COA Report

A publication of the California Orthopaedic Association

Spring, 2009

Change is on the Way

There's a new sheriff in town with big plans for our line of work. The Obama Administration has designs on health care delivery and has set out to rewrite the rules in ways we can only guess. The good news is unlike the previous efforts at national health care reform, hopefully everyone is going to be at the table. It is important that the MDs who speak for us won't be too "wonky" and they will understand what happens in our offices at the front edge of patient and doctor interactions. The American Recovery and Reinvestment Act (ARRA), the work product of the recent White House Seminar on Health Care, will speak volumes. An overview of the health care spending contained in ARRA is on Page 2 of this newsletter.

The health care insurance industry still seems to have first dibs on the health care dollar. But there also seems to be a recognition in the President's last national address that he acknowledges health care monies are wasted by doctors trying to collect funds that the insurers spend dollars trying to hold on to. That costs billions. What is done about that will affect all of us more than any other reform.

Mark B. Wellisch, M.D.
President

There's a huge push to expand the use of electronic "health records." That really doesn't help us care for our patients. In fact, it takes away from face-to-face patient care. It does help the "bean counters" keep track of what we do and don't do and makes "pay for performance" (P4P) more accountable. It also can force physician behavior modification by imposing treatment pathways which, in the long run may be very good for saving money, assuring patient safety, and reducing our time spent on some types of patient care. Who writes and keeps up the pathways is the key to success. If big PHARMA is involved, then you can count on the big savings ending up

(Continued on Page 2)

Register by April 17, 2009 to Save $150

COA's 2009 Annual Meeting QME Course

Instructional Course: Practice Survival Course: Tools for Success

May 14-17, 2009 Fess Parker Resort—Santa Barbara

Attend the meeting to learn about:

- **Advances in trauma fracture care**
- **National Health Care Reform**
- **Survival of Orthopaedic Practice**
- **Workers' Compensation en banc decisions—Almaraz/Guzman**
- **New QME regulations and more.**

The meeting will be accredited for 18 hours of Category I CME and 6 hours QME CME hours. Registration materials are on-line at: www.coa.org

President's Column (continued from Page 1)

as big profits for them.

There is likely to be a subsidy to physicians who buy an electronic health care record (EHR) system of up to $40,000 per physician. I have two cautions regarding the purchase of this item. First, the Administration is talking about a "certified" EHR and, so far I don't know what constitutes a certified EHR. Secondly, the costs for an EHR can cripple your bottom line. My practice of 6 orthopaedists and a physiatrist was put out of business by our purchase of this costly hardware and software. Albeit, those costs were the straw that broke our backs, there were obviously more reasons, but chronologically when we added those costs; we had to close our doors.

Drugs and medical devices are, after rising health insurance premiums, a major factor in the percentage of gross national product (GNP) spent on health care. Unfortunately, the only mention of that in the budget proposal is to allow patients to buy drugs out of the country and hopefully decrease prices by competition.

The budget proposal also mentions improving oversight to reduce fraud, waste, and abuse in certain programs like the prescription drug program, Medicare Advantage, and Medicaid. Hopefully, that's not just lip service.

A ray of great news was the expansion of SCHIP to cover more children's health needs.

Also, there's a push to expand underserved and rural health care by reducing or forgiving student loans to practitioners who practice in those areas.

Finally, what might affect us quite a bit is $1.1 billion for "comparative effectiveness research." Which is likely to be outcomes based clinical pathways. Something that the AAOS has been working on for years.

The change that's on the way will depend on the details and perhaps with input by us, it can benefit us. Don't forget that the best results in politics only happen with your input. Being quiet means being ignored.

Mark Wellisch, M.D.
President

CMA Toolkit
on the "Prohibition on Billing Patients for Services that are the Responsibility of their Carrier"
can be found on COA's website: www.coa.org

Health Care and the American Recovery and Reinvestment Act (ARRA)

New England Journal of Medicine, February 20, 2009

On February 17, 2009, President Obama signed into law a $787 billion economic stimulus package. Health care spending included in the Act is outlined as follows:

- Comparative Effectiveness Research Program—$1.1 billion
- Continuation of Health Insurance Coverage for Unemployed Workers—a 65% federal subsidy of up to 9 months—$24.7 billion
- Department of Defense and Veterans Affairs—$1.4 billion
- Health Information Technology—financial incentives to physicians and hospitals to promote the use of electronic health records and grants—$19.2 billion
- Health Resources and Services Administration—equipment and health information technology at community health centers—$2.5 billion
- Medicare—teaching hospitals, hospice programs, and long-term care hospitals—$338 million
- Medi-Cal—additional federal matching funds—$87 billion
- National Institutes of Health—$10 billion
- Prevention and Wellness—clinical and community-based prevention activities that will address rates of chronic diseases, immunizations for low-income children and adults, reduce health care associated infections—$1 billion
- Public Health and Social Services Emergency Fund—$50 million to improve the security of information technology.

For a complete copy of the New England Journal of Medicine article describing the Act, fax a request to the COA Office—916-454-9882.

President Obama Releases 2010 Budget Blueprint

On Thursday, February 26, 2009, President Barack Obama released an outline of his proposed fiscal year 2010 budget. While the Budget proposal titled, "A New Era of Responsibility" represents a summary of the Obama Administrations priorities and policies, the responsibility of passing the Federal budget rests with Congress.

Most notably, the Budget:

- Reserves $630 billion over the next 10 years to finance fundamental reform of our health care system
- Adds to the $19 billion of health information technology (HIT) funding from the American Recovery and Reinvestment Act (ARRA)
- Creates new Medicare demonstration and pilot projects focused on increasing quality, lowering costs, improving beneficiary education, and aligning provider payments with costs
- Builds on the $1.1 billion dollars included in the ARRA for comparative effectiveness research
- Enhances the Food and Drug Administration (FDA) medical product safety program
- Establishes a new regulatory pathway to approve follow-on biologics at the FDA
- Dedicates additional resources to initiatives at the Department of Health and Human Services to reduce fraud and abuse in the Medicare and Medi-Cal programs
- Provides additional funding to enhance the emergency care systems

To read more details about the President's Budget, go to the White House website: http://www.whitehouse.gov/omb/budget

Information from the AAOS Advocacy Now, March 10, 2009.

Register Now . . .

Santa Barbara—2009

COA's 2009 Annual Meeting/QME Course

Instructional Course: Practice Survival Course: Tools for Survival

Dear Colleague:

Register today to be part of ***COA's 2009 Annual Meeting/QME Course*** and ***Instructional Course*** to be held May 14-17, 2009 at the historic Fess Parker's Doubletree Resort in Santa Barbara. Located across the street from the beaches of Santa Barbara, it's a great setting for the entire family.

An instructional course entitled, "**Practice Survival Course: Tools for Success"** will be held on **Thursday, May 14** with practical information that will help improve reimbursement for your practice. **Attend this course with your practice manager and take home practical information.**

During the **Annual Meeting/QME Course- May 15-17,** you will interact with a distinguished faculty of orthopaedic and legal specialists in the following areas:

- ◊ **Economic Survival of Orthopaedic Practices**
- ◊ National Health Care Reform—**American Recovery and Reinvestment Act of 2009**
- ◊ **Use of Physician Extenders in Orthopaedic Practice**
- ◊ **Pearls and Pitfalls in Pediatric Fracture Care**
- ◊ **Latest Techniques for Fixing Proximal Humerus, Distal Radius, and Clavicle Fractures Hands-on saw bones labs**
- ◊ **Orthopaedic Management of the Graying Population – the Role for Orthopaedic Surgeons**
- ◊ **Practical Pathways for Maintenance of Certification**
- ◊ **QME course** will help you understand the recent **Almaraz-Guzman decisions**, focus on "Clinical Indications for Common Surgical Procedures and Injections and Discuss What's Reasonable and What's Not;" provide a forum to "Ask the Experts" about your tough and interesting Medical-Legal cases; and, be updated on the DWC's efforts to adopt post-surgical rehabilitation, back, and pain treatment guidelines and changes to the **QME Regulations** and new reporting requirements.
- ◊ **Legislative Update** to hear about efforts on the state and federal level to legislation and/or regulations which directly impact your practice.

You can earn 18 Category I CME hours of which 5 hours will qualify for CME in radiologic technology. You can also earn 6 hours of QME CME credits.

Orthopaedic Office Managers will have a special meeting on Friday, May 15 to network and discuss other practice management issues with colleagues. **We would encourage your Office Manager to attend.**

Spouse events will include a **Welcome Breakfast**, a docent tour of the **exclusive Lotusland estate and private gardens, and a trolley tour of Santa Barbara.** The **Presidential Reception** will be a Beer and Wine Fest featuring beers from local micro-breweries. **The Gala Dinner** will allow attendees to relax and enjoy "Best of Santa Barbara" cuisine.

This meeting will draw orthopaedic surgeons and their staff from all orthopaedic specialties, so be sure to register early to reserve your space.

We look forward to the interaction and discussion at the meeting.

Mark Wellisch, M.D.
President

Norman Otsuka, M.D.
Program Chair

News of Interest

Medicare Coding Alert

Jan Henstorf, M.D., Chair, COA's Economics Committee

Kyphoplasty

In the conversion from National Heritage Insurance to Palmetto GBA as California's Medicare fiscal intermediary, the reimbursement policy for kyphoplasty has been changed. For Medicare patients, the new policy may require two diagnoses to be listed in order to be reimbursed.

For Kyphoplasty, there are only four codes that can stand alone:

198.5 Secondary Malignant Neoplasm of Bone and Bone Marrow
203.00 Multiple Myeloma, Without Mention of Having Achieved Remission
203.01 Multiple Myeloma in Remission
238.6 Neoplasm of Uncertain Behavior of Plasma Cells

When utilizing the diagnosis code:

733.13 Pathological Fracture of Vertebrae for Kyphoplasty, you **must also list one of the following secondary diagnosis codes defining the cause of the osteoporosis:**

733.00 Osteoporosis, Unspecified
733.01 Senile Osteoporosis
733.02 Idiopathic Osteoporosis
733.03 Disuse Osteoporosis
733.09 Other Osteoporosis

Without a second diagnosis code, your billings for kyphoplasty will be rejected by Palmetto GBA.
No policy change was made to vertebroplasty.

Contact the COA office at 916-454-9884 if you have any questions, would like a copy of the revised Palmetto policy, or if you continue to receive denials when you bill for kyphoplasty even after you list the second diagnosis.

Delegation of Services Agreement—Physician Assistants

More orthopaedic practices are using the services of a physician assistant to assist them with musculoskeletal services in their office. When an orthopaedic surgeon is utilizing a physician assistant, it is required that the physician assistant work under protocols that are spelled out in a Delegation of Services Agreement (DSA). The DSA specifies the names of the supervising physicians and what types of medical services the physician assistant is allowed to perform, how they are performed, how the patient charts will be reviewed and countersigned, and what type of medications the physician assistant will prescribe on behalf of the supervising physician.

The Physician Assistant Committee (PAC) has recently amended the requirements for the DSA to include:

1) A physician assistant may provide medical services that are delegated in writing by a supervising physician who is responsible for patients cared for by the physician assistant. The physician assistant may only provide services that he or she is competent to perform that are consistent with his or her education, training, and experience, and are delegated by the supervising physician.
2) More than one supervising physician may sign the DSA only if each supervising physician has delegated the same medical services to the physician assistant. A physician assistant may provide medical services pursuant to more than one DSA. For a copy of a sample DSA, please see the PAC website: www.pac.ca.gov
3) The PAC or its representative may require proof or demonstration of competence from any physician assistant for any medical services performed.
4) If a physician assistant determines a task, procedure, or diagnostic problem exceeds his or her level of competence, the physician assistant must either consult with a physician or refer such cases to a physician.

For additional information, contact the Physician Assistant Committee at: 916-561-8780.

People in the News

COA Members Honored at the AAOS Annual Meeting/Board of Councilors

Blair C. Filler, M.D. of Los Angeles was awarded the **2009 William W. Tipton, Jr., M.D. Leadership Award** for his dedication to quality orthopaedic care and far-reaching work in CPT coding issues. Dr. Filler has worked tirelessly to develop lines of communication with public officials and advocate for patients and orthopaedic surgeons.

Dr. Filler (left) receiving the Tipton Leadership Award from Dr. Tony Rankin.

Ramon Jimenez, M.D. of Monterey received the **2009 Diversity Award**—for making it his mission to increase diversity in orthopaedics. Throughout his career, Dr. Jimenez has been a role model and mentor to Latinos and other minorities, encouraging them to pursue the specialty and helping them thrive as orthopaedists. He provided guidance and direction to the Academy's early diversity efforts, through his work on the Patient Education Committee and the Diversity Advisory Board.

Dr. Jimenez (left) receiving the Diversity Award from Dr. Tony Rankin.

Peter J. Mandell, M.D. of Burlingame was elected **Chair** of the **AAOS Council on Advocacy**. The Council on Advocacy works with states to develop successful strategies on state and federal legislation.

Board of Councilors

Thomas Barber, M.D., of Oakland assumed the Chairmanship of the AAOS Board of Councilors.
Leslie Kim, M.D. of Daly City was elected to the Executive Committee of the AAOS Board of Councilors.

OREF/Current Concepts in Joint Replacement Award

Nelson SooHoo, M.D. of UCLA in Los Angeles, has been awarded the 2008 OREF/Current Concepts in Joint Replacement Award for his research entitled, "*Development of quality-of-care indicators for patients undergoing total hip or total knee replacement"* a study that articulates a "potential model for translating evidence-based practice into improved outcomes for the large number of patients undergoing total hip and total knee replacement." His research was supported by grants from OREF, UCLA, and the American Orthopaedic Foot and Ankle Society.

Dale Butler, M.D. of Grass Valley and **Todd Moldawer, M.D.** of Van Nuys have been appointed to the California **Radiologic Technology Certification Committee**. The RTCC advises the California Department of Public Health on radiation safety and certification requirements for individuals using x-radiation in treating patients.

The **Orange County Medical Association** annually recognizes physicians in their county for their leadership, teaching, mentoring, research, and humanitarian service. **Congratulations** to the following orthopaedic surgeons who were honored and recognized for their work in 2009:

Afshin Aminian, M.D.	Emil Dionysian, M.D.	Nicholas Rose, M.D.
Donald Bittner, M.D.	Tad Funahashi, M.D.	Benjamin Rubin, M.D.
John Cook, Jr., M.D.	Zafar Khan, M.D.	Michael Shepard, M.D.
Rick Csintalan, M.D.	Michiyuki Kono, M.D.	Harry Skinner, M.D.
Jeffrey Deckey, M.D.	James Lau, M.D.	Daniel Stein, M.D.

The 2008 Phoenix Lifetime Achievement Award in Medicine was awarded to **Mark Reiley, M.D.** of Berkeley.

Looking Forward in 2010— Any Hope From the Obama Administration?

Ralph DiLibero, M.D., Editor
COA Report

Healthcare reform is on the docket, but it is not clear as to what will actually be reformed. The aim seems to be to quickly develop interest in a program that would insidiously sew the seeds for an eventual administration goal -- National Single Payer Health Coverage for all residents in the United States in about seven to ten years. The watershed event to evolve this process would begin with a federally financed insurance pool for presently uninsured patients who cannot otherwise be insured through private coverage or job-related entitlements. The hope from the Obama Administration is that this pool would gradually grow and evolve to be all-encompassing. There is also considerable interest among the Congress and Senate to expand the Medicare or Medicaid beneficiary pools so that they could also include this risk pool of patients.

Physician and patient interests would be best served by insisting on the sacrosanct privilege of the patient-physician relationship and the rebuttably presumed correct autonomy of physicians to determine what is medically necessary and correct to prescribe and administer to their patients. The quality of medicine should be determined by physicians. Access should be defined as direct access to healthcare delivery and not as access to waiting lists. Cost-effectiveness should never supplant quality or access.

Again, physicians will be facing the inevitable reality of the federal budget. Medicare and Medicaid cash reserves cannot keep up with medical inflation and increased medical costs. Medicaid is looking to cut the amount of present financing funds going to: medical schools, outpatient hospital and clinic services, government-owned healthcare facilities, and targeted case management services. These cuts will increase the burden on private facilities to care for the indigent. There is no current federal effort to correct Medicare's flawed sustained growth formula. Therefore, continued overall cost shifting will drive up the cost of private healthcare premiums directly to paying patients and businesses providing healthcare coverage for their employees. Federal programs will continue to decrease overall reimbursement. Physicians will face the consequences -- decreased revenue from increased cuts. Many physicians have opted out of the Medicare programs; however, states are now considering mandating participation in Medicare-Medicaid programs as a condition for maintaining state medical licensure.

The present state of affairs with the balance billing issue has given third party payers increased leverage over practicing physicians. Over the short haul, there will be an effort to decrease the reimbursement scale to non-contracted physicians as opposed to contracted physicians. This effort, an unsound policy, would only worsen the compliant rate of physicians willing to take on-call duties at emergency rooms and induce further emergency room closures. CMA is considering submitting an appeal of the Prospect decision, but this would take over a year to process. A dispute resolution process has been established in the Department of Managed Health Services, but it is unclear whether it will be a cost-effective option for physicians.

Billing problems – delays and denials will continue because of confusing coding deadlines. The AMA is continually changing and releasing new CPT codes. Each year a codebook is published which releases codes to become effective the following January 1, but the codebook is not available to physicians or payer agencies until late November of the previous year. That does not allow enough time for office managers to change the billing codes or payer agencies to define and assign a benefit to each new code. CMS revises and institutes new ICD-9 codes (soon to be completely revised ICD-10 codes) by publishing a listing of the codes in the Federal Register each spring that appear on-line each summer and go into effect on October 1 each year. Additionally there are annual changes, updates, and new HCPCS II codes each year that payer agencies have to contend with; and that process takes place over a period of months. Your office manager has to continually check the appropriate websites to gather current information. A suggestion that may help: The best way for your office manager to find a way through this murky non-system is to personally call the intended payer and inquire as to the assigned benefit amount for the particular code in question. If there is no assigned benefit amount, then the code has not been fully processed into the payer's reimbursement protocol and the claim would more likely be paid with the submission of an older code.

New COA Program Discounts—Credit Card Processing Fees

COA members are saving 6.25% - 30% on their merchant service fees charged when processing credit card charges through a new Wells Fargo COA Member Benefit Program. Since Wells Fargo processes the credit card charges directly and not through a third party, they are able to offer these discounted rates.

You can sign up for this program without changing your existing bank accounts. Wells Fargo will simply deposit the funds into your existing accounts. You can also use your existing equipment or software for processing the charges.

As the COA program grows, we will use the market clout of the COA program to drive down the fees even more.

There is no cost to have Wells Fargo analyze your existing merchant service fees to see if they can save you money. Contact Douglas Keenum, COA's Wells Fargo to get a quote. Contact information:

Phone: 916-203-1085 or 800-451-5817
E-Mail: douglas.b.keenum@wellsfargo.com

QME Revised Regulations Effective February 17, 2009

On February 17, 2009, the Division of Workers' Compensation implemented revised QME/AME Regulations which govern the QME/AME process including the definition of a physician's office, panel QMEs, consultations, QME timelines for reporting, service of the reports, QME CME, and other ethical QME standards. The regulations include several new DWC forms as well. **No changes were made to the Medical-Legal Fee Schedule.**

A summary of these changes along with the text of the regulation and the new forms can be found on COA's website: www.coa.org.

AMA CPT Assistant New Coding Updates

The AMA's CPT Assistant has recently published the following coding updates for orthopaedic procedures:

Plantar Common Digital Nerve Injection Procedures
January, 2009
Conversion and Revision for Hip Arthroplasty
December, 2008

To obtain a copy of the coding updates, fax a request to the COA office—916-454-9882.

Classified Ads

VENTURA COUNTY MEDICAL CENTER
ORTHOPEDIC CLINIC
3291 LOMA VISTA ROAD
VENTURA, CA 93003
805- 652-6149
805 652-5788 (fax)

The Ventura County Health Care Agency is looking for an Orthopaedic surgeon to join our 7 surgeon team.

Position: Orthopaedic Surgeon
Board certified or board eligible.

Open: April, 2009

Contact: Leticia Rodriguez, Manager or
Dr. John Taketa, Medical Director

Phone: (805) 652-6149 or (805) 760-4662

Orthopaedic Medical Office—Share Space

Orthopaedic medical office located in Laguna Hills—attached to Saddleback Memorial Hospital.

Current orthopaedist looking to share office space - 2,385 sq ft—consisting of 3 exam rooms, 1 large procedure room, and x-ray room onsite. Use of office and waiting area.

For more information, e-mail:
Sandra: workbiz320@yahoo.com

Transcription/Billing — Transcriptionist specializing in Work Comp, chart notes, etc. One-day turnaround. You can use Dictaphone calling a toll-free number, digital or tapes.

Call Karen at 775-626-9604, 707-373-2187 or email at powell0222@sbcglobal.net. Refs available.

Advertisement

"ORTHOPAEDIC OUTPATIENT CLINICS: LIFE VEST IN SHARK (STARK) INFESTED WATER?"

By: Anthony Hunter Schiff, J.D., M.P.H.
Schiff and Bernstein
Phone: 310-277-8445

Several California hospitals have begun to operate orthopaedic outpatient clinics as a vehicle through which to recruit new physicians or to retain their existing physician bases. In certain settings, hospitals utilize these clinics as a pathway to help insure full time orthopedic surgical coverage. These clinics do not require separate licensure; they are exempt[1] because they operate as outpatient departments of the hospitals. This article focuses on key issues that present from the operation of these outpatient clinics.

First, physicians are primarily attracted to the outpatient clinic model as a means to reduce their practice overhead significantly. In the typical private practice setting, physicians are responsible for providing (and paying for) office space, equipment, furniture and furnishings, supplies, personnel, billing and collection, and administrative support (collectively, the "**Facilities**"). Under the outpatient clinic model, the hospital provides the lion's share of these items. The physicians remain responsible to provide professional liability insurance, billing and collection services, and reduced management and administrative support.

For each patient encounter in the outpatient setting, the hospital seeks to recover the cost of providing the Facilities by submitting a separate bill to the applicable third party payer. Correspondingly, the attending physician (or his or her orthopedic group) submits a bill to the same payer with a location modifier to denote that the patient encounter occurred in an outpatient facility. In theory, the hospital should receive reimbursement from the payer for the cost of the Facilities. In turn, the physician should receive a reduced fee from the payer for his or her professional services in recognition of the payment to the hospital for the Facilities. And, in theory, the savings to the physician from not having to provide (and pay for) the Facilities should be greater than the aggregate reduction in fees occasioned by the application of the location modifier in billing for professional services.

Unfortunately, theory sometimes conflicts with practice when the hospital and physician submit bills to commercial payers, and when physicians receive global surgical fees that include reimbursement for post-operative visits. The Medicare program recognizes the billing dichotomy in the clinic setting. The Medicare program will reimburse the hospital in respect of the Facilities furnished for each patient visit. Likewise, the Medicare program will reimburse the physician for professional services at a lower rate in recognition of the location modifier.[2] In contrast, the majority of commercial payers are either unable or unwilling to separately reimburse both the hospital and the physician. Instead, these commercial payers reimburse the physician for the office visit as if the encounter occurred in the private practice setting, even when the physician includes the location modifier on the bill. As a result, the physician receives a global fee from the commercial payer that includes reimbursement for the Facilities.

Likewise, a physician will receive a ***global surgical fee*** both from the Medicare program and commercial payers. That fee will include reimbursement for post-operative visits. Those visits will occur in the outpatient clinic setting in which the physician will utilize the Facilities. However, the facility fee received by the hospital in connection with the surgery (inpatient or outpatient) will not include reimbursement for the Facilities in the outpatient clinic setting.

Importantly, the physician should not retain the entire surgical global fee, even if the hospital permits the physician to do so. Instead, the physician should utilize a portion of the global surgical fee to reimburse the hospital for the Facilities. The failure of the physician to reimburse the hospital and/or the unwillingness of the hospital to accept reimbursement from the physician for the Facilities could be construed as consideration paid by the hospital to the physician in exchange of patient referrals, a violation of federal and state anti-kickback laws.

Aside from the billing-related issues, there remain many traps for the unwary. First, physicians will no longer be able to operate ancillary services covered by federal and state self-referral prohibitions (*e.g.*, diagnostic imaging and physical therapy) following affiliation with an outpatient clinic. Physicians typically operate these services pursuant to the so-called in office ancillary services exception to the self-referral prohibitions. This exception requires the physicians to control the office space in which they operate the covered ancillary services.[3] The hospital controls the office space under the outpatient clinic model. As a result, the physicians likely will lose ancillary service revenue. However, physicians can mitigate this financial loss by attempting to sell their ancillary service product lines to the clinic-sponsoring hospital.[4]

Second, physicians that affiliate with an outpatient clinic continue to bill and collect fees for their professional services. In the absence of a valid recruitment arrangement, the sponsoring hospital cannot guarantee the net income of the physicians that staff

(Continued on Page 10)

the outpatient clinic. Hence, the income of the participating physicians generally remains dependent on their productivity and, correspondingly, their ability to compete successfully with other physicians that staff the outpatient clinic for patients from traditional referral sources.

In some instances, an orthopedic group will attempt to negotiate the exclusive right to provide orthopedic services in the outpatient clinic, similar to arrangements under which a hospital "closes" an inpatient department and awards an exclusive contract to a group of physicians. Under California law, however, a hospital that contracts with the Medi-Cal program cannot "close" any department or service other than radiology, anesthesiology and pathology.[5]

Third, a physician typically affiliates with an outpatient clinic through a professional services agreement ("**PSA**") with the sponsoring hospital. The PSA is an important document and governs the relationship of the physician and hospital during the term of the affiliation with the outpatient clinic. Among other matters, the PSA should address the obligation of the hospital to furnish the Facilities, the separate billing and collection functions of the parties, the payment by the physician of a portion of the global fee to reimburse the hospital in respect of Facilities furnished for patient visits in outpatient clinic. The PSA should also cover the obligation of the hospital to provide those ancillary services that are necessary for quality patient care in a convenient location. In addition, the PSA should cover obligations of the parties regarding the provision of professional liability, comprehensive general liability and property damage insurance coverage. In many instances, the proposed PSA is either silent on many of these key provisions, or the provisions are *very* hospital friendly.

The PSA should also address the term of the affiliation, the events that permit either party to terminate the arrangement, and the rights of the physician following dissociation from the outpatient clinic. While the PSA often times will provide for a fixed term, the PSA may also give either party the right to terminate at any time, without cause, with advance written notice. In that case, the term of the PSA is only as long as the notice period, notwithstanding the expectation of the participating physician. *Importantly*, the physician needs to consider how he or she will practice following dissociation from the outpatient clinic. For example, the physician may need to lease new office space and fund the cost of tenant improvements. The physician will also have to provide furniture and equipment, and hire support personnel. In essence, the physician will have to recreate the Facilities that the hospital had been providing under the PSA.

The looming financial exposure can be more acute in the case of an orthopedic group that sells its leasehold interest, tangible assets, and ancillary service product lines to the sponsoring hospital concurrently with the execution of the PSA. For one, even if the orthopedic group could recreate the Facilities, the cost of rebuilding the ancillary service product lines, and especially an ambulatory surgical center, could be prohibitive following the termination of the PSA. This result could be problematic for an orthopedic group that relied on ancillary service revenue to help supplement professional fees, and pay overhead. In short, the "exit" provisions are critical because the proceeds of any sale prior to affiliation with the outpatient clinic are generally not sufficient alone to permit the physician(s) to retire. The time to consider these issues is *before* the parties execute the PSA, after which the hospital will have substantially greater leverage.

Physicians should understand that the implementation by hospitals of the outpatient clinic model is a relatively recent development. There are currently no court cases that address the legal issues that present, nor has the Legislature addressed this health care delivery system through new statutes or regulations. Given this legal vacuum, some hospitals have attempted to structure the outpatient clinic in ways that historically have proven problematic. Physicians are cautioned that such arrangements could run afoul of several federal and state laws, including antitrust, anti-kickback, and the corporate practice of medicine prohibitions. Physicians should understand that participation in any such improper transaction could constitute unprofessional conduct and expose the physicians to disciplinary action by the Medical Board of California.

In closing, there are pros and cons to the outpatient clinic model. If structured correctly, physicians or groups of physicians can benefit greatly from their affiliation with an outpatient clinic. That said, and as in many transactions, the "devil is in the detail."

1. Section 1206(d) of the Health and Safety Code.
2. A physician submits a false claim when failing to include the location modifier in the bill. The lack of the location modifier implies that the physician furnished the Facilities when, in fact, the hospital furnished such items in connection with the patient encounter. By excluding the location modifier, the physician is requesting payment for goods and services not actually furnished to the Medicare beneficiary, the very essence of a false claim.
3. Physicians typically give up their private practice offices – and the overhead associated with those offices – following affiliation with an outpatient clinic.
4. The purchase price must be fair market value and should be determined by an independent third party. Differences of opinion between the hospital and physician often arise over the valuation methodology. Not surprisingly, the purchase price can vary markedly depending on the methodology employed by the appraiser.
5. California Welfare & Institutions Code Section 14087.28

Legislative News of Interest

The following bills have been introduced in the 2009-10 Legislative Session all potentially impacting orthopaedic practice. COA's Legislative Committee is reviewing the bills and will be recommending positions to COA Board of Directors.

AB 356 (Fletcher) – Mini- C-Arm – Physician Assistants

Existing law requires the Department of Health Services to provide for the certification of licentiates of the healing arts to supervise the operation of x-ray machines or to operate x-ray machines, or both, and to prescribe minimum standards of training and experience for these licentiates.

This bill would revise the definition of licentiates of the healing arts to also include a physician assistant who is licensed pursuant to the Physician Assistant Practice Act who practices under the supervision of a physician and surgeon.

AB 366 (Ruskin) Medi-Cal – Orthopaedic Implants for Cancer PatientS

Under existing law, the California Medical Assistance Commission is authorized to negotiate inpatient hospital services contracts binding upon the State Department of Health Care Services.

Currently this is a spot bill. The bill will be amended to require the Medi-Cal/CCS program to reimburse for orthopaedic implants for cancer patients.

AB 445(Salas) Use of X-ray equipment: prohibition: exemptions.

Existing law establishes a program for the certification and regulation of radiological technologists. Existing law, with certain exceptions, prohibits a person from operating or maintaining any X-ray fluoroscope, or other equipment or apparatus employing roentgen rays, in the fitting of shoes or other footwear or in the viewing of bones in the feet. Violation of these provisions is a crime.

This bill would exempt from this prohibition the use of a mini C-arm digital radiography device in connection with the diagnosis of bone fractures, in a licensed trauma center or an emergency department of a licensed hospital, by an orthopedic resident, an orthopedic nurse practitioner, or a physician assistant, when under the direct or indirect supervision of a certified radiological technologist.

AB 542(Feuer) Adverse medical events.

Existing law requires specified health facilities to report patient adverse events to the department within 5 days.

This bill would expand the specified adverse events requiring reporting to include, among others, manifestations of poor glycemic control, catheter-associated urinary tract infection, and surgical-site infection, and would require a surgical clinic to comply with these health facility adverse event reporting requirements. The bill would require the department to collect adverse event information, and investigate adverse events.

AB 718(Emmerson) Prescription drugs: Electronic transmissions.

The Pharmacy Law regulates, among other matters, the dispensing by prescription of dangerous devices and dangerous drugs, which include controlled substances. Existing law authorizes the electronic transmission of prescriptions under specified circumstances.

This bill would require every licensed prescriber, or prescriber's authorized agent, or pharmacy operating in California to have the ability, on or before January 1, 2012, to transmit and receive prescriptions by electronic data transmission.

AB 721(Nava) Physical therapists: Direct Access

This bill is a reintroduction of a bill last year which seeks to expand a physical therapist's scope of practice to include direct access to patients. The bill would allow physical therapists to initiate treatment without a physician first evaluating the patient and diagnosing the patient's problem. The physical therapist could treat the patient for any duration of time without any physician input. The bill also broadens the definition of "physical therapy."

Physical therapists claim this bill is necessary to allow more timely access to physical medicine services. COA disagrees. We believes the collaborative arrangement that exists between orthopaedic surgeons and physical therapists results in the most optimal patient care. In our experience, if there is a delay in a patient receiving physical medicine services, it is generally due to the insurance carrier denying authorization for the service, not a delay in the physician making the referral.

COA has opposed direct access in the past, but are open to working with the physical therapists to resolve problems that may exist in referring patients for physical medicine services.

SB 726(Ashburn) Hospitals: employment of physicians and surgeons.

Existing law establishes, until January 1, 2011, a pilot project to allow qualified district hospitals to employ a physician and surgeon, if the hospital does not interfere with, control, or otherwise direct the professional judgment of the physician and surgeon. The pilot project authorizes the direct employment of a total of 20 physicians and surgeons by those hospitals, and specifies that each qualified district hospital may employ up to 2 physicians and surgeons, subject to certain requirements. Existing law requires the Medical Board of California to report to the Legislature not later than October 1, 2008, on the effectiveness of the pilot project.

This bill would revise the pilot project to authorize the direct employment by general acute care hospitals meeting specified requirements of an unlimited number of physicians and surgeons under the pilot project, and would authorize such a hospital to employ up to 5 licensees at a time. The bill would extend the pilot project until January 1, 2016, would require the board to report to the Legislature not later than October 1, 2013, on the evaluation of the effectiveness of the pilot project, and would make conforming changes.

AB 832 (Jones) Licensure of Outpatient Surgical Centers

Existing law defines "surgical clinic" as a clinic that provides ambulatory surgical care and is not part of a hospital or is a place that is owned, leased, or operated as a clinic or office by one or more physicians or dentists.

The bill would require outpatient surgical clinics to be licensed and not just Medicare certified regardless of physician ownership. The bill excludes a doctor's office or other place that provides only prescribed services. This bill would require any person seeking licensure as a surgical clinic to provide documentation of satisfactory completion of prescribed structural building requirements.

AB 877(Emmerson) Healing arts.

Existing law provides for the licensure and regulation of various healing arts practitioners by boards within the Department of Consumer Affairs.

This bill would declare the intent of the Legislature to enact legislation authorizing the Director of Consumer Affairs to appoint a specified committee of 7 members to perform occupational analyses and to prepare written reports on any legislation that seeks to expand the scope of a health care provider.

Welcome to COA's Newest Members

Suzanne M. Ackley, M.D.	Orange
Raed M. Ali, M.D.	Fullerton
Richard Todd Allen, M.D.	San Diego
Arash Aminian, M.D.	Fullerton
Amarpal Arora, M.D.	San Diego
Tarek Bittar, M.D.	Granada Hills
Joseph Bowen, M.D.	Loma Linda
Ryan Cordry, M.D.	Moreno Valley
Jerry Dean Crum, M.D.	Susanville
Kevin Dahl, M.D.	Loma Linda
Kevin C. Forsythe, M.D.	Stockton
Theodore Georgis, M.D.	Torrance
Eric Giza, M.D.	Sacramento
Robert C. Grumet, M.D.	Aliso Viejo
Chad Harbour, M.D.	Loma Linda
Andres Indresano, M.D.	San Diego
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Eric O. Klineberg, M.D.	Sacramento
Taylor A. Konkin, M.D.	Chico
Renee S. Lauritzen, M.D.	San Luis Obispo
Ethan Lichtblau, M.D.	Montreal
Matthew J. Meunier, M.D.	San Diego
Mark C. Nelson, M.D.	San Diego
Kevin J. Pelton, M.D.	Los Angeles
Thomas J. Phillips, M.D.	Cerritos
Ben B. Pradhan, M.D.	Pasadena
Charles Preston, M.D.	Walnut Creek
Michael McKeon Price, M.D.	Santa Barbara
Davie E. Rogers, M.D.	Glendale
Babak Samimi, M.D.	Los Angeles
John Schlechter, DO	Orange
Donald J. Sheffel, M.D.	Fort Bragg
Hasan Syed, M.D.	Loma Linda
Munir M. Uwaydah, M.D.	San Fernando
Stephen R. Veiss, M.D.	Livermore
Nikolaj Wolfson, M.D.	Los Angeles
Christopher Woodson, M.D.	Los Alamitos

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

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