COA Report

A publication of the California Orthopaedic Association

Summer, 2009

57th President of COA

Friends and Orthopaedic Surgeons:

I am deeply honored to become the 57th President of the California Orthopaedic Association. This is truly a winning team. You are proven champions at the state, national and professional level.

Over the last several years, COA has scored significant victories in the California state legislature, defeating those who would reduce the quality of musculoskeletal care, deny patient access to appropriate specialty care, or restrict your ability to practice orthopaedics. We have developed strong relationships with our legislators by becoming the respected information resource for patient access and safety in musculoskeletal care. I believe they realize the orthopaedic health of our patients is foremost in our minds.

Nationally, the California Orthopaedic Association has met with the attention of our state's Congressional and Senatorial delegations as the shape and direction of health care reform becomes clear. We have an excellent working relationship with key personnel in Congressional Committees and Federal Departments whose actions regulate the business of the practice of medicine.

Professionally, we have several very strong voices at the level of the Board of Directors of the American Academy of Orthopaedic Surgeons. During last fall's discussions of a proposal to make Emergency Department Call a Standard of Professionalism, we gathered a coalition of 13 state orthopaedic societies to oppose this measure with the united voices of over 50% of the Fellowship of the Academy. During the last 3 years, the California Orthopaedic Association has been honored as the state society of the year and your Executive Director has been recognized for her professional excellence for the second time. Because of the strength of the COA, the interests of the community based orthopaedic surgeons who comprise the majority of our Fellowship are now well represented and thoughtfully considered. California counts!

Mark Wellisch, M.D. (left) passing the COA gavel to Richard Barry, M.D. (right)

But a championship team is only as good as its preparation for the next opponent….and the profession of Orthopaedic Surgery faces an array of determined and destructive opponents!

(Continued on Page 2)

AAOS Election Alert

See Page 3 of this Newsletter for more information.

Calendar of Events

Preparing for the QME Test/ Mandatory Report Writing Course
October 9-10, 2009—Huntington Beach

2010 COA Annual Meeting/QME Course
April 15-18, 2010
New Ritz-Carlton Highlands - Lake Tahoe

President's Column (continued from Page 1)

We face major changes in the economic arena of heath care delivery. It has been said that , "…anything which is good for physicians will go away!" We must be unwavering in our commitment to our patients. Orthopaedic Surgeons ARE the primary care physicians for the musculoskeletal system. Patients MUST have access to quality orthopaedic care within their local community. We must act together to constructively influence the future viability of our profession!

The California Orthopaedic Association is working to enhance the survivability of your practice through management enhancement programs, specialty medical education, administrative education on ancillary income stream opportunities, Workers' Compensation activism, procedure coding courses and a number of other initiatives. We are working for the survival and growth of our profession through political activism and advocating with a clear voice the importance of timely patient access to quality musculoskeletal care.
I see our biggest challenge as the need to develop a vision of the future of orthopaedic surgery in California.

I need your input and your insight. We are planning a very strong program at the next annual meeting to discuss the future. I strongly encourage you to make plans to attend the 2010 California Orthopaedic Association Annual Meeting/ QME Course April 15-18th at the new Ritz-Carlton Highlands Northstar, Lake Tahoe to join us for these discussions.

To succeed, we must have YOUR help. We need activists! I need you to contribute your passion for our profession. Volunteer to become involved within the COA. Support the California Orthopaedic Association PAC, the strength of which gives us effective access to those to whom we can enlighten. We must join together to act with a unity of purpose. Please ask each and every one of your colleagues to become active members of the COA and to contribute to our mission.

I need you to contribute your professional standing. Contact your State legislators and your Congressional Representative with a letter of concern and develop a relationship of trust. Take any and every opportunity to educate colleagues, patients, legislators, business and community groups on the importance of professionalism and patient access.

Together, we have been able to accomplish much. Yet, as a profession, we face significantly greater challenges soon to come. Going forward, we must strengthen our organization, we must speak with one voice; and we must act with one purpose. Continued excellent orthopaedic patient care is paramount!

We **ARE** the California Orthopaedic Association!

Richard J. Barry, M.D., President

AMA Takes First Steps to Build Physician Web Portal

Two companies have announced their involvement with the American Medical Association on a project to build an online portal that would give physicians easy access to a suite of practice management services.

Covisint, a subsidiary of Compuware Corp., is partnering with the AMA to build a Web-based platform where physicians can access multiple services through a single log-in portal.

Through the portal, doctors would be able to access e-prescribing systems, electronic medical records, practice management solutions, clinical information and physician-to-physician messaging as well as educational and practice management information.

The Covisint system will meet physicians wherever they are in the health IT adoption process.

The systems that physicians can access through the portal can be either Web-based systems they download or their own client-hosted systems that can be integrated to work on the portal's dashboard. The systems that will be available will be from vendors that the AMA has reviewed and formed partnerships with.

The first company announcing its availability through the portal is DrFirst which is an e-prescribing system that will be offered free of charge during the pilot project. After that, rates consistent with market standards will go into effect.

Pilot tests will be conducted with various physician groups before the service is launched nationwide which is expected early next year. *Source: AMNews, May 11, 2009*

Physician Assistants and Nurse Practitioners in Specialty Care

A report by the Center for the Health Professions at the University of California, San Francisco released a report dated June, 2009 examining the use of physician assistants and nurse practitioners in six emerging specialty practice models including orthopaedics. The report summarizes the training of NPs/PAs, gives workforce data, and discusses their specialty training programs. It also provides examples of how practices are utilizing NPs/PAs including an example from Kaiser Permanente Fontana Medical Center in California.

The report finds that the use of NPs/PAs have reduced patient wait times to see specialists. In fact, the report cites that "orthopaedic practices commonly rely on physician assistants to do many orthopaedic assessments and procedures. The prevalence and long track record of this model throughout the United States suggests it will become even more widely adopted."

For a copy of the Center for the Health Professions report, fax or e-mail a request to COA providing us your name and e-mail address—Fax: 916–454-9882 E-Mail coa1@pacbell.net.

AAOS Nominations Committee—Ballots to be Mailed in mid-June
Your Vote Counts, So Please Vote

TO: AAOS Fellows

AAOS Election Alert

FROM: Richard Barry, M.D., President

SUBJECT: Ballots – AAOS Nominations Committee

Several years ago, the AAOS Board of Directors found it necessary to limit the number of terms a fellow could serve on the AAOS Nominating Committee. This was necessary because although there are over 16,000 eligible candidates in the Academy, only a relatively small pool of candidates continued to be elected to this powerful committee. Since each voter is unable to properly vet each candidate, this modification brought about little change in the composition of the Nominating Committee since votes are cast mainly based on name recognition which occurs predominantly through publications and lectures.

While we believe that AAOS Fellows who publish and lecture extensively should have a voice, the election process has imposed a significant handicap on those leaders who are well known and recognized in their respective States, but not necessarily on the national stage because their career paths do not bring them national attention. These state and regional leaders have demonstrated excellent leadership in their societies and would bring an additional dimension to the table.

We believe that the large numbers of AAOS fellows that these state and regional leaders stand for have been under-represented in selecting the future leaders of our Academy.

We Need Your Help.

Leadership of the following state orthopaedic societies, California, Florida, New York, and Texas have carefully evaluated the candidates for the AAOS 2009-2010 Nominating Committee and have selected the following Fellows as worthy of your consideration and your vote:

Dwight Burney, III, M.D. from New Mexico
John T. Gill, M.D. from Texas
Stuart Hirsch, M.D. from New Jersey
Douglas Jackson, M.D. from California
Richard F. Santore, M.D. from California
Edward A. Toriello, M.D. from New York

We believe that these candidates will bring to the discussion a viewpoint that will only improve the selection process.

We urge you to critically read their personal statements when you receive your ballot and support their candidacy with your vote. Please also encourage your colleagues here in California and in other states to support these candidates. Ballots are expected to be mailed in mid-June.

Thank you for your consideration of this request.

News of Interest

Massachusetts Considers Capitated Insurance Payments

Fee-for-service pay could be a thing of the past for Massachusetts physicians by the time 2015 rolls around, if a group of health care leaders in the state get their way. A commission is set to propose that the entire state leave behind fee-for-service payments over the next five years in favor of capitated payments, this time designed to avoid the problems that pushed capitation out of favor over the last decade.

"Global payment" is the preferred name for this per-member payment, split between doctors and hospitals, with the amount determined in part by the quality of care delivered. Advocates say that as with its move toward universal coverage, Massachusetts' payment system changes could be a national model. The state intends the change in payment systems to shift from rewarding a high volume of services toward improving overall patient health.

"Payment reform is one of the most powerful levers we have to drive and support health system change," said Sarah Iselin, the Massachusetts Division of Health Care Finance and Policy's Commissioner and Co-Chair of the state's Special Commission on the Health Care Payment System. The Commission is made up of health plan executives, state finance officials, President-Elect of the Massachusetts Medical Association (MMS), CEO of the state's hospital association, and the head of the Group Insurance Commission which purchases health insurance for state and municipal employees.

The state's Blues plan introduced a limited wave of capitation last year with its "alternative quality contract," which several large physician-hospital organizations signed onto this year. But the special commission is set to push for per-member payments to replace fee-for-service for all payers—including Medicare and Medicaid—within 5 years. The commission meets in late June and its recommendations will need legislation to implement.

Many physicians, who were part of the boom of capitation agreements during the 1990s found they had taken on financial risk they were not equipped to deal with. Patients, in some cases, distrusted doctors because of a perceived incentive under capitation to delay or skip care. Dr. Mario Motta, President of the MMS said that a 100% global-payment system may not be ideal, but there's no reason not to adopt a hybrid system, using fee-for-service where it makes sense. Source: *AMNews, June 8, 2009*

Resource to Obtain the Services of Interpreters . . .

The California Pan Ethnic Health Network has developed a list of phone numbers that can be called to obtain the services of an interpreter when treating patients covered by the health plan.

The services are free of charge.

To obtain a copy of the list go to COA's website: www.coa.org

We would encourage COA members to consult this list when an interpreter is needed to help ensure good communication with all patients.

Congrats—Orthopaedic Residents

Resident Awards

The following Resident Awards were presented at the COA 2009 Annual Meeting:

Orthopaedic Hospital Resident Award
Eugene Farng, M.D., UCLA

Lloyd W. Taylor, M.D. Resident Award
Vidyadhar Upasani, M.D., UC San Diego

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

J. Harold LaBriola, M.D. Resident Award
Michael (Rob) Fraser, M.D.
Naval Medical Center, San Diego

2009 Annual Meeting/QME Course

Over 400 Orthopaedic Surgeons and Practice Managers attend COA 2009Annual Meeting/QME Course and Instructional Course in Santa Barbara …..

COA Elects New Officers—2009-2010

President—Richard J. Barry, MD from Davis
First Vice President—Glenn B. Pfeffer, MD from Los Angeles
Second Vice President—Tye J. Ouzounian, MD from Tarzana
Secretary-Treasurer—Kevin J. Bozic, M.D. from San Francisco

The Founders' Award was awarded to Norman Zemel,, M.D. (left) for his lifelong dedication to quality orthopaedic care.

The William W. Tipton, Jr., M.D. Leadership Award was awarded to Steven D. K. Ross, M.D. for his dedication to political issues/activities.

Ralph DiLibero, M.D. (center)
and Richard Barry, M.D. (right) presented the awards.

Attendees Enjoying the Meeting ….

Other Meeting Highlights ….

- Lecture and Sawbones labs entitled, "Latest Techniques for Fixing Humerus, Distal Radius, and Clavicle Fractures."

Symposiums/Lectures entitled:

- Indications for Surgical Procedures—What's Reasonable and What's Not
- Economic Survival of Orthopaedic Practice
- The Future of Health Care—Where Are we Headed?
- International Classification of Functioning
- Pearls and Pitfalls in Pediatric Fracture Care
- Use of Physician Extenders in Orthopaedic Practice
- Update on State and Federal Physician Self-Referral Laws
- Orthopaedic Management of the Graying Population
- From Bench to Bedside: Growth Factor Technologies—An Evidence-Based Approach
- Growth Factor Applications in Contemporary Fracture Surgery.

Platelet Rich Plasma Grafts for Use in Musculoskeletal Medicine

Kristin S. Tate, M.P.H.
Harvest Technologies

The use of Platelet Rich Plasma (PRP) grafts in treating patients in the musculoskeletal arena had grown exponentially in the last few years. Although providers practicing musculoskeletal (MSK) medicine began using PRP for tendonosis and tendonitis in the early 1990's an informed patient population fueled by media attention has accelerated demand for this therapeutic alternative. The intention of treatment with PRP is to augment the native healing process at the site of pain.

A PRP matrix graft is defined as a "tissue graft incorporating autologous growth factors and/or autologous undifferentiated cells in a cellular matrix whose design depends on the receptor site." PRP is obtained from a sample of the patient's blood drawn at the time of treatment. This sample is then placed in a specialized "table-top" device (such as Harvest Technology's SmartPReP2) that allows for automated extraction of a thin layer of concentrated platelets and a "buffy coat" layer containing an elevated level of leukocytes. Both the concentrated platelets and the "buffy coat" are suspended in a small amount of plasma for subsequent grafting. This PRP graft is then activated at the time of injection with the addition of calcium and thrombin or when coming in contact with collagen.

PRP has been found to contain up to 10 times the concentration of platelets found in whole blood although a PRP platelet count with a 5 to 6 fold baseline value appears to be adequate to achieve significant outcomes. Platelets contain two types of granules – the alpha granules and dense granules. The alpha granules contain coagulation proteins, growth factors, cytokines, chemokines and various other proteins such as adhesion proteins. Platelets are known to contain at least 6 PDGFs vital to bone and soft tissue healing. The dense granules contain the factors necessary for platelet aggregation. It is necessary for platelets to be activated at the level of tissue injury in order for the PRP graft to be successful. In this fashion the platelets successfully release their contents and begin the cascade of events that lead to the restoration and growth of normal collagen.

Once it has been made the PRP graft can be placed directly into the damaged tissue to initiate and accelerate repair and regeneration. The successful placement of the graft into the exact location of damage is necessary for optimal results. This application can be accomplished in the office setting by employing needle-guided radiological visualization of accurate placement (MSK ultrasound, fluoroscopy, CT, MRI) and in the OR setting via open or arthroscopic techniques.

The natural acceleration of patient healing achieved with PRP has been proven to be inherently safe. The PRP graft is derived from autologous blood drawn at the time of treatment. Any allergic potential would be due to additive agents such as local anesthetics employed for patient comfort at the time of injection. Thorough screening should bring the risk of allergy effectively to zero. The application of the PRP graft should occur under sterile conditions. Under such conditions the risk of infection is the same as that of any percutaneous technique – 1:50:000. It has also been shown that PRP is bacteriocidal, especially against Staph. Aureus and E. Coli. As seen with any needle-guided delivery method there is the possibility of hollow organ puncture. This risk is lessened when MSK ultrasound or CT are employed to ensure accurate placement of the graft. The most common drawback to PRP injections is their painful nature, which can be minimized via appropriate local anesthetic placement prior to introduction of the graft itself.

The rapid interest in PRP and its case-based success has led to widespread use of the technique in the treatment of various tendon, ligament, muscle, bone, nerve, and cartilage injuries. The anecdotal evidence of its efficacy is marked. Unfortunately, their exists only a small number of published articles on it's application in the human musculoskeletal arena.

Mishra studied the use of PRP in patients whose lateral epicondylitis failed surgical intervention. He treated these patients with PRP and at final follow-up (2 years) he found a near 93% improvement in the patient's perception of pain and that 94% had returned to full sporting or work activities.

Barnett et al conducted a case series on plantar fascia patients. He injected PRP graft to both the medial and central bands of the plantar fascia. 7 of 9 patients had complete resolution of pain at their 1 year follow up visit and all 9 patients had ultrasound evidence of improvement in the appearance of the plantar fascia.

Scarpone reported a study on patients with shoulder pain who had partial thickness rotator cuff tears in the absence of AC joint narrowing. The patients enrolled had all failed traditional conservative measures including NSAID's, physical therapy and steroid injections. 12 of 14 patients had statistically significant improvement in both pain and strength at 8 weeks.

Sanchez reported on a case control study of 12 athletes with Achilles tendon rupture who underwent surgical repair. The group treated with PRP had statistically significant improvement in time to functional recovery. In a follow-up report he carried out a case study of open suture repair of Achilles tendon rupture both with and without PRP. The PRP treated group recovered their ROM sooner, had no wound related complications, and took less time to return to running and full activities.

Sanchez also published a study of 20 athletes with small intra-substance muscle tears whose injury sites were injected with PRP under ultrasound. He reported that the patients recovered up to two times faster than would be expected with other conservative treatment regimens.

PRP matrix grafts are rapidly gaining popularity in the management of patients with musculoskeletal complaints. These autologous grafts provide a safe, effective, and relatively low cost option to patients with a variety of tendon, ligament, bone, nerve, cartilage, and muscle pathology. First line treatment methods such as rest, bracing or kinesiotaping, evaluation of kinetic chain abnormalities and physical therapy should be considered before pursuing the application of a PRP graft. There exists a solid need for randomized placebo controlled trials to support the clinical evidence put forth in the literature to date. Future studies using validated clinical measures, and radiological, biomechanical and tissue injury / healing-responsive biomarkers as secondary outcome measures are needed to determine whether PRP grafts can play a definitive role in a cure for musculoskeletal injuries.

Kristin S. Tate, MD, MPH, Crane Clinic Sports Medicine
BlueTail Regenerative Therapeutics
Harvest Technologies—Jo Clenney—jclenney@harvestech.com

People Must Be Healthkeepers Too

By: Ralph DiLibero
Editor, COA Report

A government has a duty to its people. A nation that does not tend to the basic fundamental healthcare of its residents is both foolish and doomed. Eradication of infectious diseases and epidemics, disease prevention including control of traumatic injuries, and medical preparedness for possible bioterrorism or natural disasters are essential prerequisites.

There seems to be a growing non-partisan momentum flowing and speaking through our byways and airways to advocate for a change in our American healthcare delivery systems. Is this momentum gathering a chorus of voices that are calling in a synchronized fashion to develop a defined program, or is this just a lot of hot air buzzing to storm about in a heat-accelerated but randomized Brownian motion?

Today, we really have an overwhelming consensus that there is a healthcare crisis and a need for more people to have access to healthcare, perhaps through some sort of Universal Healthcare Coverage. If so, let's begin with the end in mind. What is our goal, our end game? Specifically, what do we consider acceptable as a maximum essential benefit? Exactly what do we desire to be contained in a most basic benefit package, and are we all willing and able to accept that package? What do we consider to be the essence of essential healthcare delivery service in any type of healthcare reform? Just exactly what are we really aiming for? Do we really see a clear target?

Certainly, we must provide a comprehensive health program for four groups of our American residents -- for the poor, for the chronically disabled, for those whose medical condition puts them near to the end of their lives, and for those in the precious early years of life -- our "tired, poor, homeless, tempest-tossed, wretched refuse….. all those yearning to breathe free." In economic terms, those who fail to otherwise purchase healthcare due to their known insurance hazard, and due to existing cherry picking of enrollees in select competitive markets that cleverly avoid any adverse selection process and leave millions of our fellow Americans uninsured or underinsured.

A healthy and productive population reinforces a healthy and productive government, and vise versa. Aged American Disability and Depression (AADD), continues to grow like a plague across the land in of our advancing 21st Century, and there are not sufficient sustainable federal funding mechanisms nor adequate federal reserves to properly care for our increasingly aged population. Our government has a duty to care for them. However, I do not advocate for our government to pay for the total healthcare of each and every resident. Such a system would not only quickly bankrupt our government, but also insult a person's pride and honor by removing a sense of personal responsibility.

A right in our American republic is a right to be able to act, to do, to produce. The purpose of childhood healthcare delivery and mass education of our children is to ensure a future healthy and productive population. People have the right to act politically by way of voting. Through that productive process, people can demand that their democratically elected representatives legislate a specific healthcare financing system into the law of our land. Before that legislative action occurs, the people should have a chance to voice their specific will through our democratic voting process. If the people do not want Universal Healthcare Delivery Coverage, or if the people are not willing to pay for a basic coverage, then that serious conundrum needs to be publicly debated and solved first, solved and accepted by the people before our legislators bring about an undesired solution or a solution with unanticipated harmful consequences. Personal healthcare choices that do not impact one's neighbor are one's American right to personal choice and personal liberty.

Patient care in any healthcare delivery system must focus on individual patient need, administered by practicing physicians through a sacrosanct doctor-patient relationship. Any delivery system should seek to facilitate and enhance that doctor-patient relationship. Government financing must be driven by medically necessary patient need, and the financing must adequately satisfy individualized patient centric care at that level of service. Further financing beyond the level of medical homes for additional layers of healthcare delivery services should be readily available, affordable and subject to the discretion of the individual patient. Catastrophic healthcare insurance is certainly necessary. Routine maintenance of one's health is best accomplished on a pay-as-you-go basis except for the aforementioned four groups of American residents.

With limited and really not enough sustainable long-term money in the present system, tax credits and tax deductions to inspire various healthcare delivery incentives might help, but those incentives won't be enough to adequately remunerate for care given in a universally covered system. Bureaucratic processing entanglements, red tape, and layers upon layers of administrative interference due to our legislators continually yielding to special interest politics shrink the percentage of the healthcare dollar that is then available and actually goes to reimbursement for hands-on healthcare delivery. The undue cost attributable to medical-legal defensive practice patterns -- extra tests and procedures -- have to be eliminated by meaningful tort reform. There must be an end to insurance schemes that result in restricted access to tests and procedures along with delays, down coding, and denials, done to enhance profits of health plan stock investors or the corporate insurance plans themselves. Balance billing is and will be essential. An appeal to the highest court to reverse current lower court judicial decisions is of high priority and must be accomplished as soon as possible. Balance billing can assure provider participation and thereby increase the sustainability of both private and public insurance plans. A sustainable and growing funding source for adequate remuneration is a sine qua non prerequisite for a governmental program. A sales tax increase or an income tax increase may be ultimately necessary to support naturally expected increasing costs in basic universal coverage, but this can be stopped or held to a minimum if healthcare reform is directed to cut out the administrative fat and preserve the point-of service lean.

Mandates are worse than simply useless; mandates are ultimately counter productive and do increase cost. Coercion is infringement upon personal liberty. All present mandates should be allowed to expire after a fixed period of time. It must also be clearly understood that a basic healthcare coverage will not satisfy every patient's desire to optimize personal health.

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Advertisement

People Must Be Healthkeepers Too (continued from Page 7)

Health insurance is just only one of many ways to finance healthcare delivery. Financing to optimize a patient's functional capacity can come from many sources other than insurance corporations, such as direct out-of-pocket pay from patients, patient pre-funded health savings and loans, government programs, tax-free corporate grants, business employment, philanthropy, and individual or collective physician charity. And let us not forget the Health Savings Account (HSA) as a proven financing mechanism for a greater percentage of people every day. Health insurance must be sold in a transparent and competitive marketplace in order to reduce cost. Mandates upon insurance carriers also increase cost. An ideal insurance would be comprehensive in benefit, transparent, and portable without restrictions for pre-existing medical conditions or changing medical conditions and specify dedicated dollars for non-contracted and point-of-service healthcare delivery.

Ideally, the contracting and payment-reimbursement structure should be contracted directly with the patient. A patient has the ultimate power to best control healthcare delivery expenses. Transparency in comparative total disclosure of physician billings, fees, and physician coverage availability is essential for a patient to make an informed decision regarding healthcare delivery. Risk bearing organizations also need to be transparent in their benefit packages and physician network offerings. Patients must be given this freedom, this inalienable American right to act on their own behalf with available autonomy through transparency. In a free market, all types and all levels of insurance can be offered and people would have the opportunity for choice, to pick and choose the price and benefit package that best suits the individual.

The pharmaceutical industry is ultimately our friend, an exceedingly rich friend, but nonetheless a true friend. Drug treatments, albeit expensive remedies, have significantly prolonged our lifespan; many of us cannot continue to live without them. Competition among the Big Pharma companies has been limited because of excessive regulation and mandates from an American FDA that has been more responsive to lobbies and political influence and fear of lawsuits than to the simple evaluation, certification, and reporting of patient safety statistics. Tort reform with an acceptance by the courts of active and transparent post-release Phase IV testing can bring back competition into the pharmaceutical marketplace, increase the development of breakthrough pharmaceutical remedies, and radically reduce drug costs to the American public.

Universal access to actual healthcare delivery must be assured, not universal access to waiting lists. Information technology should add transparency to the authorized release of patient medical records through the internet. Community healthcare delivery safety nets are life-saving and cannot be abandoned.

Our American democracy responds to our cultural ecology, which is determined by our morals and ethics. There is also a natural evolution with a ebb and flow of gradually changing morals and ethical values. Our national economic policies are thusly directed to respond to our evolving cultural ecology. Beware and forewarned; it is very possible for our government to engineer the changing course of our morals and ethics, especially when we are under great economic stress. During such times, it might seem to make sense to surrender our traditional values, only to be readjusted by an internalization of a more established set of dysfunctional globalized norms. We are, after all, in the Globalization Era. It might at times look like quickly accepting multinational or transnational concepts of economics and moral values could save our floundering economy, but watch out my fellow Americans.

To act in such a rash manner and embrace an internalization of global norms would be contrary to our constitutional concepts of personal liberties to act freely and unimpaired by needless governmental controls. Those principles have separated us and made us the great and envious world power that we are. On the other hand, our personal liberties might need adjustment to provide for the concept of entitlement rights that many of our citizenry demand. The American colonial "give me liberty or give me death" line in the sand becomes distorted by the winds of fortune, and our eyes, inflamed by blown particles of sand, might not be seeing things all too clearly.

Do we want to maintain our imperfect but finest system of governance, or do we drift ever closer to a socialistic state? Do we want to maintain our imperfect but finest system of healthcare delivery, or do we drift ever closer to single payer socialized governmental healthcare delivery? Yes, healthcare delivery expenses must be controlled, but let not the tail wag the dog, and do be prepared to move ever so cautiously so that we can beware of and avoid tragic unanticipated and unintended consequences.

Those sandy winds of fortune need to be addressed. Now, right now, the time is ripe for a choice that is clear and demands immediate legislative action -- the time has come to draw the line in the sand that time cannot erase and from which we shall never retreat. To ensure the legality and permanence of this line, we must proceed through the political process of legislative action. We must write and promote a legislative bill that clarifies our position and the inalienable rights of our patients to act freely and unencumbered in our free society.

We must insist that no law shall be passed that would interfere with a person's right to pay directly for lawful medical services and no law shall be passed that restricts a person's freedom of choice -- to choose independent private physician healthcare delivery. All patients, physicians, and insurers must be granted the right to privately contract among one another and not be legally restricted in this contracting by any present type or any future type of public plan.

Physicians must also reestablish collegiality among themselves and with their hospitals. The hospital once functioned as the social center of a doctor's life. Medical societies should work hand in hand with hospitals towards recruiting doctors for a common goal of collegiality. Remuneration comes in many forms, not just in dollars: there is recognition, honor, gratitude, and respect. From these emotional supports, physician charity is built and sustained. The heart of happiness hides in the heat of our hunt for the right to freely do that which one does well. For me, happiness is making healthcare happen.

Ralph J. DiLibero, MD, Editor

News of Interest

FTC's "Red Flags" Rule Will Affect Most Health Care Providers

On August 1, 2009, most health care providers must comply with the "Red Flags" rule, a requirement authorized by Congress as part of the Fair and Accurate Credit Transaction Act of 2003 (FACT Act). The legislation requires various federal agencies to adopt regulations requiring financial institutions or creditors to develop and implement a written identity-theft prevention program.

The government released the final Red Flags regulations on November 9, 2007, set for enforcement on November 1, 2008. In the summer of 2008, health care providers learned that the Federal Trade Commission (FTC) interpreted the rule to apply to health care providers, considering them "creditors."

Requirements of the Rule

The rule requires that, "[e] each … creditor that offers or maintains one or more covered accounts must develop and implement a written Identify Theft Prevention Program that is designed to detect, prevent, and mitigate identity theft in connection with the opening of a covered account or any existing covered account."

The rule defines "creditors" as people or entities that regularly:

- Extend, renew, or continue credit;
- Arrange for someone else to extend, renew or continue credit; or
- Are the assignees of a creditor who is involved in the decision to extend, renew, or continue credit.

While health care providers do not generally consider themselves creditors, the FTC includes them in the definition of creditors when they accept insurance and bill patients after services are rendered for any amounts that insurance does not pay, or if they regularly allow patients to establish payment plans after services have been rendered.

Health care providers who determine that they are creditors under the FTC's definition must then decide whether they maintain covered accounts. A covered account is:

- An account used mostly for personal, family or household purposes that involves multiple payments or transactions. According to the FTC, this includes patient billing records.
- Any account for which there is a foreseeable risk of identify theft.

If you do not believe that your practice maintains covered accounts, the rule requires that you must periodically re-evaluate this determination.

What an identify theft program entails

If your medical group meets both aspects of the test, you will be required to implement an identity-theft prevention program. The Red Flags rule defines identity theft as a fraud committed or attempted by using the identifying information of another person without authority. In a health care context, identify theft may involve using a person's name and/or insurance information without his/her knowledge to fraudulently obtain medical services or benefits. Medical identity theft has added risk that medical information about a patient could be commingled with medical information of an identity thief.

A compliant identity theft prevention program must:

- Identify relevant "red flags" for the creditor's covered accounts and incorporate those into the program;
- Detect those red flags;
- Respond appropriately to any red flags to prevent and mitigate identify theft; and,
- Ensure the program is updated periodically to reflect changes in risks.

Red flags comprise patterns, practices, or specific activities that indicate the possible existence of identity theft.

Guidance on preventing identify theft

The FTC included guidance for developing a compliant identity theft prevention plan in Appendix A of the regulation.

For example, the FTC directs creditors to examine certain risk factors, including:

- The types of covered accounts maintained (for most practices, that will include patient billing accounts);
- The methods used to open accounts (e.g., your patient intake procedures);
- The methods to access the covered accounts (e.g., which entities or individuals have access to your electronic or paper files); and,
- Your practices experience with identify-theft.

In administering a compliant plan, a practice must:

- Obtain approval of the program from its board or board committee;
- Involve the board or senior management designee(s) in oversight, development, implementation and administration of the program;
- Train staff; and,
- Exercise oversight of service provider arrangements.

Medical Group Management Association (MGMA) offers resources to its members at mgma.com/redflagsrule to assist you in developing a identify theft prevention program, including a free Webinar, links to the rule and Appendix A and sample procedures.

Source: Medical Group Management Association

The California Medical Association developed a "Red Flag Rules" Toolkit to help physicians develop a compliant identify theft prevention program. Their toolkit is available online: www.cmanet.org

The FTC is also releasing a template to help entities comply. For the FTC template, go to the their website: www.ftc.gov

News of Interest

Health Plan Requirements Cost Practices Billions

A study published May 14 in *Health Affairs* estimates that physician practices' interactions with insurers cost $23.2 billion to $31 billion annually. The study found that the average physician spends 43 minutes per work day—more than 3 hours a week—dealing with health plan administrative requirements.

The time physicians, nurses, and other practice staff spend interacting with insurers costs an average of $68,274 per physician per year. The survey also found that primary care physicians in a solo or two-physician practice spends 4.3 hours per week dealing with plans on everything from contracting to reporting quality data, while a surgical specialist spends 2.1 hours per week.

The survey was conducted by researchers affiliated with the Medical Group Management Assn, Weill Cornell Medical College in New York, University of Toronto, and University of Chicago.

While the survey does not give us specific information to orthopaedic practices, it does indicate that it is very costly for physicians to comply with all of the carrier demands.

For a copy of the Health Affairs article, fax or e-mail a request to COA providing us your name and e-mail address— Fax: 916–454-9882 E-Mail coa1@pacbell.net.

Stimulus Bill Alters HIPPA Rules

A "Healthcare Alert" from Paula Cozzi Goedert of Barnes & Thornburg LLP indicates that the American Recovery and Reinvestment Act, better known as the Stimulus bill, expands the reach of privacy and security rules implemented under HIPPA to cover business associates and covered entities. A covered entity is defined as a health plan, health care clearinghouse (billing services, community health information system, etc.) or a hospital or physician who transmits health information in electronic form.

Under the stimulus bill, several HIPPA security provisions now apply to "business associates." A business associate is someone who, on behalf of a covered entity, performs an activity involving the use of disclosure of individuals' health care information. That includes the performance of legal, actuarial, accounting, consulting, data aggregation, management, administrative, accreditation, or financial services to or for a covered entity. That means business associates of covered entities will now have an affirmative duty to protect the confidentiality of electronic protected health information created, received, maintained or transmitted in performing services for or on behalf of covered entities. This affirmative duty must be in your written contract with the business associate. So your business associates will need to implement written policies to among other things, prevent, detect, contain and correct security violations of electronic information, and develop safeguards to limit access.

For a copy of the Healthcare Alert, fax or e-mail a request to COA providing us your name and e-mail address—Fax: 916–454-9882 E-Mail coa1@pacbell.net.

You can also contact Ms. Goedert directly at:

Paula Cozzi Goedert, Barnes & Thornburg LLP
1 North Wacker Drive Suite 4400, Chicago, IL 60606
Direct Dial: 312-214-5660 Fax: 312-759-5646
paula.goedert@btlaw.com

Cigna Offers Cost Estimator Tools

After 18 months of trials with about 200 doctors and hospitals, Cigna has announced that its Cost Estimator is available to all of the hospitals and physicians contracted with the plan.

The online tool offers a real-time estimates of how much a patient will owe and what Cigna will pay for a given service (http://www.cignaforhcp.com)

FTC Consent Order—Alta Bates Medical Group

Alta Bates Medical Group, a group of over 600 physicians located in Northern California, has agreed to settle Federal Trade Commission (FTC) charges that it violated federal anti-trust laws by fixing prices charged to health care insurers.

According to the complaint, since 2001, Alta Bates has orchestrated collective negotiations for fee-for-service contracts without consulting its individual physicians regarding the prices that each independently would accept. The complaint charges that Alta Bates has not sufficiently clinically or financially integrated their practices to create efficiencies sufficient to justify this collective negotiating contracting practices. In the consent order, Alta Bates agrees not to collectively negotiate fee-for-service reimbursements and engage in related anticompetitive conduct.

Passing the Antitrust Test

A series of Federal Trade Commission opinions and guidelines offer clues as to when the federal government will approve joint contracting for the purposes of forming clinical integration programs. Here are some key questions legal experts say the FTC is likely to ask:

- What do physicians plan to do together from a clinical standpoint?
- How are these activities designed to improve quality of care, reduce the cost of care or produce other efficiencies?
- How will the program foster independence among physician participants?
- How will physicians be motivated collectively to achieve the program's goals?
- How significant will the physician's investment in the program be?
- How will performance be monitored and measured?
- Why is joint price negotiations reasonably necessary to achieve the program's intended goals?
- What are the likely competitive effects of joint negotiation?

Source: "Improving Health Care: A Dose of Competition," FTC, Justice Department; McDermott Will and Emery

Welcome to COA's Newest Members

Karim Abdollahi, M.D.	Laguna Niguel
Raed Ali, M.D.	Fullerton
Bradley Aspey, M.D.	Los Angeles
Brooke Ballard, M.D.	San Diego
Stefano Bini, M.D.	Oakland
H. Ward Brooks, M.D.	Fallbrook
Andrew Bulczynski, M.D.	Marina del Rey
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Please visit our website www.californtho.com for more information on the group.

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