COA Report

A publication of the California Orthopaedic Association

Fall, 2013

PRESIDENT MESSAGE

Leslie H. Kim, M.D., President

What We Can Do *For* Ourselves...

At an annual orthopaedic training program dinner, I heard the program director speak eloquently to graduating residents about career phases: yearning, learning, earning, and returning. This has stuck with me as I have tracked my own professional career. The passages have, however, become compressed--more parallel pursuits than serial states. Long practicing orthopaedists are yearning for the "good old days," and learning new techniques from those recently trained; both junior and senior orthopaedists feel compelled to earn now before reimbursements drop further in the future. And what about returning? (answer below)

The profession is changing--as is the world around us. The multi-tasking and tech savvy millennial generation is moving to the mainstream. Traditional health care financing is yielding to the uncertainty of new models designed to "bend the cost curve," while economic growth stagnates in a "flattened" world. Polarized politics is mired in deficit spending. Entrenched industries are being disrupted by the exponential growth of technology, including revolutionary biotechnology. And is the COA changing? (answer below)

But first, what *can* we do? We can passively endure governmental/regulatory actions, such as SGR cuts, bans on IOAS, prohibition of PT employment, etc. — or, we can donate to our PAC and actively advocate on our behalf (Peter Mandell and Tom Barber, erstwhile and current AAOS Advocacy Council Chairs; Roland Winter, COA's Legislative Committee Chair). We can commiser-

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For Your Advance Planning . . .

COA's 2014 Annual Meeting and
QME Course
May 29—June 1, 2014
Portola Hotel and Spa
Monterey

PORTOLA HOTEL
Monterey, CA
is already accepting COA hotel reservations.
Group Rate: $179

Call: 888-222-5851
Or go to: https://reswebpasskey.com/go/coa2014annualmeeting
For COA's personalized registration webpage.

President's Column (Continued from Page 1)

ate over legislative "reform" of Workers' Compensation — or, we can publicly testify in the regulatory process, meet personally with the DWC Administrative and Medical Directors, and reconvene major stakeholders in a forum to improve the system (COA Workers' Compensation Committee, Lesley Anderson and Basil Besh). We can accept politically prescribed scopes of practice — or, we can maintain professional standards and resolve disputes outside the political arena (COA /CMA Podiatry Task Force, Steve Ross and Carol Frey).

We can participate--or not participate--in Covered California without much understanding of what it is and will become— or, we can learn more and provide input to the program (presentations at COA Annual Meetings by their Executive Director, ongoing COA dialogue with their Senior Medical Advisor, COA survey of members). We can dread a proposed ballot initiative by trial attorneys that will result in higher liability insurance rates, increased malpractice claims, and mandatory physician drug testing — or, we can support organized medicine, contribute to the defense of MICRA, and procure a substantial grant from the AAOS in this effort (California Councilors Roland Winter, Michael Laird, and Basil Besh).

We can watch third parties value our services and define "centers of excellence"— or, we can proactively measure and report orthopaedic value based outcomes rather than just cost (Kevin Bozic, COA Past President, AAOS Quality Council and CJRR Chair). We can observe third parties like Yelp rate our practices on the internet — or, we can engage them to report more meaningful and accurate information (Glenn Pfeffer and Robert O'Hollaren, COA representatives in collaborative efforts with Healthgrades and Castlight). We can puzzle over reporting of clinical outcomes, - or we can research Patient-Reported Outcome tools and publish an educational white paper (Nicholas Abidi).

We can resist changes in fee-for-service payments and the effects of ACOs, PHOs, bundled payments, etc.– or, we can realign ourselves and learn to prosper in a value-based system (Cal Ortho On-Line, James Caillouette, former COA President). We can succumb to deteriorating practice efficiencies — or, we can learn to improve them in small, large, and multi-specialty groups (COA Annual Meeting, Tom Grogan, 2014 Program Co-chair and AAOS Practice Management Committee Chair). We can scramble to satisfy educational requirements for MOC — or, we can ease the burden with COA's OKU-10 study flashcards and offered SAE credits (Jeff Bogosian, COA Annual Meeting).

We can feel unfulfilled in our jobs, lacking the satisfaction of using all our skills to help others — or, we can volunteer locally and abroad to serve the disadvantaged (Clarence Shields, COA's 2013 Orthopaedic Hero Award recipient). We can be overwhelmed by medical literature that is estimated to be doubling

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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 over 600 patient success stories live. 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 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 stories.

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. 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.

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

Go to http://anationinmotion.org to participate.

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 will help us do just that.

For questions or comments, contact Sandy Gordon, AAOS Public Relations Department.

The California Orthopaedic Association

Presents a course for orthopaedic surgeons and orthopaedic practice managers . . .

Transitioning the Workers' Compensation Official Medical Fee Schedule (OMFS) for Physician Services to RBRVS as of 1/1/2014
and
Implementation of ICD-10—How to Prepare
Course Moderator: Tom Grogan, M.D.

Tuesday, December 10 , 2013 – Westin South Coast Plaza Hotel, Costa Mesa, CA
Thursday, December 12 , 2013 – Oakland Airport Hilton, Oakland, CA
Registration: 8:00 am Course will be held from 8:30 am—4:00 pm

2014 will bring two important changes to orthopaedic practices—Transitioning the Workers' Compensation OMFS for Physician Services to a Medicare RBRVS system—effective January, 2014 and Implementation of ICD-10 as of October, 2014. The new Workers' Compensation fee schedule will affect reimbursement and Ground Rules.

This is the only course that will focus on orthopaedic issues.
Attend this course to see how these changes will affect your practice.

The course will cover:

Transitioning the Workers' Compensation OMFS for Physician Services to RBRVS

Faculty: Sue Honor-Vangerov, Esq.—Certified coder and former manager of the DWC Medical Unit

- OMFS reimbursement levels—how the transition will affect orthopaedic practices—Summary of the changes
- New ground and billing rules
- Understanding how to bill Evaluation & Management services during the post-operative global surgical period
- Changes to consultation codes/prolonged service codes/multiple surgery rule/report codes/physical therapy billing
- Unique California codes

The "Implementation of ICD-10" Faculty: Mary Jean Sage, The Sage Associates/Tom Grogan, M.D.

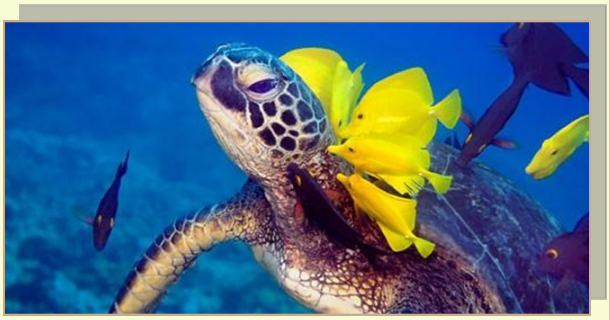
- Planning upgrades to practice management systems/EMR
- How to set up your "pick" list to refine the list of possible ICD-10 codes
- Training your staff—who needs to be trained and what do they need to know
- Developing the most efficient internal structure for implementation
- How translation software can help in the conversion
- Walk through orthopaedic case examples including a conversion of ICD-9 codes to ICD-10

Registration fee: (includes continental breakfast and lunch)
$185 per person—COA Member/Office staff (all orthopaedic surgeons in group are COA members)
$200 per person—COA Non Member/Office Staff

To register for the course, complete the following information:
Name of attendee(s): _____ _____
Medical Group: _____ Email confirmation: _____
Address: _____City: _____ State: _____ Zip: _____
Course you would like to attend: ☐ 12/10/2013—Orange County ☐ 12/12/2013—Oakland

Method of Payment: ☐ Check is enclosed Charge $_____to my credit card.
AmEx/Visa/MC# _____ Exp. Date_____ Security Code: _____
Register on-line at: www.coa.org There will also be on-site registration.

Registration will open Dec. 16
COA's 2014 Annual Meeting and QME Course
Monterey, CA



Attend and receive . . . . . .

Thursday, May 29, 2014

- 6 QME CME hours
- 2 Category I CME hours
- An update on disability evaluation issues
- ICD-10 Implementation

Friday, May 30, 2014

- 7 Category I CME hours
- Knowledge on practice management strategies/ Covered California—Health Exchange
- Focused discussion group with other similar practices (Small/solo practice, Utilizing IT Apps, Large Practice Groups, Hospital Employed Physicians, Workers' Compensation, and Orthopaedic Practice Managers' Forum)

Saturday, May 31, 2014

- 4 Category I CME hours
- 4 hours qualify for the ABOS MOC Scored/Graded Self Assessment Test and Radiology Certification
- What's new in Adult Reconstruction and Sports Medicine—Lower Extremity

Sunday, June 1, 2014

- 6 Category I CME hours
- 6 hours qualify for the ABOS MOC Scored/Graded Self Assessment Test and Radiology Certification
- What's new in Sports Medicine – Shoulder and Upper Extremity/ Hand Surgery/Trauma

Attend <u>all days</u> and receive a $100 discount on registration fees.

Register early—take an additional $50 discount.

ABOS MOC Scored/Graded Self Assessment Testing—Complimentary for COA members.

Send your practice manager—they also receive a discounted registration fee.

Register on-line at: http://www.coa.org/coa-annual-meeting.html

People/Entities in the News

Noridian

Arthur Lurvey, M.D. and Bernice Hecker, M.D.

Noridian has taken over as the Medicare Part B fee-for-service contractor for California as of September 11, 2013. Dr. Lurvey will transition from Palmetto to Noridian and become their Contractor Medical Director. Dr. Bernice Hecker, M.D., is the Medical Director for Noridian and will be speaking at COA's 2014 Annual Meeting.

Alexandra Page, M.D.—San Diego

has been appointed Chair of the AAOS Health Care Systems Committee. Dr. Page was COA's 2013 Annual Meeting Program Chair .

Carol Frey, M.D.—Manhattan Beach

is the author of a just released book entitled, "Don't Worry: My Mom is the Team Doctor: The Complete Guide to Youth Sports injury and Prevention for Parents, Players, and Coaches.

UC Davis- Dr. Julie Freischlag

who originally trained at UCLA has become the new Medical School Dean at UC Davis. She will assume this new position on February 10, 2014. Dr. Freischlag spent the last eleven years at Johns Hopkins where she became the chief surgeon, the first women to hold that position.

Workers' Compensation—David Lanier

has been appointed by Governor Jerry Brown as the successor to Marty Morgenstern , who retired from his position as Secretary of the state Labor and Workforce Development Agency—the Agency who has overall jurisdiction over Workers' Compensation issues. Lanier has served as Chief Deputy Legislative Affairs Secretary for Governor Brown, Special Advisory to the Assembly Speaker's Office of Member Services, and for state Assembly-women Grace Napolitano and Carol Migden. Lanier must be confirmed by the Senate.

President Message

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every 5 years, is subsequently proven unreliable up to half of the time, and is the basis for debated CPGs /AUCs — or, we can continuously educate each other with enlightened discussion in a trusted community of peers (James Huddleston, 2014 Annual Meeting Program Co-chair, proposed COA Scientific Council with on-line forums and virtual journal clubs)

Which leads me back to COA and giving back to our profession. I will be working with the Media Committee to enhance our website with more interactivity, by adding user submitted and targeted "push" content, on demand webinars/ presentations, commenting, rating, tagging, and other social networking tools. We need to leverage COA's greatest strength: the collective wisdom and actions of its members. When new website functionality becomes available, I urge you to share thoughts, knowledge, and questions to help each other. We cannot simply labor under the delusion that "if you build it, they will come." It will not happen without you. But if you come, they will come.

We can quietly acquiesce in the future of our changing profession, and have no effect in creating it., - or we can . . . ◆

Leslie H. Kim, M.D.
President

AAOS International Initiatives

William Stetson, M.D., Chair
AAOS International Committee

Although the American Academy of Orthopaedic Surgeons has been involved in international activities at some level since the early 1980's, it was in 1994 that a dedicated international activities function was established. A new International Committee was created and international staff hired to begin the long-range strategic planning process to grow global relationships and activities. William Stetson, M.D. who practices in Burbank, California serves as Chair of the AAOS International Committee.

Today, AAOS is involved in global activities at many levels and continues to look for new opportunities to help meet its primary mission of orthopaedic surgeon education and improved musculoskeletal healthcare for patients worldwide.

AAOS has a "balanced portfolio" of mission vs. margin initiatives.
Below is a list of current programs:

- Each year, AAOS conducts nine to twelve international education programs in all areas of the world. The programs range from guest lecturers, to multi-year commitments in a region or country. To date, AAOS has held programs on every continent reaching more than 56,000 orthopaedic surgeons. The AAOS International committee works closely with the national orthopaedic associations to ensure the educational content is appropriate to local needs, infrastructure, and surgeon skill sets. In the past, AAOS also has co-developed programs with some of our sister specialty societies.
- Each year, AAOS awards 20-25 scholarship programs to young orthopaedic surgeons from countries with limited resources. For more information visits: www.aaos.org/internationalscholarship
- In 2009, AAOS launched the Visiting Faculty and Professional Development Program in Vietnam. The program includes on-site didactic, skills labs, and live surgery education in three sites in Vietnam. It also includes scholarships for three Vietnamese surgeons to spend time with the U.S. Visiting Professors at their institutions here in the United States.
- Together with Orthopaedics Overseas, the Pediatric Society of North America, and the Institute for Global Orthopaedics and Traumatology, and the Orthopaedic Trauma Association, AAOS has developed a comprehensive trauma program in Kumasi, Ghana.
- As a direct outcome of the disastrous Haiti earthquake of January 2010, AAOS continues to be actively involved in helping to reestablish orthopaedic education and training in Haiti in collaboration with Partners in Health. In addition, AAOS works with the Society of Military Orthopaedic Surgeons, the Orthopaedic Trauma Association, and the Pediatric Society of North America, to oversee the formal Disaster Preparedness Course.
- In partnership with Orthopaedics Overseas, AAOS holds a biennial physician education program aimed at encouraging U.S. orthopaedic surgeons to volunteer their services overseas for up to three months.
- Substantial annual charitable donations of educational products to libraries, hospitals and orthopaedic associations in the less fortunate nations of the world that must cope with huge patient loads and a paucity of educational resources and infrastructure.

For more information about AAOS International Initiatives, or to make a contribution to continue to expand our efforts, please contact international@aaos.org ◆

Coding Tips and Guidelines

KAREN ZUPKO & ASSOCIATES, INC.
A practice management consulting and training firm working for and with physicians since 1985

Want to know if CMS is issuing a bonus or a penalty? There's an app for that.

Incentive programs are complicated. Many people aren't feeling positive that they have met the rules and deadlines. There is an on-line tool that tells you for sure if you will receive a bonus or a "payment adjustment." All one has to do is answer a few yes or no questions.

Orthopaedic Coding Articles

The Differences Between Modifiers 51 and 59
AAOS Now, June, 2013

AMA CPT Assistant

Revision Arthroplasty – February, 2013
Nerve Conduction Studies—March, 2013
Shoulder Revision—March, 2013
Spinal Instrumentation—July, 2013
Revision of Unicompartmental Knee Arthroplasty to Total Knee Arthroplasty—July, 2013
Non-Face-To-Face Services: Interprofessional Telephone/Internet Consultations—October, 2013

Question:
For coding purposes, to which compartment of the knee do the medial and lateral gutters and recesses belong? For example, if loose bodies are removed from the medial gutter and a medial meniscectomy is performed, are these procedures considered as performed in the same compartment?
Answer:
The gutters are part of the medial or lateral compartment, not the patellofemoral compartment. Therefore, it would not be appropriate to separately report loose body removal in the medial gutter along with a medial meniscectomy.

Question:
What is the appropriate code to report corrective surgery involving the removal of the medial eminence (bunion), removal of dorsal osteophytes from the metatarsal head, and removal of an osteophytic rim from the base of the proximal phalanx? Dorsal closing wedge and medial closing wedge osteotomies of the proximal phalanx with fixation using a single screw were also performed.
Answer:
If both osteotomies were performed on the phalanx (a bi-directional osteotomy) it would be appropriate to report code 28298, Correction, hallux valgus (bunion), with or without sesamoidectomy, by phalanx osteotomy. If one of the osteotomies was performed on the phalanx and the other on the metatarsal, it would be appropriate to report code 28299, correction, hallux valgus (bunion), with or without sesamoidectomy; by double osteotomy. The resection of the osteophytes and the medial eminence would be included in the other codes.

Question:
A patient undergoes open treatment of a comminuted intra-articular distal radius fracture (25609), and the surgeon also performs a pronator rotation flap. In addition to code 25609, open treatment of distal radial intra-articular fracture or epiphyseal separation; with internal fixation of 3 or more fragments, would it be appropriate to report code 15736, Muscle, myocutaneous, or fasciocutaneous flap; upper extremity, for the pronator rotation flap?
Answer:
No. It would not be appropriate to report code 15736 for the pronator rotation flap, as it is performed through the same incision and is part of the fracture treatment procedure. ◆

CMS Announces Implementation of the revised CMS 1500 Claim Form

January 6, 2014—CMS begins accepting revised 1500 forms.
January 6, 2014-March 31, 2014—CMS continues to accept old 1500 forms.
April 1, 2014-CMS will only accept the revised 1500 forms.
The new form will add:

- Indicators for differentiating between ICD-9 and ICD-10 diagnosis codes.
- Expand the number of possibility diagnosis codes to 12
- Qualifiers to identify the provider roles (Item 17) ordering, referring and supervising.

Did You Know that Medicare Allows Missed Appointment Charges?

Until recently, there has been some uncertainty regarding whether a provider is permitted to charge a missed appointment fee to Medicare patients in view of Medicare's assignment and limiting charge regulations. However, the Center for Medicare and Medicaid Services ("CMS") explained the following:

CMS's policy is to allow physicians and suppliers to charge Medicare beneficiaries for missed appointments, provided that they do not discriminate against Medicare beneficiaries, but also charge non-Medicare patients for missed appointments. *See, CMS Manual System, Pub. 100-04 Medicare Claims Processing, Transmittal 1279 (October 1, 2007).*

The missed appointment charge is not a fee for health care services rendered, but rather, as CMS explains, it is a "charge for missed business opportunity." This is important because providers (whether participating or non-participating) are only permitted to directly charge Medicare/Medicaid patients specified cost-sharing amounts for health care services. For instance, balance billing is not permitted because, in accepting Medicare/Medicaid's payment, a provider has agreed not to charge any other amount directly to his or her patient other than the specified cost-sharing amount. If the missed appointment charge was classified as a fee for service, a provider would not be permitted to pass it on directly to the patient; however, since it is classified as reimbursement for missed business opportunities, it may be charged to an offending patient.

If you are considering implementing a missed appointment charge, you should consider the following:

1. You can charge a patient for a missed appointment, but this charge is not reimbursable under Medicare or Medicaid; therefore, do not waste your time submitting a claim to Medicare/Medicaid because it will be denied.
2. You cannot charge one fee to Medicaid/Medicare patients, while charging a different fee (or no fee) to self-pay/commercial payer patients. Such unequal treatment violates the Medicare and Medicaid statutes and regulations.
3. It is a good practice to have new patients sign and acknowledge your office's policy regarding missed appointment charges. This will help eliminate any confusion if your patients balk at paying your fee.

   From a business standpoint, it makes sense to build flexibility into your missed appointment charge. For example, many physicians give their patients one 'free' missed appointment. The underlying rationale is obvious: Most patients become upset when they receive a statement for a missed appointment, so it makes good business sense to use discretion when deciding who should or should not be compelled to pay a missed appointment charge.

Workers' Compensation News

DWC Clarifies Interpreter Rules

The Division of Workers' Compensation has reminded claims administrators that failure to provide a necessary interpreter at a medical treatment appointment may constitute a failure to provide medical treatment. Examples of a failure to provide medical treatment include a situation where the lack of an interpreter's service prevents the exam from going forward or inhibits the injured worker's ability to communicate with the primary treating physician. Such conduct could also result in penalties and/or sanctions against the claims administrator.

Labor Code Section 4600(g) provides that injured workers who cannot communicate effectively in English with their physician are entitled to the services of a qualified interpreter at all medical treatment appointments. "Qualified interpreters" for purposes of medical treatment appointments may be, but are not required to be, formally certified. They can be provisionally certified by agreement of the employer prior to providing interpreting services. Employers may, but are not required to pay for the services of interpreters who are not formally or provisionally certified.

Interpreters certified for medical treatment appointments or medical legal exams qualify through successfully passing the Certification Commission for Healthcare Interpreters (CCHI) exam or by passing the National Board of Certification for Medical Interpreters (National Board).

Despite a state statute that requires interpreters to keep discussions between physicians and injured workers in confidence, Focus Interpreting in Orange, requires an interpreter to report within 24 hours of the medical appointment, whether the doctor discussed medications, work status, maximum medical improvement, work restrictions, treatment recommendations, and whether a case manager was present. Focus has indicated that national firms such as One Call, have required them to provide exam summaries. One Call has now clarified that their interpreters should not include exam summaries when submitting an invoice for their services. Interpreter services FAQs and information on recently approved interpreter services regulations are posted on DWC's website. ◆

Lien Activation Fees

SB 863 requires lien claimants to pay a $100 fee to "activate" all liens that were filed before January 1, 2013, but have not yet gone through a lien conference.

A lawsuit was filed in federal court to stop the collection of these lien activation fees. The lawsuit contended that the retro application of the lien-activation fee requirement is an unconstitutional government taking since the state has taken away their previously held reasonable expectation of being paid for their services and places a financial burden on them that they are unable to seek payment of all of their liens. The plaintiffs have 33,933 pending liens and assert that paying the $100 fee to "activate" each of them before the end of the year is cost-prohibitive.

A federal trial court judge has agreed and prevented the Division of Workers' Compensation from collecting lien-activation fees from the plaintiffs.

In response to this ruling, the DWC has indicated that they will suspend the collection of the lien activation fees on all liens filed prior to January 1, 2013. The $150 filing fee imposed on liens filed after January 1, 2013 remains in effect.

DWC Plans to Open Santa Barbara Satellite Office

The DWC announced plans to open a satellite office in Santa Barbara to provide access to injured workers previously served by the Goleta District Office. The Division has indicated that they plan to open the office in December, 2013. ◆

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.

IT Technology—News of Interest

Google Scholar is Changing the Medical Research Approach

AMA News, July 8, 2013

Every day, orthopaedic surgeons and their patients are faced with the appropriateness ratings.

I'm sure by now we are all used to using Google in circumstances where we just can't seem to find the answer anywhere else. On the other hand there are people who turn to Google first as a research source. As you may know, Google has search options that will narrow down your search for a better result. For example, Google Maps, News, Images and Shopping can all be used to provide a more specific search result. With that said, recent studies have shown that young residents are beginning to turn to Google Scholar as a research tool for answering medical questions.

Technically Speaking
Technology and your practice

According to an article written by Pamela Lewis Dolan in the *American Medical News,* July 8, 2013, "The study found that 68% of residents use Google regularly. Of those, 75% use it to help them locate a trusted website they have used before, and 71% use it to find general information about a topic or disease. But when searching for diagnostic strategies from a journal, 44% went to Google Scholar; 44% said they used Google Scholar to search for the most current treatment in a journal; and 38% use it to search for a specific paper they have seen before." (Dolan)

Google Scholar can be helpful for someone who needs to save time by cutting back on the amount of time spent on research. Initially, Scholar searches are sorted by relevance, meaning that the articles that are found are considered to be the most relevant to what is in the search bar. However, there is the option to sort the articles by date and the search will yield the most recent articles on what is in the search bar. Some sites will require a subscription to view the entire article and will only provide an abstract of the article. On the other hand, there are a good number of articles that can be viewed in their entirety. Unlike a "normal" Google search, Scholar provides the luxury of being able to simply click "Cite" under the link to the article and it has three options of citations that are already formatted to be imported into a bibliography manager. The list of what Scholar has to offer goes on and on. If you are looking to save time spent on research, Google Scholar is a good option to begin brushing up on online research skills. ◆

Try it.
Go to "Google Scholar"

When the Rx is an app

Apps to monitor, manage and control aspects of health care, some physicians are finding they help increase patient compliance and education

As physicians notice that more patients rely on smart phones and devices, they realize that apps can be helpful to educate patients in musculoskeletal procedures, help in monitoring health, and assist in their rehabilitation. The American Medical Association has launched a "weight loss" app.

There has been a lot of discussion about the potential benefits of mobile health—known as mHealth in health IT circles—that several organizations have formed to promote mobile health solutions and study their efficacy and potential risks. Discussions are taking place about how a $1 app could be a viable alternative to prescribing a medication and help patients monitor their health.

The mHIMSS website has a guide to help physicians evaluate apps

Researchers predict that the prescribing of apps will grow more common as outcome-based payment models become more prevalent and physicians look for ways to use them for health management.

Orthopaedic apps will be discussed at COA's 2014 Annual Meeting.

Share your experience with your colleagues.

Let us know if you have discovered a useful app for your orthopaedic patients.

2013 Legislative Wrap-up

State Legislative Wrap-Up

AB 1000 (Employment of Physical Therapists)

Governor Jerry Brown has signed AB 1000 into law which takes effect January 1, 2014. AB 1000 was co-sponsored by the California Orthopaedic Association, the California Medical Association, and the California Physical Therapy Association to clarify that physical therapists (PTs) and other health care professionals can legally be employed by a licensed medical corporation in California. In 2010, a Legislative Counsel opinion raised questions as to whether the employment of PTs was legal and the Physical Therapy Board of California threatened to send cease and desist letters to employed PTs. The bill also gives patients the ability to seek treatment directly from a PT without first being evaluated by a physician for a limited period of time (45 calendar days or no more than 12 visits). The bill does not expand or modify the scope of practice for PTs and reinforces that they are not authorized to make a medical diagnosis. The bill also includes patient notification requirements, a mandate that the patient be referred immediately should the patient's condition be beyond the scope of the PT for an in-person examination, and a clarification that carriers are not required to pay for services rendered by the PT without a medical diagnosis.

Initiative to Alter MICRA

Trial lawyers are waging an aggressive campaign to weaken or overturn California's landmark tort reform legislation—the Medical Injury Compensation Reform Act (MICRA). A statewide ballot initiative is gathering signatures attempting to qualify for the November, 2014 ballot.

Among other things, the initiative would Increase the $250,000 cap on non-economic damages to over $1 million and index it to ongoing cost-of-living increases. This change is expected to increase medical malpractice premiums by some 40% and consumers will see dramatic increases in their health care costs and limits on access to care

This will be an expensive fight with the trial attorneys. We need your help.

Join the fight to preserve MICRA.

Your contributions will be appreciated.

Congress Continues to Work

Members must act in December to avoid 24% cuts to physician payments *Modern Physician—November 22, 2013*

With time running out to prevent a major pay cut for doctors, the Senate Finance Committee scheduled an "open executive session" for Dec. 12 to discuss repealing and replacing the Medicare sustainable growth-rate physician payment formula.

Democratic and Republican House and Senate leaders have released a draft proposal of legislation that contains elements physicians are not thrilled with—such as a 10-year payment freeze and certain quality measures.

But if Congress does not act, an SGR-driven 24.4% Medicare pay cut is set to take effect Jan. 1, 2014.

The legislation "would end the SGR's annual cycle of uncertainty and protect seniors' access to their doctors," the Senate committee's leaders—Sen. Max Baucus (D-Mont.) and Sen. Orrin Hatch (R-Utah) said in a media advisory (PDF). "It would also help shift Medicare away from the inefficient fee-for-service payment model by rewarding the value of care over volume."

The cost of replacing the SGR has been projected at $138 billion, a significant decrease from a previous estimate of $297 billion because of slower projected growth in Medicare spending. The proposal, however, doesn't mention a means to cover that cost, and Baucus and Hatch said they would "address offsets for the legislation separately."

The American Medical Association House of Delegates held its interim meeting Nov. 16-19 and the AMA's president, Dr. Ardis Dee Hoven told delegates that doctors must remain at the negotiation table, despite their misgivings over parts of the deal.

"The proposal before us is a mixed bag," Hoven said in a speech. "I'm not going to sugarcoat it—there are things I really don't like about the proposal: Chief among them, the idea of a 10-year payment freeze."

Hoven said the freeze "doesn't make sense" because Medicare payments are currently 20% below the cost of delivering care. "It makes you want to throw up your hands and scream," Hoven said. But, she said, "walking away right now would be a colossal mistake."

Given Washington's current state of dysfunction, the fact that the Congress was able to come up with a bipartisan proposal is in itself an incredible accomplishment and "proof of the widespread recognition that the SGR has to go," she said.

A freeze would do away with the regular chaotic cycle of looming decreases and last-minute fixes, which included five temporary legislative "patches" to suspend SGR-driven pay cuts in 2010 alone. " On Nov. 19, AMA members and delegates from 35 states met with Congressional leaders to advocate for a permanent SGR replacement.

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