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COA Report

A publication of the California Orthopaedic Association

Spring, 2010

PRESIDENT MESSAGE

Friends and colleagues, I am honored to take over as the 35th President of the California Orthopaedic Association. On behalf of all of us I want to thank Richard Barry, our immediate past President, for his leadership over the past year. His focus on our mission and dedication to our membership leaves the COA in a strong position to deal with the tumultuous changes in healthcare that lies ahead. While it is a time of change, it is also a time of opportunity.

One of the greatest areas of opportunity, both for patients and orthopaedic surgeons, lies within the Workers' Compensation system. An increasing number of self-insured employers and Workers' Compensation payers are realizing the failure of the current utilization review system, which has increased costs without improving patient outcomes.

Several insurers are rethinking how they work with their treating physicians. Instead of an adversarial relationship, they are starting to form partnerships with their doctors. Physicians are allowed to direct care for their patients, and UR is used only on a retrospective basis or in complex cases. COA is working with these payers to develop guidelines for expected lengths of disability and return to work strategies, and is planning to hold educational sessions to make both physicians and payer employees more effective managers of care under the system.

While not yet as widespread as we would like, we are seeing this trend grow. Orthopaedic surgeons who are doing a good job treating injured workers are being invited to participate in preferred Medical Provider Networks. State Compensation Insurance Fund (SCIF) we have been told is retooling their network—intending to move back towards a hand-picked group of physicians. COA is helping to drive the system in this direction. It's the only system that makes sense. We will marshal our forces to achieve the best outcomes for injured workers.

A critical role for the COA is to help our members navigate the rolling sea of change that we face. We are committed to our academic and employed members, but have a particular commitment to orthopaedic surgeons in pri-

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

Advance Planning

2011 COA Annual Meeting/ QME Course

May 19-22, 2011

Ritz-Carlton Laguna Niguel

Registration information will be posted at: www.coa.org as it becomes available.

President's Column (continued from Page 1)

vate practice, who are undoubtedly under the greatest strain. It is for this reason that the COA continues to focus on the business of running an orthopaedic office, and giving you the tools to make informed decisions. This is why you saw a large part of our 2010 Annual Meeting devoted to understanding various practice options, and providing you and your practice manager with practical, benchmarking information. By all accounts, this aspect of the meeting was a great success.

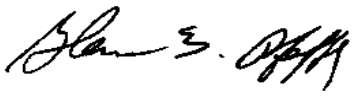
If you were not able to attend the Annual Meeting, I would urge you to review the meeting materials which have been posted on the COA website under the Annual Meeting archives. For COA Members, we are also making available a video of the Practice Survival Course presented at the meeting.

An additional area of great change is with the Centers for Medicare and Medicaid Services (CMS). Whether or not the health reforms prevail in their current form, medicine will be forever changed as CMS begins to implement various aspects of the recent reforms. We are seeing change in how Medicare will deliver care to seniors, for example, through bundled payment systems. There will be more emphasis on the quality of the care rather than the quantity of care. The COA is closely tracking these changes and will let you know as opportunities arise.

I would like to hear about your practice, both challenges and opportunities, and how the COA can help. Please contact me through my Cedars-Sinai email, pfefferg@cshs.org

Make sure you calendar the **2011 Annual Meeting, May 19-22, 2011** at the Ritz-Carlton Laguna Niguel, which will continue to provide you with critical practice information.

Very best,



Glenn B. Pfeffer, M.D.
President

Obituaries

It is with our deepest sympathy that we inform you that the following COA members have passed away:

Saul Bernstein, M.D. - April 19, 2010
Dr. Bernstein was a member of COA's Board of Directors representing the Los Angeles District. He practiced in Los Angeles at the Southern California Orthopaedic Institute (SCOI). He passed away after suffering a massive heart attack at the age of 74.

Richard Mercer, M.D.—March 25, 2020
Dr. Mercer practiced in the Mountain View area and was a clinical instructor at Stanford. He was an AAOS delegate to the AMA for many years. He passed away in his sleep at the age of 77.

People in the News

Richard Barry, M.D. of Davis was elected Chairman of the AAOS Board of Councilors at its meeting in New Orleans. One of his many goals is to clarify the strategic vision of the future of the profession of orthopaedic surgery. Dr. Barry is COA's Immediate Past President.

COA Board of Director's Elections
The following COA members were elected to the noted seat on the Board of Directors:

COA Board of Directors

Dori Neill Cage, M.D.	San Diego District
Paul Burton, M.D.	Inland Empire District
Jan Henstorf, M.D.	Northern California District
Amir Jamali, M.D.	At Large Member
Amy Ladd, M.D.	At Large Member
Francois Lalonde, M.D.	Young Orthopaedist
G. Sunny Uppal, M.D.	Inland Empire District
Erik Zeegen, M.D.	Young Orthopaedist

CA AAOS Board of Councilors

George Balfour, M.D.	Los Angeles District
John Gonzalez, M.D.	Inland Empire District
Michael Laird, M.D.	Los Padres District
Roland Winter, M.D.	Sacramento Valley District

For information from your Board of Councilor representative, go to the report for your area:
Orange District—http://www.coa.org/willsnewsletter.pdf
Northern California—Monterey area—
http://www.coa.org/klassennewsletter.pdf

Douglas Jackson, M.D. of Long Beach received the AAOS 2010 Diversity Award.at their Annual Meeting in New Orleans. Dr. Jackson has encouraged diversity in the orthopaedic specialty for more than 30 years, both as a leader and volunteer with the AAOS and within his community.

Zenith Insurance has hired **Pamela Foust,** a former California Workers' Compensation judge, as a member of its legal department. Foust joined Zenith after 25 years on the Workers Compensation Appeals Board where she most recently worked in the Santa Monica office.

Linda Whitney has been appointed **Executive Director of the Medical Board of California**. Linda has worked for the Medical Board for many years as their chief of legislation. Over the years, she has worked with COA on various legislative issues.

Donald Berwick, M.D. has been appointed **Administrator of the Centers for Medicare & Medicaid Services (CMS).** Dr. Berwick is a pediatrician who is was President and CEO of the Institute for Healthcare Improvement. His appointment needs confirmation by the U.S. Senate.

Highlights—COA's 2010 Annual Meeting/QME Course

The Ritz-Carlton Highlands Hotel at Lake Tahoe was a spectacular setting for the COA meeting held April 15-18, 2010. With snow-covered slopes and sunny days, attendees were able to enjoy the setting and take advantage of spring skiing.

New COA 2010-2011 Officers Elected

President:	Glenn Pfeffer, M.D. of Los Angeles
First Vice President:	Tye Ouzounian, M.D. of Tarzana
Second Vice President:	Kevin Bozic, M.D. of San Francisco
Secretary-Treasurer:	Leslie Kim, M.D. of Daly City

Resident Award Winners

Program Chair Amir Jamali, M.D. presenting the Resident Awards:
- Joe Lee, M.D., UC Irvine
- Eric Varley, M.D., UC San Diego
- Derek Amanatullah, M.D., UC Davis

Founder's Award winner, Jeffrey Bogosian, M.D. (left) with COA Founder, Blair Filler, M.D. (right). Dr. Bogosian won the 2010 Award for his work in developing instructional study tools to help COA members prepare for their Board Maintenance of Certification tests.

Richard Santore, M.D. (left) and Ramon Jimenez, M.D. (left) winners of the **William W. Tipton, Jr., M.D. Leadership Award**. Drs. Santore and Jimenez won the award for their work to elect a community-practice orthopaedic surgeon to the AAOS leadership so that the Academy has the benefit of input from all orthopaedic practice settings.

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Highlights from the COA Annual Meeting/ QME Course

Economic Survival Course

Recognizing the economic pressures most orthopedists are facing and anticipating the coming changes from healthcare reform was the impetus for a new direction for this year's Annual Meeting. Moderated by Drs. Robert O'Hollaren and Jan Henstorf, the sessions provided a comprehensive overview of the present and anticipated economic challenges faced by physicians in private practice.

Mike McCaslin from the national firm of Somerset CPAs, presented an overview of the national economic and legislative trends which are impacting orthopedic practice. He stressed that most practices will need to make changes to accommodate the new payment and reporting requirements which will be forthcoming from the government and insurers.

Another focus of the first day of the meeting was on improving the business processes for orthopedic practice. The meeting was fortunate to have speakers from several of the larger single specialty orthopedic groups on the west coast. Eric Worthan, who is the CEO of Panorama Orthopedics in Denver presented his perspective on the types of overhead control, office efficiencies, and financial reporting that successful practices are using to stay ahead of the curve.

Most practices are dealing with, or are investigating integrating an electronic medical record system into their practices. The consensus was that all practices will eventually need to institute this technology, but there are many pitfalls with respect to choice of systems and implementation. Therefore, an in-depth discussion of available EMR systems, and the do's and don'ts of a successful implementation program were discussed by Mark Anderson of the AC Group, and David Schlactus of Hope Orthopedics in Oregon. This information provided a solid foundation for beginning the selection process and excellent guidelines for how to approach integration of a system into a practice. Additional presentations on improving office efficiency were given on the topics of digital radiography and insurance payment verification software.

The second day focused on income enhancement strategies with extremely useful benchmarking data from the Western Orthopedic Forum, presented by the Somerset group. This data allowed participants to obtain current information on income and expense data for a wide range of ancillary services. Presentations by Carlos Prietto, M.D. on imaging centers and physical therapy as well as a discussion of the results from physician owned surgery centers by Dale Butler M.D., gave participants a sense of the financial results that could be obtained from these enterprises. This series of presentations was capped off by an excellent presentation from Dr. Jack Bert from St. Paul Minnesota on the results that can be obtained from a highly integrated orthopedic practice. The talk looked at the possibility of an integrated orthopedic practice acting as a "musculoskeletal home" in the accountable care model of orthopaedic service delivery.

The final day of presentations focused on newer types of orthopedic service lines such as physician-owned implant distributorships, hospital co-management agreements, and medical tourism. A consensus of the panel of presenters was that new service and product lines are available, and may be able to add significant patient and physician benefits in the right practice setting. The meeting ended with an excellent discussion on the process of practice integration for those physicians wishing to expand their geographic and economic footprint. The process involved in developing an implementation strategy was discussed by Mike McCaslin. It appeared that the consensus opinion was that such information has the potential to improve practice performance for those wishing to maintain the viability of the private practice model.

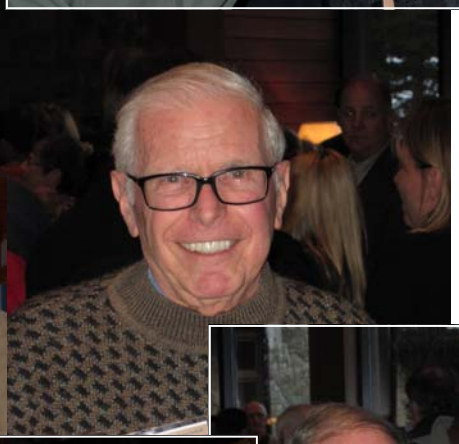
Robert O'Hollaren, M.D.
Course Moderator

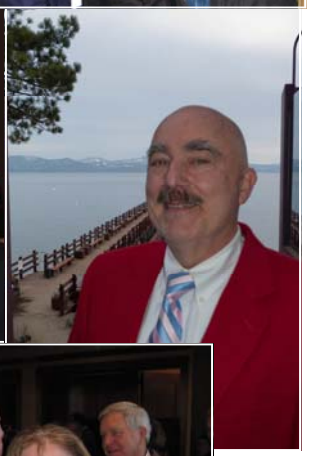
COA Members

If you were not able to attend the Annual Meeting, hear what you missed at the Economic Survival Course….contact the COA office—coa1@pacbell.net to request a copy of the video. Cost: $200 for COA members.

You can also visit the COA website: www.coa.org for an archive of presentations at the meeting.

Attendees enjoying the social functions at COA's 2010 Annual Meeting/QME Course





A special Thank You to Charles Touton, Ralph DiLibero, and Jeff Coe for taking these photos at the meeting. Great Job.

Highlights from the COA Annual Meeting/ QME Course

QME Course

The QME course at the COA Annual Meeting was a great success.

Many members approached me at the meeting and complimented us on the course. I thank all of you who were kind enough to do so.

The course can be thought of having three distinct portions. One was the "How I do it" section in which several speakers, experts shared their approaches to writing a ratable disability report. The speakers included Tye Ouzounian, M.D. who focused on the lower extremity. I did the upper extremity. Paul Wakim, DO covered the spine. These were worthwhile and informative presentations for QMEs, AMEs, and the treating orthopaedist. I thought Tye and Paul did great jobs and I want to extend my appreciation for their efforts.

Steve Feinberg, M.D. did an overview with the eye to the four corners of the guides and how other sections could be used to expand or narrow the rating provided. He too did a great job. Some of the interpretations were rather innovated and can be found in the PowerPoint presentations which are on-line at the COA's website: www.coa.org in the Annual Meeting/QME Course archives. I came away with the determination to study the 5th edition again and again to find those little pearls that will make my reports and ratings of greater value.

Another portion of the course was devoted to communication skills from the perspective of the Workers' Compensation payors. Sue Honor-Vangerov, JD from the Division of Workers' Compensation gave us the regulator's views and comments regarding the proposed changes to the Official Medical Fee Schedule (OMFS). She informed attendees that there is continued pressures to convert to an RVRBS schedule. While she implied that the DWC feels that reimbursement is already low in California, the political powers support a revenue neutral transition which means that as Evaluation and Management (E&M) codes are increased, surgical fees will go down. The initial DWC proposal reduces surgical codes to 147% of Medicare and over the 4-year transitional period reduces reimbursement to 125% of existing Medicare rates. E&M codes would be increased to 113% of Medicare rates and be gradually increased to 125% of Medicare in year 4.

Attendees were very much opposed to this proposal. You had to be there to hear the intensity of the discussion.
Gideon Letz M.D., Medical Director of State Compensation Insurance Fund (SCIF) spoke about the need to return injured workers to the work place as soon as possible; at modified duties if need be. He pointed out the financial and social problems associated with prolonged absence from employment.

Mark Hyman, M.D. who along with Mark Melhorn, M.D., has authored a book published by the AMA on the topic of causation. He gave a lecture on that topic. The goal of their book is to give all of us guidance when we address the issue of AOE-COE. His talk was a brief introduction to his theme and it too can be found in the PowerPoint summary of the QME course.

Steve Feinberg also gave us a talk on functional restoration —continuing the theme of restoring the injured worker to function and employment.

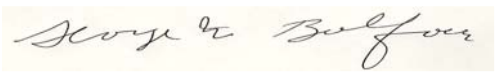
Judge Allyson Hall gave us her interpretation of what judges need to see in our reports in order to facilitate their role in resolving disagreements in Workers' Compensation cases.

Lastly, we had an entertaining session in which defense attorney, Don Barthel, JD and applicant attorney, Elliot Berkowitz, JD discussed Almaraz/Guzman I and II & Benson decisions. In addition, Steve Feinberg, M.D., Andrew Sew Hoy, M.D. and Bruce Fishman, M.D. discussed the decisions from an evaluator's perspective and how it impacts on our evaluations.

If you missed the course, the presentations are on-line at the COA website: www.coa.org.

If you need the QME CME hours for your QME recertification, the course is also available as a distance learning audio course. It is accredited for 6 QME CME hours.

Calendar COA's 2011 Annual Meeting/QME Course now so that you don't miss the QME course at the Ritz-Carlton in Laguna Niguel—May 19-22, 2011. It will be another informative course.



George Balfour, M.D.
QME Course Moderator

Billing Tips

Hyaluronic Acid (Viscosupplementation) Intra-articular Knee Injection Series

Intra-articular hyaluronic acid injections are one of the FDA approved treatment options for knee osteoarthritis.

As of 1/1/2010, there will be four active Medicare J codes for the various HA medications. They are:

J7321 Hyalgan or Supartz
J7322 **INACTIVE AS OF 1/1/2010**
J7323 Euflexxa
J7324 Orthovisc
J7325 Synvisc OR Synvisc One
FOR MEDICARE BILLING OF SYNVISC:
J3490 will no longer be active for Synvisc One
When billing for Synvisc, use 16 units (HICFA line 24 G)
When billing for Synvisc One, use 48 units (HICFA line 24 G)

It is unclear if private insurances will follow suit with the above Synvisc guidelines. Time will tell.

Workers' Compensation bill review organizations are still problematic in regards to correctly processing HA medications. One of the main issues is that their allowances are based on one cc, rather than the 2 cc dosage. Go to http://www.dir.ca.gov/dwc/pharmfeesched/pfs.asp and fill in the appropriate boxes to see what the current WC fee schedule is for HA's. BE SURE TO TYPE IN "2" on the line, "Metric decimal number of units", as all prefilled vials are 2 cc's.

As you should already be doing, you need to get prior authorization from ALL insurance companies (EXCEPT Medicare). Be sure to get this authorization IN WRITING, in case there is an unexpected denial after services are rendered. To simplify difficulty in getting correct reimbursement, you may want to consider notifying the Utilization Management/Prior Authorization Department that they need to provide the medication. Some insurance companies handle this through their pharmaceutical benefits department, in which case the drugs will be sent to either the patient or your office. However, some process it via their medical benefits department, in which case the patient will need to take a written RX to a pharmacy, along with a copy of their written authorization. By not providing the medication yourself (also known as "buy and bill") will eliminate hours of claims reviews/follow-up on unpaid or incorrectly paid claims. (You will still need to do "buy and bill" for Medicare patients, but their reimbursement is straightforward and prompt, as long as you bill with correct codes and diagnoses).

Another option for obtaining pre-authorizations is one that is offered by some of the HA manufacturers. It is a pre-authorization service that will obtain the authorization, and also will do follow-up on unpaid/incorrectly processed claims. Check with you sales representative for details on this. All HA manufacturers also have Reimbursement Departments to assist with billing issues.

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Billing News

Workers' Compensation— Utilization Reviewers

As we all know, many times the WC utilization reviewer does not have all of the injured worker's medical records. They act on your request for authorization with very little information on the care previously provided to the patient.

In speaking with orthopaedic surgeons doing utilization review, they indicate that if the treating physician just summarized the most **recent physical findings and diagnostic tests in their request for authorization of surgery**, it will often times be enough information for them to approve the request. Without this information, they say that often they have to deny the request for lack of information.

While it's not your responsibility to provide all of the medical records for the utilization reviewer, adding this additional information to your request could help to eliminate inappropriate denials.

AETNA—New Rate for Assistant Surgeons

Effective May 1, 2010, AETNA will change their rate for physicians assisting at surgery. The rate will change from 20 percent of the negotiated rate to 16 percent of the negotiate rate.

They will reimburse multiple eligible assistant surgery codes as follows:

- 16% for the primary procedure
- 8% for the second eligible procedure
- 4% for each additional eligible procedure

CMS Approves Three National Organizations to Accredit Suppliers of Advanced Imaging Services

The Centers for Medicare and Medicaid Services (CMS) is designating three national accreditation organizations—the American College of Radiology (ACR), the Intersocietal Accreditation Commission (IAC), and the Joint Commission (TJC) - to accredit suppliers furnishing the technical component (TC) of advanced diagnostic imaging procedures. The accreditation requirement will apply only to the suppliers furnishing the imaging service and not to the physician's interpretation of the images. As required by the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA), all suppliers of the technical component of advanced imaging will have to become accredited by January 1, 2012. MIPPA defines advanced diagnostic imaging as including MRI, CT, and PET.

CMS Change Request 6670 indicates that as of February 1, 2010, your Medicare contractor will assume that a diagnostic service was not performed if there is no "yes/no" indicator marked in Item 20 of the CMS-1500 claim form.

Membership in COA and COA's Political Action Committee (OPAC)

COA's Political Action Committee continues to help COA speak with a loud voice in Sacramento, with other elected officials, and with payors that you interact with every day.

If you have not contributed to OPAC, it's time you got involved and joined over 61% of COA members who contribute to the PAC.

2010 Dues Statements are in the mail to those of you who have not yet renewed your membership in COA or joined for the first time. Please return it with your payment as soon as possible.

COA is reinventing itself as health care changes. We continue to look for ways to be most relevant to our members. If you have suggestions as to activities that COA should become involve in, let us know. Your input is welcomed by COA's leadership.

Thank you . . .

to the following COA members who have generously supported COA's Political Action Committee (OPAC) by donating more than the suggested minimum amount of $100.

Nicholas A. Abidi M.D.
Charles H. Alexander M.D.
Mark A. Anderson M.D.
Lesley J. Anderson M.D.
Brian C. Bashner M.D.
Ali R. Berenji M.D.
David M. Broderick M.D.
Lamont J. Cardon M.D.
Gregory D. Carlson M.D.
Robert M. Cash M.D.
Larry A. Danzig M.D.
Donald A. Dinwoodie M.D.
Morteza M. Farr D.O.
Malcolm E. Ghazal M.D.
Kirk F. Granlund M.D.
Donald R. Huene M.D.
Andre Michael Ishak M.D.
Kenneth K. Ishizue M.D.
Michael Gayle Klassen M.D.
Raymond A. Koch M.D.
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David P. Mesna M.D.
Jack C. Nichols M.D.
James P. O'Hara M.D.
Russell S. Petrie M.D.
Alexander Raskin M.D.
John D. Santaniello M.D.
Todd A. Shapiro M.D.
Richard C. Smith M.D.
James D. Spiegel M.D.
Willard B. Wong M.D.
Frederick R. Young M.D.
Edward W. Younger III M.D.

Special Recognition

To **Robert Cash M.D**. who deserves an extra thank you for contributing **$1,000** to OPAC.

Don't Forget to Vote

June Primary

There are many contested elections on the June, 2010 ballot, so we encourage you to vote and get involved with candidates in your local area. Below is a summary of the Propositions that will also be on the ballot.

Propositions on June Ballot

Proposition 13: Introduced by Roy Ashburn (R-Bakersfield). "will prohibit tax assessors from re-evaluating new construction for property tax purposes when the point of the new construction is to seismically retrofit an existing building" . Supporters include Tom Bordonaro, San Luis Obispo County Assessor, and Barbara Albry, member of the Board of Equalization District 2. No known opponents.

Proposition 14: Open Primaries Introduced by Senator Able Maldonado (R-Santa Maria). If passed, this proposition would change the way a candidate runs for office. Instead of having a Republican and Democrat primary, all parties would vote for which ever candidate they want in the primary. The two candidates with the most votes would then face off in the election. Supporter include Governor Schwarzenegger, a few legislators and many editorial writers. In addition, a committee was formed called "Californians for Open Primaries" in favor of the bill. One of the main arguments for this proposition is that law-makers won't be pre occupied with raising money and fighting for reelections. Opponents include "Protect the Democratic Party - Vote no on Prop 14", the chairs of both the Republican and the Democrat party. Many opponents believe an open primary could lower the chances of a smaller parties' candidate from being nominated. In addition, open primaries allow voters in each party to vote for the candidate they believe their own party could beat in the election.

According to a poll on California propositions.org, 55% of those polled support this measure while 33% oppose it.

Proposition 15: Fair Elections Act This proposition was introduced by Loni Hancock (D-Berkeley). This proposition would put a new fee on lobbyist that candidates running for office would use for campaigning. Lobbyist and lobby employers would pay a fee of $700 each year to the Secretary of state. Candidates who meet criteria would get money for their campaigns. Supporters include several support initiatives have been formed including "Californians for Fair Elections" and a few legislators. An argument supporters use is that candidates will no longer have to take money from special interest groups in order to run for office. Opponents include the Institute of Governmental Advocates, the California Chamber of Commerce, and many lobbyists. Some of these groups have filed lawsuits against this proposition citing the First Amendment. A poll by Lake Research Partners found that 64% of people polled support this proposition.

Proposition 16: Two-Thirds Requirement for Local Public Electricity Providers Act This proposition, sponsored by Pacific Gas and Electric gives voters the power to decide, by a two-thirds vote, whether or not taxpayer money is used to give electricity to new regions. Supporters California Tax Payer Association and the Californian Chamber of Commerce. Those in support argue that if this proposition passes, electricity costs will be driven down and it gives tax payers more "choice and control" over government electricity. Opponents include several legislators, and The Utility Reform Network. They argue that this initiative will not drive down cost but will instead limit consumers

Proposition 17: Allows Auto insurance companies to give discounts to drivers who have had continuous insurance coverage. This initiative will allow auto insurance companies to reward drivers who have had continuous car insurance (even if they switch between companies) and to punish (by increasing rates) those who have had lapses in coverage. Mercury Insurance is the sponsor of this proposition. Supporters include CalChamber, and California Alliance for Consumer Protection. These groups argue that drivers who switch insurance companies for better rates should receive the same benefits for having continuous coverage as drivers who stay with a single insurance company. Opponents include Consumer Watchdog, and Consumers Unions. Opponents argue that individuals who do not have continuous coverage can be penalized even for reasons such as not having a vehicle.

For more information go to:
http://www.californiapropositions.org/node/36
or http://ballotpedia.org/wiki/index.php/California_2010_ballot_propositions

Billing Tips
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Workers' Compensation Payment Tips

One practice of Worker's Compensation bill review companies is to show their clients (WC carriers) how much money they can save them by using their services. Their practice is to reduce/deny charges wherever they have an "open window." The key is to lock all the windows. Here are some of my proven billing practices.

1. PR-2 forms can be billed every 45 days. HOWEVER, you can bill and you WILL get reimbursed for a PR-2 form within the 45 days if the PR-2 includes:
   - change in treatment
   - change in work status
   - request for treatment/service

When submitting your claim, do NOT assume that because one of the above three is addressed in the report that it will be paid. On the claim form you need to write in BOLD letters, **"Change in treatment plan, do not disallow"** next to the line item. Also, use a highlighter to highlight the area on the PR-2 form.

2. When performing a consultation and submitting a consultation report, it is important to know the following:
   - review organizations LOVE to down code consults/reports to new patient codes and disallow 99080. They will claim that you cannot do a consult if the patient has not had previous medical care. NOT TRUE.
   - Per California WC Labor Code, you CAN do a consult and take over care of the patient.
   - The key to getting paid for a consultation is to get the request from the adjuster in WRITING. This cannot simply be notes taken by the office for a verbal authorization. It must include either your own form that you fax to the adjuster for their signature that must be returned to you prior to the consultation or a typed authorization on the carrier's letterhead specially authorizing CONSULTATION AND REPORT. INCLUDE A COPY OF THE AUTHORIZATION WITH YOUR CLAIM FORM.

If you have followed the above scenario and they still down code or deny your charges, you can and should appeal the denial and you should prevail. Call the adjuster or the supervisor of the claims review company and let them know that if they do not correct the reimbursement error, you will submit a complaint to the Division of Workers' Compensation. This threat is very powerful and I have positive results 95% of the time.

The key to getting things paid appropriately is to be PRO-ACTIVE. You must submit your bill correctly. The review organization is banking on you simply accepting the down codes or denials. The GOAL is to send in all of the documentation to support your claim when you submit the claim so you don't have to spend costly time appealing the denial.

Billing Tips from : Elizabeth Blondefield
Grady Jeter, M.D.
San Jose

Billing for Care Delivered Over the Phone

Excerpted from AMNews, February, 2010

For many physicians, the frustration of the telephone is that they have to spend a lot of time using it, yet they don't get paid.

But it is possible to get paid for your work on the phone. It takes the right coding for the right situations, the right documentation and persistence.

For instance, a billable call can be initiated only by an established patient or the patient's guardian. In addition, the conversation cannot be related to a face-to-face appointment that occurred within the past week or will happen within the next 24 hours or the next earliest available appointment. In other words, the call has to substitute for in-office care.

The relevant codes are:

- 99441—5 to 10 minutes of medical discussion
- 99442—11 to 20 minutes of medical discussion
- 99443 —21-30 minutes of medical discussion

To increase the likelihood of payment, the call must be documented like an in-person visit, with particular notation of the time spent. In addition, experts advocate spelling out in contracts with insurers that such services will be covered.

Once a practice starts billing for telephone care, you should keep track of which insurers will pay and which don't. If an insurer does not cover phone calls, it may be possible to bill the patient. Most insurers allow patients to be billed for medically necessary noncovered services.

There's always a risk that some patient may switch physicians if a practice implements a policy of charging for extensive phone calls, but physicians who have implemented this policy say this is not a significant problem. In fact, some patients prefer the telephone appointment as it saves them time away from work and makes it easier to get access to their physician.

Even if you do not bill the telephone visit, it is important to document the discussion in the patient's record.

Are Patients Still Packing Their Bags and Going Abroad for Their Medical Care?

What's the Role for U.S. Surgeons Providing Care to Patients From Other Communities/ States or Other Countries?

While the economic recession has eroded the growth rate for medical tourism by approximately 13.6 percent from 2007 to 2009, the economic recovery is expected to spur a sustainable 35 percent annual growth rate for the medical tourism industry by 2010, according to a report (http://www.coa.org/deloittestudy.pdf) released in October, 2009 by the Deloitte Center for Health Solutions.

According to the report, in 2007 more than 750,000 Americans traveled abroad for medical care. Since 2007, medical tourism has experienced a slow down driven by the economic recession and consumers putting off elective medical procedures over the past two years. Even in the downturn of the market, 540,000 Americans traveled abroad for their medical care in 2008 and a projected 648,000 Americans traveled abroad in 2009. Patients are traveling abroad for many elective surgeries such as cosmetic and dental procedures, but also for joint replacements and other orthopaedic procedures.

The Deloitte Report also indicated that over forty percent of respondents to the survey indicated that they would travel outside of their immediate area for care if their physician recommended it or for a 50 percent cost savings.

While medical tourism is still developing, it seems that more payors and patients are seeking medical care outside of their local communities in an effort to try and save costs or gain more ready access to the procedure. Blue Shield and Health Net are actively engaged in a pilot project sending patients from California to Mexico. Anthem Blue Cross and Blue Shield of Wisconsin sends patients to India, United Group Program in Florida is sending patients to Thailand and India, and Blue Cross and Blue Shield of South Carolina send patients to Thailand. The COA has been contacted by an entity representing self-insured employers in Canada, wanting to bring injured workers to California to obtain the medical care for the injured worker so they can get back to work more quickly. They indicate that some 850,000 Canadians are on surgical waiting lists – with a 26 week wait for a hip replacement.

Medical facilitators such as Healthbase.com work with patients and insurers to set-up arrangements for patients who seek their medical care out of the country or at least out of their local communities. Medical tourism is expanding to fill this need.

What's unclear is why U.S. surgeons have not offered an alternative for these patients... That is also changing.
The Mayo Clinic, Stanford and other academic centers, selected orthopaedic surgeons and other physicians have had patients traveling to their offices/facilities from other countries for many years. Other orthopaedic groups are also recognizing this new business opportunity and are developing strategies to market their services to these patients. Orthopaedic surgeons affiliated with an ambulatory surgery center, particularly those that can do a 24-hour stay are well positioned to competitively price their services and favorably compete with the foreign facilities or U.S. physicians using acute care facilities for the hospital stay. Entities such as MediBid.com began operations in January, 2010. MediBid is different from other medical entities arranging care for these patients in that they do not have facilitators who will help set-up arrangements for patients. They rely on the Internet to link physicians with patients needing a medical service. Patients go on-line and post a medical ailment for which they are seeking care. For an annual fee for an individual doctor, orthopaedic surgeons can gain access to these patient listings and bid on the service. The bid should include the cost and an explanation as to what the bid includes (e.g., surgeon's fee, facility fee, implant costs, anesthesiologist fees, any follow-up care or rehabilitation, etc.) If the patient accepts the bid, the physician's office contacts the patient directly to obtain additional medical information such as: the local doctor's opinion, patient's medical history, diagnosis, and to get copies of their medical records and diagnostic tests – whatever the surgeons needs to determine whether the patient is an appropriate candidate for their practice setting. If you find that the patient is not a good candidate, either due to the patient's condition and/or co-morbidities, the physician has the ability to turn the patient down. If the practice accepts the patient, they communicate with them just like any other patient. It is important to have all of the screening tests performed prior to the patient traveling to your facility to help ensure that there will not be other health problems that will delay or make the patient a bad surgical candidate.

Orthopaedic Surgery Center of Orange County (OSC), an orthopaedic surgery center in California, is exploring the business opportunity of medical tourism and is accepting patients from out of the area and/or other countries. Gabrielle White, Director of OSC, says that "Running a surgical center or a practice has its own challenges especially in California due to higher overhead costs, over-regulation and lower reimbursements, its more important than ever to not only keep up with change but to try to keep ahead of it. This brought me to explore an area of healthcare that has been around for decades but recently has been viewed as a threat to U.S. providers- 'Medical Tourism." OSC's goal in medical tourism is to provide an affordable alternative with the U.S. for patients needing orthopaedic surgery, but who cannot afford the cost of a hospital stay in the U.S. and/or prefer not to have surgery in a foreign country. They are also an alternative for patients who prefer not to be treated as an inpatient in an acute care facility. Surgeries they perform include, but are not limited to, joint replacement including hip and knee, certain spine procedures, and other elective orthopaedic surgeries that can be performed in a 24-hour ASC setting. They pick their patients carefully to make sure they are appropriate, control their costs, and can perform the procedure(s) well under the costs charged by an acute care facility for the same procedure.

(continued on Page 13)

COA Members Oppose Division of Workers' Compensation Efforts

The Division of Workers' Compensation is undertaking two projects of potential concern to COA members:

Reimbursement for ASCs
The DWC is updating the Ambulatory Surgery Center (ASC) Fee Schedule to be consistent with the Medicare paid to ASCs. Currently, under California's Workers' Compensation system, both a freestanding ASCs and hospital-owned ASCs are reimbursed at the same rates for their facility fees– the higher rate Medicare pays hospital-owned ASCs. .

DWC is now proposing to reduce the reimbursement to for a free-standing ASC to be consistent with Medicare's reimbursement rates for a free-standing ASC. We are told that this will result in a 40%-50% reduction in facility fees for free-standing ASCs.

COA is working with the California Ambulatory Surgical Association to oppose unreasonable reductions in facility fees which we believe could lead to access problems for injured workers. If ASCs no longer allow surgeons to bring injured workers to their facilities, surgeons will be forced to take these patients to acute care facilities. This will delay care, increase costs, and potentially put the patient at additional risks for infections and complications. There is nothing positive in this action for injured workers. The DWC is holding a meeting with stakeholders at which COA and several orthopaedic surgeons will be in attendance.

Transition of the OMFS to a Medicare RBRVS System
The DWC is also proposing to transition the Official Medical Fee Schedule (OMFS) for physician services to Medicare's RBRVS system. They would transition the fee schedule from current reimbursement rates to 147% of Medicare 2009 reimbursement rates in the first year for surgical fees. For the next three years, the surgical fees would be reduced to ultimately bring the reimbursement rate to 125% of 2009 Medicare rates. Under this transition, some orthopaedic surgical codes would be decreased as much as 57% and other codes, such as injections, would be increased. Radiology codes would be decreased. Evaluation and Management codes would be increased as would other codes under the physical medicine section of the fee schedule. Fee schedule Ground Rules would also be affected.

COA has sought input from our members to determine the actual impact on various orthopaedic subspecialty practices and is in the process of analyzing their data.

COA has not opposed efforts to update the fee schedule, but is urging the Division to transition the fee schedule in such a way to avoid reductions to surgical fees. No formal regulations to make this change has yet been released by DWC. COA will notify you as soon as additional information is available.

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

To lobby California's Congressional Delegation on the implementation of health reform and the urgent need to fix the Medicare SGR.

From left to right, Chris Wills, M.D., Betty Jo Wills, Chris Taylor, George Balfour, M.D., U.S. Senator Dianne Feinstein, Jeffrey Smith, M.D., Diane Przepiorski, Michael Laird, M.D. and Mathias Masem, M.D.

From left to right, Mathias Masem, M.D., Betty Jo Wills, Chris Wills, U.S. Senator Barbara Boxer, Michael Laird, M.D., Roland Winter, M.D., Diane Przepiorski, and Michael Klassen, M.D.

Chistopher Wills, M.D. launches his political career with his wife, Betty Jo, at his side.

Are Patients Still Packing Their Bags and Going Abroad for Their Medical Care?
(Continued from Page 11)

The OSC selection patient criteria include:

- Less than 64 years of age
- SA 1 – healthy with no systemic disease
- ASA 2 – healthy with system disease which is controlled, e.g., controlled high blood pressure
- Family/friend support system post op
- BMI (body mass index – height v. weight) of 32 or less

OSC is Medicare and AAAHC certified and has 16 credentialed orthopaedic surgeons who schedule procedures at their ASC at least weekly. The have 4 operating rooms, 10 post op recovery beds, and 2 private post op recovery rooms. The orthopaedists at the Center perform an average of 4,800 orthopaedic surgeries each year, mostly elective outpatient procedures with no more than 2 total joint or spine procedures in one day. This allows them to provide the highest quality of medical and nursing care to all their patients. The arrangements with the surgeons need to be properly structured so as not to be in violation of any of the Stark referral laws meaning there must be direct agreements with each provider and they cannot be compensated for the referrals they make to the facility. OSC evaluates whether the patient is appropriate for the ASC setting and if so, sends the patient information and contact to the surgeon's office to move forward in the planning of care.

OSC points out in their marketing materials that the advantages for having surgery performed at their facility include:

- No high hospital bills
- No foreign travel with 20+ hour flights
- No need for passports or vaccinations
- No language barriers
- No cultural adjustments while trying to recover from surgery
- Travel to a beautiful area of California

To date, through their medical tourism program, OSC has been successful in attracting patients from other U.S. locales for surgeries ranging from total hip and partial knee replacement, to bunion and arthroscopic shoulder reconstruction. Some of these patients were not appropriate candidates for a 24 hour stay and; thus, they negotiated a rate with their partner hospital that was acceptable. OSC has only treated insured patients so the medical screening process was made easier by the involvement of the health plan. They have advertised in the Medical Tourism magazine which put them in touch with "facilitators" looking for surgeons who are willing to treat these patients. It remains to be seen how successful MediBid will be with patients going on-line to post their medical needs, but OSC has signed up with all of these services so that they are well-positioned to attract the medical tourism business to their practice. While the program has proved viable, they have not seen this market flourish as was projected. The downturn in the economy may have been a factor, but, at this point it does not appear that the travel market is as large as the magazines and companies make it out to be. However, by going through this exercise, they are now prepared for the "episode of care" or "bundled pricing" models that appear to be on the horizon. Ms. White said, "We learned through this experience how to carve out a rate for all of the participants up front, including the implant vendors, anesthesiologist, the physical therapists, and even the local Hyatt hotel where patients would recover after discharge." If physicians use firms that utilize facilitators, it is important to structure the arrangement in such a way to not violate any Stark self-referral laws.

Other creative marketing plans cited in the medical tourism articles include: launching a website targeted to patients in other countries, developing relationships with foreign companies that provide private health insurance as an employee benefit, developing relationships with medical tourism facilitators who are placing patients, bidding for surgeries posted on the Internet, creating medical care packages with foreign travel agents or monitoring health-oriented social networking web sites. Most importantly, orthopaedic surgeons should develop creative joint arrangements with other partners in the health care delivery system such as third-party payers piloting or considering medical tourism offerings.

*A **Special Thank You** to Gabrielle White,*
Director of Orthopaedic Surgery Center of Orange County
for sharing their experience with medical tourism.

AAOS Publishes Hospital Employment of Orthopaedic Surgeons A Primer for Orthopaedic Surgeons

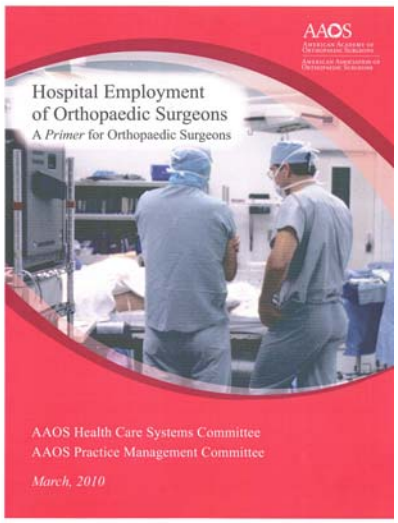
Has your local hospital asked you about full-time employment? Are you considering trading the hassles of an independent practice for the security of a hospital position? Before you make any decision, you'll want to check out the new primer from the AAOS Health Care Systems Committee (HCSC), with input from the Practice Management Committee.

Hospital Employment of Orthopaedic Surgeons was introduced at the 2010 AAOS Annual Meeting and is the fourth in a series of primers designed to provide AAOS members with basic information and important tools for decision-making. Previous primers covered human resources, electronic medical records, and picture archiving and communication systems.

"The content of the *Primer* relates primarily to orthopaedic surgeons who are considering hospital-based employment," says **Kevin J. Bozic, MD, MBA,** HCSC chair. "Much of the information, however, applies to already-employed orthopaedists, or orthopaedic surgeons in any practice setting who are in competition with a hospital-based physician group."

The primer consists of the following nine major sections, plus a list of additional resources:

- Reasons physicians are seeking hospital employment
- Reasons hospitals are seeking to employ orthopaedic surgeons
- Types of hospital employment
- Potential drawbacks
- Determining feasibility and appropriateness of becoming a hospital employee
- Legal considerations
- Tips for ensuring long-term success
- Using consultants and advisors effectively
- Implications of increased employment of physicians by healthcare institutions



Getting it Together: Integrating Options for Orthopaedic Surgeons

Frank Gamma, MBA, FACMPE, and Douglas Free of Kessenick Gamma & Free, LLP, have prepared a "White Paper: entitled, "Getting it Together: Integration Options for Orthopaedic Surgeons" for COA Members.

In the White Paper they discuss the following integration issues and options:

- Levels of Integration
- Consolidation of Business Services
- Ancillary Service Joint Ventures
- Clinical Integration
- Orthopedic IPA
- Fully-Integrated Medical Group
- 1206(l) or Medical Foundation Model
- Outpatient Department Model

The White Paper (http://www.coa.org/gammafreearticle.pdf) presents several practice options for you to choose from

COA appreciates the work of Frank Gamma and Douglas Free in preparing this summary of practice integration options.

News from the Medical Board of California

The doctor will see you now!

California becomes first state to shorten patient wait times for appointments

Excerpt from an article by Cindy Ehnes, Director, California Department of Managed Health Care (DMHC) published in the Medical Board of California Newsletter, April, 2010

One of the common consumer complaints received at the DMHC Help Center is not being able to see a doctor on a timely basis. A recent study found that the average wait time for new patients to see a family practice physician in Los Angeles is 59 days. This is not just a California problem or unique to HMOs-patients across the country are literally sick of having to wait weeks to see an in-network doctor. In January, 2010, California became the first state in the nation to provide patients with predictable wait times. The development of these regulations has been one of the most extensive and important endeavors in DMHC history. While it has been a challenge to incorporate so many diverse perspectives, the regulations have emerged with a strong, direct way to eliminate unnecessary delay for consumers, while also taking into consideration the realities of today's health care marketplace, such as geographic differences, provider shortage, and the rising costs of providing care.

The physician community has been genuinely concerned that they will need to use stop watches to meet the time standards, or that the regulations will potentially interfere with clinical judgment. This is not the case. In reality, the regulations put the burden of providing time-specific standards on the health plan, not the individual provider. That means that plans must have a strong and varied provider network to ensure that appointments can be made within the specified timeframes.

Examples of some of the consumer protections included in the regulation:

- 48 hours for urgent care appointments that do no require prior authorization
- 96 hours for urgent care appointments requiring prior authorization (including specialists)
- 10 business days for non-urgent primary care appointments
- 15 business days for non-urgent appointments with specialists
- 10 business days for non-urgent appointments with a mental health care provider
- 15 business days for non-urgent appointments for ancillary services (x-rays, lab tests, etc.) for diagnosis or treatment of injury, illness, or other health conditions
- 24-7 triage or screening by telephone
- 30 minutes or less wait time for telephone triage during normal business hours
- 10 minutes or less wait time during normal business hours to speak to a plan's customer service representative

Under the new rules, patients must get a callback from a health professional within 30 minutes, rather than simply a recording directing them to call 911. The DMHC maintains a toll-free hot-line for consumers to call with a complaint—1-888-466-2219 or on-line at www.healthhelp.ca.gov

New Notice to Patients Required

Effective June 27, 2010, Title 16, California Code of Regulations section 1355.4 will require physicians to inform their patients that they are licensed by the Medical Board of California and include the Board's contact information. The notice must contain the following information:

NOTICE TO CONSUMERS
Medical doctors are licensed and regulated by the Medical Board of California
(800) 633-2322
www.mbc.ca.gov

Physicians may provide this notice by one of three methods:

- Prominately posting a sign in an area of their offices conspicuous to patients in at least 48-point type Arial font.
- Including the notice in a written statement, signed and dated by the patient or patient's representative, and kept in that patient's file, stating the patient understands the physician is licensed and regulated by the Board.

Failure to comply could result in a citation and fine by the Medical Board.

Expert Reviewers

The Medical Board is looking for physician expert reviewers. Participating physicians are reimbursed at $150 per hour for conducting case reviews and oral competency exams and $200 an hour to provide expert testimony. They will also be reimbursed at their usual and customary fees for physical exams. Contact the MBC if you are interested in participating—www.mbc.ca.gov/licensee/expert_reviewer.html

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

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

MEDICAL OFFICE SPACE FOR RENT

Disability Evaluation Physician Group has fully furnished office and exam room space in Stockton, Sacramento, Modesto, Castroville and Clovis/Fresno for rent.

Flexible availability on a daily or weekly basis. For details contact Jeanne Lerner (800) 245–7899, ext 100.

Welcome to COA's Newest Members

Alon Antebi, DO	Lancaster
Osep E. Armagan, M.D.	Simi Valley
Michael Bahk, M.D.	Simi Valley
Michael W. Cluck, M.D.	Campbell
David T. Easley, M.D.	San Diego
Cornelis Millard Elmes, M.D.	Fairfield
Simon Gortz, M.D.	San Diego
Yuhwan Hong, M.D.	Sacramento
Kenneth J. Hunt, M.D.	Redwood City
Zafarul Husain, M.D.	Corona
Bradley Jones, M.D.	Redding
Kevin J. Lawson, M.D.	Sault St. Marie
Jai Huang Lee, M.D.	Los Angeles
Jonathan Linthicum, M.D.	Willits
Nicholas Mast, M.D.	Redwood City
Eric Meinberg, M.D.	San Francisco
Russell M. Nord, M.D.	Fremont
Jon E. Oda, M.D.	Madera
Scott L. Rosenzweig, M.D.	Santa Monica
Deirdre Ryan, M.D.	Los Angeles
Donald R. Schwartz, M.D.	Santa Ynez
Eric F. Shepard, M.D.	Santa Barbara
Ian A Stine, M.D.	Pleasanton
Robert Tamurian, M.D.	Sacramento
Bradley Duc Tran, M.D.	Laguna Woods
James M. Van Den Bogaerde, M.D.	Sacramento
Andres S. Wong, M.D.	Redlands