COA Report

A publication of the California Orthopaedic Association

Fall, 2012

PRESIDENT MESSAGE

Kevin J. Bozic, M.D., MBA, President

The 2012 Presidential election is over, and the fate of the Patient Protection and Affordable Care Act (PPACA) has been solidified. Over the next four years, health care providers, payors, and policymakers will be working hard to implement key aspects of PPACA. The California Orthopaedic Association (COA) will face many challenges and opportunities in helping our members prepare for the numerous changes that lie ahead.

COA is already hard at work preparing for the future. Our recent addition of Cal Ortho Online summarizes the principles of bundled payments, and provides a checklist of issues for orthopaedic surgeons to consider before entering into bundled payment contracts. We are also creating a new Committee to explore issues of interest to employed physicians, in response to the growing number of COA members who are employed by health systems, hospital foundations, and multi-specialty groups. We are also exploring strategies for members to incorporate collections of Patient Reported Outcomes (PROs) into their electronic health records, anticipating that this will be a requirement for both commercial and government payors in the future. Finally, we continue to support the California Joint Replacement Registry, which is growing in size and impact.

The 2013 COA Annual Meeting, to be held April 18—21, 2013 at the beautiful Terranea Resort in Rancho Palos Verdes, will offer members many opportunities to educate themselves on the provisions of PPACA and to begin to prepare themselves for health reform.

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For Your Advance Planning . . .

COA's 2013 Annual Meeting/QME Course

C-Bones 2013 Annual Meeting

April 18—21, 2013

TERRANEA®

L.A.'S OCEANFRONT RESORT

President's Column (continued from Page 1)

With a theme of "Preparing for Value-Based Health Care," the meeting features national and regional experts as part of a full-day program on many topics related to health care reform.

We will hear from **Peter Lee, Executive Director of the California Health Exchange ,** who will explain how health exchanges will affect the provision of healthcare services in California. We will learn about trends in value-based reimbursement, registries, and patient-centered medical homes.

Finally, **Mark Smith, President of the California Health Care Foundation,** will deliver a keynote address, challenging us to become actively engaged in the changes that will shape the future of healthcare delivery and payment in California.

Interactive Q&A sessions are planned, enhancing communication on the issues that are of most interest and concern to you. **Facilitated, small-group mentoring sessions allow direct interaction with faculty**, focusing on specific challenges facing solo/small group surgeons, practice productivity, employed physicians, and Worker's Compensation practices.

Diverse clinical topics will also be covered, but with an emphasis on evidence-based medicine as it applies to daily practice. Nationally recognized moderators and speakers will focus on topics that offer practicing surgeons information to optimize diagnosis and treatment of disorders in Trauma, Sports Medicine, Total Joint Arthroplasty, Foot & Ankle, and Hand. In addition to CME hours, by opting to take the pre- and post-meeting test, participants can **earn up to 10 hours of Maintenance of Certification (MOC) "Self-Assessment Exam" credit, designed to meet the American Board of Orthopaedic Surgeons (ABOS) requirement for MOC/MOL.**

The QME Program has been consolidated on Thursday to provide 6 hours of QME CME with topics including PRP and CRPS. Experts will explore implications of the 2012 Work Comp legislation for QMEs/AMEs.

All of this will take place at the beautiful oceanfront Terranea Resort in Rancho Palos Verdes, less than 30 minutes from the LAX airport. In addition to the intrinsic natural beauty, on-site and nearby golf courses, the resort offers fine dining, a spa, family activities, and easy access to Los Angeles attractions. We hope you will be able to join us for what promises to be another spectacular COA Annual Meeting.

I look forward to hearing your thoughts about how COA can continue to work on your behalf to prepare orthopaedic surgeons and their patients for the many opportunities and challenges that lie ahead.

Kevin J. Bozic, MD, MBA
San Francisco, CA

New Ways to Show Value: A Nation in Motion: Surgeon Stories and Ortho-pinions

Thanks to your on-going support and inspiring patient stories, the AAOS "*A Nation in Motion* campaign continues to be a tremendous success and to date, has almost 600 patient success stories live on anationinmotion.org. But, as we continue to tell the stories of our patients, and their successes, it is now time to tell your own stories, to illustrate the caring, compassionate, dedicated and interesting people who are behind those scrubs.

Here are three opportunities to **market your practice** and help show **the value** that your orthopaedic surgeons bring to our specialty:

Share Orthopaedic Surgeon Stories
Promote your orthopaedic practice and share your story. Help us to create a vivid portrait of orthopaedics and include **your practice information**. Submit answers to questions like *Why did you become an orthopaedic surgeon? What do you do in your free time?* Share your Orthopaedic Surgeon Story at **anationinmotion.org.**

Ortho-pinions Be a surgeon columnist! **Ortho-pinions**, the Academy's orthopaedic surgeon-authored column, consists of 400-1,000 word essays about various aspects of orthopaedic practice aimed at patient/public audience. Columns narrate common bone and joint scenarios. For more details, column guidelines, and to submit an Ortho-pinion, visit anationinmotion.org. Submissions should have a light and friendly tone geared towards a curious patient or neighbor. Columnists should choose a topic that comes up in practice, life or medicine that reiterates the well-roundedness and the different specialties which make up orthopaedics. We want to illustrate the many-dimensions of the people, like you, who make up this specialty. For more details, column guidelines, and to submit an Ortho-pinion, visit anationinmotion.org.

Share Patient Stories Invite patients whose stories embody ***A Nation in Motion*** to submit their stories on the campaign website, anationinmotion.org. Or, ask them for permission to use their stories and you or someone on your staff can submit them on their behalf.

The AAOS is extremely proud of all of its members who already have participated in the campaign and who continue to take steps to promote the message that orthopaedic surgeons keep our nation moving. In an era of healthcare change, it is now more important than ever for orthopaedic surgeons to stand out to policymakers and the public as the specialists who provide value. Orthopaedic Surgeon Stories, Ortho-pinions, and patient stories from each of you will help us do just that.

For questions or comments, contact Sandra Gordon, AAOS Public Relations Director at gordon@aaos.org.

Attend
COA's 2013 Annual Meeting
QME Course
C-Bones 2013 Annual Meeting

TERRANEA
L.A.'S OCEANFRONT RESORT

and receive . . . . . .

Thursday, April 18, 2013	6 QME CME hours An update on disability evaluation issues C-Bones Annual Meeting/networking opportunities
Friday, April 19, 2013	8 Category I CME hours Knowledge on practice management issues Focused discussion group with other similar practices (Small/solo practice, Employed physicians, Workers' Compensation, Improving office efficiencies)
Saturday, April 20, 2013	5 Category I CME hours 5 hours qualify for the ABOS MOC Scored/Graded Self Assessment What's new in Foot & Ankle Surgery/Adult Reconstruction and Trauma
Sunday, April 21, 2013	5 Category I CME hours 5 hours qualify for the ABOS MOC Scored/Graded Self Assessment What's new in Hand Surgery, Sports Medicine - Upper and Lower Extremity

Attend all days and receive a $100 discount on registration fees.
Register early—take an additional $50 discount.
Send your practice manager—they also receive a discounted registration fee.

Agenda and Registration Form will be posted at: www.coa.org

People/Entities in the News

Division of Workers' Compensation
Destie Overpeck, JD Chief Counsel for the Division of Workers' Compensation has been appointed as the Division's acting Administrative Director. Destie has served as DWC's Chief Counsel since 2005 and has been involved in working on many of the Workers' Compensation reforms.

Kaiser Permanente
Kaiser Permanente President and Chief Operating Officer **Bernard Tyson** will replace retiring CEO and Board Chair George Halvorson.

Ronald Navarro, M.D. has been selected as Regional Coordinating Chief of Orthopaedic Surgery for Southern California Permanente Medical Group. Dr. Navarro also serves on COA's Board of Directors and is one of the AAOS Councilors representing the Los Angeles District.

California Medical Association
CMA has announced that **Juan Carlos Torres**, will take over as Vice President of Government Relations replacing Jodi Hicks who went to work for Dimare, Van Vleck & Brown, a lobbying firm in Sacramento. Mr. Torres worked for Senator Darrell Steinberg, former State Senator Hilda Solis who is now U.S. Labor Secretary, Assembly Members Hector De La Torre and Assembly Majority Leader Marco Antonio Firebaugh.

City and County of San Francisco
Peggy Sugarman, former Chief Deputy Administrative Director of the California Division of Workers' Compensation, has taken over as Director of Workers' Compensation for the City/County of San Francisco.

Covered California
The California Health Benefit Exchange has approved "Covered California" as the name for the new health insurance exchange they are creating to expand health insurance coverage through the Affordable Care Act. **CHBE's Executive Director Peter Lee** will speak at COA's 2013 Annual Meeting to update us on progress that they are making in rolling out this new coverage in California. Health plans are qualifying to be part of the Exchange. Payor contracts are signing up physicians to be part of their networks. The exchange is projecting early enrollment in October, 2013 with coverage available to nearly 5 million Californians in January, 2014.

ACGME
The Accreditation Council for Graduate Medical Education, the American Osteopathic Association and the American Association of Colleges of Osteopathic Medicine are working together to establish ACGME as the accrediting body for osteopathic graduate medical education programs. This will provide physicians in the United States with a uniform pathway of preparation for practice.

New COA Leaders Elected

Congratulations to the following COA leaders for winning elections to COA's Board of Directors and/or the AAOS Board of Councilors representing California:

COA Board of Directors
Re-Elected to a Second 3 Year Term
Dori Neill Cage, M.D.—San Diego
G. Sunny Uppal, M.D.—Inland Empire

Elected to First 3 Year Term
Lesley Anderson, M.D.—Northern CA
John Steinmann, D.O.—Inland Empire

AAOS Board of Councilors
Re-Elected to a Second 3 Year Term
Michael Laird, M.D.—Los Padres
Roland Winter, M.D.—Sacramento Valley

Elected to First 3 Year Term
Richard Biama, M.D.– Inland Empire
Ronald Wyatt, M.D.—Northern CA
Richard Vanis, M.D.—Los Angeles
Paul Braaton, M.D.—Sequoia

Jay Lieberman, M.D. named professor and chair of the Department of Orthopaedic Surgery at the University of Southern California's Keck School of Medicine.

Paul Wakim, DO has joined the ranks of former Presidents Jimmy Carter and George H.W. Bush as recipients of the prestigious Ellis Island Medal of Honor. The award is given to immigrants, or descendents of immigrants who served to enhance humanitarian activities in the U.S. and abroad. Dr. Wakim is involved in the development of a cultural center for the Lebanese Americans in Los Angeles.

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Division of Workers' Compensation Moves Forward with Implementing Regulations

The Division of Workers' Compensation is holding meetings and issuing proposed regulations at a rapid pace—often with only 15 days of notice and time to comment. COA has commented on the regulations as they are issued.

Ambulatory Surgical Fee Schedule—in support of additional reimbursement to cover implanted hardware and devices and allograft costs. With the severe reduction in ASC reimbursement facility rates under the 2012 Workers' Compensation reforms, there is a fear that ASCs will not allow surgeons bring surgeries with high implant/allograft costs to their facilities.

Hospital Fee Schedule—in support of adequate reimbursement for spinal devices to ensure that access to medically necessary surgeries are not restricted for injured workers.

Transition of the Official Medical Fee Schedule—Physician Services To an RBRVS system

Ground and billing rules will be very important in the transition from our current RVS fee schedule to an RBRVS system. COA was successful in writing into the 2012 Workers' Compensation reforms that the Division must adopt rules that are different from Medicare on global surgical follow-up days. COA will be urging the Division to delete the surgical follow-up days, allowing surgeons to bill for these services. The same language was in the reforms on billing for consultations.

We also commented on other Ground/Billing rules that are unique to a Workers' Compensation system that need to be retained in the transition (e.g., payment for reports, 15 minute increments for prolonged service codes, additional reimbursement when an interpreter is needed, and billing for duplicate reports requested by the payor, etc.).

Finally, we urged the DWC to convene stakeholder work group meetings to walk through the existing Ground Rules and Medicare's Ground Rules to discuss which Ground Rules should be retained and new Ground Rules that are needed to clarify billing issues or improve efficiency of the system.

If you have ideas on important Ground Rules that should be retained or added to the system, we would like to hear from you. Discussions are likely to begin in December, 2012.

The DWC is expected to also release regulations yet this year on:

- Limiting QMEs to 10 practice locations
- $150 lien filing fee/$100 lien reactivation fee
- Fee schedule for copier services, interpreters, and home health services

COA is carefully monitoring the impact that each of these changes are having on our members.
Let us know how they affect your practice.

People/Entities in the News

(Continued from Page 4)

Leslie Anderson, M.D., COA's Chair of the Workers' Compensation Committee has been selected by the California Division of Workers' Compensation to serve on their Medical Evidence Evaluation Advisory Committee. The MEEAC develops DWC medical treatment guidelines.

Basil Besh, M.D. from Fremont and **Raymond Raven, M.D.** of Pasadena have been selected to participate in the AAOS Leadership Fellows Program for 2013-14. Dr. Besh also serves on COA's Board of Directors and is a AAOS Board of Councilor representing the Northern California District.

Bernyce Peplowski, M.D., former Medical Director for State Compensation Insurance Fund and **John Duncan,** former Director for California's Department of Industrial Relations, have been hired by United HealthWorks.

Peter O. Newton, M.D. was elected President of the Pediatric Orthopaedic Society of North America. **William Hennrikus, Jr., M.D.** was named their Communication Council Chair.

William Stetson, M.D. was the Olympic team physician for the U.S. men's and women's volleyball teams at the 2012 London Olympics.

New COA Member Benefit

To give COA members 24-hour access to their Category I and QME CME Certificates earned by attending COA courses, we have posted the Certificates for 2011 and 2012 on-line.

Go to COA's website—www.coa.org—click on "Access on-Line/Print CME Certificate" to print your certificate(s).

AAHKS Develops Documentation Worksheets—Hip and Knee Procedures

Excerpt from the "*AAHKS Update, June, 2012*"

CMS Major Joint Replacement (Hip & Knee) Medical Necessity Documentation & Checklists

David Halsey, MD, AAHKS Health Policy Chair

As you may be aware, the Center for Medicare and Medicaid Services (CMS) Recovery Audit Contractor (RAC) Program, along with many of the major private payers, are reviewing your hip and knee arthroplasty cases to assess the medical necessity and indications for surgery. At times, these hospital chart reviews have used checklists generated by third parties and the criteria may seem arbitrary.

The American Association of Hip and Knee Surgeons (AAHKS) is working to identify the hospital chart documentation requirements that are used in these audits. It is expected that through the CMS Medicare Learning Network website, these documentation requirements and compliance tips will be made publically available. (https://www.cms.gov/MLNGenInfo/)

AAHKS has not contributed to the content of these criteria nor endorses the mandatory use of any particular checklist.

The information provided here is simply to make you aware of the type of documentation requirements being used and to assist you in your efforts to comply with the CMS requirements for documentation of medical necessity as you care for your hip and knee patients. AAHKS will continue to work with CMS and other insurers to make sure that any medical necessity criteria used for audits are grounded on the best available evidence-based research.

Should you have comments please address them to: David Halsey, MD (david.halsey@uvm.edu) as Chair of the AAHKS Health Policy and Practice Committee.

What You Need to Know

The American Association of Hip & Knee Surgeons is providing this summary to make you and your staff aware of a new Center for Medicare and Medicaid Services (CMS) initiative to improve compliance with documentation requirements for major joint replacement procedures. The content presented here is consistent with the CMS Medicare Learning Network article that is likely to appear on the CMS website in the coming weeks. The MLN article presents a guide and two checklists, which are tools that arthroplasty surgeons can use to facilitate approval of arthroplasties by CMS. Familiarity with these recommended interventions prior to arthroplasty will minimize delays in arthroplasty for your patients. The use of the guide and check-lists are not mandatory and do not ensure Medicare payment for a submitted claim.

Background

Reducing Medicare payment errors is a major focus for CMS. In 2010, the President announced three goals for cutting improper Medicare payments by 2012: reducing overall payment errors by $50 billion, cutting the Medicare fee-for-service error rate in half, and recovering $2 billion in improper payments. Medicare has initiated a number of auditing projects with the intention of reaching those goals.

Medicare auditors have found that most improper payments are due to documentation errors, and not fraudulent claims. The MLN article is intended to provide you with information that will help you successfully comply with Medicare rules to avoid denials of claims and resulting overpayment requests. Accurate and complete documentation in the physician records is critical. Ultimately, the responsibility for this accurate documentation will fall to the orthopaedic surgeon performing the arthroplasty and the documentation will need to appear in the hospital medical record. In the vast majority of cases, the full requirements of the "appropriateness for arthroplasty" will have been prescribed to the patient by both the primary care (referring) physician and the orthopaedic surgeon.

Tips to Avoid Denial of Claims: Properly Documenting Medical Necessity

Specifically, be careful to fully document indications for the major joint replacement procedure such as:

1. Pain should exist at the hip or knee, including pain that interferes with ADLs (functional disability), pain that is increased with initiation of activities or pain that increases with weight bearing.

2. Unsuccessful conservative therapy (non-surgical medical management) should be documented and should have been tried for at least 3 months. This could include a trial of NSAIDs (or contraindication to such therapy) and/or documented physical therapy (or documented clinical contraindications to a PT program or inability to participate or complete a PT program).

3. In addition, clear contraindications to arthroplasty should be identified. These include: active infection of the joint to be replaced; active systemic bacteremia; active skin infection or open wound at the surgical site; neuropathic arthritis; severe, rapidly progressive neurological disease; or severe medical condition that make risks of the surgery outweigh the potential benefit.

4. Arthritis of the knee or hip should be confirmed by plain radiograph or MRI. A standing or flexed knee weight bearing radiograph is often sufficient to confirm osteoarthritis of the knee.

5. The plain radiograph should demonstrate one of the following:
   a) subchondral cysts,
   b) subchondral sclerosis,
   c) periarticular osteophytes,
   d) joint subluxation,
   e) joint space narrowing, or
   f) avascular necrosis.

In order to address one potential cause for denial, this documentation must be present in the hospital record at the time of surgery. Therefore, it is suggested that you send your office note(s) with this documentation to the hospital prior to the day of surgery. ◆

Sample Checklist for Documenting Medical Necessity for Total Knee Arthroplasty (TKA)

Please note, this checklist is not mandatory and does not replace the underlying medical records.

The hospital record for the patient includes the following history:

__ History of patient's illness from onset until the present
__ Prior courses of treatment and the result of prior treatment
__ Current symptoms and functional limitations due to disease
__ Joint examination with objective findings consistent with historical details

The hospital record for the patient includes the following information from the medical record:

__ Preoperative physician and therapist evaluations and treatment records
__ Preoperative imaging studies showing end-state joint disease
__ Operative finding supporting end-stage joint disease
__ Documentation of patient's functional limitations or need for adaptive behavior or use of assistive devices

The hospital record for the patient includes documentation of the following specific indications:

__ Failure of previous osteotomy, OR
__ Distal femur fracture, OR
__ Malignancy of distal femur, proximal tibia, knee joint, soft tissues, OR
__ Failure of previous unicompartmental knee replacement, OR
__ Avascular necrosis of knee, OR
__ Advanced joint disease demonstrated by X-Ray OR MRI

AND

One or more of the below conservative treatments have been tried and failed for 3 months or more except in special circumstances where delay of definitive care is not appropriate:

__ Anti-inflammatory medication: _____
Duration of treatment: _____
__ Analgesic: _____ _____ _____

__ Home exercise: Duration of treatment: _____
__ Physical therapy: Duration of treatment: _____
__ Use of cane or walker: Duration of treatment: _____
__ Weight loss: Duration of treatment: _____
__ Brace: Duration of treatment: _____
__ Cortisone shot(s): Duration of treatment: _____
__ Viscosupplementation: Duration of treatment: _____

The hospital record indicates that the patient does NOT have any of the following contraindications to TKA:

__ Active infection of the knee joint, OR
__ Active systemic bacteremia, OR
__ Active skin infection or open wound at surgical site, OR
__ Neuropathic arthritis, OR
__ Severe, rapidly progressive neurological disease, OR
__ Severe medical condition that make risks of surgery outweigh the potential benefit

Sample Checklist for Documenting Medical Necessity for Total Hip Arthroplasty (THA)

Please note, this checklist is not mandatory and does not replace the underlying medical records.

The hospital record for the patient includes the following history:

__ History of patient's illness from onset until the present
__ Prior courses of treatment and the result of prior treatment
__ Current symptoms and functional limitations due to disease
__ Joint examination with objective findings consistent with historical details

The hospital record for the patient includes the following information from the medical record:

__ Preoperative physician and therapist evaluations and treatment records
__ Preoperative imaging studies showing end-state joint disease
__ Operative finding supporting end-stage joint disease
__ Documentation of patient's functional limitations or need for adaptive behavior or use of assistive devices

The hospital record for the patient includes documentation of the following specific indications:

__ Malignancy of the pelvis or proximal femur or soft tissues of the hip, OR
__ Avascular necrosis of the femoral head, OR
__ Fracture of the femoral neck, OR
__ Acetabular fracture, OR
__ Nonunion, malunion, or failure of a previous hip fracture surgery, OR
__ Advanced joint disease demonstrated by X-Ray OR MRI

One or more of the below conservative treatments have been tried and failed for 3 months or more except in special circumstances where delay of definitive care is not appropriate:

__ Anti-inflammatory medication: Duration of treatment: _____
__ Analgesic: _____ _____ _____

__ Home exercise: Duration of treatment: _____
__ Physical therapy: Duration of treatment: _____
__ Use of cane or walker: Duration of treatment: _____
__ Weight loss: Duration of treatment: _____
__ Brace: Duration of treatment: _____
__ Cortisone shot(s): Duration of treatment: _____

The hospital record indicates that the patient does NOT have any of the following contraindications to THA:

__ Active infection of the hip joint, OR
__ Active systemic bacteremia, OR
__ Active skin infection or open wound at surgical site, OR
__ Neuropathic arthritis, OR
__ Severe, rapidly progressive neuro-logical disease, OR
__ Severe medical condition that make risks of surgery outweigh the potential benefit

California Employment Development Department (EDD) Implements New Electronic Claim Filing System

Laurel Waters, M.D., FCAP FASCP
Medical Director

California's Employment Development Department (EDD) has implemented a new electronic claim filing system. The system allows claimants, physicians/practitioners, and employers to create an online account to submit Disability Insurance and Paid Family Leave claims electronically. The option to file a paper claim for DI and PFL benefits remains available by using the new Optical Character Recognition (OCR) claim forms.

The State Disability Insurance (SDI) program is a temporary and partial wage-replacement insurance plan for California workers. This program is funded by State-mandated employee payroll deductions and administered by the EDD. The SDI program has two components:

- Disability Insurance (DI) pays up to 52 weeks for eligible workers who suffer a wage loss when they are unable to perform their regular and customary work due to non-occupational illness or injury, or due to pregnancy or childbirth.
- Paid Family Leave (PFL) pays up to 6 weeks (within a 12-month period) for eligible workers who suffer a wage loss when they need to take time off from work to care for a seriously ill child, parent, spouse or registered domestic partner, or to bond with a new child.

When you treat a patient under the SDI program, we encourage you to submit DI and PFL claim information through the SDI Online system.

Benefits to submitting claims information online include:

- Improved access to services.
- Reduction in claim processing time.
- Improved service delivery to customers.
- Electronic confirmation of forms receipt.
- Complete and accurate claim information.
- Automated business logic intelligence to detect and manage fraud and abuse.

For more information about SDI Online, or to order State Disability Insurance OCR claim forms, visit our website at http://www.edd.ca.gov/disability/ or call 1.855.342.3645.

The California Medical Association (CMA) recently hosted a webinar about SDI Online which is available for downloading on COA's website: www.coa.org—in the Library of Webinars or at: http://www.cmanet.org/resource-library/detail/?item=state-disability-insurance-online-for-your&. After you select the "Add to Cart" and "Proceed to Checkout" buttons, you need to either log-in to your account or create a new free one. The initial section of the webinar provides background about SDI. This is followed by a series of screen shots demonstrating the process of obtaining a physician account in SDI Online, registering your representatives and various uses of your account. A more advanced webinar will be held March 13, 2013.

Laurel Waters M.D., FCAP FASCP
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Help Patients Facing an Amputation

The Amputee Empowerment Partners (AEP) are volunteers who want to share their stories in order to help someone that is faced with a loss of a limb. In addition to their personal experiences with limb loss, the volunteers participate in a comprehensive training program that prepares them to become certified peer visitors. Coping with the situation becomes a little easier when you have got a mentor who really understands. The program has over 700 trained peer mentors nationwide who provide support, and friendship to new amputees. To help facilitate communication among all people affected by amputation and limb deficiency, the AEP e-community was developed. The community is rapidly growing and includes amputees, parents, siblings, friends, caregivers, and healthcare providers.

We can help patients facing a loss of limb.

Our services are free.

Please call on our California Regional Coordinators to talk with your patients facing a loss of a limb.

News of Interest

Get Involved in the AUC Process

Appropriate use criteria are the next step in quality improvement By: Jayson Murray, AAOS

Reprinted from the AAOS Now, September, 2012

Every day, orthopaedic surgeons and their patients are faced with making decisions about treatment options that, unfortunately, often don't have strong evidential support. In addition, what might be considered appropriate care for a 35-year-old generally healthy patient might not be appropriate for a 70-year-old patient with multiple co-morbidities.

Clinical practice guidelines (CPGs) may provide some direction. But their strong reliance on evidence may mean that recommendations for many generally accepted treatments are labeled "weak" or "inconclusive" because high levels of evidence may not be—and may never be—available to support their effectiveness compared to other treatments.

As a result, many medical specialties—including the AAOS—have begun developing appropriate use criteria (AUCs) to determine the appropriateness of select procedures. **An "appropriate" procedure is one for which the expected health benefits exceed the expected adverse consequences by a sufficiently wide margin.** The goal of AUCs is to improve patient care and obtain the best outcomes while considering the subtleties and distinctions necessary in making clinical decisions.

Evidence-based information, in conjunction with the clinical expertise of physicians from multiple medical specialties, will be used to develop the Academy's AUCs. In turn, the AUCs will also be used to develop Orthopaedic In-Training Examination questions, educational webinars, content for Orthopaedic Learning Center courses, and informative displays at the AAOS Annual Meeting.

Development steps

The first step in creating an AUC is to select a topic (Step 1). AUC topics are derived from AAOS CPGs that establish the effectiveness of various procedures for a given disease, disorder, or condition. The AAOS AUC Committee works in conjunction with the Guidelines Oversight Committee and the Evidence-Based Practice Committee, with input from the Board of Directors, in determining potential topics to address with an AUC. The AUC Committee makes the final determination of AUC topics.

AUC topics are carefully selected based on the following four parameters:

- The procedure is widely and frequently performed.
- The procedure is associated with a substantial amount of morbidity and/or mortality.
- The procedure consumes significant resources.
- The procedure has wide geographic variations in use.

After the topic has been selected, the AUC Committee seeks individuals to participate in each of the three panels (Writing, Review, and Voting) involved in the development of the AUC (Step 2). AAOS fellows and members of orthopaedic specialty societies may nominate themselves or other orthopaedic surgeons for each of the panels. Because members of the Voting Panel must be free of any conflicts of interest, only orthopaedic surgeons who are without relevant conflicts should be nominated to serve on the Voting Panel.

The Writing Panel is a group of 6 to 10 clinicians who are experienced in the procedure under study. Writing Panel members must have completed their disclosures in the AAOS Orthopaedic Disclosure Program; however, conflicts of interest will not affect appointment to this panel.

The Writing Panel is primarily responsible for creating the content for AUCs (Step 3). Through teleconferences and emails, panel members discuss AUC methods, select clinical indications, write definitions and assumptions, approve scenario matrix and literature reviews, and approve modifications suggested by the Review Panel.

AAOS staff develop a literature review by updating and supplementing the literature review that was developed for the corresponding CPG (Step 4). The literature review will be used by the Voting Panel to complement their expertise and experience as they develop the appropriateness ratings.

Review and approval process

The Review Panel is a group of 10 to 30 clinicians who are specialists in the selected procedure. Review Panel members must have completed their disclosures in the AAOS Orthopaedic Disclosure Program; however, conflicts of interest will not affect appointment to this panel.

After the Writing Panel develops the indications, the Review Panel receives the matrix of clinical scenarios, the list of definitions and assumptions, and the literature review (with "mapped" evidence) (Step 5). The panel members then review the materials to ensure that they are representative of patients and scenarios likely to be encountered in a clinical setting. Review Panel members can then suggest that the Writing Panel make changes or modifications in the indications, scenario matrix, definitions and assumptions, or the literature review.

The Writing Panel makes edits (Step 6) based on the Review Panel's suggestions. After all edits have been made, the Writing Panel approves the final list of indications, definitions, and assumptions. The draft AUC then goes through two rounds of voting.

The Voting Panel is a multidisciplinary group of 10 to 20 clinicians who have been deemed not to have conflicts of interest related to the topic under evaluation. All Voting Panel members must have completed their disclosures in the AAOS Orthopaedic Disclosure Program. The AAOS Board of Directors and Committee on Outside Interests

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Become an AAOS-Registered Disaster Responder

Now in its second year, the **Disaster Response Course** **(DRC)**, developed by the Society of Military Orthopaedic Surgeons (SOMOS) and co-sponsored by the AAOS, Orthopaedic Trauma Association (OTA) and Pediatric Orthopaedic Society of North America (POSNA), is the required component of the pathways for AAOS members to become disaster-response trained and selectively identified in the **AAOS Disaster Responder Database**.

Why is that important? When desperate situations created by disaster at home or abroad occur, registered disaster responders can connect more efficiently with volunteer organizations to act rapidly and deploy to help.

The Disaster Response Course offers hands-on lab training to address the application of orthopaedic care techniques critical to disaster-inflicted injuries and treating the wounded in austere environments where resources are scarce, electricity rare, and injuries are traumatic. Vascular injuries, compartment syndrome and burns may be conditions not frequently treated by most AAOS Fellows in their daily practice, but these injuries are more commonly seen in disasters. In addition to addressing these hands-on clinical skills, this course covers important personal and team preparation, from working with the military to cultural and ethical considerations.

A diverse group of faculty from SOMOS, AAOS, OTA and POSNA, offer a wealth of expertise in austere environments. Participants gave the inaugural, sold-out 2011/2012 courses great reviews. “I found not only the presenters but also the participants to be knowledgeable and involved in international musculoskeletal health care, which truly added to the depth of my experience,” said one 2011 participant.

The course is offered in Naples, Florida in December 2012 and Chicago, Illinois in March 2013, just prior to the AAOS 2013 Annual Meeting. POSNA has joined the course as a co-sponsor for the first time. “We are thrilled to have POSNA as a co-sponsor of the Naples and Chicago courses,” says COL Tad L. Gerlinger, MD, Course Director. “Pediatric considerations are critical in any kind of disaster situation, and the insight to these special issues that our partners at POSNA bring is critical.”

Completion of the Disaster Response Course is required to register as an AAOS-Registered Disaster Responder. Find out more about becoming an AAOS-Registered Disaster Responder and browse disaster preparedness resources at www.aaos.org/disaster. For more information, email disasterprep@aaos.org.

Disaster Response Course - Naples
Developed by SOMOS, Co-Sponsored by AAOS, OTA and POSNA
December 14–15, 2012
Naples Grande, Naples, Florida
Visit www.aaos.org/6808NPL to register

Disaster Response Course - Chicago
Developed by SOMOS, Co-Sponsored by AAOS, OTA and POSNA
March 18–19, 2013
Orthopaedic Learning Center, Rosemont, IL
Visit www.aaos.org/3353 to register

These courses are open only to AAOS Fellows and International Affiliate Members.

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October 10, 2012

ASCs Benefit from Enacted Bill Authorizing Clinic Permitting After Consequences of DPM Interpretation of Capen v. Shewry

Pharmacy Board Can Now Issue a Permit to an ASC to Purchase, Store, and Dispense Medications

On September 22, 2012, Governor Jerry Brown signed Senate Bill (SB) 1095, enacting revisions to Business and Professions Code (B&P) Section 4190 which currently requires the issuance of a Pharmacy Board Clinic Permit for surgical clinics wishing to purchase drugs at wholesale for administration or dispensing to registered patients of the clinic. The revisions enacted by SB 1095 will go a long way toward remedying the adverse consequences of the California Department of Public Health's (CDPH) interpretation of *Capen v. Shewry*, 155 Cal.App.4th 378 (2007).

Historically, surgical centers have been required by California law to be licensed by CDPH. However, CDPH interpreted the 2007 *Capen* decision, to hold that surgical clinics owned wholly or in part by physicians are to be regulated solely by the Medical Board of California. Based upon this interpretation, in 2008 CDPH stopped renewing or issuing new surgical clinic licenses to entities that had *any* physician ownership. Note that although physician owned surgical clinics are no longer required to obtain a license from CDPH, they are still required to meet the requirements for operation of an outpatient setting that administers anesthesia found in California Health and Safety Code Section 1248.1. This section authorizes Medicare-certified or accredited surgery centers to operate without a license provided that they meet certain requirements regarding the administration of anesthesia. Additionally, a surgery clinic is required by B&P Section 4190 to obtain a pharmacy clinic permit issued by the California Board of Pharmacy (Pharmacy Board) prior to purchasing in its own name any prescription medications from manufacturers/distributors or storing and dispensing such medications. However, the Pharmacy Board can not issue a clinic permit to a surgical clinic that does not hold a CDPH license. As noted above, CDPH no longer renews or issues licenses to physician owned ASCs. **Therefore, since 2008, physician owned surgical clinics have been unable to obtain the Pharmacy Board clinic permits necessary to authorize the clinics to obtain drugs from manufacturers in the clinics' names and have technically not been in compliance with B&P 4190.**

As a work around, many surgical clinics prepared policies that required each physician to maintain a separate drug supply or that the drug supply be wholly owned by the physician medical director or some other single prescriber. Additionally, the U.S. Drug Enforcement Agency (DEA) issued guidance suggesting that the Medical Director and at least one other back-up physician obtain DEA certificates at the surgical clinic location in order to allow for the dispensing of controlled substances.

Effective January 1, 2013, SB 1095's revisions to B&P 4190 will allow the Pharmacy Board to issue clinic permits not only to surgical clinics that are licensed by CDPH, but also to surgical clinics accredited by an accreditation agency, or certified to participate in the Medicare program.

Since the Pharmacy Board never officially approved of the work around measures described above, we recommend that all physician owned surgical clinics which do not hold a clinic permit issued by the Pharmacy Board, apply for such a permit as soon as new permit applications are made available by the Pharmacy Board (hopefully, around January 1, 2013, or earlier).

For additional information, please contact Stacie Neroni or Hope Levy-Biehl in Los Angeles at 310.551.8111; Paul Smith in San Francisco at 415.875.8500; or Joseph LaMagna at 619.744.7300. ◆

Get Involved in the AUC Process

Continued from Page 7

have established specific conflict-of-interest standards that apply to all members of the Voting Panel for AUCs. These policies are intended to minimize the perception of bias and ensure the integrity of AAOS AUCs. Following an assessment of conflicts of interest, any applicants with conflicts of interest are excluded, and the members of the AUC Voting Panel are appointed from the pool of applicants who have no conflicts of interest.

To reduce bias, less than 50 percent of the Voting Panel members should be surgeons who perform the procedure under consideration. The remaining members of the panel should be orthopaedic surgeons, physicians, and other healthcare professionals who are not considered experts on the topic but who would be involved with patients who may have this condition or need this procedure. For example, a physician who might refer the patient to an expert in this area could serve on the Voting Panel.

The Voting Panel is primarily responsible for rating the scenarios that comprise AUCs via two separate rounds of voting. During the first round, which lasts approximately 1 month, panel members individually rate the scenarios created by the Writing Panel via an electronic survey (Step 7a). Treatments for each scenario are rated on a 1 to 9 scale.

The second round of voting takes place after a face-to-face discussion to consider the differences in the results of the first round appropriateness ratings (Step 7b). After this discussion, Voting Panel members vote again and may change any of their Round One appropriateness ratings.

The final AUC document is reviewed and approved by the AUC Committee, the Council on Research and Quality, and the AAOS Board of Directors (Step 8). After the AUC has been approved, the AAOS department of research and scientific affairs will publish it on the AAOS website and begin the dissemination process with an official press release. The AUC will also be released as an interactive web-based application and a summary will be published in the *Journal of the AAOS, AAOS Now,* and *The Journal of Bone and Joint Surgery*.

For more information about AAOS AUCs, including frequently asked questions, AUC development procedures and processes, and AUCs currently in development, visit www.aaos.org/auc ◆

Jayson Murray is the manager, appropriate use criteria, in the AAOS department of research & scientific affairs. He can be reached at jmurray@aaos.org

Anthem Blue Cross amending some physician contracts to include individual/exchange product

On October 24, Anthem Blue Cross sent a notice to 8,345 physicians who are part of the Blue Cross Select PPO network announcing its intent to participate in the California Health Benefit Exchange, the state's new insurance marketplace called for under the Affordable Care Act. Beginning in 2014, individuals and small business will be able to purchase health insurance using tax subsidies and credits from the exchange.

According to the notice, Blue Cross is creating a new provider network called the "Anthem Individual/Exchange Network," which will serve both individuals who purchase coverage through the exchange and individuals who purchase coverage from Anthem Blue Cross in the individual market outside of the exchange. In other words, the fee schedule would apply to all individual business, whether bought on or off of the exchange. Blue Cross has clarified that this fee schedule change will not apply to Small Business Health Options Program (SHOP) business purchased through the exchange.

It's important to note that the letter also states that Blue Cross is amending the physician's Blue Cross Prudent Buyer Agreement to automatically include the new individual/exchange network, effective January 1, 2014. The new fee schedule associated with this product was included with the notice.

The California Medical Association has been actively working with exchange stakeholders to address significant concerns regarding the exchange grace period, monitoring of network adequacy and clinician-level performance measurement in qualified health plans offered in the exchange. (Click here for more information about contracting with exchange plans.)

Though not mentioned in the Blue Cross cover letter, Sections VI and VIII of the enclosed amendment provide instructions for physicians who wish to opt out of the individual/exchange network. Physicians who do not wish to participate in this network must notify Blue Cross of their intent to opt out by **December 31, 2012**. Opt out notices should be in writing and sent via certified mail, return receipt to the address specified in Section VI of the amendment. Physicians are encouraged to carefully review all proposed amendments to payor contracts. You do not have to accept substandard contracts that are not beneficial to your practice. Physicians who did not receive a letter and are unsure whether they are affected by this change or those who have general questions about the amendment can contact Blue Cross's Network Relations Department at (855) 238-0095 or networkrelations@wellpoint.com. ◆

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GENERAL ELECTION RESULTS

By: Timothy Shannon, COA Lobbyist

Presidency:

President Obama surprised almost everyone by nearly "running the table" in the swing states, losing to Romney only in North Carolina. This result, coupled with a continuing majority of Democrats in the U.S. Senate, means that the Affordable Care Act (aka "Obamacare") will be implemented and not rolled back.

Congress:

- Physician Ami Bera, M.D. (D) has beaten incumbent Dan Lungren (R) in CD 7.
- Long-time incumbents defeated:
  - Pete Stark (D) lost to Eric Swalwell (R) in CD 15
  - Howard Berman (D) lost to Brad Sherman (D) in CD 30
  - Joe Baca (D) lost to State Senator Gloria Negrete-Mcleod (D) in CD 35
  - Brian Bilbray (R) has lost to Scott Peters (D) in CD 52

COA-supported Juan Vargas (D) moved to Congress in an easy victory over Michael Crimmins (R).

The California Congressional delegation will see significant changes with 14 new members being sent to Washington, DC (a 26% change).

State Senate:

President pro Tempore Darrell Steinberg has achieved a two-thirds Democrat supermajority in the state Senate, picking up at least four hotly-contested seats:

- Marty Block (D) defeated George Plescia (R) in SD 39
- Fran Pavley (D) defeated Todd Zink (R) in SD 27
- Richard Roth defeated Jeff Miller in SD 31
- Cathleen Galgiani (D) has won a narrow victory over Bill Berryhill (R)

In addition, former Assembly Member Hannah Beth Jackson (D) defeated Mike Stoker (R) in a formerly Republican area represented by Tony Strickland (R).

State Assembly:

Speaker John Perez has also achieved a two-thirds supermajority in the Assembly. Here are the two seats he picked up:

- Rudy Salas (D) beat Pedro Rios (R) in AD 32
- Sharon Quirk-Silva (D) beat incumbent Chris Norby (R) in a close race in the AD 65th Orange County District. This was one of the biggest surprise in the state legislative races.

Unfortunately COA-member Dr. Matthew Lin (R) lost to Edwin Chau (D) in AD 49 by 7%. This was a Democrat District held by Mike Eng, and Dr. Lin was a long-shot who had done remarkably well in the primary.

There will be 38 new members of the State Assembly. That's a 48% change of the 80 members in the Assembly each with the possibility to serve 12 years.

What does a supermajority mean?

If these results hold up, it will be the first time since 1933 that one party enjoys a two-thirds majority in the state Legislature.

The most striking effect is that tax increases, which require a two-thirds vote, could be enacted without a single Republican vote. Speaker Perez indicated that the Assembly would not try to do this, in contravention of Governor Brown's promise that no tax increase would be implemented without a vote of the people. Proposition 30, the temporary sales and income tax measure, that just passed was put on the ballot by initiative petition. A two-thirds majority would allow a tax increase to be put on the ballot by the Legislature, without having to circulate petitions to qualify an initiative. Also, in theory a two-thirds majority by the Democrats would allow the party to override a Governor's veto without a Republican vote.

Ballot measures:

The big one was the passage of **Proposition 30** by a surprisingly large margin, 54% to 46%. Heavy campaigning by the Governor in the last two weeks before the election paid big dividends, as the Proposition had slipped below the 50% approval rate in the polls. The temporary taxes will avoid devastating "trigger cuts" in education and may, at least temporarily, stave off cuts that would undoubtedly be inflicted on other programs, including health care.

Voters also rejected **Proposition 32,** which would have had the effect of limiting the ability of the unions to raise campaign money through worker payroll deductions. Millions of dollars were spent on both sides on this issue, and it is likely voters mobilized to oppose Proposition 32 voted to support Proposition 30, which was heavily supported by unions. ◆

With change comes opportunity. If you are acquainted with any of the new State or Congressional members, send us an email—coa1@pacbell.net to let us know of your relationship.

California Orthopaedic Association
1246 P Street
Sacramento, CA 95814

Welcome to COA's Newest Members

Brian Barlow, M.D.	San Diego
Jonathan Botts, M.D.	Sherman Oaks
Mohamed Ibrahim, M.D.	Modesto
Elspeth Kinnucan, M.D.	Fair Oaks
Jeffery Krygier, M.D.	San Jose
Robert Mayle, M.D.	San Francisco
Brian Perri, D.O.	Los Angeles
Steven Porter, M.D.	Porterville
Richard Rogachefsky, M.D.	Torrance
Kasra Rowshan, M.D.	Newport Coast
Christopher Sherman, D.O.	National City
Jason Snibbe, M.D.	Beverly Hills

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We appreciate your prompt payment, so that COA does not need to devote staff time to follow up with you.

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