# COA Report

A publication of the California Orthopaedic Association

Summer, 2011

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## PRESIDENT MESSAGE

Dear Orthopaedic Colleagues

It is my honor to serve the California Orthopaedic Association as its 33rd President. I would like to thank and congratulate our outgoing president, Glenn Pfeffer, his program chair, Basil Besh, and our Executive Director, Diane Przepiorski for organizing a superb educational and social program during our annual meeting. COA continues to provide one of the best and most pertinent programs for our membership. We are fortunate to have such a dedicated team of leaders.

I have attended AAOS meetings for nearly thirty years and have been actively involved with the AAOS for over fifteen years. Although I have been a COA member since 1989, I did not attend an annual meeting until ten years ago in Palm Springs. I immediately realized that the COA provided a vital service that is not filled by other medical or specialty organizations. The COA, through its excellent leadership, has continued to remain the premier organization for California specific practice and practice management issues. We intend to continue to fulfill this vital role.

New COA President, Tye Ouzounian, M.D. (left) presents COA plaque of appreciation to Immediate Past President, Glenn Pfeffer, M.D.(right)

This is certainly a time of change and uncertainty for orthopaedic practices as we move into the new challenge of healthcare reform with accountable care organizations, e-prescribing, electronic medical records and mandatory reporting. We have observed some of our colleagues merging into new orthopaedic groups and others leaving well established practices to continue their careers in hospital or foundation based settings. Some individuals and groups will do well, but not all of these transitions will work well for the individual provider. Recent AAOS publications have documented personal experiences regarding the potential catastrophic results that may occur as our practices evolve. Well

(Continued on Page 2)

## Advance Meeting Notice

**2012 COA Annual Meeting/QME Course**

April 19-22, 2012
Park Hyatt Aviara, Carlsbad, CA
(North San Diego County)

Meeting/hotel information is posted at: www.coa.org and will be updated as it becomes available. You can already make your hotel reservation. Book early to get the discounted rate of $215.

## President's Column (continued from Page 1)

established orthopaedic groups have been financially destroyed by poorly timed business and management decisions. In other states, orthopaedic surgeons have found that their ability to renegotiate, once their initial contract has expired, is compromised after they have been employed in a hospital based setting and no longer have a private practice to negotiate with.

I certainly am not in a position to tell you what practice model is best. The decision involves a variety of variables which are different for each of us. Age, personal ambitions, family goals and obligations, the ability to work independently or within a group, and other factors all play a role in the decision. In time, certain models may prove to be more stable for the long term viability of orthopaedic practice. At this time, a variety of practice options are still available to most of us. COA will continue to provide information so that each of our members are able to make an informed decision that will best suit their personal and professional needs.

We, as orthopaedic surgeons, are a well organized and proactive group. I personally believe that physicians have greater strength as a collective group rather than as individuals. An organization such as ours is also stronger if we function as a cohesive group. It has been observed that our membership is aging and younger orthopaedic surgeons are not consistently seeking membership in the COA. In order for us to continue as the premier orthopaedic association, I believe we must reach out and encourage the next generation of orthopaedic surgeons to join. Currently we are encouraging orthopaedic residents to become involved in COA and we will be offering educational sessions specifically designed for the younger physician.

Our next Annual Meeting/QME Course will be held on April 19 – 22, 2012 at the Park Hyatt Aviara Resort, in Carlsbad, CA. I am working closely with my program chairman Nicholas Abidi on ideas for the program. If you have specific topics or items that you feel would be of benefit to include, please feel free to contact me directly at ouzouniant@aol.com, or through the COA office at coa1@pacbell.net

Warmest regards,

Tye Ouzounian, MD
President

# People in the News

## COA Elects New Officers—2011-12

The following COA leaders were elected at the 2011 Business Meeting:

| | |
|---|---|
| President | Tye Ouzounian, M.D. |
| First Vice President | Kevin Bozic, M.D. |
| Second Vice President | Leslie Kim, M.D. |
| Secretary-Treasurer | Robert O'Hollaren, M.D. |

In addition, the following were elected or re-elected to serve on COA's Board of Directors. CA AAOS Board of Councilors also serve on COA's Board.

**COA Board of Directors**

| | |
|---|---|
| William McMaster, M.D. | Orange District |
| Boyd Flinders, II, M.D. | Los Angeles District |
| Robert O'Hollaren, M.D. | Los Padres District |
| Paul Braaton, M.D. | Sequoia District |
| Gabriel Soto, M.D. | Sacramento Valley District |
| Stephen Weber, M.D. | Sacramento Valley District |

**CA AAOS Board of Councilors**

| | |
|---|---|
| Ronald Navarro, M.D. | Los Angeles District |
| Christopher Wills, M.D. | Orange District |
| Malcolm Ghazal, M.D. | Sequoia District |

### COA Members Are Honored

**Founder's Award**
Robert O'Hollaren, M.D. (right)
**William W. Tipton, Jr., M.D. Leadership Award—**
Richard Barry, M.D. (left)
Presenter: Ralph DiLibero, M.D.

## Residents Win Awards

**Lloyd W. Taylor, M.D. Resident Award**
Orrin Franko, M.D. UC San Diego
**Orthopaedic Hospital Resident Award**
Michael Lin, M.D., UC Irvine
**J. Harold LaBriola, M.D. Resident Award**
Derek Amanatullah, M.D., UC Davis
**OREF Resident Award**
Nicholas Bernthal, M.D., UCLA

## Welcome to New COA Newest Members

| | |
|---|---|
| Hrayr Basmajian, M.D. | Los Angeles |
| Chad Brockardt, M.D. | Loma Linda |
| Dennis Cramer, M.D. | Riverside |
| Vance Eberly, M.D. | Downey |
| Jaime Hernandez, M.D. | Van Nuys |
| Gregory Mundis, M.D. | La Jolla |
| Gavin Pereira, M.D. | Sacramento |
| Jennifer Peter, M.D. | San Francisco |
| Mario Sablan, M.D. | Merced |
| Abhindrajeet Sandhu, M.D. | Walnut Creek |
| Anan Shah, M.D. | Lancaster |

# COA 2011 Annual Meeting /QME Course

Ritz-Carlton Laguna Niguel

Nearly 500 orthopaedic surgeons and their practice managers attended COA's 2011 Annual Meeting/QME course. The meeting contained practical practice management information to assist our members in evaluating their options in all types of practice settings. If you were unable to attend, go to the COA website, (www.coa.org) click on the Annual Meeting to see what you missed. **Be sure to calendar the 2012 Annual Meeting/QME Course which will be held April 19-22 , 2012 at the Park Hyatt Aviara Resort, Carlsbad and plan to attend with your practice manager.**

There are too many terrific photos from the meeting to publish on this page.

Go to the COA's website (www.coa.org) and click on the Annual Meeting/QME Course and then the Archives of the 2011 meeting to view an album of photos from the meeting. Many are great family photos. You may download any of the photos.

THANKS to Charles Touton, M.D. and Milana Lostica for taking these photos.

Injured worker Chris Wills shows up for his mock evaluation with Peter Mandell.

# Workers' Compensation News

## Mileage rate for Medical-Legal Travel Expenses Increased

The mileage rate for Medical-Legal travel expenses has been increased to 55.5 cents per mile effectively July 1, 2011.
This rate must be paid for travel on or after July 1, 2011 regardless of the date of injury.

## Ruling—5th District Court of Appeal

By: Lesley Anderson, M.D., Chair, COA's Workers' Compensation Committee

The 5th District Court of Appeal denied State Fund's petition for a writ of review in the case of SCIF vs. WCAB (Almaraz). This will leave the prior en banc ruling of the WCAB decision intact. In that decision, the WCAB ruled that the ratings under the AMA Guides are rebuttable and that the rater may use all four corners of the AMA guides to support their rating if adequate rationale is given. This has allowed applicant attorneys to rebut some permanent disability ratings and left open more liberal interpretation of the Guides.

It is presumed that State Fund will appeal to the State Supreme Court, who previously denied the petition to review Guzman. In the 6th District Court of Appeal ruling on Guzman, the companion case heard in a separate district, the Court ruled that the AMA Guides are rebuttable, provided that the rater uses all "four corners of the AMA Guides" to explain their reasoning behind utilizing other sections of the Guides that may better reflect the disability. This has led to some creative ratings and we continue to encourage those who are providing ratings to use sound medical judgment and reasoning for using other sections of the AMA Guides to explain a different rating. A complete explanation should be provided to assist the judge in determining the most accurate impairment rating.

According to Huntington Beach Orthopedic Surgeon Paul Wakim DO:
"The recent decision by the 5th District Court not to hear an appeal to the en banc decision in the SCIF v. WCAB as it relates to the Guzman II ruling, does not change the current status quo. What this means to the QME/AME or Medical Legal evaluators is that they may continue to use any chapter within the four corners of the AMA Guide 5th Edition to rate injured workers. The majority of requests use this ruling to enhance the AMA rating of the injured worker by finding impairment in different chapters of the Guides that may otherwise not be pertinent to the area of injury.

Most commonly used, is the rating on hernias on Page 136 Chapter 6 Table 6-9 of the AMA Guides 5th Edition to rate back impairment. Note that class-2 hernia impairment indicates that the patient may be rated between 10%-19% based on the fact that the injured worker has "frequent discomfort, precluding heavy lifting but not hampering some activities of daily living." Thus a patient that has a rating of DRE 2 for the lower back may be rated higher by analogy to the hernia class-2 on the similar presentation.

Similarly, painful conditions that affect Activities of Daily Living (ADL) may be rated using the CRPS guidelines, if applicable. That is to say as long as you have objective findings for impairment, you may occasionally rate by analogy to other areas in the AMA Guides that may not be involved in the injury. Remember you must always give the rationale behind your rating by analogy or otherwise".

It is expected that further clarification will be needed regarding some of the guidelines noted in the Guzman decision. In addition, there are still questions about how to handle cases where the applicant suffers a disability that is not found within the four corners of the Guides, according to William Herrera, co-chair of the California Applicants Attorneys Association.

## WCAB *Important En Banc Decisions*

### *Clarifies Interpreter Issues*

The Worker's Compensation Appeals Board (WCAB) ruled in an en banc decision that employers and carriers are required to pay for reasonably required interpreter services during medical treatment visits. The WCAB's decision involved a $13,988 lien filed by E&M Interpreting against State Compensation Insurance Fund. The case is Guitron v. Santa Fe Extruders—No. ADJ163338, 3/17/11, en banc. "One element of an interpreter lien claimant's burden is to show that the injured worker required an interpreter," the WCAB said in the 6-0 decision. "If an injured worker used an interpreter, but did not need one, the defendant would not be obligated to pay for the interpreter services."

The judge noted that the question of whether interpreting services are reasonable and necessary is unsettled by case law, but is of extreme importance. He ruled that interpreting services for two of Guitron's medical treatment visits — those with his primary treating physician — were reasonable and necessary, but balked at the self-procured chiropractic and physical therapy treatment. The judge wrote in his decision that E&M had failed to prove that a Spanish interpreter was necessary during a visit to a clinic in East Los Angeles, where Spanish is the predominant language.

The WCAB Commissioners, however, said in the en banc decision that the judge should not have assumed simply because the clinic was in East Los Angeles that interpreting services were unnecessary. If the treating physician spoke the same language as the injured worker, then State Fund would have had valid grounds on which to refuse payment, but the judge suggested in his ruling that if the doctor did not speak Spanish, surely a member of his staff did. "However, we would not require a physician to use an employee with other work responsibilities as an interpreter, merely because that employee was able to speak the patient/injured worker's language," the WCAB wrote in the en banc decision.

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# Workers' Compensation News

## Ex Parte Communications

By: Pamela Foust, Vice President Claims Legal
Zenith Insurance Company

In general, an ex parte communication is a communication between a party or its attorney with the judge or neutral medical evaluator concerning the merits of a case, where the communication takes place outside of the presence of the adverse party or attorney. The communication can be oral or written in form and is not limited to written communications authored by the doctor or the parties and their attorneys. In the context of medical evaluations, an ex parte communication can take place where one attorney sends the doctor medical records or other documentary evidence without giving notice to the other side. Under some circumstances, the transmission of documents to a doctor may be deemed a prohibited ex parte communication even if the opposing attorney or parties is copied.

A year has now passed since the Court of Appeal's decision in Alvarez v. WCAB and there is still widespread confusion concerning this issue. Doctors and attorneys feel that they may unwittingly violate some aspect of the prohibition against ex parte communications. Additionally, both doctors and attorneys are concerned that an opponent, who is unhappy with a medical opinion, might look for an excuse to disqualify the AME or Panel QME. Sometimes this concern is not unfounded.

**Who may communicate and under what circumstances?**
Labor Code Section 4062.3 prohibits ex parte communications between evaluating physicians and parties or their attorneys. Thus, doctors should never engage in a telephone conversation with an attorney in connection with a case. If the doctor answers the phone and finds the attorney on the other end, the best course of action is to immediately hang up. A fast and safe mode of communication is email with scanned attachments. The physician might consider requesting the attorneys' email addresses at the time of the referral. Communications can then be transmitted simultaneously to all attorneys involved. Transmittal by fax is also a viable option. Both of these methods avoid the delays of the U.S. mail.

A conference call between the doctor and all parties or their attorneys does not constitute an ex parte communication. However, the problem with oral communication is that without any written record, there is the potential for misinterpretation of something that the doctor said. The same potential exists in connection with discussions that may take place between the doctor and the attorneys before they go on record at a deposition. Casual remarks about the weather or sports are fine, but it is better to wait to go on the record for discussions concerning the case itself.

In a panel decision, the WCAB held that communications between an attorney and the doctor's office staff regarding administrative matters such as the scheduling of appointments was not a prohibited ex parte communication because the statute clearly refers to communications between the doctor and the parties or their attorneys. Members of the doctor's clerical staff are neither doctors, parties, nor attorneys. If a communication with an attorney is permissible, then it would follow that the office staff may communicate with a claims adjustor. WCAB panel decisions are not binding precedent, but they may serve as guidance, particularly if the reasoning is sound.

It must be cautioned that claims adjusters are parties in that they are representatives of the party insurance company or third party administrator. Therefore, there should be no communication between the doctor and a claims adjuster. However, communication between the doctor and vendors such as a translating service is permissible because such a service is not associated with either the parties or the doctor. Additionally, the ex parte rules do not apply to oral or written communications by the employee or the dependent of a deceased employee, in the course of the examination or at the request of the evaluator in connection with the examination.

**What communications may be sent to the physician?**
No documents may be sent to an AME unless the parties agree. However, for a Panel QME, the rules are a bit more complicated. The controlling statute and regulation for ex parte communications is Labor Code Section 4062.3 and Title 8 California Code of Regulations Section 35 which provide that any party may send the Panel QME treatment records as well as medical and nonmedical records relevant to a determination of the medical issues. However, notice of the "information" a party proposed to send to the Panel QME must be served on the opposing party 20 days in advance after which the opposing party has 10 days to object to consideration of "nonmedical records." In the case of a timely objection, the nonmedical records cannot be sent.

The statute goes on to provide that "communications" with the doctor before the medical evaluation shall be in writing and shall be served on the opposing party 20 days in advance of the evaluation with no provision for objection. In the event of a violation, the statute provides for a new evaluation from a different Panel QME as well as costs and attorney fees incurred by the aggrieved party as a result of the prohibited communication.

There is no basis for objecting to the transmission of medical records. However, if one attorney proposes to send the doctor nonmedical items such as the deposition of a lay witness or surveillance films, and the other attorney objects, the proposing attorney is not supposed to send it and the doctor should not review it.

# News of Interest

## 5010 Conversion—6 months left to implement

Because nearly all Medicare Part B claims transactions are submitted electronically, orthopaedic practices must be prepared for new standard formats that go into effect on January 1, 2012. These new electronic data interchange (EDI) standards-Version 5010- replace the current versions of the standards (4010) for healthcare transactions. Contact your practice management software vendor to see what you must do to meet the new standards. The AMA has developed a "5010 Toolkit—The Physician's Practical Guide to Implementing HIPAA Version 5010." The Toolkit can be accessed at: http://www.coa.org/docs/AMA5010Toolkit72011.pdf

## One in 10 E-Scripts has an error

Electronic prescriptions are as likely as handwritten ones to contain errors, according to a study from a group of Boston-based researchers. The study, "**Errors associated with outpatient computerized prescribing systems**," is published online in the Journal of the American Medical Informatics Association. The report is based on a retrospective study of 3,850 computer-generated prescriptions received by a commercial outpatient pharmacy chain in three states in 2008. A clinician panel reviewed the prescriptions to identify and classify medication errors, potential adverse drug events (defined as those that might cause patient harm) and the rate of prescribing errors by prescription type and by system type. The researchers found at least one error in 11.7% of the prescriptions reviewed. "About one in 10 computer-generated prescriptions included at least one error, of which a third had potential for harm," the researchers wrote. "This is consistent with the literature on manual handwritten prescription error rates."

A wide range of error rates was seen across e-prescription systems, from 5.1% of prescriptions written on one system to 37.5% on another. "The number, type, and severity of errors varied by computerized prescribing system, suggesting that some systems may be better at preventing errors than others," the researchers wrote. Omitted information was the most common e-prescription error, occurring in 60.7% of faulty prescriptions. The researchers concluded that implementing a computerized prescribing system without comprehensive functionality and processes in place to ensure meaningful system use does not decrease medication errors.

## Physicians Work as Locum Tenens Without an Agency

AMNews is reporting that San Francisco physicians are coming out of retirement and going back to work as an independent *locum tenens.* They do not want to share the fees with a *locum tenens* agency and be sent all over the country, so, instead, they are marketing their services directly to their colleagues and the hospital to cover when the local physician is on vacation, out on sick leave, or away for a meeting. You must be prepared to do the legwork and reach out to physicians in your specialty in your area. Older physicians with established networks with the local physicians may be able to do this more easily than younger ones. Physicians who do not live in a metropolitan area may find that they must travel to get enough assignments. Physicians need to ensure that they have liability coverage which may be provided by the practices through a temporary rider to cover their services. While, physicians working as an independent *locums tenens* is not common, it is another practice option.

## What's on the Medicare Pay Menu?

The American Medical Association recommends that Medicare test several physician payment models over five years that could form part of a replacement of the Medicare fee-for-service system:

- **Partial capitation**—An accountable care organization receives a per-patient monthly payment to cover all the costs of care for a group of patients.
- **Virtual partial capitation**—An ACO receives a per-patient budget for a group of patients instead of an up-front fee. Physician payments are adjusted to keep total pay within the budget.
- **Condition-specific capitation**—A group of physicians receives a fixed amount to care for a specific patient condition, such as total hip replacement.
- **Accountable medical home**—A group of physicians receives upfront resources to restructure the way they deliver primary care. In return, the practice or group commits to reducing hospital admission rates in patients.
- **Inpatient care warranties—**Physicians and hospitals set Medicare payment rates and give warranties for inpatient treatment, agreeing not to charge more for infections and complications.
- **Mentoring programs—**Medicare offers financial and technical support to small physician practices working with regional health improvement collaborative.
- **Private contracting —** Patients and physicians freely contract for services, allowing them to agree on rates for services without having to forgo Medicare payment.

Source: AMNews, May 23, 2011

## AMA Publishes Guide on Employment Contracts with Hospitals

With hospitals hiring more physicians, the AMA wants to ensure that physicians have a good understanding of what they are signing. The AMA Organized Medical Staff Section and the AMA have developed a new manual, "The Annotated Model Physician-Hospital Employment Agreement." The manual covers scope of duties, compensation, expense reimbursement and employer-paid benefits, as well as loyalty and confidentiality covenants. The manual is available online at:: http://www.ama-assn.org/go/employmentagreement It is free to AMA members and costs $149 for nonmembers.

## Someone is watching you

By: Mary LeGrand, RN, MA, CCS-P, CPC
KarenZupko & Associates

Did you know that the Centers for Medicare & Medicaid Services (CMS) lists more than 4,000 acronyms for various programs? In recent years, several new acronyms have been added, including the following:

- RAC—Recovery Audit Contractors
- CERT—Comprehensive Error Rate Testing
- ZPIC—Zone Program Integrity Contractors
- PSC—Program Safeguard Contractors
- MAC—Medicare-Affiliated Contractors

What all these programs share is a common goal—they are all tasked with measuring, detecting, and correcting improper payments. In addition, they are part of the effort to identify and curb potential fraud in the Medicare fee-for-service (FFS) program. This article looks at three of these programs (RACs, CERTs, and ZPICs) and what they mean for orthopaedic practices.

**RAC targets**

The RAC program began as a demonstration project in 2005 and has since been expanded nationwide to help curb Medicare overpayments, underpayments, and improper billing patterns. The goal of the program is to identify improper payments (overpayments or underpayments) made on claims for healthcare services provided to Medicare beneficiaries. Overpayments can occur when healthcare providers submit claims that do not meet Medicare's coding or medical necessity policies. Underpayments can occur when providers submit claims for a simple procedure but the medical record reveals that a more complicated procedure was actually performed.

The following common problems can attract attention under an RAC audit:

- ***New patient visits billed within the 3-year period***—This problem can arise if a non-physician provider (NPP) sees the patient initially, but the first time that the physician sees the patient, the physician reports a new patient visit (9920x). If an NPP does the initial visit, the patient will be considered an established patient at the practice for the next 3 years.
- ***Improper use of modifiers***—Spending time to learn about the appropriate use of modifiers can pay off. The failure to use modifiers 25 and 57 accurately for services provided on the same day or the day before a surgical procedure can trigger the RAC to issue a Recovery Demand letter.
- ***Consolidated billing rules for skilled nursing facilities (SNF)***—Many practices are unsure how to report services such as radiographs taken in the office, supplies, and therapy professional services when a patient is in a covered Part A SNF. Previously, Medicare would demand a refund and practices would have to file a corrected claim, reporting the technical component of the radiograph charge to the SNF and the professional services component to Medicare Part B. Now, these claims are on the RAC target list.

**Be CERTain!**

The CERT program measures improper payments in the Medicare FFS system, but it cannot identify fraud. During each reporting period, this program randomly reviews 50,000 carrier claims. The process is defined as: "When medical records are submitted by the provider, CERT reviews the claims in the sample and the associated medical records to see if the claims complied with Medicare coverage, coding, and billing rules. If not, CERT assigns the erroneous claims to the appropriate error category. When medical records are not submitted by the provider, CERT classifies the case as a no documentation claim and counts it as an error. "Then, CERT sends providers overpayment letters/notices or makes adjustments for claims where an overpaid or underpaid determination was made. CERT calculates the projected improper payment rate based on the actual erroneous claims identified in the sample."

Claim problems pertinent to orthopaedics include the following:

- ***No documentation***—Claims are placed into this category when the provider fails to respond to repeated attempts to obtain the medical records in support of the claim.
- ***Insufficient documentation***—Claims are placed into this category when the medical documentation submitted does not include pertinent patient facts (such as the patient's overall condition, diagnosis, and extent of services performed) or if the physician's signature is missing or illegible.
- ***Medically unnecessary service***—It's trouble when CMS claims reviewers request documentation from the chart so that they can make an informed decision about whether the services billed were medically necessary based on Medicare coverage policies.

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## Someone is Watching You

(Continued from Page 7)

- ***Incorrect coding***—This category covers the circumstances when providers submit medical documentation that supports a lower or higher code than the code submitted.
- ***Other***—Claims—such as for services not rendered, duplicate payment errors, not covered or unallowable services—that do not fit into any of the other categories are part of this category.

Orthopaedic practices should take the following steps to reduce their risk of audit under the CERT program:

1. Any CERT notice letters received by the practice should immediately be forwarded to the practice manager and physician managing partner. Time is of the essence.
2. Internal compliance plans should be reviewed regularly to ensure the practice is performing coding, documentation, and claims submission audits.
3. Every service reported must have a diagnosis, and the billed diagnosis must establish medical necessity and be documented in the office note, emergency department note, hospital note, or operative note. This should not be left to the biller who does not understand the difference between spinal stenosis and lumbago. A significant loss of revenue can result if the biller submits a diagnosis of lumbago for back pain that is due to spinal stenosis.
4. Coding is the responsibility of the physicians and NPPs who perform the services. Practices should use the results of periodic audits to close gaps and meet internal objectives.

If you billed it, it can be audited. If you billed it and the documentation does not support the service, the risk assessment begins.

**ZPIC for fraud**

Perhaps the most serious and least understood program is ZPIC, which seeks to identify fraudulent activity. In addition to responding to complaints of alleged improper billing activities, ZPICs will conduct data mining on services looking for trends of services reported and violations of local or national coverage determinations. Typically, this is a long, detailed process that requires comparative analysis of current trends to past trends. A recent ZPIC audit of an orthopaedic practice sought documentation related to the medical necessity of the provision of ancillary services, as well as monitoring of testing results, and failed conservative measures as the patient progressed along the care continuum.

Orthopaedic practices should document the medical necessity of all testing, therapy, and treatments in addition to the patient's response to the therapy. Clearly document the move from conservative management to more intensive management of a condition to support decisions for surgery based on clear statements of medical necessity. For example, prior to hip or knee arthroplasty, the patient's responses to conservative treatments such as nonsteroidal anti-inflammatory drugs, physical therapy, and the use of external supports should be documented.

Paying close attention to business practices within the office and adhering to the office compliance plan is key. Now is the time to begin identifying risk, if any, within the practice and to develop action plans to close the gaps and correct any business processes.

*Reprinted from AAOS Now, April, 2011.*
*Mary LeGrand, RN, MA, CCS-P, CPC, is a consultant with KarenZupko & Associates, Inc., and focuses on coding and reimbursement issues. The article has been reviewed by members of the AAOS Coding, Coverage, and Reimbursement Committee.*

Hoag Orthopedic Institute

Hoag Orthopedic Institute in Irvine, California is seeking an experienced Operations Executive who is motivated by the challenge to provide operational leadership & oversight as well as grow our Physician partnership at the Orthopedic Institute. The Chief Operating Officer (COO) position is a great opportunity to join a highly regarded hospital that has received national recognition for providing quality healthcare services. Hoag functions as an integrated delivery network, providing the full spectrum of health care services. Along with the main hospital, Hoag has a growing ambulatory network that stretches across Orange County.

The successful candidate will be a polished Operations Executive who will bring strong leadership and experience in running a successful & profitable surgery center. The COO must be able to build relationships with Physicians & Medical Staff and communicate effectively across the entire organization. The COO will be politically astute and be comfortable with presenting to various audiences, including the board. The candidate will be responsible for building a solid strategic business plan to support Hoag's long term initiatives as well as increase our Physician growth over the next few years. The new COO will be seen as a savvy leader, a knowledgeable operations executive, and a good team builder.

The Chief Operating Officer (COO) is responsible for coordinating and managing the organization's day-to-day operating activities, including Clinical Operations, Clinical Excellence, Facility and Equipment Services, Community Outreach, Ancillary Services and interfaces with Hoag Memorial Hospital Presbyterian's administrative and purchased services leaders. As a member of the executive management team, the Chief Operating Officer (COO) will participate in operational decision-making processes necessary for the successful attainment of the organization's mission in addition to maintaining an awareness of changes in healthcare matters that could have an impact on the success of the hospital.

If you or anyone you know of is interested in this position, please contact:

Michael Krug
Manager, Talent Acquisition
Michael.krug@hoag.org
949-764-8793

## Practice Management Option

# Divisional Mergers

### *Consider this Option for Keeping your Practice Viable*

By: Craig R. Mahoney and Kevin Ward

*If you are an individual orthopaedist or in a small orthopaedic practice, you may be feeling that the professional and financial returns you are seeking are becoming more difficult to attain. Thus you may be thinking about how to grow your existing practice or whether to integrate your practice into a hospital-based organization or a multispecialty practice. Although these are currently the two most prominent options for practicing orthopaedic surgeons, we'd like to propose a third alternative—a divisional merger.*

**What is a divisional merger?**

A divisional merger is a business agreement outlining a formal relationship between parties, while preserving the identity and best practices of the underlying individual businesses themselves. This is similar to corporations such as General Mills, which have many divisions, each of which has its own identity (Pillsbury, Yoplait, Green Giant, and so on). In orthopaedics, this type of agreement would allow the individual practices to maintain autonomy in key decisions (such as referrals and marketing), while merging some contractually outlined services that can be shared (such as payer contracting, imaging, and transcription). For example, merging at the divisional level would allow two or more orthopaedic practices in the same town that offer similar services to create a financial superstructure outlining the specific financial arrangement between the groups. Each of the "divisions" maintains its individual facilities, referrals, and service orientation. Before the merger takes place, cost-sharing and timeframes for consolidated transactional services could be agreed upon.

**Advantages of a divisional merger**

An immediate advantage of a divisional merger is leverage in negotiation. Increasing the size of the group increases your negotiating power with payers, hospitals, and any of the possible future payment vehicles (such as accountable care organizations). In most cases, a divisional merger also allows you to avoid antitrust issues. Secondly, increasing the size of the group also increases the pool of capital available for business-related expenditures. A small practice may not have the capital to invest in ancillaries, such as advanced radiographic equipment, magnetic resonance imaging scanners, or other clinical items. A larger practice can acquire these in a more strategic fashion.

With size, there also comes increased patient demand. Additional capital can provide flexibility when seeking to integrate services that will be beneficial to patient care at your facility. This may also help with your efficiency and effectiveness in treating patients. Together, you may also find opportunities to invest in marketing, personnel, and other resources that allow you to focus on patient care and increasing patient flow. Finally, a divisional merger will increase your "presence" in the marketplace. Providing care to a larger number of people, under a unified corporate umbrella, makes your practice more widely recognized within the community. This presence extends to integrated services, as more patients can have more services under one roof, and using standard protocols, these services can be delivered in a consistent and expeditious fashion. To sum up, a divisional merger provides each practice with the ability to maintain its corporate culture while integrating where it is convenient and cost effective.

**Disadvantages**

A divisional merger can ultimately create more administrative complexity, simply by virtue of its structure. Some individual practitioners might feel it will change the way care is delivered within their office and potentially create friction between their staff and the new merged organization. In addition, large organizations tend to have a more homogeneous management structure and a more structured decision-making process. This may lead to a belief that decisions are not quickly made or tailored to the needs of patient care for each group. When done right, divisional mergers allow separate practices to maintain their individual flavor, but integrate where it is most appropriate.

Another potential downside of divisional merger is financial complexity. Each group may have its own financial model and methods, which now must be harmonized. This may lead to adjustments for each group, which in turn could create either too much information or not enough information being provided to the individual physician about his or her practice.

This may be even more critical for tracking, reporting, and managing ancillary services. If this is a current issue in your practice, problems will likely increase under a divisional merger. Our advice is to hire the best accountants available before the merger takes place.

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## Workers' Compensation News

## WCAB *Important En Banc Decisions*

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The WCAB Commissioners reiterated that Labor Code 4600 requires employers to provide reasonably required interpreter services during medical treatment appointments for workers who do not speak English.

Secondly, they noted that interpreter lien claimants have the burden to prove that:

- The services provided were reasonably required.
- The services were actually provided.
- The interpreter was qualified to perform the service.
- The fees were reasonable.

This en banc decision helps provides some direction on the reimbursement of interpreter services, but does not address the circumstance when the medical provider chooses to use their employee as the interpreter and bills for their services.

### *WCAB Rules Non-MPN Physician Reports Not Admissible*

*By: Richard M. Jacobsmeyer*

In a split vote en banc decision, the WCAB has issued a comprehensive decision addressing one of the issues that have been floating around since the implementation of Medical Provider Networks in 2004. In Valdez v Demo Warehouse the WCAB held such reports are not admissible either on issues of medical treatment or on those involving compensation. In this case the employee treated with the employer's MPN physician for the first 30 days after injury and thereafter was directed by her attorney to a physician outside the MPN. The employee made no effort to utilize any of the internal MPN challenges to her initial treating physician's recommendations or treatment and simply started treating outside the MPN. Approximately a year later the matter went to trial on the issue of TTD beyond the first 30 days. The employer took the position that the reports of the non MPN physicians were not admissible and therefore no substantial evidence existed on the issue of TTD. The WCJ deferred the issue of whether an MPN was properly in place determining the trial was on the issue of TD only. Based on the non MPN reports, TD was awarded along with reimbursement to EDD for its payments during the same time.

Defendant appealed asserting the reports of non MPN physicians were not admissible and therefore no evidence existed to support the WCJ's opinion. The WCAB granted Reconsideration and issued the en banc 5-1-1 decision with Commissioner Brass agreeing with the majority but dissenting on a portion of the decision and Commissioner Caplane dissenting in the holding regarding admissibility. In its holding the WCAB ruled such non MPN physicians do not qualify as "treating physicians" pursuant to Labor Code § 4600 nor as medical legal evaluators under Labor Code § 4061/4062. Pursuant to Labor Code § 4616.6 such reports are not admissible on medical treatment issues. Since the reports are neither treating physician reports nor validly obtained medical legal reports, they are not admissible.

> "…Therefore, the non-MPN physician is not authorized to be a PTP, and accordingly, is not authorized to report or render an opinion on "medical issues necessary to determine the employee's eligibility for compensation" under section 4061.5 and AD Rule 9785(d). (Cal. Code Regs. tit. 8, § 9785(d).) Moreover, for disputes involving temporary and/or permanent disability, neither an employee nor an employer are allowed to unilaterally seek a medical opinion to resolve the dispute, but must proceed under sections 4061 and 4062.[1] Accordingly, the non-MPN reports are not admissible to determine an applicant's eligibility for compensation, e.g., temporary disability indemnity."

In its decision the WCAB reviewed the statutory processes for challenging MPN physician by the employee. The Board noted employees have extensive rights with an MPN to challenge the opinion of a treating physician, none of which were utilized by the applicant in this case:

> "…This was despite the fact that within the MPN she would have had several opportunities to challenge any treatment, diagnosis, or lack thereof with which she disagreed and treat with someone other than Dr. Nagamoto.
>
> More specifically, after the initial medical evaluation arranged by the employer within the MPN pursuant to section 4616.3(a), "[t]he employer shall notify the employee of his or her right to be treated by a physician of his or her choice," including "the method by which the list of participating providers may be accessed by the employee." (Lab. Code § 4616.3(b); Cal. Code Regs., tit. 8, § 9767.6(d).)

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## Workers' Compensation News

## WCAB *Important En Banc Decisions*

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In addition, AD

> Rule 9767.6(e) (Cal. Code Regs., tit. 8, § 9767.6(e)) provides that "[a]t any point in time after the initial evaluation with a MPN physician, the covered employee may select a physician of his or her choice from within the MPN."
>
> Furthermore, pursuant to section 4616.3(c), where an injured worker "disputes either the diagnosis or treatment prescribed by the treating physician," he or she "may seek the opinion of another physician in the [MPN]," and of "a third physician in the [MPN]," if the diagnosis or treatment of the second physician is disputed."

The Board further noted even after these remedies had been exhausted, the employee could request an independent medical review of the treatment recommendations as a 4th level of dispute resolution. The WCAB further considered whether the employee's right to obtain an evaluation under Labor Code § 4605 with his or her own consulting physician rendered the reports admissible and rejected that idea. Relying on the previously stated reasoning regarding admissibility of reports under Labor Code § 4616.6 and 4061/4062 the majority ruled use of Labor Code § 4605 does not generate reports which meet the criterion of admissibility. The WCAB also included in its decision that such reports were not only inadmissible but not the financial obligation of the defendant. The case was remanded for the WCJ to make the determination on whether the employer had properly implemented the MPN.

Commissioner Brass dissented only to the extent the WCAB should not have a blanket rule on such reports which were never admissible, allowing a case by case consideration of when the reports might be relevant. Commissioner Caplane would have allowed non MPN reports be admissible on compensation issues. She rationalized Labor Code § 4616.6 only excluded the reports on medical treatment issues and not allowing the reports into evidence effectively punished the employee and rendered the employee's use of his own physician moot.

**COMMENTS AND STRATEGIES**:
This issue is one which has been commented on by several WCAB panel decisions with mixed results. Initial decisions commented such reports would be "unquestionably admissible." Later decisions have seemed to back off that language (including a case commented on by the undersigned a few weeks ago – see my 3/30/11 "Power Press Exception & LC 4064 Nugget" for a discussion of the Scudder panel decision). In this decision, the WCAB has issued a definitive opinion which is now binding on all trial judge and WCAB panels. The WCAB appears to have recognized the inherent unfairness of allowing an employee to effectively buy his/her own report outside the medical legal process that is meant to apply to both sides.

An additional issue that will come up in cases where the employee has obtained treatment outside the MPN pursuant to Labor Code §4605 is the potential lien claim of the physician for such treatment. I have been taking the position that such treatment, which is clearly the responsibility of the employee, is still a lien on the employee's benefits if the physician has filed a lien claims. I put the employee/applicant attorney on notice that my client will withhold sufficient sums from PD to cover the lien claim. Failure to do so, in the face of a lien, may expose the employer to the treatment expenses. Where such a lien has been filed, it is imperative the claim not be resolved with the employer agreeing to hold the employee harmless on the lien claims. Such an agreement ultimately makes the employer responsible for the bill as it puts the employer in the employee's position relative to the treatment bills. I have required the employee and his counsel to address the bills directly either by agreeing to pay from the settlement or else arrive at an agreement with the doctor for a disposition. However where there is no such agreement, distribution of the proceeds of settlement, in the face of a lien, can result in the employer being responsible for the treatment costs.

Needless to say, a critical part of this decision is the ability of the employer to prove a properly implemented MPN. Such proof requires the employer provide affirmative evidence regarding sending of MPN notices and posting of notices under Labor Code §3550. Unfortunately providing such proof frequently requires the employer provide direct evidence of how the MPN was implemented, how notices were distributed and evidence of the proper postings (it is interesting that when employees testify they almost always claim the employer has never posted the Labor Code § 3550 notices and yet I have almost never walked into an employee break room without seeing them prominently posed on the wall).

Claims administrators should make an effort to get ahead of the curve on this issue and maintain an MPN Evidence file. That file

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# COA Members Go To Washington, D.C. . . .

## Report on the National Orthopedic Leadership Conference

Washington DC April 2011

By: Michael Klassen, M.D.
CA Councilor—Northern CA

Recently, the California members of the Board of Councilors (BOC) and Board of Specialties (BOS) attended the National Orthopaedic Leadership Conference in Washington DC, April 6–8, 2011. In addition, COA's leadership attended the NOLC.

The NOLC meeting commenced with a symposium on physician-owned ancillary services and the laws, economics, and public affairs associated with those physician-owned ancillary services. The discussion was led by Dr. Jim York from Baltimore, Maryland. The regulations, federal and state, were discussed. There was also discussion in regard to hospital relationships with physician-owned services and how to build a team for legislative and regulatory activities when involved in ancillary services such as advanced imaging, physical therapy, and specialty hospitals.

Dr. York discussed the Maryland patient referral law, which is one of the strongest laws in the nation that states MRI, CT and radiation therapy are excluded from basic healthcare services and are not allowed in a physician's office unless done by a radiology group or an office consisting of solely radiologists. That is different from California where the California Orthopaedic Association has led a strong team-building effort to counteract this foothold that has been achieved in Maryland by the radiologists and to protect our ability to continue to have these services in our offices.

Our second symposium was on the Independent Payment Advisory Board (IPAB) and was presented by Congressman Phil Roe (R-Tennessee). The IPAB was the center of attention during the entire conference. The IPAB is a board that is appointed by the President consisting of 15 members with fewer than half of the members of the IPAB being healthcare providers. No sitting member of the IPAB can be a practicing physician or otherwise employed while serving on the board.

The IPAB has the sole function to recommend cuts to achieve what has been described in our group as unrealistic spending targets for 2014. The IPAB can directly recommend cuts to Congress; these cuts are deemed to be approved unless overturned by a 60% vote of Congress. Providers representing roughly 37% of all Medicare payments including hospitals, hospice care are exempt from the IPAB cuts until 2020.

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## WCAB Important En Banc Decisions

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should contain copies of all of the MPN notices, the procedures used to communicate the initial notices and a picture of the employer's posting notices. It should also contain declarations under penalty of perjury by the person responsible for the MPN implementation describing the process followed to communicate the notices (whether by mail or provided in the employees' paycheck as an example).

A declaration under penalty of perjury regarding the employer posting notices can also be made by the employer's safety officer or other party responsible for posting such notices. (Administrative Director Regulation §10114.2 allows such declarations to be admitted into evidence where properly served before trial.) In any case where the employee has challenged the employer/carrier's MPN, this file, along with the actual notices sent to the employee at the time of injury, should suffice to document a properly implemented MPN and may avoid the need to provide live testimony especially if the issue arises at an expedited hearing. I have recently also taken the position that the validity of an MPN is not an issue for an Expedited Hearing as it is not one of the enumerated issues for expedited hearing and decision. This can avoid the applicant testifying that notices were not received and postings not made without the employer having an opportunity to present its side of the case. However with a properly developed MPN Evidence file, even an Expedited hearing might result in a finding the MPN was properly noticed.

The deposition of an employee is also an opportunity to document the MPN implementation. It would be a good idea to confront the employee with a picture of the employer's notices, which he might well remember once shown, as well as any copies of notices. One technique that can be used to confirm receipt of such notices is to include any releases the employee is asked to complete with the MPN notices. If the employee has returned the medical releases and history forms, it is difficult for him/her to claim they did not receive the other material in the same package.

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Footnote: A panel at the California Applicants' Attorneys Association Summer Convention discussed the limits to the impact of an en banc WCAB decision. In this case, a panel of judges and applicants' attorneys explored whether reports from non MPN doctors might still be admissible in cases where injured workers require emergency care or a carrier has denied medically necessary care to a specific body part. Associate Chief Judge Mark Kahn said that when a judge is faced with a lack of justification for the non MPN physician's report, the judge is unlikely to admit the non MPN report. The applicant attorney's felt that such reports might still be admissible in cases with different facts than the Valdez case.

## Divisional Mergers

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Other financial questions also need to be addressed before the merger agreement is signed. For example, what happens if one "division" has subpar financial performance and the other does not? How are the expenses allocated, and who pays for the shortfall? Conversely, how will ancillary income be shared, and under what model will we produce the best outcome for the physician's bottom line? The goal is to allow each group to maintain its individual character, and be successful financially, once the groups are financially merged.

Keep the regulatory landscape in mind, especially antitrust issues. Be aware that this process will cause you, and each group, to think long and hard about things you never had to consider. For example, you may need to answer regulatory questioning about pricing and give commitments that you will have to live by in the future. You may also have to address competition, or the possible reduction in competition, associated with a divisional merger. Be ready to discuss facts, figures, and your stance on market share, access, and how your undertaking benefits the community.

To ensure that the divisional merger will not derail the goals of your individual practice, keep your eye on the priority items and put plans in place to deal with them should problems arise.

**Summary**

A divisional merger is a stunningly simple concept on paper—two entities become one, keeping the best of both. In reality, it requires a single legal entity, consolidated billing, uniform accounting, and must pass the consolidated business test. It may also require the merging of retirement accounts, profit sharing plans, or pensions. Be ready to evaluate these requirements, hire competent counsel to guide you through the process, and make sure "you dot every i and cross every t" while going through the process.

In these troubled economic times, many individual orthopaedic groups and practices continue to fight for independence. A divisional merger may be one avenue to consider that allows practices to maintain that independence while providing the financial strength, integration, and cost effectiveness you desire to continue forward.

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*Reprinted from AAOS Now, April, 2011*

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# Workers' Compensation News

## Ex Parte Communications

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In one panel decision, the WCAB found an advocacy letter to be not only a communication that was not subject to objection, but also information in the form of a nonmedical record that should not have been sent after opposing counsel objected. The letter in question was more than a bit adversarial (e.g., "The community is aware that the only way for many of the claims to be worth any money now is for the attorneys to add on internal, psyche and sleep claims.") Therefore, although the WCAB panel decisions do not constitute binding precedent, a doctor should probably not read an advocacy letter if the other side objects to it. This does not mean that advocacy letters are prohibited. It only means that their review by the doctor may be prevented by timely objection.

If the doctor is appointed by the judge as opposed to being agreed upon by the parties or selected from a panel, the rules are a little different. In that case, all communications and transmission of documents for the doctor's review are supposed to go through the judge unless the judge orders one of the attorneys to perform these tasks.

Physicians should read Labor Code Section 4062.3 and Title 8 California Code of Regulations Section 35 carefully and have them available for reference should a question arise.

Labor Code Section 4062
http://www.coa.org/docs/LC40623.pdf

Title 8 CA Code of Regulations Section 35
http://www.coa.org/docs/8CCR35.pdf

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## National Orthopaedic Leadership Conference

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Therefore, it is the feeling of the NOLC that the IPAB cuts are directly disproportionate to providers such as orthopedic surgeons. Furthermore, there is no permanent and sustainable solution to the SGR. The SGR in fact is not addressed. On Wednesday night April 6th, there was a fund-raiser that had been put together by a host committee including myself for Speaker of the House John Boehner and we raised approximately $225,000. Speak Boehner, unfortunately, was not able to attend the event as he was called to the White House by President Obama at the last moment and I am sure that many of you were able to see that on television. It seemed to be something that was on the news on a minute-by-minute basis.

On Thursday, April 7th, we had Capitol Hill Day, which is where the members of the BOC & BOS members visited the members of Congress in an effort to lobby those members in regard to our orthopaedic-directed issues. There were four main items of discussion that we presented to our congressmen and senators. COA leaders and the California Board of Councilor members met with 41 of the California Representatives and Senators. In addition, COA met with staff at the Centers for Medicare and Medicaid to discuss the recently released accountable care regulations. The first is entitled the "AAOS Act". This is legislation that is recommended by the American Association of Orthopedic Surgeons that will provide reports to Congress, issued by various government agencies that analyze the extent of which musculoskeletal research is funded. It will collect data from a number of new investigators who have entered the research field, identify existing trauma care initiatives in order to enhance cooperation across federal agencies, urge the Office of Minority Health to consider musculoskeletal disease and conditions as an additional health priority, promote bone health initiatives among adolescent girls through the Office of Women's Health and increase reporting requirements to improve and align the treatment management of musculoskeletal disease for populations with health disparities.

The annular direct and indirect expenses for musculoskeletal disease in the United States is approximately $849 billion. One in four Americans have a musculoskeletal problem that requires medical attention. The AAOS Act will bring that to the forefront of our political colleagues. We asked them to become co-sponsors of the "Access to America's Orthopaedic Services Act of 2009".

The second point of discussion with our legislators was the integration of clinical services for in-office ancillary services. The AAOS recommended that Congress enact public policies that encourage the integration of clinical services in order to achieve a more efficient healthcare delivery of services. These are radiologic services, physical therapy, and to include specialty hospitals. The AAOS also encouraged CMS to work with the Academy to address concerns about utilization increases through the development of appropriate use criteria and we asked the Congressional Representatives and Senators to co-sponsor House Bill 1159 to repeal the provision of the Patient Protection and Affordable Care Act that restricts the establishment and the growth of existing specialty hospitals and our continued safe harbor provision for the integration of clinical services for in-office ancillary services.

Next on our agenda with our legislators was a discussion on meaningful medical liability reform. California is somewhat unique in our MICRA environment and we have been successful, as Texas has, in reasonably limiting noneconomic damages. Our tort reform remains strong to this point. We were encouraging our elected representatives to enact MICRA legislation on a national level.

The fourth point that we made to our legislators was to co-sponsor HR 452, which is to repeal the Independent Payment Advisory Board (IPAB). The stance of the Academy at this time is to try to support the repeal of the IPAB which gives an unaccountable governmental body with minimal Congressional oversight decision-making process on Medicare payments that specifically affect orthopedic surgeons and other Medicare providers.

Our California delegation then proceeded to the Capitol Hill Club for lunch with our guest speaker, Majority Whip Representative Kevin McCarthy (R-Bakersfield). Representative McCarthy discussed healthcare issues and the repeal or defunding of certain aspects of the recent healthcare legislation and also the effects of the budget and the current budget crisis.

On Friday, we attended two more symposiums. The first symposium was on accountable care organizations (ACOs) and we were led by Mr. Alan Wile, Executive Director of the National Academy for State Health Policy, who presented the current medical care bill and how it would apply over the next decade. We also heard from Dr. William Hazel, Secretary of Health and Human Services for the State of Virginia and how these policies have affected Virginia as well as many other states. Additionally, Dr. Kevin Bozic, from the University of California of San Francisco, presented in great detail the ACO models and he noted that there is a new primer on Accountable Care Organizations put out by the AAOS. The final symposium on Friday was led by Dr. Jeffrey Anglen, Chairman of the Board of Specialties and the American Board of Orthopedics and it was specifically related to limiting resident work hours to 80 hours per week and discussions of orthopedic work hour restrictions. This was followed by the Joint Business Meeting of the BOC and BOS.

Congressman Kevin McCarthy R-Bakersfield) was the keynote speaker at the COA group lunch.

Congressman Kevin McCarthy (R-Bakersfield) with Michael Klassen, M.D. at district fundraiser that Dr. Klassen held in California.

An unprecedented number of bills affecting orthopaedic practice have been introduced in the 2011-2012 Legislative Session. Here are some of the highlights.

## *Scope of Practice:*

**AB 352 (Eng)** would establish a "super" new category of radiology assistants who would be required to complete a higher level of training and could provide evaluation and management services. The radiologists have introduced similar bills in the past. COA has traditionally sought an amendment to the bill to clarify that other physicians and surgeons may also supervise these "super" radiology assistants as we felt there was a possibility that at some point, only these super radiology techs would be able to perform the high-end diagnostic tests – CT scan, MRI, etc. If this bill had passed without our amendment, this would have effectively taken these tests out of a physician's office unless they also employed a radiologist.

The radiologists are now open to accepting the COA amendment which will allow other physicians and surgeons who have a fluoroscopy supervisor's certificate to supervise these radiology assistants. With these amendments, COA has gone neutral on the bill.

**AB 783 (Hayashi)** would clarify that a medical/podiatric corporation may employ physical and occupational therapists. COA supports and is a co-sponsor of this bill along with the California Podiatric Medical Association, California Medical Association, and Kaiser Permanente. The bill became necessary after the California Physical Therapy Association obtained a Legislative Counsel's opinion which called into question whether a medical/podiatric corporation could legally employ licensed health professionals who were not specifically noted in statute. The CPTA sent threatening letters to employed physical therapists which prompted them to call and raise the issue with COA. The bill failed passage in the Senate Business & Professions Committee. COA will continue to seek other solutions to resolve this issue.

**SB 233 (Pavley)** would clarify that physician assistants may treat patients in the emergency room working under protocols with their supervising physician. A problem arose in a San Diego hospital where they would not let the orthopaedic PA render services in the OR. COA is working with the author of the bill to ensure that this gray area is clarified, but that the scope of practice of the PA remains the same. Also, the emergency room physicians see this as an opportunity to write portions of the EMTALA federal law into state law, particularly the part about the ER physician being able to demand that the on-call specialist physically appear in the OR even though their PA may be handling the case. While the EMTALA law does state that the physician onsite can require the on-call specialist to come to the ER when they are on-call, there are other provisions of EMTALA that put this requirement into reasonable perspective, particularly if the on-call physician is already treating an emergency patient at a different hospital. Rather than write the entire EMTALA law into state law, COA is working with the ER physicians to work out acceptable language.

**SB 924 (Walters)** would expand the scope of practice of physical therapists to allow them to initiate treatment without a physician and surgeon first diagnosing the medical problem. COA has long opposed granting physical therapists direct access as physical therapists, that COA has consulted, believe the most optimal care is rendered in collaboration with the physician and surgeon, not in independent practice. They also believe that there needs to be a medical diagnosis made before treatment is started. The bill missed its deadlines and has become a two-year bill.

## *Workers' Compensation:*

**AB 378 (Solorio)** would limit the reimbursement for compounded medications. As introduced, the bill contains a broad definition of "pharmacy goods" which included "any dangerous drug or dangerous device as defined by Section 4022 of the Business and Professions Code." COA is working to narrow the bill only to compounded medications.

**SB 127 (Emmerson)** This COA-sponsored bill would require the Division of Workers' Compensation to annually update the CPT codes contained in the Official Medical Fee Schedule (OMFS) for physician services. Currently the fee schedule uses the 1997 CPT codes. The bill is pending in the Assembly Appropriations Committee.

**SB 923 (De Leon)** would require the Division of Workers' Compensation to transition the Official Medical Fee Schedule – physician services – to an RBRVS system. The bill is silent on the conversion factor and Ground Rules which would be implemented. COA has opposed the bill as we believe the conversion factors and Ground Rules need to be included in the bill.

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