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COA Report

A publication of the California Orthopaedic Association

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PRESIDENT MESSAGE

Shifting from Volume to Value in Healthcare[1]

Most healthcare stakeholders, including patients, physicians, hospitals, payors, and healthcare policy makers agree that the long-term viability of our healthcare system is dependent on our ability to 'bend the cost curve' of healthcare spending. Per capita healthcare spending in California and throughout the country continues to outpace inflation, and poses a major threat to our long-term economic viability. Higher per capita healthcare spending in the United States when compared with other developed countries is driven by many factors, including an inefficient, volume-based payment system that is bloated with administrative waste; a fragmented, poorly integrated delivery system; defensive medicine; resource intensive end-of-life care; and the continual introduction of newer, more 'advanced' healthcare technologies of uncertain benefit.

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

However, cost containment alone will not solve our problems, and efforts to reduce healthcare spending without considering the impact on quality and access to care could result in unintended grave consequences to our healthcare system. As in other sectors of the economy, a focus on 'value' could be the key to an effective and sustainable health care system.

How 'value' should be measured in healthcare is controversial. Most would agree that the value of any product or service reflects the benefits derived per dollar spent. In healthcare, the benefits derived include both the quality of care (e.g., pa-

(Continued on Page 2)

For Your Advance Planning . . .

COA's 2013 Annual Meeting/QME Course

C-Bones 2013 Annual Meeting

April 18—21, 2013

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L.A.'S OCEANFRONT RESORT

President's Column (continued from Page 1)

tient outcomes) as well as the service (e.g., patient satisfaction). Costs include the direct medical costs associated with the delivery of healthcare services, including personnel, drugs, devices, and facility fees, as well as the so-called 'time' costs associated with lost productivity for patients and their families while undergoing treatment for an acute or chronic illness or condition.

Healthcare providers and their patients need better information regarding the quality and cost of the health care they deliver and receive. Increased transparency of the costs, quality, and patient experience associated with healthcare services could enable patients and their healthcare providers to make value-based decisions. Patient choice creates incentives at all levels, and motivates providers to develop innovative strategies to deliver high quality, cost-efficient care. The value of healthcare services may also be improved as providers compare their practice to others and adopt best practices. However, measuring and reporting information regarding the costs and benefits of healthcare services is fraught with challenges. Cost and quality must be measured and reported in a format that is easily obtainable and accessible in real time to those who need it (e.g., patients and their healthcare providers), clinically relevant, easy to understand, actionable, and appropriately risk-adjusted.

The COA is actively engaged in a number of initiatives and healthcare reforms that promote high value healthcare. We have reached out to develop collaborations with health plans, employer/purchaser groups, hospitals, legislative and regulatory agencies, and other provider groups on a number of value-based payment and delivery reforms, including musculoskeletal quality designation programs, episode-of-care or 'bundled' payments, and specialist involvement in accountable care organizations.

Most notably, we are a founding partner of the California Joint Replacement Registry (CJRR), whose mission is to promote high value joint replacement care for patients who suffer from disabling hip and knee arthritis. The CJRR is a partnership between the COA, the Pacific Business Group on Health, and the California Healthcare Foundation, whose goals are: (1) to collect and report scientifically valid data on the results of hip and knee replacements performed in California, including device safety and effectiveness, post-operative complication and revision rates, and patient-reported assessments; and (2) to promote the use of performance information regarding hip and knee replacements to guide physician and patient decisions and support programs for provider recognition and reward, and thereby encourage quality and cost improvements through marketplace mechanisms. A founding principle of the CJRR is that feedback and transparency will incentivize behavioral change among patients, providers, and health plans. We are implementing innovative technological solutions to help patients, surgeons, and hospitals collect and share data on patient outcomes, including pain, functional status, quality of life, complications, readmissions, and reoperations. With the help of the Pacific Business Group on Health, we are exploring incentives for patient, hospital, and surgeon participation in CJRR, including quality designation and inclusion in preferred networks. Finally, we are reaching out to other healthcare stakeholders to define the value of clinical registries, with the goal of developing a sustainable business model for the CJRR.

Our healthcare system faces many challenges in the years of head, independent of the fate of the Patient Protection and Affordable Care Act. The COA is doing its part to enhance the value of the healthcare we deliver to Californians. I look forward to hearing your thoughts and feedback, and to working with you over the coming year as your President.

Respectfully,

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

[1]Bozic KJ. Value-based healthcare and orthopaedic surgery. *Clin Orthop Relat Res.* 2012;470: 1004-1005.

COA Elects New Leaders—2012-13

COA Officers

President	Kevin Bozic, M.D., MBA—San Francisco
First Vice President	Leslie Kim, M.D.—Daly City
Second Vice President	Robert O'Hollaren, M.D.—Ventura
Secretary-Treasurer	William Brien, M.D.—Los Angeles

COA Board of Directors

Nicholas A. Abidi, M.D.	Northern California District
William W. Brien, M.D.	Los Angeles District
Michael B. Purnell, M.D.	Sequoia District
Michael Muldoon, M.D.	San Diego District
Jeffrey D. Coe, M.D.	At-Large Member
Jennifer M. Weiss, M.D.	Young Orthopaedist

CA AAOS Board of Councilors

Basil R. Besh, M.D.	Northern California District
Joel Smith, M.D.	San Diego District

Founder's Award

James Caillouette, M.D. from Newport Beach, is awarded the COA Founder's Award.

Congratulations

Dr. Tye Ouzounian (left) presented award to Dr. Caillouette (right)

Resident Award Winners

Lloyd W. Taylor, M.D. Resident Award
Derek Amanatullah, M.D. — UC Davis

Orthopaedic Hospital Resident Award
Jonathan Pribaz, M.D.—UCLA

J. Harold LaBriola, M.D. Resident Award
Alexander Theologis, M.D.—UC San Francisco

OREF Resident Award
Samantha Piper, M.D.—UC San Francisco

COA 2012 Annual Meeting /QME Course

Park Hyatt Aviara, Carlsbad, CA

Over 400 orthopaedic surgeons and their practice managers attended COA's 2012 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) and click on the Annual Meeting to see what you missed. Be sure to calendar the COA 2013 Annual Meeting/ QME Course and C-Bones 2013 Annual Meeting—April 18—21, 2013 at the Terranea Resort, Rancho Palos Verdes, CA. Program Chair: Alexandra Page, M.D.

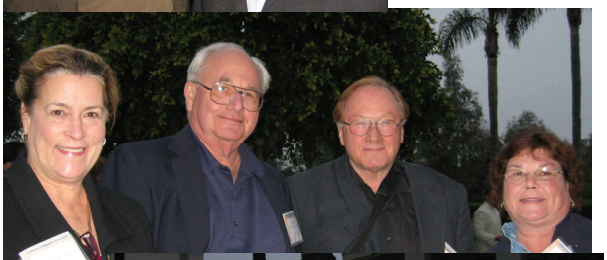
TERRANEA®
L.A.'S OCEANFRONT RESORT

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 2012 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. for taking these photos.

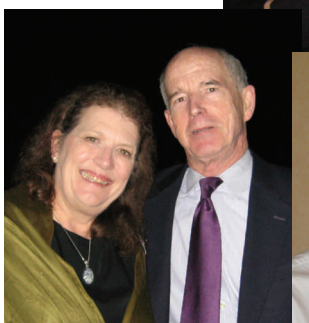









COA Develops a White Paper on Physician-Owned Distributorships

Robert O'Hollaren, M.D., Chair
COA's Health Care Delivery Committee

There is increasing pressure from state and federal regulators and other payors on physicians to take an active role in managing the health care resources for their patients and reducing the overall health care costs.

Implantable devices and implants are a significant cost for patients undergoing joint replacement and/or spine surgeries. Many hospitals have not been very effective in negotiating better pricing with the device manufacturing and distribution companies to reduce the costs of these devices; thus, implant costs have remained at very high levels.

In some communities in California, orthopaedic surgeons are coming together in an effort to reduce these unsustainable costs. They are forming "Physician-Owned Distributorships" (PODs). The physicians involved form a distributorship that buys the implantable devices directly from the manufacturer, eliminating the middleman; thus, reducing costs. The POD then sells the devices. The resulting savings are shared between the POD investors and the hospital. In spite of these savings, PODs remain highly scrutinized. Conflicts of interest are inherently possible when physicians are both the distributor and the user of a product. Some hospitals have questioned the legality of these entities and have refused to participate in these programs. Some have even adopted policies that prohibit surgeons on their medical staff from participating.

While PODs present an opportunity for orthopaedic surgeons and hospitals to control implant costs, there is also the potential for abuse if the distributorship is not structured with the highest ethical standards and the goal of reducing implant costs. Orthopaedic surgeons need to understand that unless they ensure they are listed as "also insured" by the manufacturer, they may be exposing themselves to potential product liability which is not covered by medical malpractice insurance. There is also the potential for charges of self-referral violations if the arrangements are not properly structured. There are excellent healthcare attorneys with opinions on both sides of the question of whether or not these entities can be legally structured to avoid violation of Stark Self-Referral and Anti-Kickback statutes. Some PODs have contacted federal regulators for guidance and clearer regulation of the industry.

While COA's Board of Directors has not taken a position on PODs, we do support the ethical, transparent, and value driven development of PODs which would serve to leverage market forces to drive down the overall cost of healthcare. Thus, COA's Board approved a "White Paper on Physician-Owned Distributorships" which includes some important guidelines for those members who have or are considering setting up a POD in their community.

The White Paper is posted on COA's web page – www.coa.org along with a historical backgrounder on PODs prepared by The Food and Drug Law Institute (FDLI).

New COA Member Benefit

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

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

Practice Management Information—

New COA Member Benefit

Webinars, Webinars, and more Webinars

Many organizations are utilizing webinars to share practice information including notices from the Centers for Medicare and Medicaid (CMS) on Medicare implementation deadlines important to all physician practices.

CMS, the American Medical Association (AMA), and the California Medical Association (CMA), and health care attorneys routinely schedule these educational sessions. COA has contributed to the development of some of the webinars and partnered with organizations to make the information available to our members.

We realize that it may be difficult to take time from your busy practice to view the webinars at their scheduled times. To ensure that the webinars are available to you on your own schedule, COA has established a "Library of Webinars" on our website (www.coa.org) where the webinars can be viewed at any time free of charge for COA members.

In addition to the webinars, we are also including important fact sheets on issues such as most recently, CMS E-Prescribing. This Library will grow and become a repository of practice management information important to orthopaedic practices.

We would encourage you to review these webinars/information sheets.

If you or your staff has participated in a webinar that you feel was informative and beneficial to other orthopaedic practices, let us know and we will attempt to include the webinar in our Library.

AMA Report Card—Improvement in First-Pass Payment Accuracy

The AMA's National Health Insurer Report Card provides an annual check-up for the nation's largest health insurers and diagnoses the strengths and weaknesses of the systems they use to manage, process, and pay medical claims. A cornerstone of the AMA's "Heal the Claims Process" campaign, the report card both highlights improvements in the industry and addresses areas of concern that demand attention.

Error rates for private health insurers on paid medical claims dropped from 19.3 percent in 2011 to 9.5 percent in 2012. This improvement resulted in $8 billion in health system savings due to a reduction in unnecessary administrative work to reconcile errors. While improvements were made this year, the AMA estimates an additional $7 billion could be saved if insurers consistently pay claims correctly.

To see how your health plan(s) have performed and to access the AMA 2012 Report Card's findings, including denial and accuracy rates and claims processing timelines go to: http://www.ama-assn.org/ama/pub/physician-resources/practice-management-center/health-insurer-payer-relations/national-health-insurer-report-card.page

AMA Practice Alert

What you need to know about new, emerging physician payment models

Budget-based payment systems are beginning to augment or even replace the fee-for-service payment model.

The American Medical Association (AMA) wants to make sure your practice is equipped with nuts and bolts information about these new payment models. The AMA has developed a new "how-to" manual to help your practice evaluate, negotiate, and manage budget-based payment systems, including payment bundling, pay-for-performance, withholds and risk pools, capitation and shared savings.

"**Evaluating and negotiating emerging payment options**" provides you with practical information and tools to help you assess the financial impact of a new payment model, negotiate precise terms of the arrangement and manage changes to your revenue cycle.

Prepare your practice to succeed under new, emerging payment systems.

Visit www.ama-assn.org/go/payment today to learn how to make these budget-based payment systems work for your practice.

Orthopaedic Coding Tips

Stop Using Highlighter Pens

Don't use them when you are sending in appeal letters or operative reports to insurance companies! Make your point in a better way. Why? Because this issue came up in Karen Zupko's recent lunch with a medical director of a large plan. *He said*, "They send these documents in and we can't read them! All mail is scanned and when it goes through the device all that nice yellow highlighter turns a medium gray, obliterating the type. If we can't read it, we can't respond, can we?"

What's the alternative to highlighter? You could use brackets around a paragraph. More importantly, write a cogent explanation of what the appeal issue is. If there are multiple issues, label them A, B, and C in the margin of your documentation and refer to them in your written text.

In the old days it was OK to write freehand appeal notes on the operative report and send them in—it's OUT now. Today, you'll be more successful if you use the official appeal forms on the major payers' websites.
Source: KarenZupko & Associates

Removal and Reinsertion of Cages

Question:
Our surgeon documented a revision of an interbody fusion and wants to report 22849 for the removal of a cage and placement of a new cage. Is this an acceptable use of the reinsertion code?

Answer:
CPT code 22849 is not appropriate to report in this scenario. If the surgeon's documentation supports a level of complexity over and above for the revision interbody fusion, the possibility of appending modifier 22 for the increased procedural service and complexity exists.

Repair of Dura During Discectomy

Question:
We are billing 63030 for a discectomy, but the spine surgeon wants to also bill for repairing the dura. The operative note states an "incident durotomy" was made. Can we also bill 63710 for the dura repair?

Answer:
No. Repair of an intraoperative complication such as this is included in the global surgical package for the primary procedure, 63030, and cannot be separately billed.
Source: KarenZupko & Associates

CPT Resolves 22633, 22634 Snafu
Earlier this year, CPT announced an omission of a reference in the guidelines applicable to the instrumentation, intervertebral device, and bone graft codes allowing these codes to be reported with 22633 and 22634. As add-on codes, the instrumentation, intervertebral device, and bone graft codes must have an applicable "parent" or primary procedure code. Unfortunately, the 2012 CPT book did not list 22633 or 22634 as an applicable parent or primary procedure code for the add-on codes.

The fix is here! The change in CPT language allowing the instrumentation, intervertebral device and bone graft codes to be reported with 22633 and 22634 has been approved by CPT and will be included in the CPT 2013 codebook. In the meantime, you can access CPT's errata pdf with this information. Look on pages 4-6 for the specific reference to the guidelines change.

Action
Appeal all previously denied spinal instrumentation (e.g., 22840, 22842), intervertebral device (22851) and bone graft (20930-20938) codes and use the above referenced pdf pages in your appeal. Source: KarenZupko & Associates

Assistant Surgeon Documentation and Codes

Question:
It is not uncommon that our surgeon assists other surgeons during their surgeries. Our surgeon does not dictate an operative note in these situations as the surgeon assumes the Primary Surgeon dictated the operative note and identified our surgeon as the Assistant. We have a situation where the insurance company is requesting our surgeon's operative notes on a spine case where he was the Assistant.

1. Should our surgeon be dictating their own operative note? 2. How do we know what CPT codes to report?

Answer:
While the question is general, the situation poses potential risk for reimbursement. We discuss indepth the answers to this in our National Academy Sponsored Coding Course. Here is the short answer to help you and your surgeon. 1) Request the primary surgeon to ensure the documentation identifies the name/credentials of your surgeon.

2) The role your physician performed should also be documented. As an example, consider phrases such as "the Assistant was present for all or part of the case", "another set of skilled hands was necessary due to the complexity of the case" or "the Assistant performed XYZ while I did ABC." While these are not the only statements that support the role of the Assistant, there is at least some documentation of the role and medical necessity.

3) Coordinate with the Primary Surgeon the procedures performed and the correct codes to report. Ideally this is done pre-operatively, everyone agrees and then signs off on post-op if the procedures planned were performed and the role of the Assistant was necessary as planned.

In the meantime, obtain the primary surgeons notes and use this in the documentation. Create an appeal letter identifying the role of the surgeon as an Assistant and the fact that Assistants do not document the operative note as they are the "second set of hands" and not the primary surgeon.
Source: KarenZupko & Associates

CPT 29826—Shoulder Arthroscopy
Question:
29826 in the 2012 Medicare Fee Schedule reimburses at $176.48 vs. the 2011 Fee Schedule in which reimbursement was at $497.97. What caused this severe reduction in reimbursement?

Answer:
Medicare reimbursements for 29826 did indeed fall significantly in 2012. The global period changed as well from a 90 global follow-up to a ZZZ add-on code. What this means is that previously 29826 was valued to include post-operative office visits and pre-operative physician time. As a ZZZ add-on code, its value only includes the actual surgical time for the procedures. The rationale for the change was that 29826 was almost always (more than 95% of the time) billed with other shoulder surgical codes. As a result, CMS requested that 29826 either be deleted or converted to an add-on code.

In practical terms, most surgeons should not be facing drastic reduction in total dollars as a result of this change because previously the surgeon would have almost certainly been paid only a portion of the total amount due to the multiple procedure reduction rule. The typical decrease is around 3%.
Source: AAOS Coding Department

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News of Interest

Medicare News

More than 100,000 health care providers paid for using electronic health records

More than 100,000 health care providers are using electronic health records that meet federal standards and have benefitted from the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs, the Centers for Medicare & Medicaid Services (CMS) and the Office of the National Coordinator for Health Information Technology (ONC) have announced. Only three months ago, CMS Acting Administrator Marilyn Tavenner and National Coordinator for Health Information Technology Farzad Mostashari, M.D., Sc.M., declared an ambitious goal of getting 100,000 health care providers to adopt or meaningfully use EHRs by the end of 2012. That goal has already been met and surpassed.

Through the end of May 2012, over 133,000 primary care providers and 10,000 specialists partnered with Regional Extension Centers (RECs) located in each state to overcome common EHR adoption barriers. Of these providers, 70 percent of small practice providers in rural areas as well as 74 percent of critical access hospitals are working with RECs. These regional organizations work to ensure these clinicians meet meaningful use and receive incentive payments through the Medicare and Medicaid EHR Incentive Programs, Over 12,000 providers working with RECS have already received their incentive payments. Over $5.7 billion in EHR Incentive Program payments were made. California's REC is CalHIPSO located in Oakland, CA. They can be contacted at: 510-285-5733. For more information on the Medicare and Medicaid EHR Incentive Programs, visit: http://www.cms.gov/ehrincentiveprograms/

Examining the Difference Between a National Provider Identified (NPI) and a Provider Transaction Access Number (PTAN)

All providers and suppliers who provide services and bill Medicare for services provided to Medicare beneficiaries must have an NPI. Upon application to a Medicare contractor, the provider will also be issued a PTAN. While only the NPI can be submitted on claims, the PTAN is a critical number directly linked to the provider's NPI. PTAN numbers are used to authenticate the provider when they are using Medicare's self-help tools. A provider must have one NPI and may have one or more PTAN numbers. If the provider has relationships with one or more medical groups or with multiple Medicare contractors, separate PTANS are generally assigned.

CMS releases top auditor issues

The Centers for Medicare & Medicaid Services (CMS) released its current quarterly newsletter aimed at helping providers, suppliers and their billing staffs understand and avoid certain billing errors. The newsletter identifies top billing errors identified by CMS contractors like the Recovery Audit Contractors (RACs), Zone Program Integrity Contractors (or ZPICs) and Comprehensive Error Rate Testing (CERT) findings.

In this newsletter, CMS identified and provided guidance on avoiding 7 common billing errors, two which affect orthopaedic practices:
- Physician Evaluation and Management (E/M) codes inpatient hospital consultations; and,
- Spinal fusion

We would urge you to review these guidelines.

Orthopaedic Coding Tips

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Coding Clarifications

AMA CPT Assistant—April, 2012
Spine Bone Graft Codes—20930-20938
CPT 20670 Removal of Implant—Skin Incision
CPT 25118—Synovectomy
CPT 26567—Osteotomy
CPT 27635—Bone Cyst
Endoscopic Tenovaginotomy
CPT 29822—Arthroscopy Shoulder

AMA CPT Assistant—March, 2012
Debridement Guidelines
Modifier Update—25 and 29
Taping Shoulders
CPT 27333—Arthrotomy

AMA CPT Assistant—February, 2012
EMGs—Add-On Codes when performed with Nerve Conduction Studies

E-mail the COA office to obtain copies of these articles—coa1@pacbell.net

A message from COA President, Kevin Bozic, M.D. to COA Members . . .

In a historic vote, the United States Supreme Court voted to uphold most of the provisions in the Patient Protection and Affordable Care Act (PPACA). The COA remains actively engaged with federal and state legislators and regulators, as well as other key healthcare stakeholders, in helping understand the implications and consequences of this law on the provision of healthcare services in California. In particular, we are committed to helping our members prepare for implementation of PPACA, and to continuing to advocate for the appropriate resources and regulatory environment necessary for us to provide the highest quality musculoskeletal care to our patients. We believe that as front line healthcare providers, our voice and input are critical to shaping the future of healthcare delivery in California. For your information, we have reprinted the AAOS Member Alert on the Supreme Court ruling below.

As always, your comments, feedback, and continued involvement in our advocacy efforts are greatly appreciated.

AAOS American Academy of Orthopaedic Surgeons
American Association of Orthopaedic Surgeons

American Association of Orthopaedic Surgeons

Member Alert

SUPREME COURT UPHOLDS PPACA

Today, the United States Supreme Court upheld the "Patient Protection and Affordable Care Act" (PPACA). Although the American Association of Orthopaedic Surgeons (AAOS) opposed much of PPACA, we recognize that there are provisions in the law that aim to help providers deliver high-value healthcare services, including the development and implementation of Accountable Care Organizations and other quality improvement efforts, and assistance for pediatric specialists serving underserved communities. In addition, there are valuable patient protection provisions within the law, such as enabling young adults to remain on their parents' insurance policies, outlawing coverage denials based on pre-existing conditions, enforcing medical loss ratio requirements, and doing away with maximum coverage limits on insurance policies.

However, PPACA also contains some provisions that could greatly hinder providers' ability to deliver patient care, thereby threatening patients' access to the healthcare services they need. The AAOS, along with its more than 18,000 members, stands ready to work with Congress to address these detrimental provisions in the law, such as continuing efforts to repeal the Independent Payment Advisory Board (IPAB) and other administrative burdens that infringe upon providers' ability to deliver safe and effective patient care. Additionally, the AAOS looks forward to working with Congress to find solutions to other issues that were not addressed by PPACA, such as achieving a permanent replacement to the flawed Sustainable Growth Rate formula and addressing federal medical liability reform. The AAOS will continue to communicate the healthcare priorities of the orthopaedic community to Congress to achieve the goals of establishing a healthcare delivery system that is affordable, accessible, and ensures the best quality patient care possible.

The Supreme Court's decision impacts the future course of America's healthcare system. The AAOS pledges its continued commitment to championing the interests of our patients and our profession as the structure and implementation of healthcare reform continue to unfold.

John R. Tongue, MD
President
American Association of Orthopaedic Surgeons
American Academy of Orthopaedic Surgeons

HLB
Hooper, Lundy & Bookman, PC
HEALTH CARE LAWYERS

HLB HEALTH LAW E-ALERT
JULY 3, 2012

Hooper, Lundy & Bookman Sues Aetna, Charging Illegal Retaliation Against Patients, Doctors and Surgery Centers Over Out-of-Network Care

On July 3, 2012, Hooper, Lundy & Bookman, PC (HLB) filed a complaint against Aetna Health of California, on behalf of outpatient surgery centers, physician groups, individual physicians and patients, charging the health plan with illegally punishing contracted physicians for performing surgeries at out-of-network surgery centers.

The complaint charges that Aetna unlawfully attempts to prohibit Preferred Provider Organization (PPO) and Point-of-Service (POS) patients from using their out-of network benefits, and penalizes its contracted physicians who refer patients to out-of-network surgery centers.

"Aetna members purchase PPO and POS insurance so that they can receive their care at out-of-network providers. However, when they attempt to do so, Aetna improperly retaliates against those members' physicians," said lead attorney in the case, Daron Tooch. "Aetna should not be permitted to sell insurance policies to members of the public with the promise that they can receive their healthcare at providers of their choice, and then engage in tactics designed to prevent those members from using those benefits."

The suit outlines alleged instances in which Aetna has threatened to terminate, and has actually terminated, contracts with physicians who refer patients to out-of-network providers. The suit also describes how Aetna pressures its members not to use their out-of-network benefits.

"It is up to patients and their physicians to decide where the surgeries are to be performed. California law prohibits insurance companies from interfering with medical decisions for fiscal reasons," said Mr. Tooch. "And although this case specifically addresses Aetna's unlawful actions pertaining to California providers, this issue is national in scope."

Claiming that Aetna is engaged in unfair business practices, false advertising, breach of contract, and intentional and negligent interference with health care providers, HLB is seeking restitution for patients and providers, an injunction requiring Aetna to cease from threatening physicians and patients, and punitive damages. In addition, HLB is also calling for a reinstatement of any provider agreements Aetna terminated for referral of members to out-of-network providers.

Unfair Business Practices

The complaint charges that Aetna has utilized unfair business practices by:

- Attempting to control, direct and participate in the selection of health facilities by PPO members.
- Failing to base determinations of whether or not to authorize health care services for members on "sound clinical practices," and failing to ensure that medical decisions regarding members are unhindered by fiscal and administrative management.
- Engaging in fraudulent, misleading and deceptive advertising.

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Hooper, Lundy & Bookman Sues Aetna, Charging Illegal Retaliation Against Patients, Doctors and Surgery Centers Over Out-of-Network Care
(continued from Page 9)

False Advertising

The complaint further charges that through its marketing and advertising, Aetna makes false and misleading statements regarding members' rights to out-of-network benefits and the ability of members to access out-of-network providers and facilities.

Breach of Contract

The complaint charges Aetna with breaching its contracts with both patients and providers. This breach occurs for patients when Aetna attempts to prohibit PPO patients from using their out-of-network benefits. According to the complaint, Aetna has breached its provider agreements by threatening physicians with termination of their in-network status for referring patients to out-of-network providers.

Retaliation and Termination in Violation of Public Policy

The complaint charges that Aetna's practice of terminating physician contracts, and retaliating against them for advocating medically appropriate health care options for PPO and POS members, is a violation of public policy.

Interference with Prospective Economic Advantage

The complaint charges that Aetna is interfering with surgery centers' relationships with both physicians and patients by attempting to prevent patients from receiving surgeries at the out-of-network surgery centers, and threatening physicians for performing the surgeries at those surgery centers.

Aetna Retaliation Against Members

In one example cited in the complaint, an Aetna PPO member was treated by Aetna in-network physicians for several medical issues he experienced. The in-network physicians then referred the Aetna member to out-of-network surgery centers for additional treatment. The complaint alleges that the Aetna repeatedly attempted to discourage the member from using the out-of-network providers, refused to authorize medically-necessary services and threatened to withhold reimbursement to the out-of-network providers recommended by in-network physicians, and in one instance refused to pay for the member's care. In this instance, after three appeals, Aetna finally paid approximately $9,000 of a $70,000 bill. The vast majority of this bill remains unpaid by Aetna.

"We urge physicians, medical groups and surgery centers throughout the country to contact legal counsel if they have experienced such actions by Aetna, or any other health insurer/health plan," said Mr. Tooch.

For additional information, please contact Daron Tooch, Glenn Solomon or Katherine Markowski in Los Angeles at (310.551.8111); or Paul Smith in San Francisco at 415.875.8500.

Workers' Compensation News

DWC Appoints Medical Director

Rupali Das, M.D. has been appointed the new Medical Director for the Division of Workers' Compensation. Dr. Das comes to the Division from the California Department of Public Health, where she was chief of the Exposure Assessment Section in the Environmental Health Investigations Branch since 2009. She joined the Department of Public Health in 1998 as a public health medical officer and focused on reducing worker illnesses in agriculture and other industries.

Dr. Das is expected to join the Division this summer and replaces Anne Searcy, M.D. who left the Division in 2008.

Ellen Flynn appointed associate chief judge for Division of Workers' Compensation

DWC announces that Administrative Director, Rosa Moran has selected Ellen Flynn as Associate Chief Judge. In this position, Flynn will oversee the Southern California offices. Flynn will take over for Mark Kahn, who is retiring after 31 years of service with DWC.

Dignity Health to acquire U.S. HealthWorks

Dignity Health, formerly known as Catholic Healthcare West, announced that it has signed a definitive agreement to acquire U.S. HealthWorks, which bills itself as the largest independent operator of occupational medicine and urgent care centers in the United States.

The deal is subject to regulatory approvals and is expected to be finalized in August.

Based in Valencia, U.S. HealthWorks is a portfolio company of Altaris Capital Partners and Three Arch Partners. It operates 172 sites nationwide, employing 2,700.

The CEO of U.S. HealthWorks is Daniel D. Crowley, who was chief executive officer of Rancho Cordova-based Foundation Health Corp. before it merged with Health Systems International in 1997.

2nd District Court of Appeal Annuls WCAB Decision in Valdez

The 2nd District Court of Appeal has ruled that California's Labor Code does not prohibit the admission of medical reports from doctors who are not part of an employer's medical provider network. In an unpublished decision, a unanimous Division Seven panel said that Labor Code Section 4616 bars reports from non-network physicians only if there has been an independent medical review under Section 4616.4.

The case, Valdez v. WCAB came before the court after a divided Workers' Compensation Appeals Board concluded that Section 4616.6 prohibits such reports from being used as evidence in a claim filed by Warehouse Demo Services employee, Elayne Valdez.

Section 4616 sets forth a multi-level process for an injured worker to change physicians within an employer's network and obtain an independent medical review—governed by Section 4616.4—to dispute a treatment of diagnosis. Section 4616.6 provides that "(n)o additional examinations shall be ordered by the Appeals Board and no other reports shall be admissible to resolve any controversy arising out of this article."

Warehouse Demo Services asserted that it had a valid medical provider network, which Elayne Valdez abandoned three weeks after sustaining an injury at work. Her attorney referred her to chiropractic, Mark Nario, and she began treating with him at her own expense. The WCAB judge relied on Dr. Nario's opinion in determining Valdez was entitled to temporary disability benefits. The WCAB reaffirmed its interpretation of Section 4616.6. It also concluded that Dr. Nario did not qualify as Valdez's primary treating physician, so his opinion could not be used to determine her eligibility for compensation.

As a result of this ruling, reports of doctors who are not part of an employer's medical provider network, can now be admissible .

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People in the News

Chair—AAOS Council on Research and Quality

Kevin Bozic, M.D., MBA has recently been appointed Chair of the AAOS Council on Research and Quality and as such also has a seat on the AAOS Board of Directors.

Healthcare Award

Long-time COA member, **Robert Henrichsen, M.D.** of Auburn has received the Healthcare Award at the May 11 State of the Community Dinner for his 45 years of commitment to his patients.

Welcome to COA's Newest Members

Sunny Cheung, M.D.	Apple Valley
Vincent Colin, M.D.	Orange
Alan Bao-Chan Dang, M.D.	San Diego
Eric Farrell, M.D.	Los Angeles
Beatriz Garcia, M.D.	Guaynabo
Andy Li-Jen Liu, M.D.	Diamond Bar
Patrick J. Osgood, M.D.	Truckee
Garrett Synder, M.D.	Ventura
Angela Tomaschko, M.D.	San Diego
Christopher Walter, M.D.	Fortuna
Amy Wickman, M.D.	Santa Barbara

If you have not yet paid your 2012 COA Dues, we would urge you to do so as soon as possible to be included in COA's 2012-2013 Membership Directory that will be published in the Fall, 2012.

Go to: www.coa.org—click on Membership to pay your dues on-line.

Thanks for your support.

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