Executive Director
Diane M. Przepiorski
5380 Elvas Avenue, #221
Sacramento, CA 95819
Phone: (916) 454-9884
Fax: (916) 454-9882
E-Mail: coa1@pacbell.net
Web Page: www.coa.org

COA Report

A publication of the California Orthopaedic Association

Summer, 2008

COA Working on your Behalf

It was wonderful to see so many of you at the COA Annual Meeting/QME Course in Newport Beach. I think we all got our money's worth from the program that Drs. Russ Petrie and Jamie Caillouette put together for us.

The "Greater Group" concept presented at the meeting may well be an alternative some of us can use to handle the changes ahead in the way we will be practicing medicine.

COA is also developing ways for you to earn additional Category I CME hours. We are looking at several options, the first of which would be reading articles and taking a short quiz. The quiz would be sent to COA, graded, and then we could award Category I hours for the activity. The first module will be on ACL Reconstruction Techniques and continue the education began at our Annual Meeting through the hands-on sawbones labs and ACL symposium This is just one new way COA is helping you fulfill the new American Board of Orthopaedic Surgeons' recertification requirement to earn 120 hours of Category I courses every three years. The Medical Board of California is also in the process of re-vamping their CME requirements. These and other modules will be published in the *COA Report* and also available on COA's website.

Mark Wellisch, M.D. (left) COA's new President accepts the gavel from Immediate Past President, James Caillouette, M.D. (right)

On an advocacy note, at the May COA Board of Directors meeting, Board mem-

(Continued on Page 2)

COA is honored by the AAOS …..

We are pleased to report to you that the California Orthopaedic Association was awarded the "State Orthopaedic Society of the Year Award" in May, 2008 at the AAOS National Orthopaedic Leadership Conference. Executive Director, Diane Przepiorski accepted the award along with COA leadership and California Board of Councilors who were in attendance at the conference.

COA is an effective organization because of the involvement of its members.

President's Column (continued from Page 1)

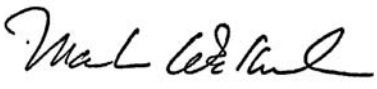
bers met with orthopaedic surgeons involved in creating a new AAOS Standard of Professionalism on Emergency Room Call. The draft AAOS SOP we reviewed would have declared it the moral responsibility of orthopaedic surgeons to take emergency room call. You can be sure that there was a lively debate. All Board members felt that an "aspirational goal" implying an obligation to cover trauma call will be interpreted by hospitals, the media, and the insurance carriers as a "mandate" for orthopaedic surgeons to take call with no input, let alone negotiation, from the individual orthopaedic surgeon. If your orthopaedic colleague did not believe you were taking your sufficient share of call, they could file a complaint with the AAOS which could result in your expulsion from the Academy.

Of even more concern, there seems to be support from the American Orthopaedic Association (AOA) and the American Board of Orthopaedic Surgery (ABOS) for the creation of this SOP. The ABOS already includes in their recertification survey questions about whether you are taking call and they consider those responses when determining whether you qualify for board certification or recertification.

COA Board members were very concerned with both of these activities and believes that the Academy Fellows will be adamantly opposed should the AAOS move forward with an SOP in this area. Should a SOP be circulated for vote by the Fellows, COA will work with other state orthopaedic societies to educate our members why we oppose this effort and why they should vote no. We will also work with the AAOS to oppose the ABOS survey questions should we see evidence that they are denying Board recertification on the basis of whether the orthopaedist is taking call.

It is beyond presumptuous for the ABOS to link public on-call service to their mission of assuring clinical skills for practicing orthopaedic surgeons. Obviously, more information will follow should this issue contain to evolve.

Finally, I would urge all of you to keep the pressure on the health insurance industry to do well by our patients, their clients. Every time they deny a patient a medically necessary service, they are risking, rather than insuring, the patient's good health. Physicians must remain advocates for our patients and report to state officials instances where the insurer has acted inappropriately to deny care. Through these reportings, we hope to rein in these activities.



Mark B. Wellisch, M.D.
President

People in the News

Memorial to Sanford (Sandy) Anzel, M.D.

By: William McMaster, M.D.

It is with regret that we inform you that Sanford Anzel, M.D. passed away on February 16, 2008 after a long illness. All who have been associated with the Orthopaedic Training Program at the University of California, Irvine understand the important commitment that Sandy Anzel made to the program since its inception. He diligently served the program in many capacities over the years. Of additional importance was his broader commitment to the Orthopaedic Community locally, nationally and internationally. He served as President of the COA, WOA, and as a Trustee on the Board of OREF and the Ortho PAC.

Of utmost value was his mentoring and nurturing of generations of young Orthopaedists both in training and in practice. It was this commitment to service and engage the future generations that encouraged many he touched to emulate his example. Everyone who interacted with Sandy was impressed with his passion for Orthopaedics.

We think it is appropriate to honor Sandy for his years of dedicated service and teaching by establishing an award in his honor. We have selected the Western Orthopaedic Association to house the award as it represents the broader western orthopaedic community and was the first orthopaedic organization to award resident research efforts through a peer-reviewed process. We think it most appropriate that this award be, "The Sanford H Anzel, M.D. Resident Research Award."

An endowment for the award has been established through the Orthopaedic Research and Education Foundation, a 501c3 established entity that very successfully manages funds for most orthopaedic associations and societies. The income will be distributed annually to WOA to award a peer reviewed competition in perpetuity. The goal for the endowment is $50K which will provide an annual award of $2500.

We hope you agree that this is a valuable effort to encourage future residents to perform quality research during their training. **Please consider making a contribution to OREF in support of this fund.** As your contribution is to OREF for educational purposes, it is tax deductible to the extent provided by law. You can contribute online: www.oref.org or mail your donation for, "Sanford Anzel, M.D. Resident Research Fund" directly to:

Orthopaedic Research and Education Foundation
6300 N River Road, Suite 700
Rosemont, Illinois 60018
Phone: 847-384-4354

People in the News

AAOS Board of Councilors Elects New Officers
In May, 2008, the AAOS Board of Councilors elected the following new officers:

Chair:	John T. Gill, M.D., TX
Chair-Elect:	Thomas C. Barber, M.D., CA
Past Chair:	Matthew S. Shapiro, M.D., OR
Secretary:	Richard J. Barry, M.D., CA

William Krissoff, M.D.
Following the death of his son, Marine 1st Lieutenant Nathan Krissoff in a roadside bombing in Iraq, Dr. William Krissoff has decided to close his practice in Truckee and follow in his son's footsteps joining the Navy Medical Corp. The March, 2008 *AAOS Now* describes the personal struggle that Dr. Krissoff and his family went through upon the death of his son.

In August, 2007, Dr. Krissoff who was beyond the cutoff age for enlistees, received help from President Bush and Karl Rove to obtain an age waiver setting in motion the necessary paperwork to allow his enlistment. On November 17, 2007, Dr. Krissoff was commissioned as a Lieutenant Commander in the Navy Medical Corps on "the green side" meaning that he will be treating Marines. Dr. Krissoff is training to be part of a forward resuscitative surgical team—a mobile unit consisting of an orthopaedist, a general surgeon, an anesthesiologist, and five or six corpsmen and nurses. Dr. Krissoff joins his other son, Austin, also a Marine who is stationed at Camp Pendleton.

Arthur Lurvey, M.D.
Dr. Lurvey former Medical Director of Transamerica covering Medicare Part B in Southern California has now been appointed "Medical Director" of Palmetto GBA. Palmetto is the new Medicare contractor for all of California replacing National Heritage Insurance Corp. (NHIC) who currently holds the contract.

Resident Awards

The following Resident Awards were presented at the COA Annual Meeting:

Orthopaedic Hospital Resident Award
James Mok, M.D., UC San Francisco

Depuy Resident Award
Safdar N. Khan, M.D., UC Davis

Lloyd W. Taylor, M.D. Resident Award
Aaron B. Cullen, M.D., UC Davis

OREF Resident Award
Vidyadhar Upasani, M.D., UC San Diego

J. Harold LaBriola, M.D. Resident Award
Neil Badlani, M.D., UC San Diego

Nearly 440 Orthopaedic Surgeons and Practice Managers attend COA 2008 Annual Meeting/QME Course and Instructional Course in Newport Beach …..

COA Elects New Officers

The following COA Officers were elected for 2008-2009:

Mark B. Wellisch, MD	**President—Encino**
Richard J. Barry, MD	**First Vice President—Davis**
Glenn B. Pfeffer, MD	**Second Vice President—Los Angeles**
Tye J. Ouzounian, MD	**Secretary-Treasurer—Tarzana**

The Founders' Award was awarded to M. Mark Hoffer, M.D. (center) for his lifelong dedication to quality orthopaedic care.

From left to right: Mark Wellisch, Mark Hoffer and James Caillouette

The William W. Tipton, Jr., M.D. Leadership Award was posthumously awarded to Charles (Chuck) McElwee, M.D. for his dedication to political issues/activities. His daughter, Cindy Olah accepted the award.

From left to right: Ben Shwachman, Cindy Olah, and Ralph DiLibero

Other Meeting Highlights ….

Rocky Delgadillo,
Los Angeles City Attorney
Reported on his lawsuits against Blue Cross and Health Net for the illegal dumping of patients and urged attendees to report other illegal carrier activity to his hotline:
http://www.protectingtheinsured.org/default.html

Orthopaedic Practice Groups shared information on how they have revamped their practices to adapt to the changing healthcare market and negotiate better contract with carriers.

Sawbones labs on ACL Reconstruction Techniques, and clinical symposiums on Articular Cartilage Treatment in the Athlete, ACL Reconstruction, and Rotator Cuff Injuries were also presented.

Workers' Compensation News ...
State Compensation Insurance Fund —Medical Community Liaisons

Finding the right person to resolve Medical Provider Network (MPN), utilization review, and/or billing issues can be a challenge. At the Annual Meeting, many members expressed frustration with finding the right person at State Compensation Insurance Fund (SCIF) to resolve these issues. In an effort to improve relations with medical providers and to comply with a State of California contract requirement, State Compensation Insurance Fund (SCIF) has hired **Medical Community Liaison Representatives** in each of their district offices**.** These individuals can be a good resource for you to resolve MPN or treatment issues for SCIF's injured workers.

We are reprinting the following list which was first published in the Winter, 2008 *COA Report* to assist you in making these contacts. In addition, COA leadership will be meeting with SCIF to better understand their selection process and discuss other network problems.

SCIF Medical Community Liaisons as of January 1, 2008.

SCIF DISTRICT OFFICE	Medical Community Liaison	*PHONE NUMBER*
BAKERSFIELD	Doris Hildenbrand - MCL	661.644.4190
EUREKA	Reuben Mendoza - MCL	707.476.1151
	Wendy White - MCL	707.476.1129
FRESNO	Elisa Moffitt - MCL	559.433.2754
LOS ANGELES/Glendale	Susan Lizardo - MCL	818.662.4058
	Brenda Coyne - MCL	818.291.7323
	Elsa Tan - MCL	818.291.7295
	Marie Deul - MCL	818.291.7307
	Hilda Hacoobei - MCL	818.291.7545
	Ray Machi - MCL	818.291.7317
LOS ANGELES/Burbank	Joan Norman - MCL	818.291.7450
OAKLAND	Rica Lasola - MCL	925.523.5759
	Kathy Simpson - MCL	707.863.5213
OXNARD	Loretta Collet - MCL	805.988.5414
	Angela Pace - MCL	805-988-5383
REDDING	Rena Miller - MCL	530.223.7108
RIVERSIDE	Donna Goldware - MCL	951.656.8412
SACRAMENTO	Markus Holden - MCL	916.924.6852
	Jessica Martinez - MCL	916.924.6890
SAN BERNARDINO	Amber Ainsworth - MCL	909.384.4952
SAN DIEGO	Grace Ann Budomo - MCL	858.552.7116
SAN FRANCISCO	Vanita Bhatia - MCL	925.523.5143
SAN JOSE	Sarah K Yip - MCL	408.363.7846
SANTA ANA	Kristine Bieber - MCL	714.565.5896
	Martin Stefen - MCL	714.479.1587
SANTA ROSA	Ann Conover - MCL	707-573-6533
	Tari Power - MCL	707.573.6484
SOUTH ORANGE	Kathy Guernsey - MCL	714.347.5187
	Norbert Redekosky - MCL	714.473.3526
STOCKTON	Julie Sarina - MCL	209.476.2670

Workers' Compensation News … Lewin Group Report is Released

The Division of Workers' Compensation has released a study conducted by The Lewin Group titled, "Adapting the RBRVS Methodology to the California Workers' Compensation Physician Fee Schedule." The release of this study will start the discussion of transitioning the Official Medical Fee Schedule (OMFS) for physician services to an RBRVS based fee schedule.

This initial study models the transition in a budget neutral manner and found that the impact on physicians will be as follows:

Increase payments to:
- Anesthesiologists by 1.3%
- Chiropractors by 5.8%
- Psychologist by 7.3%
- Emergency Room physicians by 9.6%
- Physical Medicine providers by 11.2%

Decrease payments to:
- Surgeons by 12.1%
- Neurologists by 4.9%

No Change
- Family Practice

When you consider all of the fee schedule changes, increases in Evaluation and Management codes and reductions in surgical/radiology codes, the **Lewin Report projects that reimbursement for surgeons would be decreased by 25.9%.**

These numbers represent an average of the impact on all surgical codes. COA believes that the impact will be much more severe on certain orthopaedic codes. COA and other medical associations attended meetings held by DWC to discuss the report. We urged the DWC to publish a code-by-code impact of the proposed changes so they, and providers, could measure the impact on individual physician practices.

The Lewin study acknowledges that California's reimbursement rates are some of the lowest in the nation and that further reductions to the fee schedule would likely result in injured workers having more access problems. It also indicates that there are more administrative costs in treating an injured worker versus other patients, and that the majority of other states that have transitioned to an RBRVS system, have adopted multiple conversion factors.

DWC has promised to have Lewin model other transition models and provide additional information so that providers can assess the impact on their practice.

Anne Searcy, M.D., Medical Director of the Division of Workers' Compensation, was clear that this first study is only a benchmark and does not necessarily represent the thinking of DWC. In fact, Carrie Nevans, Acting Administrative Director of DWC is on record indicating that the transition would not necessarily be done in a budget neutral manner. In addition, to the fee schedule changes, there will be changes to the Ground Rules and forms.

COA will keep you updated as more information becomes available.

AMA Releases CD Archives "The Guides Newsletter"

January 2006—December 2007"

The American Medical Association publishes "*The Guides Newsletter*" to assist physicians in understanding how to write a ratable report using the AMA Guides.

They have released a CD containing the newsletters from January, 2006 through December, 2007 which cover the use of the Guides under the 5th Edition. These CDs were made available to attendees of COA's 2008 QME Course.

COA has a limited number of the CDs which we are making available to our members at $50 each. If you would like a copy of the CD, complete and return the following order form.

ORDER FORM

Name: _____

Address: _____

City/State/Zip: _____

Charge $50 to my Visa/Mastercard credit card:
#_____

Expiration date: _____

Fax order to COA: 916-454-9882.

New Resources to Help COA Members:

- **with the WC Utilization Review Appeals Process**
- **Writing a Ratable Medical-Legal Report Using the AMA Guides**

are posted on COA's Website: www.coassn.org

Workers' Compensation News …

How to Effectively Work Within the Workers' Compensation Utilization Review System:

From the Perspective of an Orthopaedic Surgeon Who Does Utilization Review

By: William Warden, III, M.D.

Editor's Note: These comments are the thoughts of Dr. Warden and are shared with you to assist you in understanding the utilization review process. They do not necessarily represent COA's position on these issues.

Shortly after utilization review (UR) became required for Worker's Compensation in the State of California, a peer asked me if I would be interested in performing utilization reviews for an independent review company. It seemed an excellent way to gain expertise in the utilization review process, which we have all found burdensome at best, so I took the position. I started doing the reviews via internet connection between cases, although I now find I do more reviews at odd hours which can be burdensome. I thought others might benefit from insight I've gained into the process, so I am writing to share my view of the process as a reviewer who is also a practicing orthopaedic surgeon.

What does a UR reviewer do?

A reviewer evaluates requests for medical treatment to determine whether the service(s) are medically necessary "based on medical treatment guidelines." The ACOEM Practice Guidelines are presumed to be correct, although they can be overridden if there is sufficient scientific evidence. If ACOEM guidelines do not address treatment, there are alternatives:

- Other guidelines. The Official Disability Guidelines (ODG) are widely used.
- Literature. The Journal of the American Academy of Orthopaedic Surgeons (JAAOS) is often helpful.
- Insurance company guidelines/recommendations.
- "Standard of care" I rarely use this. A good example is a post-operative sling.

Typically a nurse will abstract the medical data and attempt to provide review guidelines (often not pertinent) prior to my review.

What a reviewer shouldn't do

- Deny based on causation.
- Recommend an alternative procedure (e.g., ulnar nerve transposition instead of medial epicondylectomy for cubital tunnel syndrome).
- Deny based on his or her "opinion.""

If you see any of these occur you've got just cause to file a complaint with the DWC.

What I want to see

- Just give me a guideline— this makes the review process easy from my standpoint.
- Bullet notes.
- Chart notes might work; this is what I usually send from the practice side of things.

Other Guidelines—What is the ODG?

The Official Disability Guidelines (www.odgtreatment.com) are a widely used set of guidelines that address the most common orthopaedic conditions. They are particularly helpful for processes such as arthroplasty and post operative physical therapy, areas where the ACOEM guidelines are lacking and occasionally misapplied. For example, the ODG allow 24 PT visits for a number of surgical procedures including surgery for impingement, adhesive capsulitis, instability, rotator cuff repair, and open treatment of fractures; 30 visits are allowed for open treatment of impingement and 40 for open rotator cuff repair.

Even in reasonable treatment guidelines, there are areas where you will disagree. One of the most blatant examples I've come across is in the ODG guidelines which states, "at least 2 of the 3 compartments need to be affected for a total knee replacement". A unicompartmental arthroplasty is recommended if only one compartment is involved. Clearly, the person who wrote this guideline had a poor grasp of the indications and controversy surrounding unicompartmental arthroplasty in the orthopaedic literature. Unfortunately, if a treating physician is dealing with a reviewer who does not understand the problems with this guideline, it will require a relatively cumbersome literature review to successfully appeal the decision. This emphasizes the importance of having an orthopaedic surgeon involved in the review process.

How to write an appeal

- Write "Appeal" on top, sounds crazy, but I've had companies reject my appeal based on this.
- Make it easy for the reviewer by sticking to the topic.
- Bragging about how many cases you've done or how many years you've been practicing will not help.
- Slamming a family practitioner for denying a meniscectomy might work.
- You are wasting everyone's time if you don't cite a guideline.
- Citing "standard of care" for a denial based on a guideline probably won't work.
- Attack the application of the guideline. I recently had a non-orthopaedist deny PT after ACL reconstruction by citing the ODG section for the medical management of an ACL tear. To counter this denial, a simple referral to the surgery section should work.
- Describe extenuating circumstances which might make guidelines less applicable, e.g., diabetes mellitus as a risk factor for stiffness necessitating additional physical therapy.
- Attack the guideline with its own references. Many guidelines are written based on literature which does not strictly support the guideline. For example a guideline may state that TKA should not be performed on obese patients based on a study demonstrating poorer outcomes after TKA in obese patients. A review of the article shows that the author found that although obese patients had poorer outcomes than non-obese patients, they showed greater functional improvement after TKA than non-obese patients. The authors do not conclude that TKA is contraindicated in obese patients.
- Attack the guidelines with alternative literature.

The latter two options are clearly burdensome.

Inappropriate UR

There is a UR complaint form on the DWC website http://www.dir.ca.gov/dwc/FORMS/UtilizationReviewcomplaintform.pdf
Or Google "California UR complaint form". You might also contact orthopaedic surgeon, Dr. Avrum Gratch at the DWC (510) 286-0908. The form is fairly straightforward, listing a number of valid criteria for submitting a complaint:

- Decision to modify, delay, or deny treatment was made by a non-physician.
- Modification, delay or denial (MDD) letter did not contain the reviewer's contact information.
- Inadequate explanation of the reasons for UR decision
- Failure to specify in MDD letter a four hour time block when reviewer available.
- Medical criteria or guidelines used to make decision were not disclosed.
- UR decisions were not made within required time limits.
- Treatment denied solely because the condition was not addressed by the ACOEM Practice Guidelines.
- No statement in decision that dispute shall be resolved in accordance with Labor Code section 4062.
- Payment denied even though service was authorized.
- Requested services denied for lack of information, but the reviewer did not request additional information.
- Unable to reach reviewer to discuss treatment decisions
- Failure to maintain telephone access for UR authorization from 9 a.m. to 5:30 p.m. PST on normal business days.
- Unable to leave a message after business hours.
- UR reviewer calls you after CA business hours.
- Other.

From the reviewer standpoint, I'm confident that UR companies are not happy to have the DWC following up on these complaints.

(Continued on Page 7)

COA Members Involved in Advocacy Efforts

COA leaders attend Senator Barbara Boxer's Town Hall Meeting. Left to right—John Gonzalez, Tom Barber, Carol Ann Barber, Senator Boxer, Chris Wills, Betty Jo Wills, and Ed Diao.

Senator Dianne Feinstein discusses issues at her Constituent Breakfast. Left to right—Ed Diao, John Gonzalez, Senator Feinstein, Chris Wills, Betty Jo Wills, Carol Ann Barber, and Tom Barber.

Representative Fortney "Pete" Stark meets with COA leaders to discuss Medicare reforms. Left to right—Diane Przepiorski, Betty Jo Wills, Mathias Masem, Ed Diao, Chief of Staff, Debra Curtis, Chris Wills, Blair Filler and Congressman Pete Stark.

Meeting with Lt. Governor John Garamendi—Left to right Richard Barry, Ralph DiLibero, John Garamendi, and Mark Wellisch

How to Effectively Work Within the Workers' Compensation Utilization Review System

(Continued from Page 6)

Peer to peer calls

Peer to peer calls remain problematic. Given the fact that we are asking for peers as reviewers, it's difficult to schedule mutually convenient times for phone calls. Furthermore, review companies are under pressure to get the review out in a timely fashion. When I am asked to make a call for a peer to peer review, I make the call and leave my contact information. If the treating physician is unable to return the call promptly (which unfortunately happens to me frequently from the treating side) I must submit the review without the benefit of the discussion with the requesting physician.

UR Pet peeves

- Shoulder CPM-no, based on ODG and current literature.
- Pain pump-not based on ODG and current literature (occasional exceptions).
- Cryotherapy OK with me per ODG.
- Reports that don't differentiate active versus passive ROM in the shoulder can lead to problems.
- Unbundling. Each of those unbundled procedures means more work for me.
- Egregious surgeons (e.g., a surgeon performed an ACL reconstruction on a 24 year old. At the time of surgery he found cartilage damage at the medial femoral condyle and patella, so he subsequently performed an autologous chondrocyte transplantation to the medial femoral condyle and patella. Next he performed a Fulkerson osteotomy to relieve the stress on the patella. This was followed by a lysis of adhesions and hardware removal. At each surgical procedure he performed a partial medial and lateral meniscectomy.) I was asked to review his request for a high tibial osteotomy to protect the medial femoral condyle chondrocyte graft. What would you say?
- Clueless surgeons (e.g., a surgeon would like to perform a revision rotator cuff repair on 54 year old diabetic patient status post rotator cuff and SLAP repairs with persistent pain, 90 degrees of passive elevation and an MRI arthrogram which is equivocal for a re-tear. What would you say?

Summary:

Bear in mind, I am not defending the UR process--I find it as burdensome as you. While I still get a number of UR rejections, I'm confident that I can overturn almost any denial of my requests for surgical procedures or tests. Hopefully these observations will help you with the UR process.

William H. Warden III, MD

Palmetto GBA California's New Medicare Contractor: Beginning the Transition

Palmetto GBA has been selected by the Centers for Medicare and Medicaid Services (CMS) to serve as the new Medicare Contractor for California. **The cut-off date on which all California Part B claims will transition from the current Medicare contractor, National Heritage Insurance Corporation (NHIC) to Palmetto GBA is September 2, 2008.**

Palmetto is working hard to prepare California providers for this transition. They have developed various educational and communication tools to ensure a smooth transition.

Their website is: http://www.palmettogba.com/palmetto/j1.nsf/DocsCat/Home

On this website you will find the following information:

- **EDI Application**
  After the cut-off date, providers who currently electronically transmit Medicare claims must reenroll to be able continue to electronically submit claims to Palmetto GBA. Palmetto staff encourages providers to "early board" and complete and submit the EDI Application Form as soon as possible to allow for testing of the transmissions prior to the cut-off date. EDI Applications and Frequently Asked questions are available on the Palmetto website.

- **Electronic Funds Transfer (EFT)**
  If you are currently set-up to receive electronic funds transfers, Palmetto would like you to get set-up to receive their electronic transfers as soon as possible. You should have already received a letter from Palmetto about what you need to do to make this transition which includes the need to sign and send in a new EFT Agreement. If you have not received an EFT letter from Palmetto and you currently are set-up to receive electronic funds transfers from NHIC, you should contact Palmetto. Palmetto uses the PCA Pro 32 software for these transfers.

  If you are not currently receiving electronic transfers, you must apply through NHIC at this time.

  Keep in mind that Palmetto checks will be mailed from the East coast which will add several days of mail time to checks that are mailed. This will delay providers receiving their reimbursement checks; so, Palmetto is strongly encouraging providers to sign-up for EFT.

- **Schedule of Palmetto Transition Workshops and Teleconference Calls for Part B—Providers**

  Transition Workshops in California will be held as follows:
  - Holiday Inn Downtown San Francisco—July 9
  - LA Convention Center—July 11
  - Radisson Hotel, Fresno—July 16
  Each session will have an AM and PM session which will present the same information.

  The schedule for the teleconference calls is posted on the Palmetto website as they are scheduled.

- **Provider Resource List** contains links to other important implementation information including other key dates.

During this transition, providers can also e-mail questions directly to Palmetto at: j1mac@palmettogba.com

Please notify COA if you have problems contacting Palmetto or need additional information on this transition, so that we can assist in obtaining answers to your questions.

Dispensing DME to Patients—Can it be Done?

Frank Gamma, JD and Douglas Free, JD
Kessenick, Phillips & Gamma LLP

Physicians are increasingly looking to ancillary services revenues as a means of combating declining payor reimbursements and the litany of other financial challenges facing the medical profession today. Within the specialty of Orthopedics, one source of potential ancillary services revenue may be derived from various arrangements under which the practice or an affiliated entity dispenses Durable Medical Equipment (DME) to patients, hospitals, and ASC's.

While it is possible to structure such arrangements in a legally compliant manner, it must be noted that the analysis of whether a particular arrangement is likely to pass regulatory scrutiny is anything but simple. Physicians considering the possibility of incorporating DME distribution into their practices are therefore urged to consult with an experienced health care attorney.

This article is intended to provide an overview of how applicable state and federal regulations will likely impact the manner in which physician DME arrangements should be structured. The article concludes with a summary description of a specific structure which might be workable within an Orthopedic practice.

Application of Stark—DME = DHS
As an initial matter, it must be noted that DME is classified as within the categories of Designated Health Services (DHS) which invoke application of the Stark regulations. Thus, to the extent that DME is to be dispensed to Medicare or Medi-Cal patients, the arrangement will need to comply with the many different requirements of the Stark regulations. Under the most recent changes to the Stark regulations, this appears to be a daunting task.

We say this based on language which is included in "Stark III," the most recent addition to the regulations. As was stated in the September 5, 2007 edition of the *Federal Register*, "There are few, if any, situations in which a Medicare provider would personally furnish DME and supplies to a patient, because doing so would require that the physician himself or herself be enrolled in Medicare as a DME supplier and personally meet all of the duties of a supplier as set forth in the supplier standards" (*Federal Register*, September 5, 2007, p. 51019).

Medicare's supplier standards are set forth at 42 CFR 424.57. The standards require that any supplier of DME to Medicare patients submit an advance application to CMS. The application, among many requirements, specifies that the DME supplier will honor "all warranties expressed and implied under applicable State law," and that the supplier "must not charge the beneficiary or the Medicare program for the repair or replacement of Medicare covered items…"

Moreover, the types of DME which physicians may directly bill Medicare for appears to be limited to orthotics, walkers, wheelchairs, canes, and crutches.

The above language in Stark III calls into question prior arrangements under which physicians have supplied DME to their patients under the In Office exception to the Stark regulations. It may still be possible to structure arrangements in a manner that complies with Stark; for example, possibly through the use of intermediary entities such as LLCs. This is presently unclear, however, under Stark III, and it is safe to say that physicians seeking to provide DME to their patients may wish to focus on non federal program patients, thereby removing Stark from the equation.

The California Equivalents of Stark
California law includes a much less extensive (compared to Stark) body of law which nonetheless effectively precludes many "physician self-referral" arrangements under state law. These regulations, which are primarily set forth at Business and Professions Code sections 650.01 and 650.02, apply directly to a multitude of physician self-referral arrangements such as diagnostic imaging and physical therapy, to name but a few. The California regulations do not, however, specifically apply per se to DME, and from this standpoint, the state rules are narrower than the Stark regulations. As is discussed below, this appears to give validity to the legality of properly structured, non Medicare DME arrangements under California law.

Workers' Compensation Rules
Similarly, there is another body of state laws which govern self-referrals with respect to Workers' Compensation patients (see Labor Code Sections 139.3 and 139.31). These regulations are substantially identical to California's above-mentioned general self-referral prohibitions; and, once again, there are no direct prohibitions against physician-based DME arrangements.

Anti-Kickback Considerations
California physicians seeking to provide DME to their patients must also take into account state statutes such as California Business and Professions Code section 650. This statute, which has a federal counterpart known as the federal anti-kickback law, provides for the imposition of criminal sanctions in cases in which the following five elements are present: 1) the receipt or acceptance; 2) by a physician; 3) of any consideration as inducement; 4) for the referral of patients; 5) to any "person," irrespective of any proprietary or co-ownership interest the physician may have with that "person" (which term includes corporate entities).

Section 650 has specifically been found to likely apply to physician DME arrangements. For example, in 2006 the California Attorney General's Office noted that, "For purposes of this opinion, and in keeping with the broad prohibition of Section 650, we will assume, without deciding, that in select-

(Continued on Page 11)

Sutter IPA Works with local Physicians to Implement IMR

Integrated Medical Record Initiative

June, 2008

Practice Management Issues

Sutter Independent Physicians (SIP), an IPA located in the Sacramento area, has launched a new partnership program with its physicians, primary care and specialists, to implement an Integrated Medical Record Program (IMR). The heart of the IMR is the unified patient medical record. All physicians using the SIP IMR will be using the same patient medical record which will help participating practices improve clinical quality and physician-to-physician communication while enhancing practice efficiencies through clinical integration. The SIP IMR also includes valuable interfaces with ancillary partners including the Sutter labs, Quest, LabCorp and Radiological Associates. SIP is developing interfaces with Sutter Medical Foundation and the local Sutter hospitals. To make this affordable for physicians, SIP is paying most of the costs of this implementation.

The IMR system combines the strengths of the GE Centricity Business Electronic Practice Management system with the GE Centricity Electronic Medical Record system. SIP is also fortunate to have a local partner, Sutter Connect, which is providing the software installation, training and ongoing operational and technical support for this venture. Sutter Connect has a long-standing record of performing office related services to the Sutter Medical Foundations. They have the training, system resources and experience necessary to meet the needs of the local community of physicians.

There is a national effort to install electronic health records (EHRs) in order to improve the coordination of high quality care. Virtually every segment of health care is demanding better coordination of care for a myriad of reasons. In addition, other IPAs and provider organizations are implementing their own strategies to develop a full EHR. As a result, it is not a question of if medical practices will be adopting an EHR, but when.

SIP is acting now because it believes that the value outweighs the cost and to protect SIP's future as well as the future of the independent practice of medicine. SIP understands that it will be very difficult for individual offices to implement and support these complex systems on their own and that the EHRs utility will be limited unless offices are interconnected.

SIP is pleased to announce the successful installation of its IMR into three private practices in the last three months with installations scheduled for over a dozen additional practices in the upcoming months. These practices will become the start of a comprehensive, unified patient record which will allow the participating practices to provide more effective clinical care while maintaining their individual practice autonomy at an affordable cost.

If you are part of the Sacramento Sutter IPA, we would welcome the opportunity to discuss the details and value of this exciting program with you. Please contact Ryan Leonelli of Sutter Connect at 916-854-6887 for more information.

The AC Group Releases their 10th Annual Report on Practice Management Systems

The AC Group presented an educational session at COA's 2008 Annual on Friday, May 16, 2008 in Newport Beach.

As part of that session, Mark Anderson, CEO of AC Group promised to provide COA members with a copy of their 2008 Report on Practice Management Systems and Electronic Medical Records on a complimentary basis.

This year's report provides physicians, MSOs, IPAs, and PHOs with one of the most comprehensive evaluations to date of leading PMS/EMR/EHR applications. According to the author, Mark Anderson, Healthcare IT Futurist, "Physicians and organizations such as DOQ-IT, state QIOs and IPAs are looking for a 3rd party independent evaluation of the various EMR/EHR offerings in the marketplace today. The current pressures in the industry for increased efficiency and better care delivery, coupled with significant advances in technology and applications, have enabled electronic medical records (EMRs) to take center stage. The challenge with EMRs is that it is very difficult for the average physician practice to "effectively evaluate its options."

The survey is an extensive evaluation of functional criteria that can serve as a valuable tool for the vendor selection process. The summary report is 39 pages long and covers the top ranked PM and EHR products by Practice Size.

To access the report go to:
http://acgroup.bz/2008reports.html

COA hopes this information is helpful to you. Questions should be directed to:

Mark Anderson, CEO
The AC Group
Phone: 281-413-5572
E-Mail: mra@acgroup.org

Dispensing DME to Patients—Can it be Done?

(continued from Page 9)

ing a particular medical device for use by his or her own patient, a physician is "referring" the patient to the company that supplies the device (see 89 Op. Atty Gen. Cal. 25 (February 27, 2006)). In addition, there has been a major upswing in the number of federal regulatory actions brought against various physicians and DME suppliers across the country with respect to arrangements in which fraudulent means and objectives have resulted in over utilization and over billing of DME to the Medicare program. Similar regulatory actions are entirely possible in California under Section 650. As is noted above, penalties for violating Section 650 include significant fines and potential imprisonment.

The Relevance of Federal Safe Harbors

As mentioned above, federal law provides its own equivalent to California Business and Professions Code section 650, which federal regulations are commonly referred to as the federal anti-kickback statute. As with Stark, this regulation only has direct application if Medicare or Medi-Cal patients are involved. Nonetheless, the federal rules, and certain "safe harbor" exceptions thereto, are both relevant and instructive in terms of how to best structure a DME arrangement designed to comply with California law. This is due to the fact that the federal regulations include a much more in-depth body of interpretive materials than their state law counterparts, the end result being that it is common practice to look at the applicable structure under federal law even when seeking to structure a corresponding arrangement under California law.

A prime example of this as it relates to DME arrangements is what is known as the federal Small Entity Safe Harbor. As with other federal safe harbors, the Small Entity Safe Harbor is a legal guideline, not a mandate. Nonetheless, if a given arrangement is structured in a way that meets all aspects of the safe harbor, absolute compliance with the federal anti-kickback regulations is presumed. Many arrangements do not meet all aspects of any given safe harbor, but the safe harbor still is an important benchmark for those seeking to nonetheless set up structures which are likely (but not certain) to withstand regulatory scrutiny.

In summary, the Small Entity Safe Harbor requires that no more than 40% of the entity may be owned by individuals who will self-refer to the entity such as: 1) order DME which will be purchased from the entity and then used by the referring physician/owner in his or her practice; and, 2) further requires that no more than 40% of the entity's yearly gross revenues may be generated by the medical practice related activities of the Company's owners.

As its name suggests, the Small Entity Safe Harbor has its most direct application to a structure under which a group of physicians puts together an entity (such as an LLC) and uses that entity as a vehicle for distributing DME or other items that are used in the physicians' practice. To achieve 100% compliance with the Safe Harbor, it would be necessary: 1) to include among the owners a majority of investors who will not "self-refer" the DME to patients; and, 2) to ensure that the profits of the entity which are attributable to physician self-referrals do not exceed 40% of the entity's overall annual profits. It is important to note again, however, that the Safe Harbor is a guideline only, not a legal mandate.

Regulatory Opinions

Regulatory opinions over the last few years have framed a number of other important issues to keep in mind. First and foremost, any DME arrangement must be structured in a manner which will ensure that the patient's best interests remain paramount at all times. In other words, any physician-based DME distributing structure must be set up in a manner which ensures that physicians will continue to prescribe the best device under the specific circumstances, and not allow the desire to "make a sale" to influence this decision.

In terms of the anti-kickback statutes, regulators will likely look with great suspicion on any arrangement giving off any indication of a "sweet deal" between a DME manufacturer and a referring physician. Examples of this could include circumstances where the manufacturer gives the physician inordinate discounts on the devices, or where there the physician is otherwise unduly incentivized to use a particular manufacturer's products. Finally, another key indicator might include whether the physician is economically "at risk" in the arrangement. "No risk" arrangements where a manufacturer simply provides DME to a physician and gives the physician a cut of the profits when the physician uses a device would present a textbook example of an illegal kickback.

Despite the above, at least one recent regulatory opinion in California does indicate that it is possible for physicians to legally distribute DME to their patients. In 2006, the California Attorney General's office issued a written opinion which affirmatively answered the question of whether physicians may legally prescribe a medical device distributed by a company in which the physician has an ownership interest. In reaching this decision, the Attorney General's office considered factors such as the extent to which returns on the investment would be tied to referral patterns, and whether the physician would be financially "at risk" under the arrangement. Finding no evidence of a "payment for referral" structure, and finding that the physicians were financially "at risk," the conclusion was that it is possible to structure these arrangements under California law (see 89 Op. Atty General Cal. 25 (February 27, 2006)).

A contrary result was, however, reached by federal regulators in a March 2006 opinion analyzing a proposed DME arrangement under federal law. There, regulators found that, "The proposed program offers physician practices the potentially lucrative opportunity to expand into the DME and orthotics business with little or no business risk and to retain a share of the profits…". (see Office of Inspector General Opinion 06-02 (March 28, 2006)).

(Continued on Page 12)

Dispensing DME to Patients—Can it be Done?
(continued from Page 11)

So, What Does All of This Mean?
Based on the above-mentioned laws and opinions, we believe that it is possible to set up a physician-based DME arrangement in California which would likely withstand regulatory scrutiny under California law. The arrangement would need to preserve the physician's absolute ability to use other devices based on the needs of a particular patient, and great care would need to be taken to avoid the appearance of any potential for "kickbacks."

In terms of a suggested structure, we envision a definite benefit in setting up a separate entity within the confines of the practice. In our experience this entity typically takes the form of a Limited Liability Company (LLC). This will provide added liability protections and will make it easier to show that the physician owners of the entity are "financially at risk" under the arrangement.

Our sense, especially in light of language included in Stark III, is that it will be best to exclude Medicare and Medi-Cal patients from the DME arrangement. As is outlined above, doing so will take away the direct impact of the federal regulations such as Stark.

To conclude, while we believe it to be possible for physicians to distribute DME and make a profit doing so, it is apparent that the risk or regulatory scrutiny is most definitely present. Care must be taken when structuring any such arrangement, and the structure must preserve the fact that the patient's best interests are paramount over any financial benefits flowing from the arrangement.

About the Authors:

Attorneys Frank Gamma and Douglas Free are partners in the firm of Kessenick, Phillips & Gamma LLP (www.kpglegal.com), specializing in the representation of physicians and medical groups.

DWC DME Payment Changes

The Division of Workers' Compensation has posted adjustments to the durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) section of the Official Medical Fee Schedule (OMFS) to conform to changes in the Medicare payment system.

The fee schedule is required to be updated as Medicare makes changes. Such changes are as required by Labor Code Section 5307.1.

The revised DMEPOS is posted on DWC's website: http://www.dir.ca.gov/dwc/omfs9904.htm

Blue Shield/UnitedHealthcare Make 2008 Contract Changes

Blue Shield

Good News

We previously alerted you that Blue Shield had notified its members of some contract changes as of July 1, 2008. The Blue Shield notice indicated that they intend to increase reimbursement for Office Visits (CPT Codes 99211, 99212, 99213, and 99214). Injectable drug codes will remain under a tiered Average Sales Price (ASP) payment methodology. The letter goes on to say that while some procedures will be increased, "in some instances our allowances will decrease."

While it is good that Blue Shield has sent out this notice, COA is joining with the California Medical Association to express concern that this notice is wholefully inadequate to allow physicians to assess the true impact on their practice. The notice forces the physician to figure out for themselves how the fee schedule changes will impact their practice. CMA's Legal Counsel believes that this type of notice is not sufficient to comply with the plan's legal notification requirements.

As a result of the CMA discussions with Blue Shield, they have now agreed to post their new rates on their website as of June 12.

To access the rates:

1) Go to: www.blueshieldca.com/provider/announcements
2) Click "Blue Shield Allowances for Services (Codes) with new rates effective July 1, 2008"
3) Login or if already logged in, you will be directed to the "New Rates page.
4) Click on link to applicable region.

Please be aware that only the codes that will change are listed. If a code is not listed, it is not being changed.
Thanks to CMA for negotiating this change with Blue Shield.

UnitedHealthcare

CMA has asked the Department of Insurance to force UnitedHealthcare to comply with state law, which requires insurance companies to give contracted physicians 45 days notice of any material changes to their contracts. Currently, United makes significant contract changes— namely to its fee schedules—under the guise of "routine maintenance," without notifying physicians or giving them the opportunity to cancel their contracts. United's "progressive fee schedules" are developed using third-party data. CMA has learned that payments for some CPT codes were reduced by up to 9.5% as a result of United's most recent fee schedule revision.

Over 50% of physicians contracted with UnitedHealthcare in California are on these so-called progressive fee schedules. **We would urge you to review your reimbursements from UnitedHealthcare to determine whether your reimbursements have been reduced as a result of these changes.**

Next Generation ED On-Call Panels

Our healthcare system is currently faced with a rapidly growing crisis with specialty physician coverage for emergency department and trauma call panels. Specifically, more and more hospitals are having difficulty maintaining adequate specialty physician call coverage for "unassigned" patients presenting at emergency departments and trauma centers. Unassigned patients are defined as those not having a private physician or insurer that arranges for or contracts for specialty physician care. While the severity of the ED call crisis varies from hospital to hospital, the causes for it are both large in scope and complex in nature and can be summarized as follows:

- Increasing ED visits while overall ED and trauma center capacity is declining.
- Growing uninsured population that has the propensity of using ED for primary medical care.
- Increasing use of EDs by insured patients as their entryway to the healthcare system.
- Stagnant, declining or nonexistent reimbursement for call services.
- Shortage or maldistribution of specialists.
- Increasing malpractice liability premiums.
- Increasing liability risks.
- Increasing costs of providing emergency and trauma services.
- Complex and inconsistent regulatory requirements.
- Conflict over the ethics of call requirements.

As it has become more difficult to maintain an adequate ED call panel, many hospitals have moved to a mandatory call requirement as a condition of medical staff privileges and/or offered compensation in various forms to physicians for taking call.

The Emergency Medical Treatment and Active Labor Act (EMTALA), enacted in 1986 and updated in 2003, is responsible for much of the difficulty hospitals encounter when searching for an effective long-term solution to their ED call panels. EMTALA requires that all Medicare-participating hospitals with an emergency department provide a medical screening exam, stabilization and further care or transfer regardless of the patient's ability to pay. EMTALA also requires that a hospital maintain a call panel that is "reasonable" given its resources, location, etc., and that the physicians on the panel respond in a "timely" manner. The crux of the problem with EMTALA is that while it provides a necessary safety net for patients seeking emergency medical care, it does not provide a funding mechanism to provide this care nor does it impose a requirement for physicians to take ED call. Therefore, because the responsibility for complying with EMTALA rests solely with hospitals, they are at the full mercy of physicians' relative interest in taking call, and of those who do, their economic requirements for providing services.

Clearly, the combination of physicians' unwillingness to take ED call and having no legal responsibility under EMTALA for doing so has had an undermining effect on bylaws requirements and call compensation strategies used by hospitals because they focus on the same physicians that are increasingly unwilling to take call. It is not surprising, therefore, that hospitals are increasingly pursuing new strategies that focus on contracting with a dedicated and exclusive group of physicians for ED call coverage. This is called a "next generation" ED call staffing strategy. They guarantee 24/7 ED call coverage for one or more specialties. Hospitals that have sufficient ED volume can also structure them as an in-house specialty Hospitalist service where the contracted physicians provide full-time ED call coverage and all related patient care follow-up care.

It is important to note that it is usually not feasible, financially or politically, for hospitals to pursue exclusive ED call contracts for every physician specialty. Specialties with the highest ED call volume, such as OB, General Surgery and Orthopedics, are frequently the first programs considered.

Specifically in Orthopedics, in addition to the previously mentioned reasons that specialists are increasingly reluctant to provide ED call coverage, unlike any other specialty, unassigned patients often remain in an Orthopedic practice for months if not years. This is an additional burden on the private local Orthopedists, has negative financial implications, and entails increased ongoing liability risks.

Delphi Healthcare Partners is one example where an entity is trying to help resolve the on-call problem by designing Specialty ED On-Call Backup Coverage Solutions in Orthopedics, General Surgery and OB/GYN nationwide. The company also manages Anesthesia Departments and Intensivist Services.

Delphi is normally contacted by a representative of a hospital…either the CEO or Vice President of Medical Affairs. However, local private Orthopedists often make the first contact with Delphi, inquiring about its capabilities, resources and experience and then introduce Delphi to hospital administration.

Below are some of the most salient points regarding the Delphi Orthopedic Hospitalist Program:

- The existence of Delphi designed programs is because all or a significant number of local private Orthopedists no longer want to take ED Call…particularly for unassigned and indigent patient populations.
- Delphi-program Orthopedic Hospitalists do not have private practices so they are not in competition with or a threat to local private Orthopedists

(Continued on Page 15)

Advertisement

Next Generation ED On-Call Panel Strategies
(continued from Page 13)

.

- Delphi designed program's only source of patients is unassigned and indigent patients referred from the hospital's Emergency Department.
- If some local private Orthopedists want to continue to participate in the ED On-call coverage, they can be incorporated into the Delphi designed programs. These are called 'blended' or 'shared' programs where some of the coverage is provided by local private Orthopedists and Delphi arranges the rest of the coverage. While a local private orthopedist is working on-call for Delphi, they cannot perform elective surgeries, but can see patients in their office when not needed in the emergency room.
- Delphi pays the local orthopedists when working for them a flat fee even if they are not called in.
- Delphi designed programs free up the local private Orthopedists to do more of their own sub-specialty private pay cases, and for generalists, simply more cases therefore resulting in increased revenue for the practice.
- This new incremental revenue for the local private Orthopedists obviously also has a positive financial benefit to the hospital which helps offset the cost of a Delphi designed program. It is because of this financial benefit to the hospital due to additional facility fees guaranteed by the new incremental surgical cases by the private local Orthopedists that enable the hospital to afford the program.
- Delphi designed programs often provide or evolve into essentially a fracture service. Many hand, spine, sports medicine or joint replacement specialists are no longer comfortable with fracture care and trauma services.
- Delphi has the flexibility to design a coverage system tailor-made to each unique and special situation.

Delphi's indicates that their goal, in the design of Orthopedic Hospitalist programs, is to provide a win-win-win for the hospital, for the local orthopedists, and for the physicians providing the on-call services.

This information is provided to COA members for your information as another option that is developing to help orthopaedic surgeons resolve their on-call issues in their communities.

If you want more information on the Delphi program, contact them at:

Delphi Healthcare Partners
Robert Shipman
Phone: 919-655-1305
E-Mail: rshipman@delphihp.com

Changes to California Law Regarding Supervision of Physician Assistants

Excerpted from—Medical Board of California Newsletter, 4/08

AB 3 (Bass), became effective on January 1, 2008 and changed laws related to the practice of physician assistants in CA.

Listed below are descriptions of several significant changes:

1. **Ratio of physician assistants to supervising physicians**
   Previously, a supervising physician was allowed to supervise no more than two physician assistants at any given time. Effective January 1, 2008, a supervising physician may supervise no more than four physician assistants at any one time, which was previously the ratio for underserved areas in California.
2. **Chart countersignature**
   Previously existing regulation allowed that if the supervising physician and the physician assistant adopted protocols, the supervising physician would review and sign a minimum of 10% of the patient charts. Effective January 1, 2008, the 10% minimum requirement was decreased to 5%.
3. **Patient-specific authority**
   Previously existing regulation required physician assistants to obtain patient-specific authority prior to writing a drug order from Controlled Substances Schedules II-V. AB 3 deleted the requirement that a PA obtain patient-specific authority prior to writing a drug order for a controlled substance Schedules II-V if a PA completes an approved educational course in controlled substances and if delegated by the supervising physician.

The Physician Assistant Committee is in the process of adopting regulations to implement provisions of AB 3.

Welcome to COA's Newest Members

Firooz B. Amjadi, M.D.	Bakersfield
Eric Bava, M.D.	Los Angeles
V. Randy Bernabe, M.D.	Hanford
Joseph P. Burns, M.D.	Van Nuys
Jack Chen, M.D.	Orange
Marc Chodos, M.D.	La Mesa
Bradley Crow, M.D.	La Jolla
Ramy N. Elias, M.D.	Lakewood
Seth Gamradt, M.D.	Los Angeles
Patrick Guerroro, M.D.	Turlock
David S. Kim, M.D.	Tustin
Mark Kraus, M.D.	San Jose
Gregory W. Masters, M.D.	Santa Clara
Reuven Minkowitz, M.D.	Valley Village
Jaqueline Munch, M.D.	San Francisco
Rajan Patel, M.D.	Beverly Hills
Ravi Patel, M.D.	Sacramento
William L. Shoemaker, M.D.	San Diego
David F. Sitler, M.D.	San Diego
John Skubic, M.D.	Redlands

Winners at the COA Annual Meeting

Top exhibit hall prize winners were:

◆ Peter Hanson	Complimentary Registration/Hotel 2009 Annual Meeting
◆ John Donahue	Mac Book Air Computer and a $100 Gift Certificate
◆ John Lane	52" LG Plasma TV and Bose Headphones
◆ Thor Gjerdrum	Suite Update-2009 Annual Mtg.
◆ John Kayvanfar	$200 Gift Certificate—Ruth Chris Steakhouse & $100 Ameri can Express Gift Certificate
◆ David Chang	$120 Gift Certificate at the Fess Parker Resort
◆ Van Polglase	$120 Gift Certificate at the Fess Parker Resort
◆ Emmett Cox	Bose Headphones
Frederick Young	Bose Headphones

Over 30 other prizes were also won by other attendees.

A Special Thank you to the Exhibitors who supported the COA Annual Meeting/ QME Course.

California Orthopaedic Association
5380 Elvas Ave., #221
Sacramento, CA 95819
Address Service Requested

Presort Standard
U.S. Postage
Paid
Permit #2310
Sacramento, CA

MOVING?

Please notify COA promptly if you are moving.

Name: _____

New
Address: _____

City/ST/Zip

_____

Phone: _____

Fax: _____

E-Mail:_____

Mail to: COA, 5380 Elvas Avenue #221
Sacramento, CA 95819
Fax: 916-454-9882

TO: