Executive Director
Diane M. Przepiorski
5380 Elvas Avenue, #221
Sacramento, CA 95819
Phone: (916) 454-9884
Fax: (916) 454-9882
E-Mail: coa1@pacbell.net
Web Page: www.coassn.org

COA Report

A publication of the California Orthopaedic Association

Volume XIX Issue II —— Summer, 2007

COA Advocacy at Work

The role of COA is to advocate on behalf of and to help educate orthopaedic surgeons of California. Advocacy matters can be extremely effective in advancing issues of importance to all of us and our patients. COA recently demonstrated its effectiveness while working with the AAOS Committee on Professionalism as the Committee considered adopting a Standard of Professionalism (SOP) on On-Call Professional Responsibilities.

Under Larry Herron's guidance, a letter was sent to Murray Goodman, M.D., Chair of the AAOS Committee, adamantly opposing the SOP, which in its original form, would have mandated orthopaedic surgeons to take emergency room call and removed any incentive for hospitals to negotiate on-call arrangements with their orthopaedic staff. Adoption of this SOP would have also put orthopaedic surgeons at risk of losing their membership in the AAOS should another orthopaedic surgeon in their community complain that they were not taking their share of on-call service.

Newly-elected COA President, James Caillouette, M.D. (right) receives the gavel from Larry Herron, M.D.

In California, many hospitals now provide stipends, favorable OR time, and professional service fees for uninsured patients as a result of orthopaedic surgeons' negotiations with their hospital. These arrangements are unique to each community and need to be negotiated as such.

The proposed AAOS SOP was amended after the Committee considered COA's letter and they attempted to clarify that the SOP was not intended to mandate call. However, upon additional

(Continued on Page 2)

Blue Cross and Blue Shield Announce Contract Changes

You have received several e-mails from COA alerting you to contract changes announced by Blue Cross as of June 1, 2007 and Blue Shield effective July 1, 2007.

The Blue Cross alerts and letter are reprinted on Pages 3-6 of this newsletter and the Blue Shield alert and letter on Page 10. This information is provided to you to ensure that you are aware of these changes.

We would urge you to fax in a list of CPT codes important to your practice if you are contracted with Blue Cross or Blue Shield, so that you understand the actual impact on your practice.

President's Column (continued from Page 1)

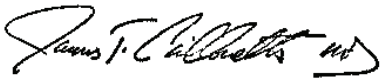
evaluation by COA's leadership, we felt it continued to need further amendments. In April, we drafted further amendments and also alerted other state orthopaedic societies to gain additional support for COA's position. We were gratified when other state societies joined us in opposing the SOP.

At the NOLC meeting in May, the Committee met and agreed that the SOP needed additional discussion. They voted to hold the SOP in Committee and even questioned whether the AAOS should be developing a SOP in this area. This was a very good outcome, as COA's Board of Directors had also questioned why the AAOS was developing this SOP. This is just one example of how COA is working for you. Many other state orthopaedic societies were totally unaware of the AAOS activities on this issue. **Thanks to COA Board member, Paul Caviale, M.D.**, who was appointed to the Committee on Professionalism, for recognizing the potential negative impact of this SOP and bringing it to COA Board's attention. **Advocacy matters. We can make a difference if we work together.**

Orthopaedic surgeons are working hard to provide the best care possible for their community of patients. At the same time, our work environment is evolving and in many regards, becoming more hostile to the provision of appropriate musculoskeletal care. Legislation, payers, trial lawyers, and even our own Academy can, at times, impose changes that impede our mission to serve our patients.

There is a saying in the world of philanthropy, "No margin, no mission." If the health care environment evolves such that the marginal benefit of providing care evaporates either through legislative change, the collapse of reimbursement coupled with the rising cost of providing care, or mandates imposed by a national organization charged with representing orthopaedic surgeons at large, then our society is the ultimate loser. Thus, with your help, COA will remain vigilant and aggressive in alerting you to changes that negatively affect your practice and maintaining "the margin."

All the best,



James Caillouette, M.D., President

To Participate in COA's Advocacy Program

- Contact elected officials when a critical issue is being discussed; and/or,
- Serve on one of COA's Committees

Send an e-mail to COA: coa1@pacbell.net or fax a note to COA: 916-454-9882 to let us know of your interest.

With your help, we can continue to make a difference.

People in the News

Catherine Hanson, JD, General Counsel for the California Medical Association for more than 20 years, will be joining the AMA legal team effective July 2. In her new position as Vice President of the Private Sector Advocacy Resource Center, Catherine will be responsible for leading advocacy efforts and working with states on their state legislative efforts. COA has worked extensively with Catherine and will miss her leadership and legal input in California, but we also look forward to working with her in her new capacity.

CMA has indicated that they will continue their in-house Legal Counsel, but the office will be moving to their Sacramento office. Tom Curtis, JD will be assisting CMA in this transition and performing some of their legal work during the interim.

Rosemary Pudlik, an insurance broker from Acordia Insurance who has administered COA's Member Insurance Program for over ten years, has moved to HUB International, another large insurance brokerage firm. Rosemary's new contact information is: 6101 West Centinela Ave. #210, Culver City, CA 90230

Office:	310-568-5916	Toll Free:	800-645-6100
Cell:	626-222-6632	Fax:	310-568-9098
E-Mail:	rosemary.pudlik@hubinternational.com		

Contact Rosemary with any of your insurance questions. She will be contacting you to transition insurance policies under the COA program to HUB International as the policies are up for renewal.

AAOS Adopts Standard of Professionalism Orthopaedist-Industry Conflicts of Interest

In addition to the SOP on On-Call, the AAOS has been working on and has now adopted a new Standard of Professionalism on Orthopaedist-Industry Conflicts of Interest which took effect April 18, 2007.

An excerpt from the SOP states, "*When an orthopaedic surgeon receives anything of significant value from industry, a potential conflict exists which should be disclosed to the patient. When an orthopaedic surgeon receives inventory or royalties from industry, the orthopaedic surgeon should disclose this fact to the patient if such royalties relate to the patient's treatment. It is unethical for an orthopaedic surgeon to receive compensation of any kind from industry for using a particular device or medication. Reimbursement for reasonable administrative costs in conducting or participating in a scientifically sound research clinical trial is acceptable.*"

Enforcement of these standards begins with acts occurring on or after January 1, 2008. A complete copy of the SOP can be obtained by contacting the AAOS or faxing a request to the COA office—916-454-9882.

Blue Contract Changes—Effective June 1, 2007

On March 5, 2007, COA sent the following e-mail to COA members alerting them to Blue Cross contract changes as of June 1, 2007.

California Orthopaedic Association
5380 Elvas Ave., #221
Sacramento, CA 95819
Phone: 916-454-9884
Fax: 916-454-9882
E-Mail: coa1@pacbell.net

TO: COA Members

FROM: Larry Herron, M.D., President

SUBJECT: Blue Cross PPO Contract Information - Changes Effective 6-1-2007

We have been receiving calls from our member, in both Northern and Southern California, letting us know that they recently received a letter from Blue Cross announcing a change to their Blue Cross PPO fee schedule effective June 1, 2007.

The Blue Cross letter indicates that: "The payment levels for many codes have been modified - there are both increases and decreases." Exhibit B is attached to the Blue Cross letter listing the changes.

A preliminary review of a some orthopaedic codes show that:
99202, 99203, 99212, and 99213 - new patient or established patient codes are increased 4%.
99204, 99205, 99214, and 99215 are not changed.

99242 - 99245 - Consultant codes - reduced 2%-17%

20550 - Trigger point injection code - increased 13.7%
20610 - Aspiration, major joint - increased 31.9%
62311 - ESI, lumbar - increased 23.2%
Spine fusion and implementation codes - reduced 13% - 54%

The Blue Cross reimbursement adjustments on your practice may be different than those listed above. If you are a Blue Cross PPO provider and have not yet received the Blue Cross letter or you have additional questions regarding these changes, the letter directs you to contact Blue Cross at (800) 933-6633, Monday-Friday from 9:00 am - 4:00 pm, and select Option 3 to discuss the changes with a Blue Cross representative or to request a revised Exhibit B of your Prudent Buyer Plan Participating Physician Agreement.

This e-mail is to alert you to this Blue Cross letter. If you are a Blue Cross PPO member, we would urge you to carefully analyze the impact of these changes on your practice.

Due to the uncertainty as to whether these contract changes applied to their practice, this e-mail prompted numerous calls and faxes to Blue Cross. We found that some Blue Cross PPO members had not received the letter and others had not received the Exhibit B providing the conversion factors for the new fee schedule. Even those receiving the entire mailing from Blue Cross were unable to calculate the new reimbursement rates as Blue Cross did not provide the relative value units used in the calculation.

CMA also received complaints from their members. They filed a formal complaint with the Department of Managed Health Care (DMHC) charging that Blue Cross violated agreements under the RICO lawsuit which required Blue Cross to provide physicians with at least 90 days notice prior to contract changes and to provide sufficient information for physicians to determine the revised reimbursement levels. COA agreed with CMA's concerns and also contacted the DMHC. The DMHC asked COA to survey our members to compile more specific information on Blue Cross' notification process and their responsiveness to physician's request for additional information.

The Blue Cross letter is reprinted on Page 4 of this newsletter and results of COA's survey on Pages 5-6. CMA also sent the COA survey to its members and expanded and validated the results of the COA survey. DMHC has reviewed the results of both studies and referred the issue to their Enforcement Division. Initially, DMHC responded that they were unable to act prior to the completion of their investigation which could result in fines to Blue Cross or requiring them to redo their notification process. CMA's Legal Department vigorously disagrees with this opinion and has urged DMHC to issue an order requiring Blue Cross to delay the implementation of the changes and redo their notification process. It is unclear whether the DMHC will act. Additional information will be provided to you as it becomes available. These efforts may delay the implementation of the changes, but is not likely to stop the ultimate implementation of the changes. **We urge you to contact Blue Cross to determine the actual impact on your practice.**

Blue Cross Contract Changes (continued from Page 3)

February 26, 2007

Re: Change in Prudent Buyer Fee Schedule

Dear Participating Prudent Buyer Physician:

In our ongoing efforts to maintain member access to affordable health care coverage and also balance your needs for fair and competitive reimbursement, Blue Cross of California (Blue Cross) is updating its Prudent Buyer Plan® *Participating Physician Agreement* fee schedule, effective June 1, 2007.

The changes included in this update are designed to realign the Blue Cross PPO fee schedule to more closely reflect industry standards. We are also responding to the growing recognition of the importance of "Evaluation and Management" services.

Important changes include:

- **The payment levels for many codes have been modified** – there are both increases and decreases – and updated to reflect the latest in relative unit value assignments and new coding in the industry. The fee schedule is not intended to mirror any particular payment methodology; rather it aims to reflect industry wide practices.
- **Blue Cross will be changing its maximum allowable rate for drugs to the average sales price (ASP) plus 6 percent.** This fee schedule will be updated at least quarterly.
- In response to physician requests, Blue Cross will **update immunizations rates on a quarterly basis** instead of semi-annually as is now the case and the rates for immunization administration will increase.

Attached is the applicable *Exhibit B* of your *Prudent Buyer Plan Participating Physician Agreement* that will be effective June 1, 2007. Since the revision of unit value assignments to procedures covers **all** procedures, we have enclosed for your convenience a pricing list that includes the most commonly billed CPT procedure codes and the new maximum allowable rates that are applicable to your payment region.

We have two options available should you want more detail on pricing for codes you specify:

- Online pricing for all of the above changes will be available April 15, 2007 via an enhanced ProviderAccess® website at **https://provideraccess.bluecrossca.com**
- You may fax the enclosed pricing form (*Request for Prudent Buyer Plan Pricing*) to Blue Cross.

If you have any questions about the revised fee schedule, please call (800) 933-6633, Option #3, Monday through Friday, from 9:00 a.m. to 4:00 p.m.

As your partner in the delivery of health care, Blue Cross continually strives to improve our services and programs. We look forward to working together to better serve your patients – our members.

Sincerely,

Josh Valdez

Josh Valdez, DBA
Health Care Management Executive, Pacific Zone

Blue Cross Contract Changes (continued from Page 4)

Summary of the COA Blue Cross Survey
Notification of Contract Changes as of June 1, 2007

Survey Results

Within 4 days, 71– orthopaedic practices responded to the survey representing 311- orthopaedic surgeons. The number of orthopaedic surgeons represented in this survey is larger than these numbers represent due to responses from orthopaedic practice consultants who did not indicate the total number of physicians that they represent. Responses were received from 53 different cities and 23 counties.

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1. As a contracted physician/group with the Blue Cross PPO plan, were you notified by Blue Cross that they planned to change their fee schedule as of June 1, 2007? Yes 59% No 41%

> "I called Blue Cross twice and received different information both times.
> … indicated that the fee schedule changes are not for all providers… There is some criteria being used to identify groups and/or individuals who will get these changes. He would not elaborate on that criteria."
> Consulting group representing more than 30 physician groups

Of those receiving a notice, when was the notice received?

February 26, 2007	15%	March 1, 2007	33%
March 2 - 31, 2007	24%	April, 2007	9%
May, 2007	12%		

Of those that received a notice, was the letter sent by certified mail? Yes 23% No 62%

Of those that received a notice, did the notice include an exhibit giving you the revised conversion factors?
Yes 58% No 23%

2. If you did not receive a letter from Blue Cross, how were you notified of the change?

From a colleague	17%	From their billing company	7%
From the March COA notice	41%	From the May COA notice	31%

3. The Blue Cross attachment listed multiple conversion factors for groups of CPT codes. For example, for surgical codes, they list 18 different conversion factors for various groups of surgical CPT codes. As a practical matter, are you able to load into your system multiple conversion factors based on groups of CPT codes?
Yes 14%
No 86%

> "Blue Cross does not use Medicare RVUs, they have their own unpublished values that they will not provide to physicians."

> "We have asked for relative (unit) values on numerous occasions but we are always told it is proprietary information a.k.a. confidential. How can you calculate their allowable fees if they only give you half of the equation? The conversion factors are useless without the relative unit values."

4. While the Blue Cross attachment lists multiple conversion factors, it did not list the underlying relative unit value. Were you able to calculate the actual reimbursement rates without having the relative unit values? Yes 2% No 98%

5. If yes, how were you able to perform the calculation to determine the actual reimbursement rates?

Of the 2% that responded that they were able to calculate reimbursement rates, they said they, "linked the Blue Cross conversion factors to a base Medicare relative unit rate for an approximate reimbursement value."

6. Did you request additional information from Blue Cross on the fee schedule changes?
Yes 33% No 67%

> "Can only request 10 codes at a time – too time-consuming."
> "From prior experience, it is not worth the resources – waste of time."

7. If you requested additional information, what was the time frame in which Blue Cross responded?
   a) How many times did you call before receiving a response?
      Called three times – no response
      Others responded called several times, but did not keep track of the number of calls
      Called one time – no response
      Approximate 2 week turnaround for a response

   b) How long you were on hold?
      Generally the hold time is at least 5 minutes

(continued on Page 6)

Summary of the COA Blue Cross Survey (continued from Page 5)

c) What date did you request additional information and what date did Blue Cross respond?
Requested information 2/26 – response received 5/21
Faxed request for information 4/20 – no response to date
Called multiple times – no response
Sent letter 4/13 received a response 4/20 sent follow-up letter 4/27 received a response 5/10
Sent second follow-up letter on 5/15 received response 5/18
Sent letter 4/16 received a response 5/9 – no negotiation
Faxed a request for the notification letter 4/17 – received the same day
Sent letter and called – no response

d) Did you ever get a satisfactory response from Blue Cross?
No one responded that they had received a satisfactory response from Blue Cross at the time of the survey.

e) Did you attempt to access the Blue Cross on-line system to obtain additional information?
Yes 52% No 48%

Of those going on-line to obtain information, were you able to receive the reimbursement information on codes important to your practice?
Yes 9% No 73% No response 18%

8. Are you attempting to negotiate different reimbursement rates with Blue Cross?
Yes 46% No 54%

"No, we cannot reach anyone."

"We were in the process of negotiating with Blue Cross when the fee schedule letter came out. We were told that Blue Cross currently has a freeze due to budget constraints."

9. As a result of these fee schedule changes, have you terminated your Blue Cross PPO contract?
Yes 14% No 82% Not Yet 4%

Are you considering dropping out of the Blue Cross PPO Network?
Yes 53% No 47%

"We will limit the number of Blue Cross patients we see."
" Several large groups in Orange County have already given their termination notice."

10. If you have terminated your Blue Cross PPO contract, will this mean that you will also be terminated from the Blue Cross Workers' Compensation network? Yes 73% No 20% Unsure 7%

Survey Summary

1. The survey gathered data from all of the largest counties in California and includes information from 311 orthopaedic surgeons.

2. Blue Cross failed to notify 45% of the survey respondents by March 1, 2007 as required by the RICO settlement. 41% of the respondents indicated that they had received no notice at all from Blue Cross.

3. The notification was not uniform in how the notice was sent (24 % by certified mail vs. 64 % regular mail) or in the materials included with the notice (58% indicated the notice included an exhibit, but 23% indicated they received no exhibit).

4. The notification did not provide sufficient information for the physician to calculate the new reimbursement rates. One respondent summarized it best to say, " How can you calculate their allowable fees if they only give you half of the equation. The conversion factors are useless without the relative unit values."

5. Blue Cross did not respond to requests for more information in a timely manner so that physicians had time to determine whether the changes affected their practice allowing them to make an informed decision as to whether they were willing to stay in the Blue Cross PPO network. In addition, physicians were unaware that they could submit more than 10 codes for valuation. Many just gave up when Blue Cross either did not respond to their requests or they could not get through to request additional information.

6. The information that Blue Cross provided to physicians is inconsistent. Physicians are told different information when they speak to different Blue Cross representatives. It is difficult for them to know whether they will be affected by these changes.

5/23/07

COA's 2007 Annual Meeting/QME Course

COA's 2007 Annual Meeting/QME Course and Workers' Compensation Course on "Select" Workers' Compensation Medical Provider Networks was held April 12-15, 2007 at the Portola Plaza Hotel in Monterey. Nearly 400 orthopaedic surgeons and their practice managers attended the meetings. **Herb Schultz, Special Advisor to Governor Schwarzenegger** attended the meeting as a special guest to discuss the Administration's view on health care reform.

COA elected the following new Officers:

President:	James T. Caillouette, M.D., of Newport Beach
First Vice President	Mark Wellisch, M.D., of Encino
Second Vice President	Glenn B. Pfeffer, M.D., Los Angeles
Secretary-Treasurer	Richard J. Barry, M.D. of Davis

Grand Prize Winners

Ali Berenji, M.D. was the Grand Prize winner of a complimentary two night stay and registration for COA's 2008 Annual Meeting in Newport Beach.

Charles Touton, M.D. won a suite upgrade to the 2008 Annual Meeting.

Over 40 other prizes , including cash prizes and gift certificates were won by attendees, including a Garmin GPS Locator won by **Lesley Anderson, M.D.**

Orthopaedic Residents Receive Awards

Joseph Gondusky, MD
San Diego Naval Medical Center
Orthopaedic Hospital Resident Award

Joseph Carney, MD
San Diego Naval Medical Center
Lloyd Taylor MD Resident Award

Robert Grumet, MD, UC Irvine (center)
OREF Resident Award

Program Chair Lisa Lattanza, M.D., Ramon Jimenez, MD and Brad LaPoint of Depuy presented the resident awards. **Thanks** to Charles Touton, MD for providing these photos.

Frank Petrigliano, MD, UCLA (left)
Depuy Resident Award

COA attendees participating in sporting events got up for a 6:30 am start for the 5K Run and Bike Ride and braved the rain soaked greens at the Links at Spanish Bay golf course.

Kristin Winter and Michael Laird won the 5K Run.

COA Members Work on Your Behalf
Advocacy Efforts Continue in Washington, D.C.

Congressman Fortney "Pete" Stark discusses Medicare reform and overall health care reform with COA delegates. As Chair of the Ways & Means Subcommittee on Health, Mr. Stark will be involved in shaping those reforms. (left/above)

COA's delegation discussed Medicare reform, Pay-for-Performance measures, Medicare payment updates with members of California's Congressional delegation.
In addition, they shared with them COA's Health Care Reform Principles developed in response to health care reform discussions in California.

Ed Diao, M.D. of San Francisco thanks Scott Boule of Representative Nancy Pelosi's office for his time in meeting with the COA delegation. The delegation also met with Wendell Primus in Representative Pelosi's Capitol office. (above)

COA Representatives, Tom Barber, Paul Caviale, and George Balfour attended Senator Dianne Feinstein's Constituent Breakfast and Senator Barbara Boxer's Town Hall Meeting. (left and above)

Worker' Compensation—News of Interest

DWC Regulations—Utilization Review

Regulations imposing fines and penalties for violation of Regulation 9792—Utilization Review— have been approved by the Division of Workers' Compensation and sent to the Office of Administrative Law for final approval. These fines can be levied by DWC against employers and insurers who fail to implement an appropriate utilization review program. The fines can be levied for the following violations of the Utilization Review statutes:

- $50,000 for failure to establish a Utilization Review program.
- $50,000 for failure to employ or designate a physician as a medical director to be in charge of their UR program.
- $25,000 for failure to comply with the requirement that only a licensed physician may modify, delay, or deny requests for authorization of medical treatment.
- $5,000 for utilization review denials that are based solely on the basis that the treatment requested is not addressed by ACOEM.
- $10,000 for failure to discuss or document attempts to discuss reasonable treatment options with the requesting physician.
- $100 for failure to disclose or otherwise make available the Utilization Review criteria used to make the treatment decision.

In addition, **Insurance Commissioner Steve Poizner**, is promising tougher action against Workers' Compensation carriers who have abused the utilization review process.

Utilization review isn't the only issue that Commissioner Poizner promised to investigate more closely. He indicated that he would also be auditing the Workers' Compensation Insurance Rating Bureau for failing to accurately predict cost increases when the system was in crisis and cost decreases after legislative reforms.

DWC Seeks Input on Revised and New Workers' Compensation Forms

The Division has sought input on a revised PR-2 Form as well as new forms to request Authorization for Medical Treatment and a Functional Improvement Form to be used by physical medicine providers to report progress made as a result of physical medicine services. These forms are intended to improve communication between the treating physician, providers to whom injured workers are referred, and carriers/self-insured employers.

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

DWC Applies Medicare Payment Changes to the Outpatient Hospital & Ambulatory Surgical Center Fee Schedule

The Division has posted an adjustment to the outpatient hospital and ambulatory surgical center fee schedule to conform to the Medicare payment changes. The effective date of the changes was April 1, 2007. These changes can be found on DWC's website.

New Address for State Fund's Oakland Office

As of May 29, 2007, State Fund consolidated employees from their San Francisco and Oakland offices to a new office in Pleasanton.

Mail correspondence should be addressed to:
State Compensation Insurance Fund, Bay Area Policy Services, P. O. Box 429, Pleasanton, CA 94566

Claims correspondence should continue to be sent to: Claims Correspondence, State Compensation Insurance Fund P. O. Box 3171, Suisun City, CA 94585. The 24-hour Claims Reporting Center phone number also remains: 888-222-3211.

Blue Shield Announces Contract Changes

Blue Shield has sent the below letter to participating providers. To obtain new reimbursement rates as a result of these changes, fax a request to Blue Shield at 916-350-8860. You are not limited in the number of CPT codes that you submit and they do not have to be submitted on the Blue Shield form.

In speaking with Blue Shield's Provider Relations Department, they indicate that the following changes are planned:

1. Tiered reimbursement for physical medicine services (CPT code 97001-97840) performed on the same day. The first modality will be reimbursed at 100%; the second modality at 85%; and, the third and all other modalities performed on the same day at 40% of the reimbursement amount.
2. Reimbursement for Evaluation and Management codes will change slightly - 99203/99213 will be increased slightly; 99205/99215 will be decreased slightly.
3. They indicate no significant change to surgery codes. It is, however, unclear whether Blue Shield will be adjusting their relative unit values to reflect the new Medicare values. If they do, we could see reductions for radiology and some surgery codes.

Blue Shield representatives also indicate that there is an error in the letter. They are responding to physician requests within 10 business days or sooner, not the 20 business days listed in the letter. It is important that you contact Blue Shield to assess the impact of these changes on your specific practice. Questions can also be directed to their Provider Services Department at 1-800-258-3091.

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blue of california

May 1, 2007

Dear Physician/Provider(s):

For over 65 years, Blue Shield of California has offered access to health care services to Californians. We continue to grow in this competitive environment while focusing on our mission to ensure that Californians have access to high quality care at a reasonable price. While maintaining our heritage as a not for profit health plan, we continue to encourage innovation and expanding access to care through public policy advocacy and support of community-based initiatives.

This notification is to inform you that Blue Shield will be implementing changes to our professional allowances. Blue Shield allowances are established by using the RBRVS (Resource Based Relative Value Scale) methodology as a guide. Clinician input and other established industry resources are also used to validate provider allowances and consideration is given to differences between E&M, specialty services and geography. This year's adjustments are effective for dates of services on or after July 1, 2007.

These changes reflect our consistent value based approach in reviewing and setting professional allowances, while ensuring our rates are competitive within the marketplace. Selected services will remain on statewide fee schedules as outlined in our Independent Physician and Provider Manual, which is available on our provider website. To ensure that our providers are fairly compensated for providing vaccines to our members, Blue Shield will continue to pay all immunizations based on Average Wholesale Price (AWP) methodology and injectable drug codes will remain under a tiered Average Sales Price (ASP) payment methodology.

Blue Shield will implement a multiple services payment policy for: Physical Medicine and Rehabilitation, Therapeutic Procedures, Active Wound Care Management, Orthotic and Prosthetic Management, and Medical Nutrition Therapy services. Blue Shield will cover the initial service at one-hundred percent (100%) of our allowance while payment for subsequent units/procedures will be reduced. This policy will apply to multiple individual services or multiple units of the same service.

Please continue to submit your usual charges when billing for services, regardless of any change in the level of payment you receive. The allowances will continue to be clearly shown on your Blue Shield Explanation of Benefits (EOBs). If you have questions about these changes or your allowances in general, please call our Provider Services Department at 1-800-258-3091 or complete and mail or fax the Allowance Review Form that is enclosed. We will respond to your inquiry within twenty (20) business days

We appreciate your ongoing participation as a Blue Shield Physician Member and are proud of our long-standing relationship with our network physicians. Our goal is to increase the ease of doing business with our provider partners and focus on the service that we deliver to you. We encourage you to visit Provider Connection at www.blueshieldca.com. Our Provider partners can view enhanced member eligibility and benefits, and check claim status. We look forward to a continued partnership in providing quality healthcare services to your patients and all California consumers.

Sincerely,

Alan Sokolow, MD, Chief Medical Officer

William J. Brown , Director, Provider Services

Legislative News of Interest

AB 1073 (Nava) Workers' Compensation Post-Surgical Rehabilitation Services
Assemblyman Pedro Nava of Santa Barbara has introduced AB 1073 which would exempt post-surgical rehabilitation services from the 24 visit cap. COA is the sponsor of this legislation. COA members have complained that utilization review reviewers will not approve additional visits if the injured worker has already used up the 24 visits, often before they are even referred to a specialist. The Chamber of Commerce and some Workers' Compensation carriers are opposed to the bill. We are discussing amendments to the bill that would condition the additional rehabilitation services on the active participation of the injured worker and the referring physician demonstrating that the injured worker continues to make measurable objective improvement.

The bill has passed the Assembly thanks to Dr. Paul Burton and patient, Polly Larsen who testified in support of the bill. The bill will next be heard in the Senate Labor & Industrial Relations Committee on June 27.

AB 1444 (Emmerson) Physical Therapist—Direct Access
Assemblyman Bill Emmerson has introduced AB 1444 which would allow a physical therapist to initiate treatment without a physician and surgeon first evaluating the patient. The bill is sponsored by the California Physical Therapy Association (CPTA) as part of a nationwide effort for physical therapists to gain direct access to patients.

Due to COA and CMA opposition, the bill missed its legislative deadline and has become a two-year bill. The CPTA is urging its members to contact members of the Legislature to urge them to support the bill. They fail to acknowledge the role of a physician and surgeon in making a diagnosis to rule out underlying medical problems before physical medicine services are initiated.

Action Requested:

If you have a physical therapist working in your office or one to whom you refer patients, who understands that the collaborative arrangement between the physical therapist and the referring physician results in the best patient care and is opposed to a physical therapist having direct access to patients, please let us know. We are compiling a list of physical therapists who do not believe that this bill will result in improved care for patients.

Welcome to COA's Newest Members

David L. Downs, M.D.	Loma Linda
Deborah A. Faryniarz, M.D.	San Jose
David L. Feingold, M.D.	Reseda
Michael C. Vance, M.D.	Orange
Eli Ziv, M.D.	West Hills

COA is an effective organization <u>because</u> of the involvement of its members.

Job Placement/Classified Ad

Orthopaedic Surgeon wants to move to CA
Spine fellowship trained orthopaedic surgeon seeks to relocate to San Diego County. 18 years of private practice in Tuscon, Arizona. CV available upon request.
To discuss a potential position, call: (520) 444-6560 or e-mail: drnicksmail@mac.com

Transcription—Work Comp, Chart Notes, Reports & Correspondence. Fast & Reliable. You call Dictaphone's 800#. References are available. Husband/wife team. 10 years experience. Call Karen or Roy at: 775-626-9604 or 707-373-2187.

Lumetra Seeks Orthopaedic Surgeons to Perform Peer Review for Medicare

Lumetra is the Quality Improvement Organization in California for Medicare. They are in need of additional orthopaedic surgeons to perform peer reviews for Medicare patients. Reviewers must be board certified, have hospital privileges, and be in active clinical practice seeing patients at least 20 hours per week.

The case usually involves a complaint (by a beneficiary or other source) regarding the quality of care, or a utilization management issue and generally involves a review of the medical records. Lumetra staff prepares questions for the reviewers based on the complaint or issue to be resolved. The reviewer responds in writing to the questions. The responses must be returned usually within 5 days or less. You may decline to comment on a case for any reason.

If the reviewer identifies quality concerns, a letter is sent to the treating physician and they are given a chance to respond. The reviewer may also be asked to respond to any feedback from the treating physician.

Reviewers remain strictly anonymous and they will not be involved in any litigation. Most reviews require about 45-60 minutes. Reimbursement is $90 per hour.

For an application, call or e-mail:
Edward Lukawski, M.D., Medical Director
Lumetra
Phone: 415-677-8408
Fax: 415-677-2195
E-Mail: elukawski@caquio.edps.org

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