

# Orthopaedic

## PRACTICE MANAGEMENT

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### Boost revenues with better documentation guidance

## Use coding audits as teaching tools for physicians

One of the biggest issues confronting orthopaedic practices is getting physicians to understand the documentation criteria for different levels of service and to ensure their documentation is based on the medical necessity of the visit. Both the 1995 and 1997 versions of the Centers for Medicare & Medicaid Services (CMS) documentation guidelines have been in use for more than a decade, but "there are still issues surrounding what they really mean," says **Jennifer Swindle**, RHIT, CCS-P, CPC-EM-FP, CCP, senior coding consultant for PivotHealth in Lafayette, IN. In fact, specialists might be more likely than general practitioners to make incorrect assumptions about whether to code an initial visit as a new patient or consult and how to select the appropriate evaluation and management (E/M) code. Thus, it's essential for orthopaedic practices to conduct regular internal coding audits, using either a certified professional

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### Recovery audit program begins

## Act now to ensure RACs don't become a compliance and claim-denial nightmare

As if orthopaedic practices don't have to jump through enough government-mandated hoops, the Centers for Medicare & Medicaid Services (CMS) is throwing yet another obstacle into their path by expanding the use of Recovery Audit Contractors (RACs). These private firms are paid by CMS to audit the claims of providers that participate in FFS Medicare, including physicians, hospitals, skilled nursing facilities, durable medical equipment suppliers, and labs. RACs receive carte blanche from CMS to rifle through paid claims for a controversial incentive: they receive a negotiated contingency fee -- a percentage of the overpayments they identify that providers are required to repay. Although they're also required

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## Custom magazine provides perfect marketing tool for NY orthopaedic practice

Marketing isn't a topic that enthralls most orthopaedic surgeons, but nearly all recognize they need to present a good image in the community, work in partnership with referring physicians, and target potential new patients. Capital Region Orthopaedics in Albany, NY, uses a handsome 32-page magazine as the principal tool to achieve these goals, and the magazine's production doesn't cost the practice a dime.

The group of 24 orthopaedic surgeons is based in The Bone & Joint Center, a five-story, 100,000-square foot facility that opened in November 2000. In addition to Capital Region Orthopaedics, the building houses Capital Region Spine, Capital Region Ambulatory Surgery Center, and Capital Region Orthopaedic Imaging, plus the Albany Medical College Division of Orthopaedics and Imaging, a rheumatology center, physical therapy practice, and an orthotics and prosthetics office. The center also features a 120-seat auditorium with state-of-the-art audiovisual capability that is used for physician and patient education programs.

With a background in retailing, **William R. Pupkis**, CMPE, the group's CEO, looks constantly for opportunities to satisfy existing customers and attract new ones. In 2004, he was attending a meeting of the American Academy of Orthopaedics Executives (AAOE, formerly BONES) when a colleague from Texas introduced him to an executive with Richardson, TX-based QuestCorp Media Group, Inc. ([www.qcpublishing.com](http://www.qcpublishing.com)), a publisher of custom magazines. The two talked, and Pupkis was intrigued at the prospect of offering a well-designed, four-color magazine as both a marketing

and patient education tool. He took the concept back to his physicians, who quickly endorsed the plan. Pupkis didn't even look at other publishers but immediately struck a deal with QuestCorp, and the first issue of *Capital Region Bone & Joint Review* was published the following January.

The glossy, four-color magazine has grown from 12 pages per issue in its first year to 32 pages. Published three times a year, the magazine features topics ranging from total joint arthroplasty to rotator cuff injuries to kyphoplasty. (See sample table of contents on p. 19.) The publisher provides basic articles for each issue, and Pupkis recruits five to six physicians from the practice to edit them to fit the nature of their work and the mission of the practice.

"It's rare that one of our physicians writes an article from scratch," he says. "Instead, they're given a bare-bones article that they customize." Because the practice is so large, each physician contributes just one article every two or three years. "It's not a burden on any of them," Pupkis points out. His administrative assistant keeps a spreadsheet listing every article that appears in each issue to ensure that topics rotate evenly through various subspecialties, such as spine, shoulder, ankle, hip, and hand. New medical research and orthopaedics technology provide additional editorial fodder.

The magazine has been the perfect tool to promote Capital Region Orthopaedics' considerable range of services and expertise, including fellowship trained surgeons in every subspecialty except hematology/oncology and pediatrics. The group also serves male and female athletic teams at most local high schools and colleges, skiers at the Ski Windham in the Catskills resort, a minor league baseball team, jockeys affiliated with the New York State Racing Association, and the New York Giants spring training camp at the University of Albany. Some of those patient experiences are highlighted in a regular *Bone and Joint Review* feature entitled

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Orthopaedic Practice Management™ is published monthly by Oakstone Publishing, 100 Corporate Parkway • Suite 600 • Birmingham, AL 35242

Telephone: 1-800-633-4743 Fax: 205-995-1926 E-mail: [service@oakstonepub.com](mailto:service@oakstonepub.com) Website: [www.cmeonly.com](http://www.cmeonly.com)  
POSTMASTER: Send address changes to Orthopaedic Practice Management, 100 Corporate Parkway • Suite 600 • Birmingham, AL 35242

Editor: **Marie Powers** Publisher: **Dean Celia**

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“Community Corner.”

The publisher prints 1,600 magazines and runs 300 extra copies of a four-page insert that features photos and bios of each physician in the group. By publishing three times a year, the bios and practice description stay fresh and up-to-date. Capital Region Orthopaedics uses the extra inserts as stand-alone marketing brochures that can be placed in waiting rooms and handed to patients and referring physicians.

Pupkis reserves several hundred copies of each issue for the waiting rooms at the Bone and Joint Center site and the group’s four satellite offices. He also sends five to 15 copies to every primary care office that makes referrals to the practice.

“Obviously, it’s a marketing piece, but it’s also a good educational piece,” he says. “Often, we get phone calls from the primary care offices asking if they can have more copies.”

### Advertising offsets cost

Pupkis and his administrative assistant concentrate on finding advertisers -- a task that was difficult the first go-around but now runs like a well-oiled machine.

“The first issue was a tough sell because all I had from the publisher were samples of other organization’s magazines,” he recalls. “It was a great deal of work on my part -- but only for a week. I gathered a list of names, put together a letter -- today I would use e-mail -- and then got on the phone and followed up. I simply described the idea and asked potential advertisers, ‘Would you get any value from advertising in such a publication?’”

Some declined, but others not only stepped forward but wanted the premier -- and most expensive -- positions on covers or inside pages. As the magazine has grown, advertising revenue has expanded proportionately since many of the advertisers are local banks, attorneys, and accountants who serve not only the target audience of patients but also referring physicians at the primary care practices.

“Now it’s a matter of going through my card box, contacting some of the people with whom we have relationships, explaining the costs of the different ad sizes, and asking if they’re interested in participating,” Pupkis says. “It’s not like selling used cars. Whenever we have a new vendor, I simply put a copy of the magazine in their hand and tell them we’d love to have them as a sponsor.”

The strategy pays off, with advertisers covering the entire cost of the magazine’s production. The practice foots the postage to mail issues to nearly 100 primary care practices and advertisers, and Pupkis doesn’t try to recoup the cost of time to the practice, which he estimates at one hour for each physician, four hours for himself, and eight to 10 hours for his assistant per issue. “Beyond that,

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**Figure 1**

WELCOME

**BONE & JOINT CENTER**  
Capital Region Orthopaedics  
Bone & Joint Center  
1367 Washington Avenue  
Albany, New York 12206  
Phone: (518) 489-2666  
Fax: (518) 489-5933  
E-mail: [feedback@theboneandjointcenter.com](mailto:feedback@theboneandjointcenter.com)  
[www.theboneandjointcenter.com](http://www.theboneandjointcenter.com)

As we roll out our third issue in 2007 (Volume III Issue 3) of the Capital Region Bone & Joint Review, I am pleased that the response to this endeavor continues to be positive.

With this issue, our Capital Region Orthopaedic's physicians explore cervical spine injuries, knee replacements, minimizing sports injuries, & treating shoulder dislocations.

In this issue, our Community Corner column is focusing on the Albany Medical College residency program and ski patrol at Ski Windham. Many patients are not aware that we have been affiliated with Albany Medical College since 1999. This has allowed us the wonderful opportunity to give back to our community by assuming a dominant role in the training of Albany Medical College orthopaedic residents.

Enjoy this new issue! We would love to hear from you with ideas for future articles. Drop us a note in the mail or contact us via e-mail at [feedback@theboneandjointcenter.com](mailto:feedback@theboneandjointcenter.com) with any comments. We wish all a wonderful holiday season.

Sincerely,

William R. Pupkis  
Chief Executive Officer

*William R. Pupkis*

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Cover photography courtesy of the New York Racing Association

OFF SITE LOCATIONS:

**Guiderland**  
1444 Western Avenue, Suite C  
Albany, NY 12203  
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**Catskill**  
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159 Jefferson Heights  
Catskill, NY 12414  
Tel: (518) 943-9567

**Clifton Park**  
Shenendehowa Medical Park  
989 Route 146, Building 300  
Clifton Park, NY 12065  
Tel: (518) 383-0317

**Latham**  
Capital Region Health Park  
713 Troy-Schenectady Road, Suite 127  
Latham, NY 12110  
Tel: (518) 608-8876

**EDITORIAL MISSION:** Capital Region Bone & Joint Review is an educational and informational resource for health care professionals, educational institutions, professional associates, and patients in the Albany area. Written in a professional-to-professional tone, Capital Region Bone & Joint Review will communicate educational news and trends involving musculoskeletal injuries and treatments, as well as contain other articles of interest contributed by the medical colleagues at the Bone and Joint Center. The information contained in this publication is not intended to replace a physician's professional consultation and assessment. Please consult your physician on matters related to your personal health.

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Source: Capital Region Bone & Joint Review

there's not a penny coming out of our pockets," he says.

Pupkis also sends a personal thank you note and copy of the magazine to each advertiser in the issue, from national financial services firms to small local contractors. The simple gesture builds goodwill and generates continuous advertising support.

Two years ago, Pupkis moved the magazine to Custom Publishing Design Group ([www.mycompanymagazine.com](http://www.mycompanymagazine.com)), a global publisher with U.S. offices in Rocky Hill, CT, and San Rafael, CA, that includes some 150 orthopaedics groups in its stable of clients. Although QuestCorp delivered exceptional editorial content, Custom Publishing offered an attractive design package and dramatically lower advertising rates, making the publication more affordable for local advertisers.

"Everyone has strengths and weaknesses," Pupkis says. "QuestCorp's editorial was phenome-

nal. Our physicians simply selected their articles, tweaked them a bit, and they were ready to go to press. Now the prices are lower so advertisers are happier and we can get a bigger magazine, but the editing requires a bit more work on our part." (See sidebar below for tips on selecting a custom publisher for your practice.)

The lion's share of work falls on his administrative assistant, who serves as the interface between the practice and Custom Publishing. She proofreads every inch of copy, from the final drafts of each article to the rough layout to the final four-color proof.

"This is a piece that represents us," Pupkis points out. "It's a key component of our marketing plan. When you put your name out in public, you want it to look good, so we wanted this magazine to look like *Time* or *Post* or *Life*. And it does."

The actual readership of each issue has been difficult to gauge. Pupkis tried to measure the impact through the group's patient survey but calls results "inconclusive." Nevertheless, there's plenty

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## Use these tips to find the right custom publishing partner

Not every custom publisher is a perfect fit for an orthopaedics practice. Even within the health care niche, some custom publishers focus on hospitals and health systems rather than orthopaedic and other specialty practices.

But there's a vast array from which to choose. The New York City-based Custom Publishing Council (CPC) has more than 80 members, including independent custom publishers and divisions of larger publishing houses, advertising agencies, and other media conglomerates. A listing of members, with links to each of their web sites, is available on the CPC web site at [www.custompublishingcouncil.com](http://www.custompublishingcouncil.com). The Council suggests visiting the sites, talking and requesting information from seven to 10 that seem suited to your project, then winnowing the list to three or four companies to pitch your magazine.

The CPC suggests that potential clients consider the following questions before searching for a custom publisher:

- What are the goals of your publication?
- Do you want your magazine to carry third-party advertising?
- Do you want a publisher that has experience in your market sector?
- Is it important that your publisher does not have a client that competes with your organization?
- Do you require other services in addition to publishing, such as Web site design and construction?
- If your publication is regional, do you prefer a

publisher located in your region?

- What is the budget for your custom publication?
- Do you see certain magazines as benchmarks for your custom publication?
- Have you thought about delivery options, particularly mail vs. distribution at point of sale or a combination of the two?
- Do you have a need to segment the publication for language or other purposes?
- Do you have a database of target customers, or are you contemplating a purchased list?
- Who will manage your publication internally?
- What services should you expect from a custom publisher, including:
  - publishing strategy
  - editorial
  - design
  - production
  - account management
  - web site design, content, and maintenance
  - advertising sales
  - database management and market segmentation
  - research
  - circulation and distribution management
  - promotion and publicity
  - multi-language editions

*Editor's note: For more information and assistance from the CPC on selecting a custom publisher for your orthopaedic practice, contact Tami Pearce at [tami@custompublishingcouncil.com](mailto:tami@custompublishingcouncil.com). ♦*

of anecdotal evidence that the magazine has legs. After the first year of publication, Pupkis asked the practice's board to support another three issues. A senior physician immediately endorsed the magazine's value, relating that his wife had even spotted a copy at her hairdresser's salon. The board approved the second year of publication, "and I don't even ask anymore," Pupkis admits.

Orthopaedic practices considering custom publishing should ask colleagues about their experiences and seek references for various publishers, he suggests. Once they've narrowed the list of prospects to three or four companies, request pro-

posals from all of them, he says.

Custom publishing is a concept that even small practices can use, Pupkis adds, indicating that he would publish a magazine even for a practice with five or six physicians. "I would probably put the magazine out only once or twice a year and it wouldn't be as large, but it would still be worthwhile," he says.

*Editor's note: Contact William R. Pupkis at 518/292-2646 or [wpupkis@caportho.com](mailto:wpupkis@caportho.com). To view the most recent issue of Capital Region Bone & Joint Review, visit the group's Web site at [www.caportho.com](http://www.caportho.com) and click on the link for the magazine. ♦*

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## Take steps to reduce the burden of ED call in your practice

When the Irving, TX-based American College of Physician Executives (ACEP) conducted a member survey on physician call strategies in 2005, it got an earful, and orthopaedic surgeons were near the top of the complaint list. Sixty-four percent of respondents reported problems getting specialists to take ED call at their hospitals. Overall, 73% of ED medical directors reported inadequate specialist coverage, and many complained of being forced onto the "slippery slope" of paying orthopaedists and other specialists to take call.

"If orthopaedists now require payment, will ENT, neurosurgery, and general surgery be far behind?" one respondent asked.

A study by **Ann S. O'Malley**, MD, MPH, senior researcher at the Washington, DC-based Center for Studying Health System Change (HSC), and colleagues released in November 2007 confirms that community hospitals across the U.S. face increasing problems securing specialists for ED call coverage. Some of the factors precipitating the shortage include decreased dependence on hospital admitting privileges as more services shift to non-hospital settings; paltry payment for ED care, especially for uninsured patients; and concerns among specialists about medical liability.

At the same time, demand for ED services is soaring. In the past decade, the rate of overall ED utilization rose by 7%, from 36.9 to 39.6 visits per

100, O'Malley and colleagues reported. The proportion of visits by uninsured patients also is rising. These patients accounted for 14% of ED visits in 2003 and 16% in 2005, according to the researchers.

Orthopaedic surgeons are among the specialties most often reported by hospitals as in short supply for call coverage, O'Malley says.

"Hospitals enforce on-call requirements through medical staff bylaws and other contractual arrangements with physicians," she reports. "With many specialists now shifting the focus of their practices away from the hospital setting or to specialty hospitals that don't have EDs, they are less reliant on hospital admitting privileges to care for their patients or maintain a practice."

Not all communities face a shortage in ED call coverage. Many maintain good relationships with orthopaedic surgeons and other specialists. In fact, **Charlotte Alexander**, MD, an orthopaedic surgeon who serves as the chief of staff at Memorial Hermann Southwest in Houston, maintains that most orthopaedists want to carry their share of the ED call workload and take a bad rap for the ED call crisis.

"Our orthopaedics surgeons are very busy, but they're willing to pull their weight in call coverage," she says. "By contrast, I cannot get ENT coverage in my emergency room."

### **Restructuring on-call systems**

Both the American Academy of Orthopaedic Surgeons (AAOS) and the Orthopaedic Trauma Association (OTA) have developed position state-

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## **Coding audits** continued from p. 17

coder (CPC) within the practice or an outside consultant.

A coding audit can reveal eye-opening patterns of under- or overcoding and even flat-line coding -- instances where a particular physician is hooked on the same level of code for every patient. Auditing ensures that a physician doesn't jeopardize the practice's revenue through payer denials and, just as important, improves the prospects for your practice to realize all of the reimbursement physicians have earned.

In general, coding in orthopaedics should follow the same bell curve as other medical specialties, though the curve is likely to be skewed in comparison to general practice.

"Not every specialty has a perfect bell, but they all should have every level of service," Swindle points out. For example, every orthopaedic practice has stable patients who are followed for several years, as well as patients with acute injuries.

"If you have a physician who always codes at a level 3 or a level 4, that should be a red flag," Swindle says. "Every patient isn't the same."

Conducting regular internal coding audits also ensures that the practice regularly updates the office encounter or surgical charge entry form to remove outdated codes that are guaranteed to trigger denials. For example, codes 99271 and 99272 for second opinion and 99261-99263 for follow-up inpatient consultation have been eliminated and shouldn't be hanging around on your forms. And new codes are introduced each year, so you need to constantly update the charge masters and electronic files your physicians use.

### **Code consultations carefully**

The results of coding audits can also serve as terrific teaching tools for your physicians, Swindle advises. For example, the key criteria in documenting new vs. established patients is the time lapse since the patient's last visit. A patient who hasn't had a face-to-face encounter with the physician -- or, in a group practice, a partner of the physician in the same specialty -- within three years should be coded as a new patient.

In multispecialty group practices, an encounter is based on the specialty of the physician who's involved, Swindle explains. In a multispecialty

group practice under a single tax ID number, when a patient has been seen by one family medicine doctor, an encounter with any family medicine doctor in that group practice should be coded as established patient. However, the patient might still be considered a new patient to an orthopaedist in the same group.

"Think in terms of multispecialty location," Swindle suggests. "Orthopaedic surgeon Dr. A sees a patient in the hospital. His partner of the same group sees the patient in the office. Even if there's no chart and the patient has never been seen in the office before, he or she is an established patient. These situations are not as cut and dry as they appear on paper, and it's sometimes hard for physicians even to know that another visit has occurred."

Orthopaedics also has one of the highest error rates in coding for consultations, according to Swindle. Even when there's a referring physician, an initial encounter isn't always a consultation. If a patient is referred so the orthopaedist can render medical advice, the visit is a consultation -- even if the orthopaedist recommends that he or she should treat the patient. When a consultation occurs, it's essential for office staff on both ends to capture complete and accurate documentation, including the intent of the consultation, Swindle says. If, however, a PCP actually refers a patient for treatment by the orthopaedist because the scope of care exceeds his or her medical expertise, the encounter should be coded as a new or established patient.

"The difference between a consultation and a visit is that someone is asking for an opinion, not asking for the orthopaedist to treat the patient," Swindle says. "If a patient has chronic shoulder pain and the primary care doctor or internist says, 'I think this might be your rotator cuff and I'm sending you to see an orthopaedist,' that's a consult. The primary care doctor isn't sure what's wrong with the patient. He's not even sure it's an orthopaedics problem. He's asking for an opinion."

By comparison, when a physician has a patient with a well-defined joint injury, for instance, that's out of his scope of expertise and sends the patient to the orthopaedist, "he or she isn't asking for advice or opinion but transferring the care of the patient," Swindle explains.

To select the appropriate code for the visit, an orthopaedist should consider:

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## Coding audits continued from p. 22

- Was there a request from an appropriate source for evaluation and opinion?
  - If so, is that request documented in the medical record, both from the referring physician and the orthopaedist?
    - Was the service rendered?
    - Was a report of the findings or opinion provided to the requesting physician or, in a multispecialty group with a shared medical record, a note made in the chart?

“The specialist documentation has to be crystal clear: ‘This doctor asked for my evaluation or opinion on this patient for this reason,’” Swindle says. “You can’t just say a patient was referred.”

### Medical necessity drives level of service

Orthopaedists use E/M codes less often than general practitioners, but using them correctly can mean the difference between a denial and appropriate revenue for the practice. E/M codes affect not just outpatient and office consultations but also home, skilled and unskilled nursing facility, and even ED visits. “Many practices audit their office visits,” Swindle says. “It’s harder to get to the hospital records, but those visits also need to meet the documentation guidelines.”

The three components that drive a physician’s E/M coding in any setting are the patient’s history and exam and the physician’s medical decision-making. Figure 1 is a terrific guide to choosing level of service for new patients and consultations in the office or outpatient setting. The table can be laminated or converted to an index card that physicians can carry in their pocket. It breaks down new patient and consultation visits by history, exam, medical decision-making, and code.

The requirements for documentation are identical between new patient and consultation, but it’s not a direct link to an established patient, Swindle cautions.

“If you look at the 99204 and the 99244, which is a high level of new patient or consultation, you need a comprehensive history and a comprehensive exam,” she says. “The only difference between a level 4 and a level 5 is the amount of medical decision-making involved. So if a physician has a comprehensive history and moderate medical decision making but only documents six exam elements, that’s a 99202 or 99242. It makes a huge difference in coding.”

There are many single-system specialty exams, but the number of bullet points for orthopaedics is identical to the general multi-system exam, Swindle points out. Simply because a patient is seen by a surgical subspecialist doesn’t justify a higher level code. Instead, the amount of decision-making prompted by medical necessity -- the complexity of the medical problem, number of medications involved, and differential diagnosing required -- should drive the level of code selected. And all of the supporting documentation -- diagnoses the physician ruled out or findings that were negative, for instance -- should be recorded to support that code.

“It’s important for coders to focus physician training not around the coding and billing issues but around the medical needs of the patient,” Swindle says. “The sicker the patient, the higher the level of service. That makes sense to physicians.

“The medical necessity of the visit should always drive the level of service,” she adds. “Then work backwards. If the level of service is at moderate complexity, what needs to be documented to support that code? That type of approach is much

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**Figure 1: Determining level of service for new patients/consultations in the office/outpatient setting**

	99201/99241	99202/99242	99203/99243	99204/99244	99205/99245
All three key criteria MUST be met, with MEDICAL NECESSITY being the critical determining factor.					
<b>Medical decision making (2/3)</b>	<b>Straightforward</b>	<b>Straightforward</b>	<b>Low</b>	<b>Moderate</b>	<b>High</b>
# diagnosis/treatment options	Minimum	Minimum	Limited	Multiple	Extensive
Amount of data ordered/reviewed	Minimum	Minimum	Limited	Moderate	Extensive
Table of risk (complexity)	Minimum	Minimum	Low	Moderate	High
<b>History (3/3)</b>	<b>Problem focused</b>	<b>Expanded problem focused</b>	<b>Detailed</b>	<b>Comprehensive</b>	<b>Comprehensive</b>
History of present illness (HPI)	1-3 elements	1-3 elements	4+ or status of 3 chronic	4+ or status of 3 chronic	4+ or status of 3 chronic
Review of systems (ROS)	None	Pertinent (1 system)	2-9 systems	10+ systems	10+ systems
Past, social, and family history (PSFH)	None	None	1-2 elements	all 3 elements	all 3 elements
<b>Overall examination</b>	<b>Problem focused</b>	<b>Expanded problem focused</b>	<b>Detailed</b>	<b>Comprehensive</b>	<b>Comprehensive</b>
Examination	1-5 bullets	6-11 bullets	12-17 bullets	18+ (2 ea in 9 systems)	18+ (2 ea in 9 systems)

Consults differ from visits, in that there is a REQUEST for evaluation or opinion. Request must be clearly supported. If more than 50% of the visit is spent in counseling or coordination of care, billing on time is appropriate.

Source: Jennifer Swindle, RHIT, CCS-P, CPC, CCP, EMS, PivotHealth. Reprinted with permission.

## Coding audits continued from p. 23

more effective with physicians than trying to count bullet points.”

### Consider using templates

Whether physicians use electronic medical records (EMR) or paper records, some respond well to a standard template. Such an approach is not without risk, since physicians can't simply push a button on their EMR to meet documentation guidelines, Swindle says. Nevertheless, a template is a useful tool for some physicians to remind them what to document.

“Many physicians cheat themselves,” Swindle says. “They document everything that's clinically relevant, but once they rule something out they assume it doesn't need to go on the piece of paper. Think about that from a patient care perspective. If you've already ruled something out but you're on vacation for a week when the patient comes back, other physicians need to know your findings to ensure continuity of care. It's not all about billing.”

Coders also can make copies of notes and circle or highlight items that count toward documentation requirements to use as teaching tools with physicians. For example, knowing which elements count toward documentation can save orthopaedic surgeons a tremendous amount of dictation time.

The individual in the practice who's in charge of coding also should conduct quarterly lunch-and-

learns with staff and sit down one-on-one with each physician each quarter to review a handful of charts and break down each component of the medical record and notes. This process helps physicians to see what information is needed to maintain or improve the accuracy of their coding, particularly in an orthopaedics setting with multiple subspecialists.

For example, the 59 modifier -- one of the most misused -- changed again in 2008. According to the American Medical Association's *Common Procedural Terminology 2008* and also the CMS Correct Coding Initiative (CCI), the modifier should be used when a physician:

- treats the same patient during a different session
- treats a different site or organ system
- makes a separate incision or excision
- treats a different lesion, or
- treats a separate injury not ordinarily encountered or performed on the same day by the same individual.

Physicians need to understand changes in coding nuances, and learning on actual medical records is one of the best ways for them to ramp up quickly.

“Physicians are familiar with their own patients, so one-on-one sessions work better than generalized information,” Swindle says. “You can teach documentation guidelines or you can teach how to use modifiers, but sometimes it's more meaningful to say, ‘You saw Mary Smith last week. Here's what you should have coded and why.’”

*Editor's note: Contact Jennifer Swindle at 765/532-8564 or jswindle@pivotohealth.com. ♦*

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## RACs continued from p. 17

to identify underpayments, it's clear their mission is geared toward finding overpayments.

And if the demonstration program that tested the RAC concept is any indication, orthopaedic practices could be one of the prime specialties in the compliance cross hairs. In the three-year demo that ended on March 27, signaling the beginning of the permanent program, inpatient rehab facilities that admitted patients following joint replacement procedures reported nearly universal denial rates associated with RAC reviews. In fact, this service is among a list of 16 of the top reasons for RAC-initiated overpayment collections during 2007. In California alone, rehab following joint replacement generated more than \$20 million in repayments

from nearly 2,000 cases identified.

Twenty states are currently under RAC scrutiny, with a handful more scheduled to join them in October and the remainder next year. Most of the RAC audits during the demonstration program focused on inpatient hospitals and SNFs, but CMS is hiring more Part B auditors to look at physicians and suppliers. Fortunately, practices have an opportunity to get things right on the front end since the initial lookback period for potential overpayments is limited to just six months of Medicare FFS claims.

Orthopaedic practices should reexamine their coding and billing compliance plans without delay to ensure they address RAC guidelines, sources tell *Orthopaedic Practice Management*.

“This is a serious compliance concern,” says

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## RACs continued from p. 24

**Michael G. Apolskis**, an attorney with MacKelvie & Associates in Chicago. Initially, practices that don't understand Medicare policy or apply it properly could have enormous exposure. On top of that, the contingency-based compensation for RACs may make them overzealous, so the first year that a RAC enters a new jurisdiction is a critical time for all providers, he says.

"The real issue is making sure that your practice has a reasonable compliance plan in place and that it's actually being followed so you can do well in the event of an audit by this system or any other system the government throws at you," adds **David C. Harlow**, Esq., principal of The Harlow Group LLC, in Newton, MA.

### RACs could wreak havoc

The RAC program, authorized by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), has been contentious from the start. The three-year RAC demonstration program began in 2005 in California, Florida, and New York -- states with the largest number of Medicare claims. Congress made the program permanent with the enactment of the Tax Relief and Health Care Act of 2006, and last year CMS expanded it into Massachusetts, South Carolina, and Arizona.

RACs identified more than \$300 million in improper payments during each of the three years of the demonstration program, resulting in total recoveries of nearly \$440 million from providers -- mostly hospitals, according to CMS. RACs identified less than \$10 million in underpayments to providers, and none from physician claims.

"The demonstration project contractors focused on hospital overpayments, since each hospital case represents a larger dollar amount -- and, thus, a larger contingency fee for the contractor -- than each physician case," Harlow says. "Physician practices have not seen the impact of the RAC program yet and will feel it more acutely in the future."

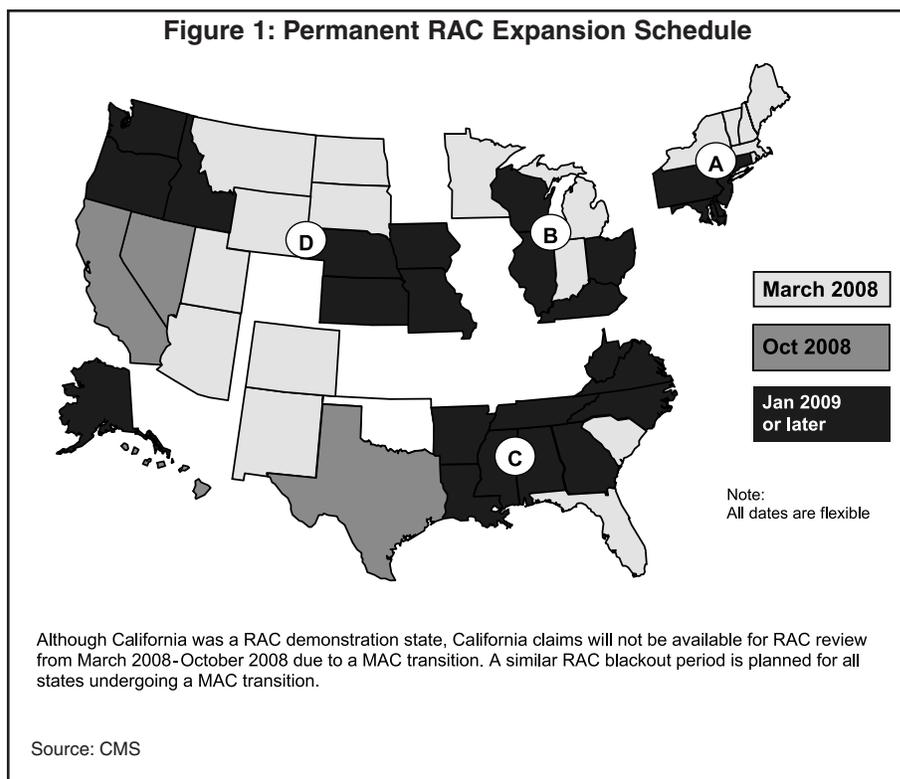
According to the fiscal year 2007 RAC status report released by CMS

on February 28, most of the improper payments were attributed either to medical necessity criteria for the setting where the service was rendered or to improper coding. Others were related to the use of outdated fee schedules or insufficient documentation to support the claim.

In addition to coding and billing issues, many orthopaedic practices are seeking to develop ancillary services and to joint venture with hospitals and other providers on ambulatory surgery centers and physician-owned specialty hospitals. By their nature, these arrangements could expose an unsuspecting orthopaedic practice to a RAC, Harlow says. He advises orthopaedic groups that participate in these arrangements to examine a host of details -- from coding and billing to financing and distribution of profits -- with an eye to the RAC program.

And RACs are more than just an administrative nuisance. When they discover an improper Medicare payment, no matter what the cause, they can demand repayment not only to Medicare but also the refund of any incorrect copays to patients. The 2007 status report did not provide an average overpayment from the demonstration project but cited actual examples of \$1,221 for medical necessity and \$1,504 for incorrect coding. That's not pocket change, especially when the errors apply across a series of claims.

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CMS insists that the use of RACs has improved the accuracy of Medicare payments to providers, noting that incorrect claims submitted by health care providers as part of the Comprehensive Error Rate Testing (CERT) program declined from 14.2% in 1996 to 3.9% last year. Nevertheless, there has been concern whether paying RACs on a contingency basis may distort contractor judgment.

"The government seems sanguine about paying contingency fees to RACs, noting that this is standard operating procedure in the private sector," Harlow says. "However, if the recoveries approach the reported overpayments, expect an outcry."

### **Determine your vulnerable services**

Whether complaints about RACs are valid are not, expect them to visit your neighborhood soon. CMS has divided the United States into four geographic regions. (See **Figure 1** on p. 25.) A single RAC will serve each region and perform the recovery audits for all types of Medicare claims in the region.

RACs seek to identify improper payments resulting from:

- incorrect payment amounts, except where CMS directs contractors otherwise;
- non-covered services, including services that are not reasonably necessary;
- incorrectly coded services, including DRG miscoding; and
- duplicate services.

RACs may only attempt to identify improper payments arising from services provided under FFS Medicare, Apolskis says. They may not address the cost report settlement process, claims more than three years past the initial determination (claim paid) date or paid before October 1, 2007, claims where the provider is without fault, and claims with special processing numbers such as Medicare demonstrations. They're also precluded from reviewing evaluation and management (E&M) services on Part B physician claims, unless the E&M claims cover services that are not "reasonable and necessary." However, RACs can examine violations of Medicare's global surgery payment rules even in cases involving E&M services, and they can review E&M services on outpatient hospital claims.

In an interesting twist, an "improper payment" is defined as an overpayment or underpayment, so any claim identified with an incorrect code that

does not result in a different payment amount isn't considered an improper payment, Apolskis adds.

The lookback period is an important ally to practices this year. Because RACs may not review claims with paid dates earlier than October 1, 2007, "even providers that have not yet implemented Medicare coding and billing compliance programs have limited exposure," Harlow explains. Practices should use this opportunity to get their compliance programs right at the front end, since the lookback period will gradually extend to three years. For example, RACs will have the authority to audit claims with October 2007 paid dates until October 2010.

Knowing the likelihood of an actual RAC visit to your orthopaedic practice and the types of claims that might be reviewed would be enormously helpful, but CMS has obscured the process by which RACs select their targets. The original scope of work included timetables by provider type and state, but in November CMS removed the reference to providers. "Now it's just a state-by-state implementation," Apolskis says. "They're not saying what types of providers will be impacted or the types of claims they'll [evaluate]."

That being said, the 2007 status document offers a clue that RAC audits are likely to be widespread and target provider organizations with large Medicare claims -- especially hospitals, SNFs, and physician groups with high-cost or high-volume procedures and services. CMS supplies the RACs with a data file containing claims history followed by monthly updates, Apolskis explains. The RACs then use proprietary software and their knowledge of Medicare regs to determine which entities to review. The CMS status document suggests that RACs also will use recent and past Office of Inspector General and General Accounting Office reports to identify claims likely to have improper payments. "Thus, OIG and GAO reports may be one way for health care providers to identify possible vulnerabilities and prepare for RAC reviews," Apolskis says.

### **Know the RAC review process**

RACs can analyze claims using two methods. During the first "automated" review, a RAC makes a claim determination at the system level without reviewing the medical record. Automated review must be guided by a clear written policy -- for example, a statute, regulation, or national or local coverage determination that specifies the circumstances under which a service will always be considered an over-

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payment. But automated review also must be based on a medically credible service, so a RAC may examine a “clinically unbelievable” issue -- one where it’s certain of a violation of medical necessity or coding rules but where no explicit policy or guideline exists, Apolskis says. And RACs may use automated review for other determinations, such as duplicate claim determinations, when they’re “certain” that an overpayment or underpayment exists.

If the conditions for automated review are not met, RACs may use the second, “complex” claim review method, which allows them to examine a limited number of medical records. CMS may apply different limits to the number of medical records by provider type, Apolskis says. For hospitals, the limit may be based on the number of beds -- for example, no more than 50 inpatient medical record requests in a 45-day period for a hospital with 150-249 beds. Moreover, RACs may not bunch medical record requests, so if the limit for medical records requests for a particular provider is 50 per month and a RAC doesn’t request medical records in January and February, the RAC cannot request 150 records in March, Apolskis explains.

When making a claim determination in the absence of a written Medicare policy, RACs are supposed to use appropriate medical literature and apply clinical judgment, and their medical directors are supposed to be actively involved in examining the medical evidence. Similarly, RACs are required to have registered nurses or therapists make coverage and medical necessity determinations and certified coders make coding determinations. Even if they make a decision favorable to the provider, however, a complex review could be an onerous exercise for orthopaedic groups. Although RACs are required to pay for medical records associated with acute and long-term care hospital claims, they’re not required to pay for medical records associated with other types of claims, including physician and outpatient surgery center claims.

Plus, the turnaround time is short. Providers have 45 days to respond to requests for medical records, though they might be able to obtain an extension if they make the request within that period, Apolskis says. Otherwise, a RAC may simply designate the claim as an overpayment.

RACs are not designed to pursue fraud and abuse, and CMS is providing them with access to a specialized data warehouse to prevent them from reviewing the same claims as other Medicare con-

tractors, according to Apolskis. Otherwise, they have broad purview to make coverage, coding, and other determinations, such as duplicate claim determinations.

## **Bad news only**

A real rub is that RACs aren’t required to advise providers of the results of automated reviews unless they discover an overpayment. They’re supposed to advise providers of the results of complex reviews within 60 days of a site review or receipt of medical records, but they can request a waiver of the 60-day period from CMS. In short, you’ll certainly get the bad news, and probably not any good news.

Even worse, the process for recouping underpayments is vague, at best. If they discover a potential underpayment of \$1 or more, RACs are expected to notify the appropriate Medicare contractor, which is charged with validating the finding. The RAC then is expected to notify the provider in writing, citing the claim(s) and beneficiary detail. However, the Medicare contractor -- not the RAC -- makes claim adjustments, and RACs have no obligation to accept case files from providers for underpayment case review, Apolskis points out. Moreover, providers do not have any “official appeal rights” in relation to underpayment determinations -- only a RAC “rebuttal” process that essentially allows them to discuss any underpayment determination.

Fortunately, RACs are not permitted to recoup or forward a claim to a Medicare contractor for adjustment if the amount of the overpayment is less than \$10, so they can’t nickel and dime you to death. They’re also prohibited from aggregating claims of less than \$10 in order to pursue overpayment recoveries from providers. To recover overpayments -- with interest, of course -- the RAC program primarily uses recoupment, which repays the improper payment by reducing your present or future payments, though RACs also are required to offer providers the opportunity to repay an overpayment through an installment plan or compromise settlement. Claims identified as overpayments are subject to the Medicare appeals process but with certain wrinkles, such as the rebuttal process, that make appeals less than palatable, sources agree.

Physicians and hospitals aren’t the only ones stewing over the RAC program. On November 7, 2007, Rep. Lois Capps (D-CA) introduced the Medicare Recovery Audit Contractor Program

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Moratorium Act of 2007 (H.R. 4105), which would suspend all RAC activities for one year following enactment. With California as one of the original RAC demonstration states, its congressional delegation was notably concerned about the burden on providers caused by RACs and the potential impact on quality of care.

Though Capps' bill has 33 co-sponsors and the support of many state hospital associations, it has languished in the House Ways and Means and House Energy and Commerce committees and congressional action on the bill isn't likely during a lame-duck election year, sources agree.

### **Take these proactive steps**

Instead, orthopaedic practices should proactively prepare for RACs as follows:

- **Examine CMS documentation on RACs and the RAC demonstration project to identify possible target areas in coding and billing in your practice.** The 2007 RAC status document and frequently asked questions about RACs are posted at <http://www.cms.hhs.gov/RAC>.

- **Educate your practice's senior leadership, compliance officer, and possible targeted service lines about the RAC program.** "The focus of the RAC program is to reverse improper payments based on coding and billing errors," Harlow says. "The best way to ensure that such errors are eliminated from a practice's billing profile is to implement a compliance plan along the lines of the OIG model compliance plan [for Medicare claims] that follows the whole life cycle of your billing and collections system. Everything needs to be coded properly and billed to the right payer. You need to keep up with changes in codes.

"All of this needs to be done in accordance with policies and procedures that are not only adopted but that staff are trained to use," Harlow adds. "Many well-written compliance plans just sit on the shelf, and that doesn't do your practice any good." Practices just beginning to implement such a plan should start small, adopt and adhere to a limited number of measures, and grow organically over time. "It's important to bite off only as much as you can chew," Harlow says.

- **Proactively self-audit charts and charges to identify codes or services that may be vulnerable to a RAC audit and develop a corrective action plan.** Conduct these audits internally or

through the use of a compliance consultant, Harlow suggests. For example, if you've identified certain overpayments in your practice in the past, pull recent claims with the same coding profile to ensure that you've corrected any systematic deficiencies.

- **Organize a task force that includes your compliance officer, your attorney, and a physician,** Apolskis suggests. That group should develop a plan to respond to RAC medical record requests, reviews, and determinations. Identify a point person within your organization to receive and respond to communications from RACs -- ideally, the person who is most knowledgeable about Medicare rules and claims -- and develop a process to gather the medical records and submit them on time. Train your staff to refer any communications with RACs to the designated respondent.

- **Know how to navigate the Medicare appeals process and develop possible arguments and defenses to RAC determinations.** For instance, consider auditing the same claims selected by a RAC internally to verify the findings and to ensure that all underpayments also were found and reported. Review your current process for deciding whether and when to appeal overpayment notices from Medicare, and conduct a cost-benefit analysis that examines a potentially larger scope of overpayment notices and takes short appeal deadlines into consideration. "Build a mechanism to determine who will decide whether to appeal, and on what basis," Apolskis says.

Providers chose to appeal only 11.3% of 2007 RAC determinations, and only 5% of these were overturned on appeal, Apolskis points out. However, more than 40% of the appealed claims were decided in the provider's favor, suggesting that providers won a high volume of low-dollar appeals. Providers might have prevailed in more low-dollar appeal issues "but chose not to appeal because the cost of going through the process outweighed the dollar amount of the claim(s) at issue," Apolskis says. Establishing a materiality threshold can help your practice to determine when the cost of internal and external resources outweighs any potential recovery from appealing a RAC denial.

*Editor's note: Contact Michael G. Apolskis at 312-332-0533 or [mapolskis@mackelvielaw.com](mailto:mapolskis@mackelvielaw.com) and David C. Harlow at 617-965-9732 or [david@harlowgroup.net](mailto:david@harlowgroup.net). Both Apolskis and Harlow publish informative blogs that offer additional information and guidance on RACs. Go to: [http://trusted.md/blog/michael\\_apolskis](http://trusted.md/blog/michael_apolskis) and <http://healthblawg.typepad.com/healthblawg/>. ♦*

ments that seek to define the responsibilities of orthopaedic surgeons and hospitals in structuring appropriate ED coverage.

“Orthopaedic surgeons have a responsibility to work in their communities with each other and their hospitals to make sure that mechanisms are in place so that emergency patients with musculoskeletal problems receive timely and appropriate care,” according to the AAOS Trauma On-Call Project. “The hospital should provide adequate facilities, equipment, devices, and well-trained ancillary personnel, as well as guaranteed operating room time to manage emergency cases the night of admission or the next day. In addition, hospitals should assume some of the financial burdens that orthopaedists and other physicians now bear alone when they take call and provide emergency services,” including lost opportunity costs in the physician’s private practice and the cost of diagnosing and treating uninsured and underinsured patients.

“The AAOS Trauma/OnCall information has been discussed and generally supported by our physicians,” says **Dale A. Reigle**, CEO of Rocky Mountain Orthopaedic Associates in Grand Junction, CO. “We used some of the information when discussing trauma call with our hospital. Currently, we are paid for call, though it was a lengthy negotiation and our docs still feel they are under-compensated.”

At Memorial Hermann Southwest, a half-dozen physicians are paid a fee per night of coverage to handle ED calls, Alexander says. Paying even a modest fee is more an inducement for call coverage in her market than other factors, though she acknowledges that once one specialty receives pay for ED call, others will clamor for equal treatment. But some hospitals justify the pay for orthopaedic surgeons by stressing that they are far and away the best positioned to handle many ED injuries, Alexander says.

## **Hospitals urged to ease the burden**

In developing a partnership to handle ED call issues, the hospital’s chief role is to reduce the burden on orthopaedic specialists, maintains **Jeffrey O. Anglen**, MD, OTA president and clinical professor in the Department of Orthopaedic Surgery at Indiana University School of Medicine.

“The key problems with taking call are that it

disrupts your practice and it may produce a great deal of work that isn’t compensated very well,” Anglen says. “Call is a service to the hospital.” In exchange for that service, the hospital can help orthopaedic surgeons by ensuring that they have a dedicated orthopaedic trauma operating suite that is protected from posting by other services; designated staff, such as X-ray and cast technicians, nurse practitioners, and physician assistants; and equipment such as traction beds, fracture tables, and implant systems.

By the same token, “every orthopaedic surgeon is trained during residency to take care of urgent and emergent musculoskeletal conditions,” Anglen adds. “ED call coverage is part of our professional obligation to our communities.”

By taking a leadership role in examining the needs of the community, orthopaedists actually can champion solutions to overcome these problems, sources tell *Orthopaedic Practice Management*.

“Quite honestly, I don’t think there is necessarily a best practice standard,” Reigle says. “Each physician’s personality, age, and stamina play a big part in call.” Whether orthopaedic surgeons use physician assistants, typically work a full or partial day following call, and take call cases to surgery or wait until the following day for non-emergencies also are factors that practices and hospitals should discuss.

“There’s no single ideal strategy,” O’Malley agrees. “All of the strategies that hospitals are using to cope with this issue are Band-Aids. The real issue is around payment incentives, which do not currently reflect where patients should receive their care for emergencies. I don’t know that there are any quick fixes to this issue that don’t involve some attention to the payment system.”

In the meantime, here are some strategies orthopaedic practices can use to address an ED call shortage in their community:

- **Collaborate with hospitals on ED schedules that provide sufficient flexibility both for the hospital and for local orthopaedic surgeons.** For example, one ACEP survey respondent noted that his hospital is paying orthopaedists and certain other specialists a flat fee for ED coverage only when it exceeds a defined “community obligation” of one in seven nights. The hospital is offering \$500 or \$250 for beeper plus FFS reimbursement if the physician is called on-site.

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• **Consider on-call guidelines that take into account the composition of physicians in your community and the needs of the hospitals.**

According to **Tom Scaletta**, MD, medical director for the emergency department at Edward Hospital and Health Services in Naperville, IL, hospitals should be reasonable with their demands especially when only a handful of orthopedists service a community's ED call needs. For example, a hefty burden falls on a single two- or three-physician orthopaedic practice in a small community, more so than in communities with multiple practices and several dozen orthopaedic surgeons to share call. Hospitals and orthopaedists also might agree to rules regarding a physician's age and experience to ensure that new physicians have appropriate supervision while senior orthopaedists aren't overworked. "It's an issue that rests on the shoulders of medical staff leadership to develop the rules for a given specialty," says Scaletta, who also serves as immediate past president of the American Academy of Emergency Medicine. "Thus, orthopaedic surgeons should get involved in medical staff leadership, such as the medical exec committee, so their voice is heard."

• **Work with the hospital to ensure that OR space and staffing, including anesthesiology coverage, is sufficient on nights and weekends.** Some hospitals also are willing to develop daily OR schedules that are friendlier to orthopaedic surgeons who are willing to take ED call, O'Malley and colleagues report.

• **Collaborate with ED physicians to develop protocols that address when to treat and/or refer a patient for orthopaedic care and when to contact the orthopaedist on call.** For example, if an older patient with multiple medical problems sustains a hip fracture, "I probably don't need to bother an orthopaedic surgeon at three in the morning if there's a system in place to alert him at seven in the morning that he's got a new patient," Scaletta says. "It's essential to develop a strategy to minimize nuisance calls." With input from orthopaedic surgeons and other related specialties, many hospital EDs are moving to models where specialists are called only for level 1 or 2 trauma call and are paid a stipend for this work, with general surgeons on the hospital staff covering the calls that ED surgeons cannot handle. Large hospitals with busy EDs might designate an orthopaedic

trauma chief or director who receives a stipend to manage the call schedule and work out treatment protocols, Anglen says.

• **Work with the hospital to recruit hospitalists who are qualified to manage orthopaedic cases that present in the ED.** Using hospitalists for a limited range of subspecialty care and working closely with affiliated tertiary centers is an especially promising strategy for smaller community and rural hospitals, according to ACEP survey respondents. When direct employment of specialists isn't feasible, participate in a community-wide effort to secure ED call by helping the hospital secure contracts with physician groups to take responsibility for call coverage.

• **Support and participate in a system to provide X-ray and other diagnostic test results online.** Such systems allow the orthopaedic surgeon on-call to review results remotely and decide whether to direct or provide appropriate treatment on-site.

• **Consider negotiating with hospitals on the nonfinancial concerns of your orthopaedic surgeons, particularly potential exposure to medical liability.** For example, some hospitals are subsidizing malpractice premiums for orthopaedic surgeons and other specialists in return for their willingness to cover ED calls. Hospitals and orthopaedic groups also can collaborate on guidelines for physician assistants to triage orthopaedic calls.

• **Although most hospitals continue to shun payment for ED call, some are amenable to reasonable stipends that address both physician and hospital needs.** The ACEP survey found that 36% of hospitals paid at least one type of specialist -- most often a general surgeon -- to take ED call. Survey respondents indicated they pay orthopaedic surgeons \$300 to \$2,000 per night for coverage. In lieu of stipends, some hospitals pay physicians at least Medicare rates or Medicare plus a percentage to treat uninsured patients, according to O'Malley and colleagues. Some hospitals also may be willing to pay physicians' professional fees for appropriate follow-up care to ensure that uninsured patients who are treated in the ED are seen in the orthopaedist's practice and don't bounce back to the ED.

*Editor's note: Contact Dale A. Reigle at 970-242-3535 or dreigle@modocs.com, Ann S. O'Malley at 202-554-7569 or aomalley@hschange.org, Tom Scaletta at 630-527-5025 or tscaletta@edward.org, Charlotte Alexander at 713-596-0630, and Jeffrey O. Anglen at 317-274-7372. ♦*



## Practice insights from the AAOS annual meeting

Last month's 75th annual meeting of the American Academy of Orthopaedic Surgeons (AAOS) in San Francisco offered a variety of valuable insights for practice managers and physicians. Here are a few of the highlights:

### **Take care with orthopaedic consent**

Having patients sign surgical consent forms is a common and required part of orthopaedic practice, but a study by **Allison E. Crepeau, MD**, an orthopaedic resident at the State University of New York at Stony Brook, and colleagues found that few patients understand these forms even when a physician or other health care provider explains them in advance.

In the study, patients about to undergo elective orthopaedic surgery were given a consent form by a physician assistant, who also spent 10 to 20 minutes reading and explaining the standardized form to patients. Immediately following the discussion, the patients signed the forms. They were then given a 24-item questionnaire to test their recall of the informed consent they just confirmed their understanding of.

Sample questions included:

- A trainee (resident) may be present in my surgery. **True** or **False**
- A sales representative may participate in the procedure. **True** or **False**
- In the event that a health care provider sustains a needle stick or exposure to my blood or bodily fluid, they may draw my blood and test me for: a) HIV, **b) hepatitis**, c) both, d) neither.

Patients answered an average of 71.5% of all questions correctly. Correct response rates dropped to 60% when the questionnaire was administered again at the first post-operative visit with the orthopaedic surgeon, one to two weeks after surgery, and at a second post-operative visit one to two months after surgery.

Age and educational level significantly affected patients' understanding of the surgical consent form. Patients over age 50 answered fewer questions correctly than those under 50, and patients with an eighth grade education answered the lowest percentage of questions correctly.

The findings are a wake-up call to orthopaedic surgeons for the need to spend adequate time and ask questions of patients to ensure they understand their surgical treatment, Crepeau says.

### **Counsel obese patients to lose weight before knee surgery**

A study **Geoffrey Westrich, MD**, associate professor of orthopaedic surgery at Hospital for Special Surgery in New York City, confirms what orthopaedic surgeons intuitively suspect and anecdotally witness in their practices: Obesity limits a patient's range of motion, prolongs recovery, and extends the need for physical therapy after total knee replacement surgery.

Westrich and colleagues compared data from 309 patients with 400 knee replacements and found that a patient's body mass index (BMI) had a direct correlation on the knee's range of motion and need for manipulation under anesthesia. Fewer than 10% of patients with a BMI of less than 25 but twice as many with a BMI above that level required manipulation to achieve greater flexibility and break up scar tissue.

Age was not a predictor for range of motion, but gender was a predictor both for range of motion and need for manipulation. Regardless of BMI, men had a 4.6-degree higher range of motion than women, and fewer than 10% of men needed manipulation six weeks after surgery compared to 18.5% of women.

"For anyone considering knee replacement surgery, recovery time is an important consideration," Westrich says. "These findings will help to set more realistic expectations for heavy patients. They need to be counseled that their weight will likely impede their recovery."

### **X-ray beats MRI to image arthritic knees**

Patients with osteoarthritis (OA) often are

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sent for an MRI to diagnose their problem, but a study by **Wayne Goldstein**, MD, clinical professor of orthopaedics at the University of Illinois at Chicago College of Medicine and chair of the Illinois Bone and Joint Institute, suggests that a weight-bearing X-ray is a better diagnostic tool.

Goldstein and colleagues reviewed a random sample of 50 patients who had total knee arthroplasty for OA to see if they had received an MRI of the knee within two years before surgery. Thirty-two of the 50 patients had received an MRI, which was ordered either by their PCP or orthopaedic surgeon, yet the MRI did not provide any additional diagnostic information that could not be provided by an X-ray. More than half did not have any X-rays performed prior to their surgical consultation.

"There are some indications for MRI, such as suspicion of avascular necrosis -- something that may not be seen on early X-rays -- but that is not a common condition," Goldstein says.

In 2008, Medicare will reimburse physicians \$457.33 per MRI and \$43.39 for a four-view X-ray.

"Virtually every adult experiencing a knee problem should first have an appropriate set of X-rays before considering an MRI, which patients often come into the office expecting -- even demanding," Goldstein says. "Physicians also need to look at why they are ordering an MRI and consider whether it's truly necessary." ♦

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