates the appropriate form letter. If I make an appeal, the same summary/recommendations/ratification pile of papers will be sent to another MD or sometimes the same MD. Since he/she is using the same input, the same conclusion will often be reached. When I have had occasion to speak with the MD reviewer, a comment will often be made to the effect of, "That makes a lot of sense and seems like a good way to proceed, but I don't think I can fit it into the ACOEM Guidelines." The Guidelines have become the defacto standard and as such are systematically used to delay or deny treatment.

On a personal note, I am struggling with my response to this new paradigm. Philosophically, these are not "my" patients. I perform a consultant role. Almost every action that I take has to pass through a "Mother may I...." grid. The patient belongs to the insurance company and they may accept or deny my recommendations or redirect the patient to another doctor as they choose. I have no problem with their ability to exercise this right, but there are several problems which arise from this situation. My patients don't have a clue that I am not really "their" doctor. My patient expects me to represent their interests, but no one is willing to pay me for the expense. Although the insurance company will pay for a company review as detailed above, they will not pay me for the time and other expenses involved with reviewing the chart, researching the ACOEM Guidelines and relevant literature, and generating a written appeal. I have generated a few appeals, and in discussing this with my office staff and reviewing the time required relative to other patient care activities, my estimate is that this activity costs me between $100 and $200 dollars from a time and resources

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(Continued from Page 12)

standpoint. Granted, this is probably more than they are paying the review company on a per chart basis, but I am not set up as a streamlined system to review charts in the manner listed above. Furthermore, I am potentially liable if I do not generate an appeal and the patient is harmed by this lack of action.

Few physicians are beating down the door to be a treating physician within the industrial system. The patients are difficult to treat. The treatment results are not as good as in other populations. There is more paperwork. There is more communication with the insurers and employers. My recommendations are at times denied. If I make an appeal, it costs me even more money. If I do not appeal, the patient has concerns regarding my commitment to them as an individual and I am liable if there is any harm. Catch 22.

My response is in process, but I believe that the ultimate outcome for my practice will be to adopt the following response:

Denial of Treatment Response Form

__ No action.

__ The following alternative treatment is reasonable to treat or relieve the disability:

____

__ There is no treatment which is likely to cure or relieve the disability other than that which has been recommended and denied. The patient is not permanent and stationary. Please contact the insurance company regarding their wishes in regards to their one choice among the following options:

- __ They may obtain a second opinion regarding the appropriateness of the recommended treatment or other alternatives. I will be happy to provide them with names of physicians whom I consider to be qualified to provide such a service if they desire.
- __ They may initiate the appeals process by sending the material to another reviewer.
- __ They may transfer the patient's care to another treating physician.
- __ They may agree to pay me to write an appeal letter which references, as best as is possible, the ACOEM guidelines, the relevant literature and the reviewer's denial letter. Such a letter will be billed in fifteen minute increments and at a rate of $250 per hour.

My uncertainty exists in regards to the information which I provide my patient following the insurance company's decision, including the ethics and business implications of possibly acknowledging or even recommending they seek legal counsel and that I cannot be held liable because of their insurance company's actions.

In order for this situation to change, two possible actions are suggested. From a legislative perspective, legislators would have to be inundated with cases from multiple doctors which exemplify how egregious and harmful the current situation has become. This would also have to include some perspective in terms of prevalence. Even if there are hundreds of egregious examples, they will have no weight, unless it can be shown that they represent a sufficiently large percentage of the total cases and represent a system problem rather than the anecdotes of disgruntled physicians.

From a legal perspective, this will be modified via case law. This is where the class action lawsuit discussed at the most recent COA meeting comes into such importance. The legislative approach requires a huge commitment on our part and even if it can be demonstrated that the situation is harming patients, it possibly will not be changed if some of the money that is flowing into the insurance industry is also flowing into the legislature. The courtroom focuses on individuals and if they can be shown to have been harmed by the system, the system will be commanded to change, independent of the percentages involved. Although I dislike legal action, my belief is that this is really the only viable way to change the current situation.

IF YOU AGREE WITH THIS ASSESSMENT OF THE UR PROBLEMS, HAVE YOUR STAFF ROUTINELY COMPLETE THE UTILIZATION REVIEW COMPLAINT FORM FOUND ON PAGE 10 OF THIS NEWSLETTER, LETTING COA KNOW OF YOUR UR EXPERIENCES. COA WILL COMPILE THE INFORMATION AND SEND IT TO THE DWC AND CONSIDER USING IT FOR OTHER LEGAL ACTION.

16th ANNUAL EDITION

CPLH 2006

CALIFORNIA PHYSICIAN'S LEGAL HANDBOOK

The all new **2006 California Physician's Legal Handbook** at over 4,000 pages is even more comprehensive than prior editions and extensively indexed by subject, law, website, form and court case. **Available in 6 volume print or CD-ROM versions!** This handbook answers the legal questions most frequently asked by physicians. It includes practical summaries of California and federal laws as well as sample forms and letters, and the actual text of the laws of greatest interest to physicians.

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Coding Information

Medicare Improperly Pays for Consultations

A March, 2006 report from the Office of Inspector General reports that the Medicare program paid approximately $1.1 billion more in billings for consultations in 2001 than it should have, accounting for approximately 75% of all consultation services Medicare approved that year. Services billed as consultations were improperly paid for the following main reasons: 1) they did not meet Medicare's definition of a consultation (19% or $191 million), 2) they were billed as the wrong type or level of consultation (47% or $613 million), or 3) they were unsubstantiated (9% or $260 million). Consultations billed at the highest level and follow-up inpatient consultations were particularly problematic; approximately 95% of each was incorrectly coded. The report can be viewed at: http://oig.hhs.gov/oei/reports/oei-09-02-00030.pdf

Medicare to Stop Mailing Standard Paper Remittance (SPR) for those Providers also Receiving Electronic Remittance Advice (ERA)

Beginning June 1, 2006, the Standard Paper Remittance received through the mail will no longer be available to providers/suppliers who also receive an Electronic Remittance Advice. CMS has developed free software and is making it available to providers who continue to need the SPR. To download the software go to: http://www.medicarenhic.com/edi/download/mrepsoftware_0306.htm

Orthopaedic Coding Articles of Interest

- **2006 E&M Code Change Overview**
  AAOS Bulletin, April, 2006
- **Shoulder Coding: Questions, Answers and Clarifications**
  AAOS Bulletin, May, 2006
- **Shoulder Arthroscopy: Why the Deep Discount for Multiple Procedures?** *AAOS Bulletin,* February, 2006
- **Two Pesky CPT Modifiers: -25 and –59**
  American College of Surgeons, May, 2006
- **Changes to the 2006 Category III Codes: Part II**
  AMA, CPT Assistant, March, 2006
- **The National Provider Identifier**
  AMA, CPT Assistant, May 2006

If you do not have access to these articles and would like a copy, fax a request to the COA office, 916-454-9882.

CALIFORNIA ORTHOPAEDIC ASSOCIATION
AMERICAN ACADEMY OF ORTHOPAEDIC SURGEONS

Treatable Causes of Chronic Orthopaedic Pain

"Missed Diagnoses, Differential Diagnoses and Treatment Options"

This course, in conjunction with the free AAOS distance learning course, satisfy California's CME requirement for 12 hours in pain management and end-of-life issues.

Saturday, December 9, 2006

Los Angeles Area
Course Moderator: Glenn B. Pfeffer, M.D.

The course objective is to instruct attendees in the management of pain associated with musculoskeletal conditions.
Topics in this course will include:

- Acute and Chronic Back Pain
- Updates on Fibromyalgia
- Managing Pain after Total Joints
- The Differential Diagnosis and Treatment of Chronic Wrist Pain
- Pain in the Non-Arthritic Hip
- The Differential Diagnosis and Treatment of Chronic Hip or Knee Pain
- The Differential Diagnosis and Treatment of Chronic Shoulder Pain
- Chronic Ankle Pain and the Athlete
- Bone Cancer/End of Life Issues
- Peripheral Nerve Blocks and Ambulatory Surgery
- Challenges of Pain Control in the Geriatric Patient
- Complex Regional Pain Syndrome/RSD
- Pain Management in the Pediatric Patient
- Chronic Ankle Pain
- Post-Operative Pain Control

By attending the course you will earn 8 hours of Category I Continuing Medical Education Credit hours which will satisfy California's CME requirement for pain management/end-of-life issues. An additional 4 hours of Category I CME in pain management/end-of-life issues will be earned by taking the free AAOS distance learning course.

Registration Fee:

$110 - COA members $135 - Non-members

$ 95 – COA members - multiple attendees from the same office

$ 65 - Residents/Allied Health Professionals/Office Staff

(includes course materials, continental breakfast, lunch, and Certificate of Completion)

To register for this course complete the following information:

Name of Attendee: ____________________ ____________________

Address: ____

City: ____________ State: _______ Zip: ________ Phone: ______________

Method of Payment: ❑ Check is enclosed. Make check payable to California Orthopaedic Association.

❑ Please charge $ _________ to my VISA or Mastercard credit card.

Visa/Mastercard # ______________________________ Exp. Date ____________

Fax this completed registration form to COA at 916-454-9882 or mail it to the COA office: 5380 Elvas Avenue, #221, Sacramento, CA 95819. If you need further information, call 916-454-9884.

Welcome to COA's Newest Members

Tyler Harris, M.D.	Vacaville
George (Rick) F. Hatch, III, M.D.	Los Angeles
Christoper Lee, M.D.	Glendale
Robert M. Murphy, M.D.	Ventura
Steven L. Schule, M.D.	Sacramento

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 because of the involvement of its members.

2006 COA Dues are now due.

If you have not yet paid your dues, please do so at your earliest convenience. Our goal is to add at least 100 new members to COA this year and retain existing members.

If we reach our goal, COA will represent over 85% of all orthopaedic surgeons in California. This helps us speak with a louder voice on legislative and regulatory issues.

To check your membership status, contact the COA office at 916-454-9884.

[MOVING?]

Please notify COA promptly if you are moving.

Name: ______________________________

New Address: ___________________________

City/ST/Zip ____________________________________

Phone: ______________________________

Fax: ________________________________

E-Mail:______________________________

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