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COA Report

A publication of the California Orthopaedic Association

Spring, 2016

Time is running out to register for . . .

COA's 2016 Annual Meeting/QME Course

May 19-22, 2016
Ritz-Carlton Laguna Niguel

Special Resident Forum and
C-Bones Annual Meeting
May 19, 2016

Join nearly 500 COA members and their orthopaedic practice managers at the meeting.
REGISTER TODAY

Payors Paying by Credit Card—Can You Say No?

Yes.
When a payor pays your claims via credit card, it effectively reduces your reimbursement by the amount that your Merchant Service charges you to process the credit card charge. This could be as much as 2%-4% of the payment. The costs adds up and comes right out of your bottom line.

If you want to say "NO" to payors paying you with a credit card, you can. According to the federal Patient Protection and Affordable Care Act, payors are required to offer providers payment by electronic funds transfer (EFT). So, this means that you cannot demand payment by a check, but you could ask that payors pay you via an EFT. Some providers do not want to give payors their banking information. To remedy this problem, you can set-up a special account at your bank for the sole purpose of receiving electronic payments. Then regularly transfer monies out of that account into your regular operating accounts to avoid large amounts of money accumulating in that account.

Continued from Page 1

Market Profile of U.S. Orthopaedic Surgeons

SK&A released a report on the number of orthopaedic surgeons in the U.S., their practice size, patient volume, hospital and ASC affiliations, and employment and ACO participation rates. For a copy of the report: http://www.coa.org/docs/SKA.pdf

Impact of Value-Based Health Care and Risk Sharing

As healthcare moves toward value-based care and risk-sharing payment models, hospitals are taking a new look at ambulatory surgery centers (ASCs) as a strategy to improve both bottom lines and quality of care. For a White Paper from Regent Surgical Health discussing this issue—http://www.coa.org/docs/Regent.pdf.

CJRR Moves to Support HOOS, JR. and KOOS, JR.

In an effort to reduce the burden of data collection for total joint replacement procedures and to support hospitals and surgeons involved in the Comprehensive Care for Joint Replacement (CJR) Medicare model, the California Joint Replacement Registry will soon support the use of the Hip Disability and Osteoarthritis Outcome Score (HOOS, JR.) and Knee Injury and Osteoarthritis Outcome Score (KOOS, JR.) for outcome data reporting. These are abbreviated data reporting tools that have also been adopted by Blue Shield of California for total joint replacements.

Medicare News

Good News—Shoulder Surgeons

AAOS Changes CMS Position on Shoulder Coding Issues

After several years of lobbying the Centers for Medicare and Medicaid Services (CMS) by the AAOS and the Arthroscopy Association of North America (AANA) to eliminate National Correct Coding Initiative (NCCI) edits for shoulder procedures, they have been successful. As of July 1, 2016, the NCCI edits will be changed to allow billing separately for CPT code 29823, Arthroscopic Shoulder Debridement, extensive, with several other arthroscopic shoulder procedures such as CPT code 29827, Arthroscopic Rotator Cuff Repair, or CPT code 29824, Arthroscopic Distal Claviculectomy. AAOS and AANA successfully argued that the shoulder is technically three anatomic synovial joints and two articulations.

CMS Finalizes Controversial Repayment Rule

The Affordable Care Act compels providers to return overpayments to Medicare within 60 days of identifying them. Failure to report overpayments can result in liability under the False Claims Act. The controversial CMS repayment rules were finalized in March, 2016. The final rule allows for a 6-year lookback instead of the previously proposed 10-year lookback. An overpayment is identified if the provider or supplier has actual knowledge of the existence of the overpayment or acts in a reckless disregard or deliberate ignorance of the overpayment. Providers sometimes seek to incorporate underpayments to reduce the amount of overpayment. This practice is expressly prohibited in the final rule.

CMS Drops Two Midnight-Rule

The "two midnight rule" has been dropped after widespread complaints from hospitals and surgeons and a lawsuit by the American Hospital Association. The rule was intended to clarify when a moderately sick patient should be admitted for inpatient care instead of outpatient observation. CMS believes that patients are inappropriately being admitted to the more expensive inpatient setting. The "two midnight rule" says that admitting physicians must have good reason to believe that a patient will require two nights in the hospital to qualify for Medicare's higher-paying hospital rates. The admission cannot just be for the convenience of the patient. Otherwise, the care is considered outpatient, which pays less. In April 2016, a federal judge ordered CMS to better justify the cuts and to reopen the policy to comments. In light of this ruling, CMS announced that they will be dropping the two-midnight rule for inpatient cuts.

AMA *CPT Assistant*—Clarifies Coding Rules on Prolonged Service Codes—Clinical Staff

Revisions and additions were made to the Evaluation and Management/Prolonged Services section of the CPT 2016 codes to allow reporting of prolonged monitoring by **clinical staff** in the office or other outpatient setting that may or may not include face-to-face services by a physician or other health care provider. The description of the coding rules can be found: http://www.coa.org/docs/CPT

Opportunities for Orthopaedic Surgeons Orthopaedic Practice Administrator/Staff

Practice Administrator

Tri-Valley Orthopedic Specialists, a successful multi-specialty surgery group seeks a dynamic experienced Practice Administrator with strong, proven leadership skills to join our organization.

Our medical practice offers services from 11 orthopedic surgeons and physicians with varying interests and specialties. We offer a wide range of services to our patients including Sports Medicine, Physical Therapy, Hand Therapy, MRI, and X-Ray imaging services. In addition to our main location in Pleasanton, we provide services to our patients with our 2 satellite locations in San Ramon, and Tracy, CA.

For more information: http://www.coa.org/docs/TriValley.pdf

Benefits: Salary is commensurate with experience. A comprehensive benefit package, as well as reasonable and negotiated moving expenses consistent with the level of this position is available.

Contact Person: Kristin Boettcher
Phone: 925-463-6272 Email: kboettcher@tvoinc.com

Synergy Specialists Medical Group
Medical Billers Needed

- Experienced Orthopedic Biller needed in San Diego. Certified coders preferred, but not required.
- Medical Assistant Needed:
  Experienced Orthopedic Medical Assistant needed in South Bay San Diego.

Please contact Tom by email at TReardon@SynergySMG.com for hours, salary and location information.

Orthopaedic Surgeons

RTCC—Orthopaedic members
At the end of 2016, the Radiologic Technology Certification Committee (RTCC) will have 2 vacancies on the Committee which are currently held by orthopaedic surgeons, Dale Butler, M.D. and Todd Moldawer, M.D. Drs. Butler and Moldawer have reached their maximum terms and cannot be reappointed.

The RTCC is under the Radiologic Health Branch which is part of the California Department of Public Health and is charged with radiation safety. This includes certifying physicians to be a radiologic supervisor and to perform fluoroscopy.

COA is looking for members who would be interested in serving on the RTCC. The Committee meets twice a year, in Sacramento and Los Angeles. The RTCC will reimburse you for your travel costs, but otherwise, this is an unpaid position.

This is an important Committee affecting orthopaedic practice. Send your CV to COA if you are interested in serving on this Committee—coa1@pacbell.net

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Ventura Orthopedics Medical Group, Inc., a growing orthopedic group with specialists in spine, pediatrics, shoulder, hand, sports, total joint, and foot and ankle is looking to add a physician with interest and experience in total joint arthroplasty, hip arthroscopy, or fellowship training in shoulder surgery. This position will start in the fall of 2016.

The group which is located in Ventura County, California, immediately north of Los Angeles County, has a tradition of leadership and service in our community with the goal of being a fully vertically integrated provider of musculoskeletal care.

You can learn more about us at www.venturaortho.com and if interested, please send your CV to James Keil, CEO, at

jamesk@venturaortho.com

Whoops, They Did It Again!

How CMS Used FAQs to Demonstrate Meaningful Use

Jason McCormick, MHA | *Campbell Clinic*

In what only can be described as the most confusing Meaningful Use requirement to date, Objective 10 of CMS's Modified Meaningful Use states that eligible providers must be "actively engaged" with a public health agency, or other specialized registry, to submit electronic public health data. What the Objective does not state is how orthopaedic providers and practices are supposed to comply with this requirement, which is one of many that reinforces the viewpoint that Meaningful Use is a program that is geared towards primary care providers, and not specialists. While searching for insight into how to ensure our providers are in compliance, or at least demonstrating due diligence to try to comply, many orthopaedic practice managers begin looking like they are sitting across from Regis Philbin anxious to use one of their "lifelines" to call a friend. The problem is that most of the friends are equally as clueless. It is just at the moment that the practice is about to sign on with an organization that promises they are the answer that guidance is provided in one of the most unexpected places – a CMS FAQ!

While it may seem like an appropriate place to find an answer, the FAQs have not historically given practice managers the insight that is offered by CMS FAQ #13657. Assuming that the practice is already aware of their responsibility to report immunization or syndromic surveillance data to a public health agency, FAQ #13657 addresses the requirements for identifying specialized registries available to providers, or demonstrating due diligence, and the criteria for claiming an exclusion for Measure 3 of the Objective. The task at hand is to not over-think the language that CMS included in the FAQ. Here's a simple blue-print for how you can determine if there are any specialized registries available to you, or if you will be able to claim an exclusion and defend your determination.

Providers should contact their respective State to see if any specialized registry is maintained by the State's public health agency. In most cases, this information can be located on the State's website and the information is provided so that providers can tell what registries are available to which type of provider. California Note: The State of California does not have a specialized registry. The California Joint Replacement Registry/American Joint Replacement Registry can help orthopaedic practices meet the reporting requirements for total joint replacement procedures, if your hospital is participating in one of the registries. Disregard any registries that are not geared towards your provider's specialty. For example, most cancer registries will not be open to orthopaedics, which makes them unavailable. Any potential registries that are left over have to be vetted to make sure they can accept electronic data from an EHR and that your EHR will be able to provide the data in an acceptable format. Providers should contact their affiliated specialty society(s) to identify any specialized registries that are maintained or endorsed by the society.

American Academy of Orthopaedic Surgeons (AAOS) does not maintain or endorse any one specific registry. American Association of Hip and Knee Surgeons (AAHKS) does endorse the American Joint Replacement Registry (AJRR). Providers that practice in facilities that do not currently submit data to AJRR will be required to register, submit a complete data set, and ensure that practice EHRs can submit data in electronic format accepted by AJRR. Providers who have determined that there are no registries available after completing the above two steps may choose to be excluded from the measure requirements.

CMS states that "the provider is not required to make an exhaustive search of all potential registries" and that "due diligence" is obtained after completing the two searches above. In contrast to the information that many have received that the only way to be in compliance with the measure is through participation with certain registries, CMS's own FAQs show that this is not the case. After checking with the practice's state public health agency and the provider's specialty association, there is no reason that orthopaedic providers cannot successfully attest to Meaningful Use, while claiming exclusions for all three Public Health measures in Objective 10.

Blue Cross News

Are you Aware that Blue Cross has Disconnected its Contract/Network Relations Phone Number?

Effective January 1, 2016, the phone line—855-238-0095—has been disconnected. Attend C-Bones 2016 Annual Meeting to learn how to contact Blue Cross.

Are you Getting Chart Note Requests from Inovalon?

COA members are complaining that they are receiving random letters from Inovalon, representing Blue Cross, for patient chart notes. There may be many reasons why a payor requests additional patient information, but what seems to be triggering these most recent requests, is the payor looking for diagnoses that may not be included on the claim form. The goal of the payor is to identify the health status and demographic characteristics of beneficiaries...the sicker the patients, the higher the plan's "risk score." Higher patient risk scores means higher reimbursement for payors. It's a federal requirement for plans to collect risk data and many plans pass on that requirement to their providers.

The California Medical Association has prepared the below document summarizing Commercial Risk Adjustment.

What is Commercial Risk Adjustment?

Over the past few months, CMA has received several calls from practices who had received requests for medical records from various payors stating the records are needed for "risk adjustment." The records requests are a result of the commercial risk adjustment program created by Section 1343 of the Affordable Care Act. The primary goal of the risk adjustment program is to spread the financial risk borne by payors more evenly in order to stabilize premiums and provide issuers the ability to offer a variety of plans to meet the needs of a diverse population.

Similar to Medicare risk adjustment audits, the commercial risk adjustment program is designed to identify the health status and demographic characteristics of enrollees in non-grandfathered plans in the individual and small group markets to determine a risk score average. The risk score is a relative measure of how costly an individual is anticipated to be. If at the end of the annual risk adjustment assessment, Plan A has a lower-risk average score than Plan B, then Plan A has to issue a payment to Plan B. In a nutshell, the program is intended to prevent payors from cherry picking only healthy enrollees.

Because the information reported by physicians and other providers is at the heart of payment adjustments, health plans must engage providers by requesting copies of medical records that accurately reflect diagnoses and/or underlying health conditions to comply with risk adjustment program requirements. [77 Fed.Reg. 17220, 17241 (March 23, 2012)]

The risk adjustment program is a requirement on the payor; however, through managed care contracts, payors typically require their contracting physicians to comply with the risk adjustment medical record requests. Non-contracted physicians are under no obligation to comply with the request. Most payors appear to be contracting with a third-party vendor to handle the record requests and collection.

A frequently asked question by physicians about the requests is whether the records can be released without written authorization from the patient under HIPAA. Both HIPAA and California's Confidentiality of Medical Information Act permit disclosures of protected health information to third-party payors for treatment and payment purposes without patient authorization, including to plans for risk adjustment purposes. However, when dealing with sensitive medical information such as mental health records or psychotherapy notes, the circumstances in which disclosures may be made to third-party payors absent the patient's signed authorization are limited. Given the sensitivity of this information, provisions allowing for permissive disclosure of these records should be interpreted narrowly and physicians should err on the side of caution with regards to disclosures absent patient authorization. For more information, see CMA On-Call document #4250, "Confidentiality of Sensitive Medical Information."

At least one payor appears to be offering to provide a scanner technician upon request, paid for by the plan, who will come to the practice to retrieve the needed records; others are requiring the practice to handle the copying/scanning and submission either by fax or mail. Additionally, the commercial risk adjustment audits usually involve only a handful of patients per practice, but if the request is voluminous, practices may wish to contact the payor and request that it send a copy/scanner service out to the practice.

California Medical Association—June, 2015.

Workers' Compensation News

Department of Industrial Relations
STATE OF CALIFORNIA

N E W S L I N E

Newsline No.: 2016-33 **Date:** March 30, 2016

DWC Releases Fourth Edition of the *Physician's Guide to Medical Practice in the California Workers' Compensation System*

The Division of Workers' Compensation (DWC) is pleased to announce the release of the fourth edition of the *Physician's Guide to Medical Practice in the California Workers' Compensation System*. This comprehensive guide helps physicians and other health care providers dispense optimal care to injured workers.

"The physician's guide was last revised in 2001, and much has happened in the last 15 years," said DWC Acting Administrative Director George Parisotto. "The guide provides up-to-date information that will help practitioners apply the reforms set forth in SB 863."

"Physician understanding of the workers' compensation system is critical to helping deliver appropriate care to injured workers," said DWC Acting Executive Medical Director Dr. Raymond Meister.

The manual contains 16 chapters, revising material from the third edition and providing new chapters on the following subjects:

- Parties to the System
- Benefits and Payments to Employees
- Reports and Timelines in the System
- Evidence-Based Medicine and the MTUS
- Utilization Review and IMR

Physician Payment and the OMFS
The *Physician's Guide* is intended as an educational and reference tool to supplement the reader's professional experience. While intended primarily for treating providers, others in the workers' compensation community may also find the information helpful, particularly Qualified Medical Evaluators (QMEs) and those preparing for the QME certification exam.

The physician's guide is posted on the DWC website.

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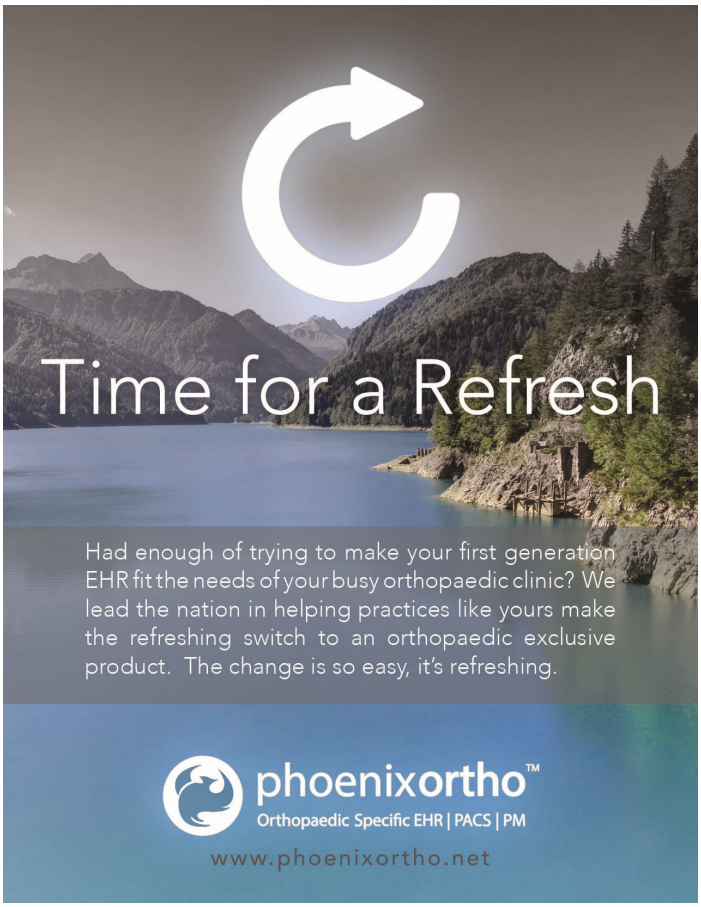

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ExamWorks

Come see us at **booth number 11 & 12** at the COA to learn why we have the **largest provider panel in California**! Look for a raffle ticket enclosed in the **ExamWorks May Mailer** and bring to our booth to see if you are the winner of our **Apple Watch**!

We look forward to seeing you there!
Abby, Stuart, Kristin, Karen, Andrew and Paige

California Orthopaedic Association

2016 LEGISLATIVE ALERT

2016 is the second year of a two-year Legislative Session.

AB 2503 (Obernolte)—COA-Sponsored Legislation

In addition to working with the Division of Workers' Compensation (DWC) on targeted Utilization Review audits for payors failure to act on a Request for Authorization for Medical Treatment (RFA) within the required timelines, COA has introduced AB 2503 to clarify that RFAs should always be sent to the claims adjuster. Too often, orthopaedic offices need to call the claims adjuster to determine where to send the RFA and sometimes are asked to send the request directly to the URO and sometimes to the claims adjuster. This causes confusion, delays treatment, and increases administrative costs.

SB 994 (Hill) - establishes an "Antimicrobial Stewardship" program in physician offices to help rein in the over-utilization of antibiotic medications. The Medical Board of California would be charged with auditing for compliance. COA has sought amendments to the bill which indicate that the surgeon would be deemed in compliance with the program if they are following the CDC guidelines for preventing healthcare associated-infections applicable to the procedure they are performing which would include use of antibiotics pre and post-surgery. COA is also seeking to have orthopaedic surgeons completely exempted from the program since the data presented has focused on the over-utilization of antibiotics by primary care physicians, not surgeons.

AB 2407 (Chavez) - is a bill sponsored by the California Chiropractic Association to ensure that injured workers are not rushed into spine surgery. The bill outlines the required conservative treatment that would be required prior to surgery and asks the surgeon to declare with certainty prior to surgery that the spine procedure will relieve the back problems. There is no evidence that injured workers are being rushed into spine surgery, in fact we believe it is very difficult for spine surgeons to get approval for surgery. Also, the bill requires conservative treatment that may be medically inappropriate for the patient. COA is opposing this bill.

California Orthopaedic Association
1246 P Street
Sacramento, CA 95814

2016 COA Membership Dues are now due

go to:
Pay On-Line: http://coa.org/members/

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

Welcome to COA's 2016 New Members

First Name	Last Name	City
Zachary	Adler, M.D.	Newport Beach
Oke	Anakwenze, M.D.	San Diego
Ricardo	Avena, M.D.	Fresno
Oladapo "Dapo"	Babatunde, M.D.	Redwood City
Piers	Barry, M.D.	San Francisco
Luke	Bremner, M.D.	Encinitas
Leo	Calafi, M.D.	Walnut Creek
Michael	Ciepiela, M.D.	Rancho Cordova
Adnan	Cutuk, M.D.	San Diego
Brian	Dierckman, M.D.	Van Nuys
Daniel	Duggan, DO	Foothill Ranch
Michael	Gardner, M.D.	Redwood City
Joshua	Gluck, M.D.	Ventura
W. Scott	Green, M.D.	San Francisco
Christian	Guier, M.D.	San Francisco
Richard	Han, M.D.	Modesto
Albert	Hsu, M.D.	West Covina
Mark	Ignatius, DO	San Francisco
Robin	Karnal, M.D.	Redwood City
Jennifer	Kho, M.D.	Modesto
Sang	Kim, M.D.	Los Angeles
David	Lee, M.D.	Long Beach

First Name	Last Name	City
Corey	Lieber, M.D.	Newport Beach
Kristin	Livingston, M.D.	San Francisco
Jeremy	McCandless, M.D.	El Cajon
A. Michael	Moheimani, M.D.	Santa Ana
Derek	Moore, M.D.	Santa Barbara
Nader	Nassif, M.D.	Newport Beach
Lan	Nguyen, M.D.	San Diego
Alen	Nourian, M.D.	Ventura
Ariel	Palanca, M.D.	Redwood City
Min Jung	Park, M.D.	Redwood City
Rowan	Paul, M.D.	San Francisco
Aaron	Pemberton, M.D.	Redding
Michael	Pomerantz, M.D.	Chula Vista
Michael	Price, M.D.	Valencia
Michael	Puniak, M.D.	San Dimas
Albi	Qeli, M.D.	Travis AFB
Adrian	Rawlinson, M.D.	San Francisco
Shahin	Sheibani-Ram, MD	Encino
Kali	Tileston, M.D.	Redwood City
Curtis	VandenBerg, M.D.	Los Angeles
Wendy	Wong, M.D.	Walnut Creek
Kirkham	Wood, M.D.	Redwood City