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COA Report

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Issues Affecting Orthopaedic Practice

Dale Butler, M.D., (left) presents the gavel to newly elected COA President, Richard Santore, M.D. (right)

We are actively underway with plans for COA's 2006 Annual Meeting/ QME Course at La Costa Resort in Carlsbad (North San Diego County). **Save the dates of April 20-23, 2006 on your long range calendars.** Dr. Kevin Bosic, of the UCSF Department of Orthopaedic Surgery, will serve as our Program Chair. Dr. Bosic, a Harvard MBA, played a critical role in the formulation and presentation of data to CMS in February of this year which resulted in the decision by CMS to increase payments to hospitals by 23% (Part A funds) for revision total joint. I attended that meeting with Kevin and other AAOS leaders and a picture of our group at CMS headquarters was just published in the last AAOS newsletter. This infusion of revenue will help all of the hospitals in California that provide revision total joint services and prevent even further barriers to access to care from evolving.

We continue to monitor any overt and covert attempts to weaken MICRA. So far, no new legislation has emerged on the state level. In Washington, an impasse remains in the U.S. Senate. There are not 60 votes in the Senate to break a filibuster on a federal professional liability bill, although legislation has once again passed in the U.S. House of Representatives.

We also continue to monitor the efforts by radiologists to limit, by regulatory and legislative means, orthopaedic surgeons from ownership of MRI and CT scanners, even within their own offices. At the federal level, word of mouth is that the radiologists did not get a warm reception on Capitol Hill earlier this year.

(Continued on Page 2)

For Your Advance Planning …

COA's 2006 Annual Meeting/QME Course
April 20-23, 2006
La Costa Resort and Spa
Carlsbad, CA (North San Diego County)

Registration materials will be mailed in January, 2006.

President's Column (continued from Page 1)

The work comp scene is in great turmoil as the impact of Medical Provider Networks (MPNs) and denials under the utilization review program continues to be felt. DWC is in the process of finalizing clarifying regulations on the utilization review process, but they likely won't be too helpful as the DWC Administrative Director, Andrea Hoch, has steadfastly refused to require that these reviewers be licensed in California. COA, as well as many other health care organizations including the Medical Board of California, have urged her to use the existing definition of "physician" under California Workers' Compensation system to define who could act as a reviewer. This would have required California licensure. The Medical Board contended, and COA supported, that these UR decisions are the practice of medicine. These out-of-state reviewers are essentially allowed to made these medical decisions without any state regulatory oversight. Ms. Hoch disagreed and the regulations do just the opposite—clarify that out-of-state physicians may participate. It seems it will take a legislative change for medicine to prevail. More Workers' Compensation information can be found on Page 4 of this newsletter.

On a positive note, attempts by insurers to pay specialists without contracts at contracted-physician rates for emergency services was ruled illegal.

These issues just further illustrate the need for strong Orthopaedic political action committees (PACs) on the state level through COA and on a federal level through the AAOS. We need to re-invigorate our grassroots capabilities of the COA, along with efforts on the federal level by the AAOS Board of Councilors led here in California by our own Pete Mandell, to identify orthopaedic surgeons who are acquainted with, or would like to get to know, state and federal legislators.

If you would like to be involved, call the COA office (916) 454-9884 and let us know.

Richard Santore, M.D.
President

People in the News

Peter Mandell, M.D. of Burlingame, has been appointed Chair of the AAOS Committee on Professionalism. This Committee is charged with implementing principles of the Professional Compliance Program adopted by Academy Fellows earlier this spring. One duty of the Committee will be to receive and review complaints of inappropriate medical expert witness testimony by orthopaedic surgeons.

Lawrence Dorr, M.D. of Inglewood, received the AAOS 6th Annual Humanitarian Award at the 2005 AAOS Annual Meeting in Washington, D.C. Dr. Dorr was honored for founding the not-for-profit volunteer organization, "Operation Walk" which has brought mobility and relief from pain to people suffering from arthritis worldwide.

Orthopaedic surgeons, **Clayton Patchett, M.D.** of Pasadena, has been elected President of the Los Angeles County Medical Association and **Ralph DiLibero, M.D.** of Palos Verdes Estates, has been elected President-Elect of LACMA.

Steven D. K. Ross, M.D. of Orange, has been elected Vice President of the American Orthopaedic Foot and Ankle Society at the Society's summer meeting in Boston.

Placement Announcements

Orthopaedic Surgeons Needed—Woodland Healthcare
The Woodland Healthcare is a 75-provider multi-specialty group in Woodland, CA which is affiliated with Catholic Healthcare West. They are seeking two orthopaedic surgeons to join their group. Contact: Megan Landgraf, Medical Group Recruiter at 530-662-3961 Ext. 4620 for additional information.

Orthopaedic Surgery Practice for Sale
Offices located in Los Angeles, Lynwood, and Van Nuys.
For more information contact: Deborah Garza, Administrator at: Deborahg@soscenters.com or call 323-655-1604 Ext. 164.

Medical Office Space for Lease
Upscale office space available in prime location of San Fernando Valley. Beautifully appointed office with x-ray, exam rooms and consultation suites. Close promixity to local hospitals and ancillary services. Contact Marlene Casillas at: marlene@scmso.com

COA 2005 Annual Meeting/QME Course

New COA Officers Elected
Founders' Award Awarded
42" Plasma TV Given Away in Exhibit Hall

COA's 2005 Annual Meeting/QME Course and Course on the Use of the AMA Guides were held May 12-15, 2005 at the Renaissance Esmeralda Resort and Spa, Indian Wells. David Hak, M.D. was the Program Chair. The following symposiums were held at the meeting: Optomizing Outcomes of Hip Fractures, Managing Osteoporotic Fractures—New Techniques and Strategies, Total Joint Arthroplasty—Current Controversies, Evaluations Utilizing the AMA Guides 5th Edition, along with the annual Workers' Compensation QME Course. Nearly 450 orthopaedic surgeons and their staff attended the meeting along with 81 technical exhibitors.

New COA Officers elected at the meeting include:

President	Richard F. Santore, M.D., San Diego
First Vice President	Larry Herron, M.D., San Luis Obispo
2nd Vice President	James Caillouette, M.D., Orange
Secretary/Treasurer	Mark Wellisch, M.D., Encino

Founders' Award

John V. Hill, M.D., of Ventura received COA's highest award, "The Founders' Award", in recognition of his outstanding contribution to the furtherance of quality orthopaedic care in California, particularly in the area of hospital medical staff issues.

John Kayvanfar, M.D. of Palmdale was the Grand Prize winner of the 42" Plasma Television in the Exhibit Hall.

Raymond Berg, M.D. (right) presents Founders' Award to John Hill, M.D. (left).

John Kayvanfar, M.D. pictured on right with his brother, James Kayvanfar, M.D. (left) also a winner of an iPod in the Exhibit Hall.

Resident Paper Award Winners

OREF Resident Award - Gareth Hammond, M.C., UC Irvine
Lloyd Taylor, M.D. Resident Award - Kenneth Wilkens, M.C., UC Irvine
Depuy Resident Award - James Ryan, M.C., UC Davis
Orthopaedic Hospital Resident Award - Seth Gamradt, M.D., UCLA

Each resident and their orthopaedic program received a cash award of $500 and the resident's travel expenses were paid by COA to attend the meeting to present their papers.

IMPORTANT — WORKERS' COMPENSATION NEWS

Workers' Compensation Contracting Disputes

COA continues to receive complaints that some Workers' Compensation Medical Provider Networks are inappropriately reducing your reimbursement for treating injured workers. Some examples of these abuses include:

HealthNet Direct Network Contracting— attempting to reduce reimbursement to 80% of Medicare rates when the physician has a contract to be paid at 100% of OMFS rates.

Blue Cross - applying their PPO rates for treating injured workers even though the physician may have a direct contract with the Workers' Compensation carrier/self-insured employer to be paid at 100% of OMFS rates.

Other third party entities—applying inappropriate discounts.

We would urge you to review your claims carefully to ensure that you are correctly paid for your services. If you find problems and after notifying the carrier/self-insured employer of the problem and the inappropriate discounts continue, send examples of these problems to Andrea Hoch, AD, Division of Worker's Compensation, 1515 Clay Street, 17th Floor, Oakland, CA 94612 with a copy to COA. **Ms. Hoch, who has responsibility for setting Workers' Compensation reimbursement rates, is under the mistaken impression that physicians are willingly accepting these discounts.**

Which Permanent Disability Rating Schedule Should Be Used?

COA has received numerous complaints that plaintiff's attorneys and some Workers' Compensation carriers/self-insured employers are requesting that disability evaluators evaluate the injured worker under the old system, 1997 Permanent Disability Rating Schedule, and the new system, the AMA Guides 5th Edition. This is time-consuming for the evaluator and calls into question how to bill for both evaluations. The DWC has posted some frequently asked questions and answers to help evaluators determine when the evaluation should be done under the old system or the new system utilizing the AMA Guides. Their frequently asked questions/answers can be found at: http://www.dir.ca.gov/dwc/faq/deu_faq.html
COA is urging the AMA to make the reporting forms contained in the AMA Guides available in an electronic format for more ease of use. They have agreed and are in the process of producing the electronic forms. We will notify you when they become available.

Official Medical Fee Schedule—Physician Services is Updated

The DWC has finalized changes to the OMFS for physicians services that went into effect May 14, 2005. The changes make minor adjustments to Table A which contains the actual fee schedule, correcting errors made when the fee schedule was adjusted in 2004. One change has been to restore the 5% reduction for physical medicine services to ensure that reimbursement does not fall below Medicare rates.
The OMFS Table A can be found at: http://www.dir.ca.gov/dwc/dwcpropregs/OMFSEmerRegs2TableA.htm
The Ground Rules which contain many coding and billing clarifications are also on-line at:
http://www.dir.ca.gov/dwc/dwcpropregs/OMFSGenInfo_Instructions_Final.pdf
This update is <u>not</u> the update expected as of 1/1/2006. The fee schedule is still being threatened by a conversion to an RBRVS-based system. As specific information on the proposal becomes available, we will notify you.

The AMA Guides Newsletter

Many questions have arisen regarding disability evaluations utilizing the AMA Guides 5th Edition. The AMA has published clarifying articles in their AMA Guides Newsletter on the following issues:

May/June, 2005	Quick Reference: Measuring Impairments of the Hand and Digits
May/June, 2005	Quick Reference: Rating Upper Extremity Sensory and Motor Deficits
May/June, 2005	Rating Total Ankle Replacement
November/December, 1996	Carpal Tunnel Syndrome: Challenges in Impairment Rating

For copies of these articles, fax a request to the COA office—916-454-9882.

ACOEM APG Insights

ACOEM is also publishing a newsletter to expand on topics contained in their Practice Guidelines. The Spring, 2005 edition of the newsletter contains articles on:

Manipulation under Anesthesia
Percutaneous Diskectomy—Medical Literature Analysis and Recommendations

For copies of these articles, fax a request to the COA office—916-454-9882.

State Legislative News

Radiology—In-Office Diagnostic Testing

There have been four separate bills introduced this year in California's State Legislature which could have had a negative impact on an orthopaedic surgeon's ability to have in-office MRI and CT Scans:

AB 516 (Yee)
SB 700 (Aanestad)
AB 929 (Oropeza)
AB 1572 (Dymally)

Due to COA's lobbying efforts, the bills have either been amended to no longer cause concern or have stalled and become two-year bills. The two-year bills can not be considered until 2006. COA expects radiologists to continue these attempts on both the state and federal levels.

In addition, COA has received reports that some radiologists claim that Medicare has changed their billing rules and now requires that when a physician contracts with a teleradiologist for the reading of an MRI, the radiologist is required to bill Medicare directly for the professional service. This would disrupt many arrangements that orthopaedic surgeons have with the radiologist to bill the entire service and pay the radiologist a set fee for reading the film. **This information is incorrect.** COA has obtained a memo from National Heritage Insurance, the Medicare fiscal intermediary here in California, indicating that Medicare has not changed their rules. Orthopaedic surgeons may still contract with a radiologist for teleradiology services, pay the radiologist a set fee, and bill for the professional and technical services.

Continuing Medical Education on Cultural and Linguistic Issues

AB 1195 (Coto) is pending in the Senate and would require all Category I CME courses, except those not addressing direct patient care, to include information on cultural and linguistic issues. In its original form, the bill required physicians to obtain 16 CME hours in cultural and linguistic issues over a four year period of time. This bill addresses national efforts to increase physician's education in how to discuss medical issues with different ethnic patients. A law recently passed in New Jersey requires CME in this area as a condition of licensure and re-licensure.

CMA has proposed several amendments to the bill and in its present form, the bill requires that all California-based CME providers include cultural and linguistic issues in all CME courses dealing with direct patient care. The bill is not prescriptive as to how that requirement must be met.

COA representatives met with Assembly Member Coto to urge him to accept the CMA amendments. One way that COA can meet this requirement in our CME courses is to make available to our members a CD course developed by the AAOS Diversity Committee, chaired by Ramon Jimenez, M.D., discussing these issues. The CD is free to orthopaedic surgeons. We also suggested that any additional mandated CME be reviewed by an outside entity to determine its need prior to the Legislature taking action on the legislation.

AB 1195 is on a one-year track and is expected to be acted on this year.

Medicare News

Apply for your National Provider Identifier (NPI)

Starting May 23, 2005, all health care providers can start applying for their National Provider Identified (NPI). The NPI will replace the existing Unique Provider Identification Number (UPIN) over the next two years, with most health plans being required to use them by May 23, 2007. NPI will be issued by the Centers for Medicare and Medicaid Services (CMS) and will be a 10-digit number unique to every provider. It is expected that the number will stay with the physician regardless of practice location. For additional information and to complete an application for the NPI, go to: https://nppes.cms.hhs.gov and follow the prompts.

Special Notice—2006 Participation Enrollment and Fee Schedule

In November of 2005, National Heritage Insurance Company will once again be sending California providers the 2006 Participation Enrollment and Fee Schedule information on CDs instead of the usual paper format. *No internet access is required to access the information.*

Providers who have billed Medicare in the past year, will automatically be mailed a CD. If after receiving the CD, they find that they cannot access the data properly, a paper copy of the fee schedule can be requested. Information on ordering a paper copy will be published in the *Medicare B Resource Preview* in September.

Bar-Coded Cover Sheets

When medical record request letters go to providers, the request includes a bar-coded cover sheet. Providers are supposed to use the cover sheet as the first page of the faxed records. The bar code on the sheet provides identifying information to the CERT Documentation Contractor. The CERT Documentation Contractor scanners cannot read cover sheets if their print quality, especially the print quality of the bar code, is poor. To help the scanning process run efficiently, please make sure the bar code cover sheet is clean and distinct.

Changes to ASC List

Medicare has released a new list of procedures that may be done in an ambulatory surgery center (ASC) as of July 5, 2005. The list contains 65 additions and 5 deletions. A complete list of the changes can be found at the American College of Surgeons' website: www.facs.org
No changes have been made to the facility payment amounts.

New Options for Physicians Who Administer Drugs in Their Offices

Physicians who administer drugs in their offices to Medicare beneficiaries will have the option of participating in a new pilot project called competitive acquisition program (CAP) beginning January 1, 2006. Physicians will be able to obtain physician-administered drugs from vendors selected by Medicare through competitive contracting. The physician will no longer have to purchase the drugs. The vendor will bill Medicare for the drugs and bill the patients for any coinsurance or deductibles. The new program will only apply to physician-injectable drugs covered that are provided incident to the physician's service. It will not apply to drugs included in the new Prescription Drug Benefit under Medicare Part D, nor will it apply to drugs that are self-administered by the patient. Of approximately 440 drugs that are billed incident to a physician service, 181 will be included in the CAP. Physicians who do not wish to participate in the competitive acquisition program can continue to purchase drugs directly from drug suppliers as they do now and be paid directly by Medicare at the statutorily set rate of 106% of the manufacturers' average sale price.

Physicians will be given an opportunity once a year to elect to participate in the program and to choose a vendor to be the physician's primary source for the Part B drugs included in the CAP.

Medicare News

CMS Changes ICD-9 Codes for Revision TJA

The Centers for Medicare and Medicaid Services (CMS) announced a major change in its coding and reimbursement for revision total hip and total knee arthroplasties. This was accomplished by many years of work by the AAOS and the American Association of Hip and Knee Surgeons (AAHKS) Health Policy Committees. In addition, the Hip Society helped advocate for these changes. COA members who participated in this effort included: COA President, Richard Santore, M.D., Kevin Bozic, M.D. of UCSF, and William Maloney, M.D., Stanford.

The Health Policy Committees conducted a series of studies to demonstrate significant differences in operative time, length of stay, complication rates, and overall resource utilization between primary and different types of revision TJA procedures. They convinced CMS to adopt unique ICD-9-CM diagnosis and procedure codes for these revisions which will become effective in October, 2005. These more precise ICD-9-CM codes will result in additional reimbursement for acute care hospitals. For a list of the revised ICD-9-CM Diagnosis and Procedure Codes, fax a request to the COA office—916-454-9882.

Correct Coding Rules of Interest to Orthopaedic Surgeons

Knee Procedures
Anterior cruciate ligament (ACL) -
Reconstructions, Chondroplasties, Miniscectomies, and Meniscal Repairs.
The April, 2005 *AAOS Bulletin* included information on billing ACLs.

Five New Knee Codes
The *AAOS Bulletin* June, 2005 edition contained a description of the five new knee codes - Meniscal transplant, Arthroscopic mosaicplasty (knee), ACI and open osteochondral allografts, and MIS joint replacement. The article describes the procedure and their intended purpose.

To request a copy of either or both articles, fax a request to the COA office—916-454-9882.

Trigger Point Injection
For CPT codes 20552, injections(s) single or multiple trigger point(s), one or two muscles and
20553, single or multiple trigger point(s), three or more muscle(s);
You can no longer code for the number of injections given, but by the number of distinct muscles injected. Physicians need to remember to document the distinct muscle(s) injected, rather than just the number of injections given. CPT descriptors for 20552-20553 clearly show that **you're to use each of these codes a single time.** If imaging guidance is performed, you may also report CPT codes 76003, 76393, or 76942. Coding Corner, by Joetta Cox, SCCMA, May, 2005.

Active Wound Care
The AMA CPT Assistant, June, 2005 included an article on correctly billing for active wound care. With the assistance and recommendations of the CPT Wound Care Workgroup, in conjunction with the AMA CPT Editorial Panel, the active wound care management codes have been clarified to reflect current clinical practice. To request a copy of the article, fax a request to the COA office—916-454-9882.

CPT/RVU Coding Guide for Orthopaedic Surgery
To help you stay current with ever-changing coding requirements, the AAOS has created a new coding resource: *The CPT/RVU Coding Guide for Orthopaedic Surgery*. This guide will help you convert CPT codes to Medicare RVU facility and nonfacility equivalents and answers more than 1,500 musculoskeletal, radiology, and integumentary coding questions. It also includes a section on evaluation and management coding complete with examples. The cost for AAOS members and residents is $75. To order go online to www.aaos.org/products or call the AAOS at 800-626-6726.

PICTURE THIS: OPTIONS FOR MAKING IMAGING SERVICES PART OF YOUR PRACTICE

By: Frank Gamma, JD, MPH and Douglas Free, Esq.

More and more orthopedic surgeons in California and nationwide are adding imaging services (defined as MRI or CT scanners for purposes of this article) to their practices. Careful advanced planning is key to successfully integrating imaging services into any medical practice, be it that of a sole practitioner or a large group. In addition to primary considerations such as whether sufficient patient demand for the services exists, the manner in which the physician's investment is structured is likely to have great impact upon the ultimate profitability of the venture and the likelihood (or lack thereof) of regulatory problems.

This article contains an overview of a number of different structural options available to orthopedic surgeons wishing to add imaging services to their practices. In addition, relevant portions of state and federal laws applicable to physician ownership of imaging equipment are briefly described within the context of the different structural options. The purpose of this article is to provide information sufficient for physicians and medical groups to determine if it makes sense for them to pursue the development of imaging services within their practices. Readers should consult with their own legal counsel as part of the planning process.

We understand that there is currently tension that exists between orthopedists and radiologists related to office based scans. As referenced below, we believe it is best for orthopedic practices to collaborate with a radiologist or radiology group in developing imaging capacity as part of the orthopedic practice. Doing so reduces the professional liability risk orthopedists assume if they are the sole reader of the imaging results. We believe that the best approach is a collaborative approach between the specialties.

With that introduction, what follows is a discussion of the options available for the development of office based scans.

Option 1: The Fully-Integrated Medical Group

Ordinarily, physicians are legally precluded from referring patients to certain types of facilities or equipment in which the physician has a financial interest. Under the federal regulations known as Stark II, these prohibitions specifically apply to physician ownership of imaging equipment. Similar prohibitions are also found under California law and the laws of many other states. However, despite these prohibitions, just as an orthopedic surgeon owns or leases plain view x-ray equipment as part of his or her practice, there are no specific legal barriers which prevent an orthopedic practitioner or medical group from owning and using imaging equipment as part of a fully integrated practice.

The laws referenced above are subject to a number of statutory exceptions, including several very important exceptions that convey certain rights to solo practitioners or fully integrated groups. The two exceptions under Stark II which are most applicable and beneficial to the practices of a sole practitioner or a fully integrated medical group are 1) the "In Office Ancillary Services Exception," and 2) the "Centralized Facility Exception."

The "In Office Ancillary Services Exception" allows physicians (or medical groups) to own and operate imaging equipment located in the same building that the physician routinely treats patients and provides substantial services unrelated to imaging services. Put another way, the "office" cannot be a location that is primarily established to provide imaging services. Rather it must truly be a bona fide office with regular hours during which a solo physician or the members of an integrated medical group see patients. If these requirements are met, the physician or medical group is able to legally refer patients to the physician or medical group's own imaging equipment and bill for both the professional and technical components of the imaging procedures. Orthopedists seeking to bill both the professional and technical aspects of these procedures often enter into independent contractor agreements with a radiologist, or group of radiologists, who read the scans, often from a remote location, and typically for a flat fee. In addition, a radiologist or radiology group can provide the necessary medical direction for such imaging operations.

Under the concept of a "Centralized Facility," an individual physician or fully integrated medical group is able to own and utilize imaging equipment located in a separate building. To qualify for this exception, a "medical group" must truly be a group, meaning, among other things, that all members of the medical group must bill under one tax ID number, and while independent contractors working within the group can still qualify under this exception, a substantial portion (75%) of each "group" member's professional services must be derived from the group's practice. This latter criterion can be met by averaging all the affiliated physicians' services.

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Picture This: Options for Making Imaging Services Part of Your Practice (continued from Page 8)

The "Centralized Facility" concept can be very useful to an orthopedic group wishing to establish an Imaging Center that may possibly be combined with other ancillary services such as physical therapy. The medical group may not have the space to accomplish this goal within the building that their office is located, in which case it becomes necessary to locate the facility in a separate space. Provided certain supervisory requirements are met, this is perfectly permissible.
In addition, although the "Centralized Facility" can only be owned by one solo physician or a single fully integrated group, the law allows other physicians to refer patients to the facility for imaging services, provided only the owner of the facility bills for the scan and provided the referring physician is not compensated in any way. Outside referrals of this nature often result in a significant source of ancillary income for a medical group that decides to open an imaging facility.

Option 2: The "Partnership of Professional Corporations"
Perhaps a solo physician or a small group determines that it cannot individually bear the costs associated with establishing an imaging center. The concept of forming what is known as a "Partnership of Professional Corporations" can provide a means of sharing the financial costs and benefits of establishing ancillary services such as imaging services, while also opening up the door for other significant cost saving economies of scale with respect to office space and staff related expenses.

This concept typically works best among physicians who have known one another for some time, are comfortable with each other's medical quality, and who offer services that complement each other's area of practice. Under the "Partnership of Professional Corporations" model, solo practitioners and/or group practices integrate and form a single merged group. Within the framework of ancillary services such as imaging services, this also allows the integrated group to avail itself of either the In Office Ancillary Services Exception (based on offering imaging services within the same building that the "group" has its practice), or the Centralized Facility option, meaning that a separate offsite location is permissible for the imaging services since the fully integrated group will bill under one tax ID number and otherwise practice as a single legal entity. This is a complex structure, but the result is a fully integrated medical group for antitrust and anti-referral purposes which allows the partner professional corporations to retain a high degree of day-to-day autonomy.

Option 3: Non-Integrated Groups Practicing in the Same Building
This option is based again on the "In Office Ancillary Services Exception," but under this variation, it is not necessary that the physicians or groups jointly owning the imaging equipment be integrated in any way. Rather this option allows solo practitioners or separate groups to jointly own and operate imaging equipment as long as each of the physicians maintains their practice, or a part of their practice, in the same building that the imaging equipment will be located. There are specific criteria which define the necessary practice activity in a building to qualify for the exception under Stark. State law is less clear in that it does not have an in-office ancillary services exception; but, we believe this arrangement meets other State law exceptions.

Under this model, a separate entity (typically a limited liability company) is formed as the entity that will own and operate the imaging equipment, and each physician or group maintaining an ownership interest in the equipment purchases units of ownership in the company and in that manner derives income from the technical component generated by the equipment. Each physician having an ownership interest in the imaging equipment also separately bills the professional component of the scans, although as mentioned above, it is common for non radiologist owners of the equipment (such as orthopedic surgeons) to separately contract with a radiologist to read the scans on a flat fee basis.

This option of a non-integrated "group," while in our opinion is less beneficial than the fully-integrated "Partnership of Professional Corporations" described above (in terms of the economies of scale that the Partnership of Professional Corporations can generate), it is nonetheless a viable option which is perhaps more likely to be workable for the typical solo orthopedic surgeon or small group practice which is located within a building that is also occupied by other physicians who have a need for imaging services in their practices.

Given that there is no single "group" under this option, the "Centralized Facility Exception" is not available, and it is crucial that the imaging equipment be located within the same building (defined as the same address according to U.S. Postal regulations) as the medical offices in which each owner of the imaging center provides substantial medical services to patients unrelated to imaging-related services. When structured properly this model can prove to be an excellent way for separate solo practitioners and groups to share the costs and benefits associated with owning imaging equipment.

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Picture This: Options for Making Imaging Services Part of Your Practice

(continued from Page 9)

There are a number of other ways in which physicians in the same building can work together, particularly through a Management Services Organization ("MSO"). California Medical Association members may access the CMA's "Information-On-Demand Service" at www.cma.net - document number 0200 for an article about the development of an MSO.

Option 4: Leasing Equipment and Personal Services

Yet another option available to orthopedic surgeons involves the concept of leasing both the imaging equipment and the staff needed to operate it. Under this model, physicians do not actually own the equipment or the imaging center. Nonetheless, by entering into leases that meet certain requirements set forth under both state and federal regulations (including requirements such as the need for the lease to be based on fair market value, with a lease term of at least one year, and not structured in a manner which compensates for or induces patient referrals), physicians utilizing this structure can use the imaging equipment as an extension of their own practices and thereby bill both the professional and facility components of the scans.

A number of companies, including some that have been formed by radiology groups, help physicians by providing "turnkey" imaging facilities based on this model. The facilities do not need to be within the physician's office to qualify under the Lease and Personal Services Exceptions, and the lease charges can typically be set up as either flat rate, or, in some cases, according to a per-scan methodology. As with the non-integrated group model described above, leasing arrangements can prove to be very helpful in allowing physicians to gain the benefits of owning imaging equipment without having to incur the expenses associated with developing a full-blown imaging center.

Conclusion

As described above, there are a number of ways that orthopedic surgeons can make imaging services part of their practices. This article has been intended to provide only an overview of some of these methods and a brief summary of certain aspects of the laws that govern physician ownership of equipment such as imaging equipment. Any physician interested in establishing their own imaging center or otherwise acquiring an interest in one should carefully consider each aspect of applicable state and federal regulations and choose the structure that will work best for their practice.

The authors would be happy to speak with COA members at no charge for 30 minutes and provide a preliminary legal analysis and proposal to represent the physician or medical group. Please contact Denice Player, at 415-995-5116, to set up an initial telephone consultation.

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Joseph Carney, M.D.	San Diego
Gary Chen, M.D.	Cerritos
David Duffner, M.D.	Palm Springs
Michael Fitzpatrick, M.D.	Laguna Beach
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