INSIDE

INDEX

BECKER'S
ORTHOPEDIC & SPINE REVIEW

Business and Legal Issues for Orthopedic and Spine Practices

November/December 2010 • Vol. 2010 No. 6

7 Healthcare Reform Changes Affecting Orthopedic Surgeons

By Laura Miller

Healthcare reform, with its many current and future changes to Medicare payment methodologies and to the "Stark" self-referral and fraud and abuse laws, is creating stricter regulations and new obligations for all physicians, including orthopedists. Wayne J. Miller, Esq., a healthcare transaction and regulatory attorney and a founding partner of Compliance Law Group in Thousand Oaks, Calif., discusses seven ways orthopedists are directly affected by healthcare reform law and how they can prepare for future changes.

1. Physician owners of specialty hospitals. Healthcare reform eliminated the "whole hospital" ownership exception under the Stark

continued on page 7

Latest Trends in Spine Surgery Techniques: Laser and Stem Cell Technology

By Laura Miller

The latest trends in orthopedics and spine surgery have tended toward minimally invasive techniques. Making the transition between open spine surgeries to minimally invasive surgery is not easy, says Mark Flood, DO, of Celling Treatment Centers in Austin, Texas. However, Dr. Flood has been able to stay at the cutting-edge of non-fusion spinal surgery by training internationally on laser and stem cell treatment techniques.

continued on page 8

24 Orthopedic Practices With Great Sports Medicine Programs

By Laura Miller

Andrews Sports Medicine and Orthopaedic Center (Birmingham, Ala.). Founded in the 1980s by James Andrews, MD, the Andrews Sports Medicine and Orthopedic Center has grown to expand practice services to recreational athletes as well as professional players. Dr. Andrews has treated high-profile professional athletes, including Michael Jordan and Brett Favre. Dr. Andrews has trained many physicians in sports medicine and is a past president of the American Orthopaedic and Sports Medicine Society. The practice's physicians provide nonsurgical treatment methods as well as orthopedic surgery, including total knee and hip arthroplasty as well as kyphonplasty. The practice offers an advanced scheduling program which allows patients to electronically schedule appointments. Physicians on staff work regularly with the Washington Redskins, Tampa Bay Rays and Cincinnati Reds. www.andrewscenters.com

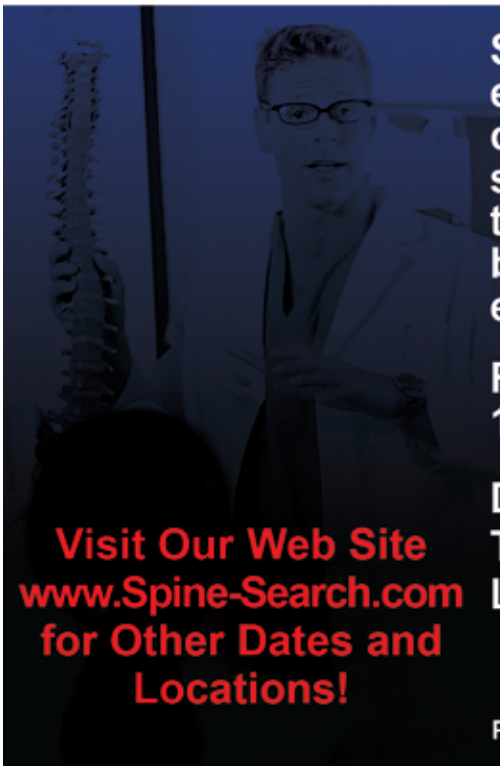
Kerlan-Jobe Orthopedic Clinic (Los Angeles). As leaders in sports

continued on page 14

Spine Specialty Day

Only $399

An Advanced Clinical Course for RN's, NP's & PA's



Spine Specialty Day will educate and empower RN's, NP's, PA's and other spine care providers with knowledge regarding spine anatomy, pathology, diagnoses and treatment options. The course will include both didactic lectures and hands-on training earning you 7 CE Contact Hours.

Register online @ Spine-Search.com or call 1.800.733.1109

Visit Our Web Site www.Spine-Search.com for Other Dates and Locations!

Date:	November 20, 2010
Time:	7:30am-5:00pm
Location:	Uniondale, New York Marriott Hotel and Conference Center

Presented by: SpineSearch www.Spine-Search.com Medtronic

Crack the Code on Outpatient Spine

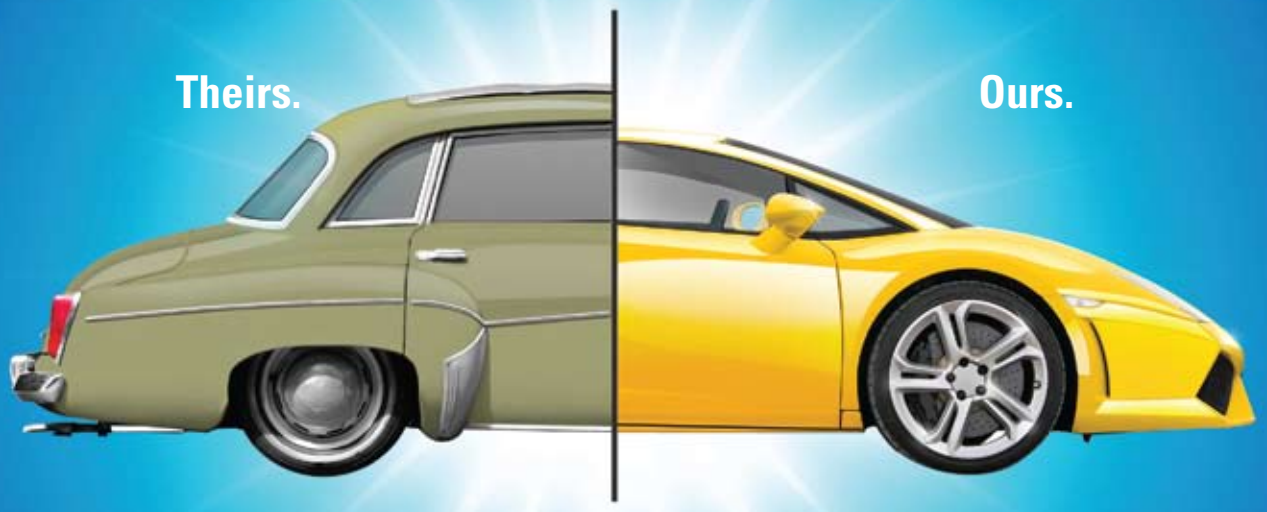
Blue Chip has the track record and proven playbook for success.

The Blue Chip Spine Book features case studies, business best practices and surgeon stories about the key issues and opportunities in outpatient spine.

Download the Blue Chip Spine Book today:
www.bluechipsurgical.com/spinebook

Or call: 513-561-8900, ext. 10

Blue Chip Partners Surgery Centers®



It's time for a new model.

What makes Practice Partners different? How about cutting edge knowledge of the ASC industry, zero development fees, proven success in improving efficiencies and execution. New or existing center, we get you there fast. So ditch the old model and let us accelerate your partnership today.

Contact us at (205) 824 6250, or visit our website at www.practicepartners.org to learn more.

Practice Partners™
In Healthcare, Inc

You specialize in **SPINE**. We specialize in ASC success.

Together we can reach great heights.

Meridian Surgical Partners aligns with physicians like you who are seeking an ASC corporate partner or have dreams of building a spine/ortho-driven facility. Through operational excellence and a ground-up approach, we empower our physician partners to achieve their definition of success. It's how we help our partners reach the top – the meridian – of a partnership.

MERIDIAN
SURGICAL PARTNERS

Physician Partnership Benefits:

- Excellent return on investment
- Decreased risk
- Reduced management and administrative burdens
- Strong focus on patient care and outcomes
- Improved quality of life

Contact us today to discuss your ASC goals.
615-301-8142 or info@meridiansurg.com

Acquisition *Development* *Management*

www.meridiansurgicalpartners.com | 615-301-8142

BECKER'S
ORTHOPEDIC & SPINE REVIEW
Business and Legal Issues for Orthopedic and Spine Practices

November/December 2010 Vol. 2010 No. 6

FEATURES

Publisher's Letter

Accountable Care Organizations – 9 Observations; Increased Integration Efforts; Increased Mergers and Acquisition Efforts; Call for Speakers: 9th Annual Orthopedic, Spine and Pain Management Driven ASC Conference & 2nd Annual Hospital Conference — Improving Profits, ACOs, Physician Hospital Integration and Key Specialties

Currently, there is a great deal of discussion relating to Accountable Care Organizations (ACOs) and physician-hospital initiatives. The movement by some systems to embrace ACO-type efforts is accelerating catch-up efforts by other systems to compete with such systems including an increase in the acquisitions of practices by hospitals. The ACO efforts are also raising concerns regarding the long-term independent practice of medicine. On a separate note, we are seeing increased merger and acquisition activity in the ASC area, the physician-owned hospital industry and the dialysis industry. We are also seeing an increased number of healthcare industry qui tam/false claims cases.

This letter provides brief observations regarding the development of ACOs. The letter also includes a call for conference speakers and a note regarding signing up for E-weeklies.

(I) ACOs

1. ACOs were established by the Health Care Reform Act to encourage greater coordination of care under Medicare. The concept is that different providers join together to coordinate care, share clinical information and report on quality measures and are financially rewarded for meeting certain performance guidelines and cost-saving benchmarks. The intended result is that greater coordination will lead to improved quality of care, prevent costly hospital visits and ultimately produce a more cost-effective healthcare system.

While ACOs have been promoted as part of the Healthcare Reform Act for Medicare patients, and pilot programs are being established, the real movement with ACOs seems to be with commercial payors at the moment. Further, the accelerated efforts by some systems to pursue ACO-type contracts is leading to a reaction by competing systems who are attempting to then accelerate the development of their own ACOs and integrated delivery systems. We are just starting to see very aggressive actions between integrated delivery systems and payors using the phraseology of ACOs to try and develop substantial steering of business by one system away from another.

2. Integrated delivery systems that control both the physician and the hospital side of care seem to be best situated to approach payors with ACO types of deals (in essence, deals that allow a system or ACO to share in savings below a baseline as long as certain quality targets are met). Because an ACO needs to contract with a broad range of parties to be successful, an integrated delivery system that already includes a lot of the needed components will be able to get to market quicker. Because the ACO movement favors integrated delivery systems as a cornerstone piece of the effort, it is

likely to cause a further acceleration of the acquisition of practices and employment of healthcare practitioners by hospitals and other health systems. ACO efforts will also put a new premium/value on primary care physicians who control patient populations. A key challenge in accelerating integration efforts relates to whether systems can aggregate resources/providers in a manner than makes sense in both a fee-for-service model and in a shared risk environment.

3. The ability to actually measure and control utilization depends on significant information systems, great nurse and physician leadership, tracking capabilities as well as having a good number of the medical coverage costs under control. To the extent an ACO has contracts with a great number of the providers that are necessary to provide healthcare services, the better it should be able to control costs. ACOs that truly invest in services and in infrastructure and provide a true value in managing costs will have a much greater likelihood of long term success.

4. The political proposition in the Healthcare Reform Act, as well as rhetoric from Washington, D.C., tends to favor the development of ACOs over Medicare Advantage plans. The overall concept of pushing down responsibility for the entire cost of care is a very similar concept in Medicare Advantage plans as it is in ACOs. Thus, it is no surprise that organizations like Humana that were major players in the Medicare Advantage plan business are now examining ways to be in the ACO business with partners.

5. An ACO can be co-owned by multiple parties or it can be owned by one party. Moreover, an ACO can be developed by a wide range of healthcare provider groups from multispecialty physician groups to integrated physician hospital organizations. This flexibility extends into payment arrangements, which may take the form of the traditional fee-for-service with a percentage return on savings or a flat rate per patient, among others. Whether an ACO is managed by one party or co-owned by multiple parties, it will need contracts with providers that will allow for controlling costs, utilization and quality. Providers who contract with ACOs will be skeptical of the potential financial benefits to them and how closely these financial benefits relate to their own efforts. The ACO model may start to remind providers of the HMO and PPO withhold contracts of a decade ago.

6. In the ACO environment, surgery centers, like many other providers, are more likely to simply be a cost center rather than a manager of patients and costs. If an ACO is really driven by a hospital system, notwithstanding the lower costs of surgery center services, there is a high likelihood that the hospital system will gravitate towards using or rewarding its own operating rooms as a strong preference and reward providers who steer business to its operating rooms rather than towards surgery centers.

7. There is no real proposition currently in healthcare reform as to single-specialty ACOs. However, we will likely see significant developments around chronic high-cost diseases.

8. Where two competitive systems contract together to either form an ACO or offer services through an ACO (or an ACO includes both independent and employed physicians), there is a risk (reality) of sharing pricing information and/or a risk of price-fixing allegations. This risk is prompting the discussion of the need for an anti-trust exemption for ACOs. While the Association of Health Insurance Plans discourages an anti-trust exemption for ACOs, providers are pushing for such an exemption. Absent this exemption, many efforts will fall into an anti-trust gray area and further encourage complete consolidation and less competition.

9. The financial arrangements that are used in ACOs, such as shared savings, raise the possibility of impermissible payments under the Anti-Kickback Statute or the Stark Act. ACOs can attempt to structure their relationships to meet the personal services or fair market value exceptions or other exceptions under the Stark Act. However, these exceptions are often not a perfect fit for these financial arrangements. There is also not a simple ability to take advantage of safe-harbors under the Anti-Kickback Statute. The integrated delivery system model generally provides greater legal comfort from an antitrust, Stark and Anti-Kickback perspective.

(II) Save the Date; Call for Speakers

1. 9th Annual Orthopedic, Spine and Pain Management Driven ASC Conference — June 9-11, 2011. Should you have a suggestion for a speaker or topic or if you have an interest in speaking, please e-mail me at sbecker@mcguirewoods.com.

2. 2nd Annual Becker's Hospital Review Improving Profits, ACOs, Physician Hospital Integration and Key Specialties Conference — May 19-20, 2011. Should you have a suggestion for a speaker or topic or if you have an interest in speaking, please email me at sbecker@mcguirewoods.com.

3. 18th Annual Ambulatory Surgery Centers Conference – Improving Profitability and Business and Legal Issues — October 27-29, 2011.

4. E-Weeklies. If you would like to be added to any of the following free electronic publications, please email sbecker@mcguirewoods.com and specify which E-weekly.

- Becker's ASC Review;
- Becker's Hospital Review;
- Becker's Orthopedic and Spine Review;
- Becker's ASC Quality, Safety and Infection Control; and
- Becker's Spine Review.

• • •

Should you have any questions or comments, please feel free to contact myself at (312) 750-6016 or at sbecker@mcguirewoods.com.

Very truly yours,

Scott Becker

SAVE THE DATES!

9th Annual Orthopedic, Spine and Pain Management-Driven ASC Conference
June 9-11, 2011
Westin Michigan Avenue,
909 North Michigan Avenue, Chicago

18th Annual Ambulatory Surgery Centers Conference
Oct. 27-29, 2011
Westin Michigan Avenue,
909 North Michigan Avenue, Chicago

If you have a suggestion for a speaker or topic or if you have an interest in speaking, e-mail sbecker@mcguirewoods.com.

7 Healthcare Reform Changes Affecting Orthopedic Surgeons
(continued from page 1)

self-referral restrictions, prohibiting doctors from owning future constructed hospitals to which they refer. However, orthopedists who currently own specialty surgical hospitals will be grandfathered in despite the new law. Unfortunately, the law stops existing doctor-owned facilities from adding investors and limits future growth. "Orthopedist facilities can't increase the number of surgery suites or expand the facility except in very restrictive ways," says Mr. Miller. "If you own an interest in a facility already, you can continue owning it. But you may find that over time a physician-owned facility won't be as competitive, especially if it is unable to keep up with the expansion of competitor non-physician owned facilities."

2. Affiliations with hospitals to form ACOs. The new legislation regarding accountable care organizations states that physicians can form ACOs among themselves or affiliate with hospitals to create those groups. Within this partnership, payment is based on the outcomes for the group as a whole. Mr. Miller says many physicians and practices are seeking to affiliate with hospitals to prepare for the future. "People are trying to be ready by organizing these ACOs now and potentially be ready for the change in reimbursement methodology that comes down the pipe," says Mr. Miller. "Practices have been doing this already because the downward economy has had a large impact on their revenue.

He notes that part of the difficulty for orthopedists and others is that the ACO concept has not been well defined. As a result, providers are scrambling to affiliate with hospitals or staff model HMOs in expectation that these arrangements will qualify as ACOs. In some states, Mr. Miller says, hospitals are able to put physicians on salary and HMOs with affiliated medical staffs are able to employ physicians, meaning the physicians are moving from independent practices to an 8 a.m.-5 p.m. job. "That's looking more and more attractive to orthopedists," says Mr. Miller. "Those who want to continue in private practice will probably need to have a close affiliation with a hospital and have a pay-for-performance or other compensation plan in place to fulfill ACO requirements. That will require a contract relationship with the hospital."

3. Prosecution for fraud or abuse. The new laws make it easier to allege improper conduct, such as fraud and abuse, which could be implicated for orthopedic surgeons who have financial relationships with device suppliers or hospitals to which they refer. "Physicians need to take a close look at those relationships, such as medical director or consulting contracts, to make sure they are bonafide and that there isn't a potential liability risk under the changed laws," says Mr. Miller. In the past, Stryker Corp., Zimmer Holdings, Smith & Nephew and Biomet were required to disclose financial relationships with physicians as a result of federal investigations and litigation. However, under the new legislation, all device companies will be required to publicly disclose their financial relationships with physicians, which Mr. Miller says could lead to more audits and investigations.

4. Compliance plan requirements. Every practice is required to have a compliance plan in place starting next year, according to healthcare reform's amendments to the fraud and abuse laws. If a practice already has a compliance plan, it will need to make amendments so it fits the specific Medicare requirements. Compliance plans will, among other terms, need to include standards upon which an orthopedist's financial relationships and agreements with third parties, including device manufacturers and hospitals, will comply with the law. "It's another incentive for the practice to focus on these relationships and show they are meeting the Stark law and fraud and abuse law standards," says Mr. Miller. Non-compliance means the physician or practice could be suspended or terminated from Medicare participation.

5. Provide notice for imaging equipment usage. The healthcare reform legislation also modifies the "in office ancillary service" exception under the Stark law that allows orthopedic practices to own, use and refer to MRI and CT scans in-house. However, now, before conducting such diagnostic tests, the practice must provide patients with a written disclosure containing information about other local facilities providing the same services. This creates more paperwork for the physicians and could cause patients to seek imaging services elsewhere if the practice prices are not competitive.

6. Rehabilitation services must be available. The new law establishes a basic coverage package that must be included in Medicaid plans that will cover currently uninsured patients. Rehabilitation services must be included in basic coverage plans. If an orthopedist accepts Medicaid patients, this requirement assures payment for rehab services. However the amount of reimbursement is not set at this time. "No matter what the coverage, rehabilitation is one of the benefits patients will get," says Mr. Miller.

While it may not be financially feasible for all practices to expand into providing Medicaid-covered rehabilitative services, those that can should expect a volume expansion in their rehab center. Mr. Miller suggests practices analyze their patient base and see whether more Medicaid patients could seek rehabilitation services in their area. "If rehabilitation is a part of the orthopedic practice, to the extent the practice can take on Medicaid patients it's a positive development that it's going to be a covered service," says Mr. Miller.

7. Rehabilitation medicine caps extended. In the past, reimbursement caps were in place for physical therapy and rehabilitative medicine. These caps have been extended by the PPACA, which means there is still an annual limit for visits per year per patient. This could present a problem for practices if it experiences an influx of new patients with conditions that do not resolve within the visit limit. ■

Contact Laura Miller at laura@beckersasc.com.

Latest Trends in Spine Surgery Techniques: Laser and Stem Cell Technology **(continued from page 1)**

"I go to courses all over the world to learn different techniques," says Dr. Flood. "You have to have a passion and dedication in order to learn these different techniques."

Dr. Flood recommends physicians first train in open surgery before learning minimally invasive techniques.

"One of the hardest things for physicians to master in minimally invasive surgery is looking through a little camera. I think the best way for physicians to learn is to do open surgery and then transition to minimally invasive surgery," says Dr. Flood. "It's easier to conceptualize when you go from open surgery to looking through the small aperture of the microscope."

Laser and stem cell technology

The laser techniques can be used for patients with degenerative disc disease as well as other spinal disorders. The laser fiber is passed through an endoscope so the physician can see the surgery site. Alternatively, the fibers can be placed through a small cannula or needle under x-ray guidance directly into the disc. Utilizing the laser in spine surgery can remove bone spurs compressing nerves, remove herniated discs and vaporize scar tissue tethering the nerves.

"When you pass the cannula into the disc, the patient has to be awake so you do not injure the nerve," says Dr. Flood. Once the needle is in place, the patient receives light anesthesia for comfort.

Using laser technology is beneficial for the patient because lasers can remove tissue without damaging adjacent tissue and limit blood loss. The lasers are usually used in combination with other access techniques because overuse can result in bone or disc damage.

"The laser procedure relieves pressure in the disc and then we use stem cells to down-regulate inflammation," says Dr. Flood. "Our goal is not to give the patient a new disc. Our goal is to get rid of the pain in the disc."

Dr. Flood harvests stem cells from an adult patient's hip and processes them in the operating room before they are placed into the patient's spine. The stem cells have the capacity to differentiate into different types of tissue.

One advantage to using these minimally invasive techniques is the ability for quick repairs if an incidental dura leak occurs. Because surgeons use a 16-18 millimeter tube during the surgery, the leak can be repaired quickly using a standard fine suture and either the endoscope or loupes.

"If you don't repair a leak, the patient typically gets horrible spinal headaches," says Dr. Flood. "Repairing any spinal fluid leak is a big deal for the patients."

Reimbursement

While laser and stem cell techniques have advantages for the patient, the technology is still relatively new and expensive for the physician.

"The laser has a number of good uses, but lasers are about $80,000-$100,000 and are not reimbursed," says Dr. Flood. "Because it's not covered by insurance, laser technology for spine surgery is harder to find. There are a few specialized centers across the country offering this kind of surgery."

The use of stem cells can also be costly for the patient and physician.

"There are codes for harvesting stem cells but typically those codes are used for bone marrow transplants," says Dr. Flood. "The codes are not intended for orthopedic applications, so typically these procedures are not reimbursed well."

Compensation for using laser technology during spine surgery usually must come from the patient, says Dr. Flood. ■

Learn more about Celling Treatment Centers at www.cellingtreatmentcenters.com.

GENASCIS™
Assets. Service. Clarity.℠

6 Ways to Avoid Denied Claims for Spine Procedures

By Laura Miller and Rob Kurtz

Mona Kaul, chief coding and compliance officer of GENASCIS, which provides revenue cycle services and supporting technologies for surgery centers, discusses the following six ways ASCs can better avoid denied claims on spine procedures.

1. Physicians must dictate all necessary information. When dictating, physicians should describe the surgical procedure in detail, allowing the coder to clearly visualize the entirety of the surgical encounter. This should include the type of approach used (endoscopic, percutaneous, open procedure, etc.), whether the procedure was anterior or posterior, the laterality and if the surgeon operated on more than one level.

Physicians should also describe any implants/graft used, and include details such as the type of implant and the number of units used (i.e., screws).

Finally, the physician's report should also establish medical necessity for the procedure, which needs to be defined through diagnosis codes.

2. Amend documentation in writing. If the coder has follow-up questions regarding the documentation within the medical record, clarification should be requested from the physician. All changes to the documentation must be made in writing and added to the patient's record for possible future reference. Do not accept verbal direction as it may be subject to interpretation and is not part of the permanent medical record.

3. Differentiate the spine anatomy. Coders must be trained on spinal anatomy. In-depth knowledge of spinal anatomy will allow a coder to differentiate between procedures such as laminotomy (hemilaminectomy) and laminectomy (unilateral). Comprehensive understanding of the anatomy will also enable the coder to appropriately capture codes for spinal arthrodesis and instrumentation procedures.

4. Identify primary procedure and multiple procedures. Coders should code the primary procedure first and then include the add-on code for each additional procedure. Do not use the -59 modifier for add-on procedures. Add-on procedures are indicated in the CPT manual with a + sign. Certain spinal procedures may require the coder to append modifier -59 when a separately identifiable procedure has been performed.

5. Locating spinal procedures in the AMA codebook. Codes for the nervous system are available in two sections of the CPT codebook: 61000-64999 and 22010-22865. Coders should select the most appropriate code for the service rendered regardless of what section it is listed in.

For example, "Decompression procedure, percutaneous, of nucleus pulposus of intervertebral disk, any method, single or multiple levels, lumbar (eg, manual or automated percutaneous diskectomy, percutaneous laser diskectomy)" is 62287, while "*Arthrodesis, anterior interbody technique, including minimal diskectomy to prepare interspace [other than for decompression]; cervical below C2 [fusion])"* is 22554.

6. Understanding rules for implant billing. Most arthrodesis procedures require the use of an implant, so it is important to note the CPT code for such procedures usually exclude the cost of the implant. Payors may require implants to be coded using separately identifiable HCPC level II codes.

Note: Some payors may require a copy of implant invoices to be sent with the claim. ASCs should identify which payors require such invoices to help ensure payors do not delay claims processing due to the lack of complete information. ■

Learn more about GENASCIS at www.genascis.com.

SAVE THE DATES!

9th Annual Orthopedic, Spine and Pain Management-Driven ASC Conference

June 9-11, 2011 • Westin Michigan Avenue, 909 North Michigan Avenue, Chicago

18th Annual Ambulatory Surgery Centers Conference

Oct. 27-29, 2011 • Westin Michigan Avenue, 909 North Michigan Avenue, Chicago

If you have a suggestion for a speaker or topic or if you have an interest in speaking, e-mail sbecker@mcguirewoods.com.

4 Technologies to Improve Orthopedic Practice Revenue Cycle Management

By Laura Miller

In the past few years, new practice management technology and software have been developed to help physician CEOs manage orthopedic practice revenue cycles and improve their practices' bottom lines. Software is available to help with the billing and coding process, credentialing, patient payment reviews and payor contracts. Dave Wold, CEO of Healthcare Information Services, explains four different types of software practices should invest in. "If the physician hasn't upgraded his or her practices' technology, there is a good chance he or she is leaving money on the table," says Mr. Wold.

1. Code deciphering software. If a practice has not staffed a professional coder to decipher the physician's report, coding software can help the physician identify the correct CPT codes from the claim documentation. The physician downloads surgical reports and the software assigns CPT codes for the claim, which Mr. Wold says certified coders identify as accurate 80 percent of the time.

Coding software also allows the physician to design individual payor edits and regulations to ensure claims are appropriately filed and will not be returned. This eliminates the need for manually entering codes into the claims. For the best results, Mr. Wold suggests physicians speak with certified coders about key words to use in their reports for improved accuracy during the transcription between codes and physician documentation.

2. Eligibility software. One of the ways practices most frequently lose money is by seeing patients who are not eligible to receive coverage on their treatment. Eligibility software allows physicians to check the availability of the patient's coverage before he or she comes into the office. The software will show the patient's coverage status and whether the patient has unmet deductibles. If the patient does not meet coverage requirements, the practice has time to speak with the patient before the appointment and make prior payment arrangements.

3. Payment tracking software. After a physician enters into a contract with a payor, he or she often assumes the contracts are met. However, payors sometimes underpay on contracts and losing this money can make a big difference to the practice. Mr. Wold said one of his clients recently identified over 500,000 underpayments while another discovered 100,000 instances where the payor stopped paying for a second procedure when contract guidelines stated the payor would. Payment tracking software allows the physician to enter in different negotiation schedules and then run the payments through to ensure the payor is meeting contract guidelines with each claim.

4. Credential software. This software allows physicians to enter in the pertinent information from their CV and licensing number in order to facilitate the credentialing application. This software records information about when the application was sent to a payor and alerts the physician when too much time has lapsed before hearing back from the payor. Mr. Wold says Medicare and other payors are sometimes behind in processing or lose applications, so physicians must follow-up.

The software also notifies the physician when a contract expires so the physician can decide whether to renegotiate the contract or let it automatically renew. If the contract is old and serves a high percentage of the patients, the physician can renegotiate for a better contract once the initial contract is expired. ■

Learn more about Healthcare Information Services at www.healthinfoservice.com.

AHA Complains of Overzealous False Claims Enforcement on Spinal Procedure

By Leigh Page

The AHA is complaining to federal regulators about overzealous enforcement of the False Claims Act in cases involving admissions for a spinal procedure, according to a report by *AHA News Now*.

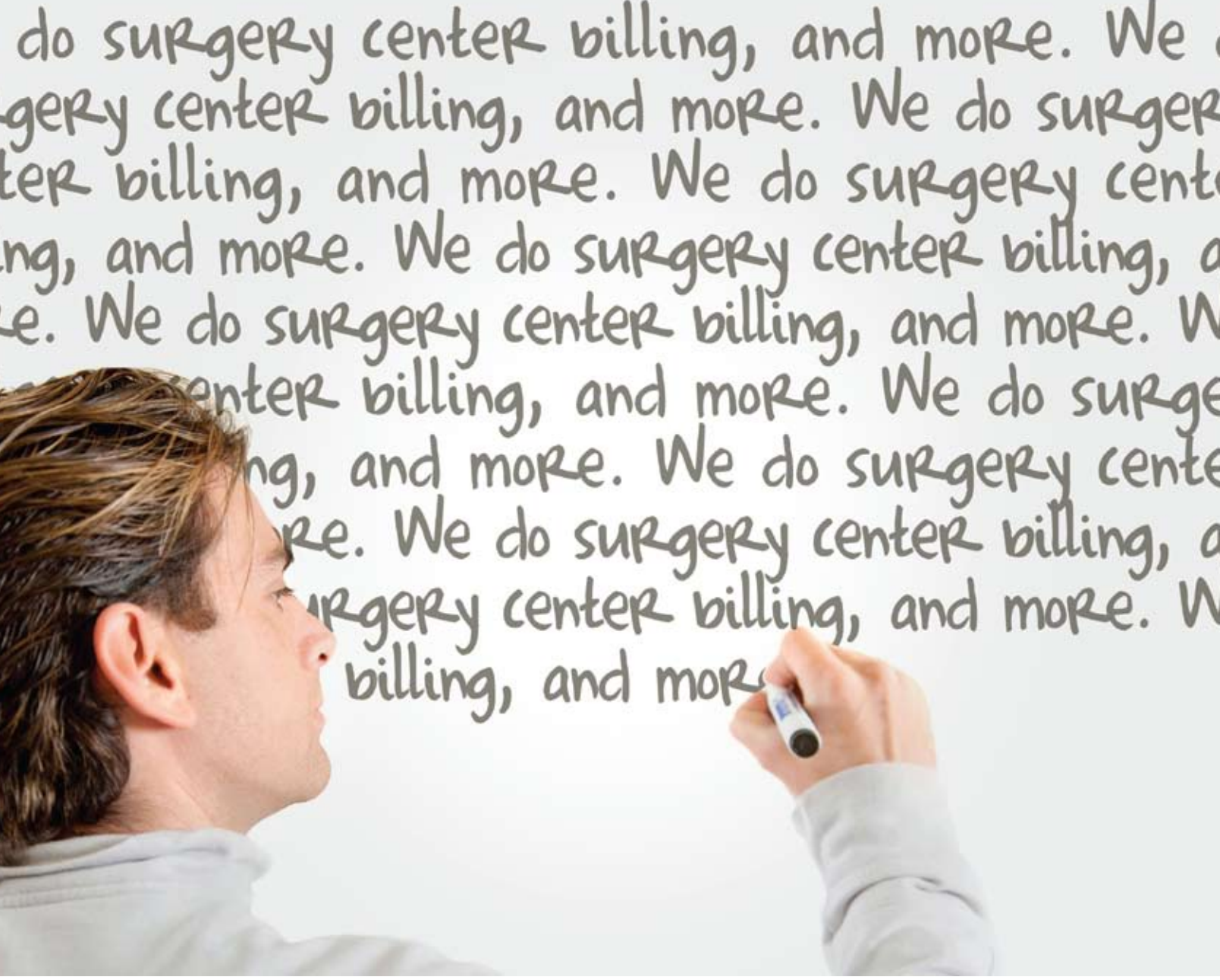
The U.S. Attorney's Office for the Western District of New York has sent "contact" letters to hospitals that that do not appear to conform with Justice Department statements that the law should not apply to billing errors, mistakes and non-culpable overutilization, the AHA said.

The contact letters refer to inpatient admissions for kyphoplasty, a spinal procedure, even though a CMS guidance said admissions for kyphoplasty may be medically necessary and the letters do not indicate the Justice Department examined for medical necessity.

The department has "seized upon data analysis that flags billing errors and/or overutilization and converted it into a presumption of FCA liability," the AHA stated in a letter to HHS and the Justice Department.

"The threat of FCA liability leads hospitals to incur expenses related to retaining specialized counsel and outside forensics accountants and, in the event of an overpayment is discovered, to negotiate a formal FCA settlement where a simple cost report adjustment is all that is really necessary," the letter added. ■

Source: *AHA News Now*.



We Can't Say It Enough.

It's true, surgery center billing is at the core of everything we do at GENASCIS™. Though there are many vendors doing billing, we recognize there's more to "billing" than just billing. We address the steps before, during and after billing—that is, the entire revenue cycle continuum. We're the only vendor with a seamless single-source solution that addresses these needs holistically.

We leverage our technology and workflows to provide unprecedented transparency throughout the process, while utilizing best practices across the entire continuum of services to ensure efficiency and compliance.

Give us a call or visit our website to learn more about our cost-effective solution.

Your Billing Means More To Us.

TRANSCRIPTION ▸ CODING ▸ BILLING ▸ FOLLOW-UP & COLLECTIONS ▸ PAYMENT PROCESSING ▸ DATA ANALYTICS

Sales: Jim Freund – 203-733-8818 • www.genascis.com
11999 San Vicente Blvd. Suite 440 • Los Angeles, CA 90049

GENASCIS™
Assets. Service. Clarity.℠

3 Clarifications for Orthopedic Injection Coding

By Laura Miller

Coding for multiple injections, medication, fluoroscopy and orthography present challenges for coders working on orthopedic claims. In most cases, clear physician documentation can avoid confusion with coding claims.

"In the case where a claim is denied or reviewed on audit, the more specific the documentation made by the physician, the better the practice or physician is going to look in appealing the denial," says Bill Gilbert, vice president of marketing at AdvantEdge Healthcare Solutions (AHS). Physicians should dictate whether the injection took place on the right or left side of the body, or whether it was bilateral.

However, the coder should also be familiar with the payor regulations. Here are three key clarifications for coders processing injection claims.

1. Bundling injection codes. Corey Stavinski, CPC, of AHS, and Peggy Bothwell, LPN, CPC, coding manager at AHS, say coders should bundle injections according to Medicare and CCI guidelines. In most cases, Medicare and the payors who follow CCI guidelines expect injections to be bundled. As always, clear documentation and an explanation of what was done and why helps the coder identify those exceptions where the injections can be unbundled. One example is a patient that receives injections to both shoulders in two separate procedures. Some commercial payors do not follow the CCI guidelines. For these payors, additional injections may be able to be unbundled.

For trigger point or muscle injections, coders use CPT 20552 for an injection to one or two muscles, and CPT 20553 for three or more muscle injections, says Deborah McEachern, CPC, of McEachern Medical Coding & Consulting. If there are multiple procedures done, the coder should capture the dominate procedure code and then use the -59 modifier for the lesser procedures. Physicians should clearly state the number of injections performed in order for the coders to accurately bundle or use the appropriate modifiers if there are two separate procedures.

2. Billing for medication. Coders should become familiar with the contracts between the payor and facility because some practices bill for medications or supply trays, while others consider these expenses part of the global package, say Ms. Stavinski and Ms. Bothwell. If the center bills for the medication, the coder must identify the correct HCPCS code and specify the amount used. In the instance of a single-use medication, the physician should document the amount left over because wastage can be coded and billed.

Medicare packages medication and supplies; however, there are certain drugs that Medicare will pay for separately, so coders should double check whether unfamiliar drugs can be billed separately.

3. Fluoroscopy and arthrography. Physicians use fluoroscopy for needle localization and guidance to make sure they are injecting in the correct location. Arthrography can also be used for guidance but it has diagnostic purposes as well. Some payors, such as Medicare, will not reimburse for fluoroscopy or arthrography in some joints. Ms. Stavinski and Ms. Bothwell say that clear physician documentation is necessary to code for the instances when physicians are able to receive reimbursement. In the operation report, physicians must include a description of the patient's anatomy, structures, where the needle was placed, the spreading of the dye, what type of dye was used and the findings within the joint area. The findings can be included in the operation report or in a separate report; it is helpful to the coder if the findings are at least in a separate paragraph in the operation report.

Additionally, coders need to know whether the equipment is owned and maintained at the facility. If the physician is using equipment owned and maintained by a hospital, he or she cannot bill for the use of that equipment. ■

Learn more about AdvantEdge Healthcare Solutions at www.ahsrcm.com.

Learn more about McEachern Medical Coding & Consulting at www.bestmedicalcoding.com.

SAVE THE DATES!

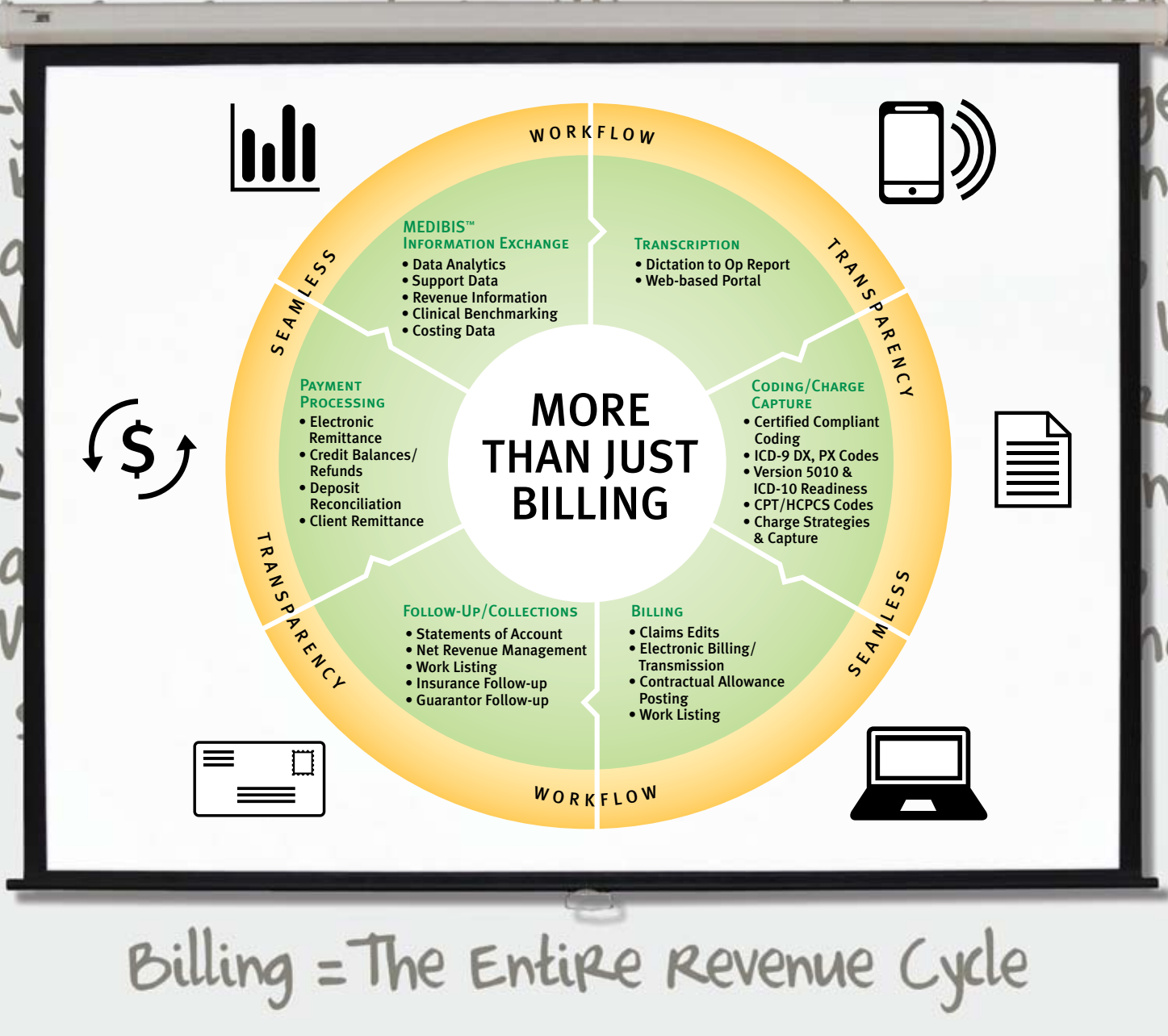
9th Annual Orthopedic, Spine and Pain Management-Driven ASC Conference

June 9-11, 2011 • Westin Michigan Avenue, 909 North Michigan Avenue, Chicago

18th Annual Ambulatory Surgery Centers Conference

Oct. 27-29, 2011 • Westin Michigan Avenue, 909 North Michigan Avenue, Chicago

If you have a suggestion for a speaker or topic or if you have an interest in speaking, e-mail sbecker@mcguirewoods.com.



Billing = The Entire Revenue Cycle

GENASCIS™ is the only provider of fully integrated, intelligent revenue cycle management solutions for ASCs.

- WE GUARANTEE YOUR RESULTS.
- Our team of experts dedicated to handling each respective step of the revenue cycle produces exceptional results.
- We leverage best practices throughout the continuum of services to positively impact compliance and revenue.
- Through risk mitigation and the elimination of financial exposure, we enable you to focus your efforts on expanding and improving your center's clinical services.

Find out how your business office is performing.

Contact us to coordinate a confidential evaluation and see how you stack up to the best practices of over 800 ASCs nationwide.

More than ever, it pays to know.

Your Billing Means More To Us.

TRANSCRIPTION ▸ CODING ▸ BILLING ▸ FOLLOW-UP & COLLECTIONS ▸ PAYMENT PROCESSING ▸ DATA ANALYTICS

Sales: Jim Freund – 203-733-8818 • www.genascis.com
11999 San Vicente Blvd. Suite 440 • Los Angeles, CA 90049

GENASCIS™
Assets. Service. Clarity.℠

24 Orthopedic Practices With Great Sports Medicine Programs
(continued from page 1)

medicine research, Kerlan-Jobe Orthopedic Clinic physicians have developed advanced surgical methods to enhance treatment, rehabilitation and recovery of patients with orthopedic conditions. The practice offers a large fellowship program for training physicians, an onsite surgery center and an extended recovery area where patients can stay up to 23 hours. Additional practice services include a pain medicine program and physical therapy program, which treats non-surgical patients to strengthen muscles and increase joint motion. Frank Jobe, MD, co-founder of the practice, pioneered the Tommy John surgery for baseball players with damaged UCLs. The Kerlan-Jobe Clinic serves as consultant to the Los Angeles Lakers, Los Angeles Dodgers, Los Angeles Angels of Anaheim and the Los Angeles Kings. www.kerlanjobe.com

The Steadman Clinic (Vail, Colo.). The Steadman Clinic's holds a strong philosophy of teamwork between the patient, physician and physical therapist working toward full recovery. Physicians commonly treat knee and shoulder injuries as well as complex foot and ankle conditions and after each procedure, physicians design an individual exercise program for their patient. Richard Steadman, MD, co-founder of The Steadman Clinic, has developed several techniques used worldwide to treat knee disorders. The practice is associated with Steadman Philippon Research Institute where researchers focus on understanding more about causes, prevention and treatment for orthopedic injuries. Physicians at The Steadman Clinic regularly work with the U.S. Women's Alpine Ski Team, professional golfers and the Denver Broncos. www.steadman-hawkins.com

University of Pittsburgh Medical Center Sports Medicine (Pittsburgh). Physicians at UPMC Sports Medicine are focused on preventing sports-related injury by teaching athletes the limitations of their own bodies. When an injury does occur, orthopedic surgeons work with sports physical therapists, performance specialists, athletic trainers and nutrition experts to return athletes back to their activities. In addition to their clinical work, the physicians at UPMC Sports Medicine conduct research, developing better treatment methods to ensure athletes can perform to their fullest potential. UPMC is the official sports medicine provider for the Pittsburgh Steelers, Pittsburgh Penguins, Pittsburgh Passion women's football team and the Pittsburgh Ballet Theater. UPMC physicians are also on the sidelines for University of Pittsburg games. www.upmc.com/Services/sportsmedicine

Midwest Orthopaedics at Rush (Chicago). The physicians at Midwest Orthopaedics are dedicated to providing innovative treatment to all athletes. In addition to surgical procedures, Midwest Orthopaedics has occupational and physical therapy, pain management, pediatric sports medicine and women's sports medicine programs. The practice produces several publications, including Orthopaedic Excellence Magazine, with up-to-date information about orthopedics. Many of the physicians at the practice have been named top physicians by Chicago Magazine. Brian Cole, MD, MBA, is nationally recognized for his leadership cartilage restoration and research. He is the head of the cartilage restoration center at Rush, which provides biologic solutions to treating damaged cartilage and preventing arthritis progression. Physicians at Midwest Orthopaedics are team physicians for the Chicago Bulls and the Chicago White Sox. www.rushortho.com

Cleveland Clinic Sports Health (Garfield Heights, Ohio). Cleveland Clinic physicians work with each patient to create individual treatment plans for the patient's specific body type and appropriate skill level. In addition to providing orthopedic services, the Cleveland Clinic offers an athletic performance program which includes motion analysis and injury prevention, individual conditioning and rehabilitation instruction. Sport-specific programs include golf, soccer, baseball, running and ice-skating. The Cleveland Clinic participates in the STOP Sports Injury campaign as well as the ImPACT: Sports Concussion Program, focused on preventing and treating injuries in young athletes. Finally, the rehabilitation services at Cleveland Clinic collaborate with the nutrition therapy and pain management departments in order to provide thorough rehabilitation for each patient. Physicians at the practice are affiliated with the Cleveland Indians, Cleveland Browns and the U.S. Soccer Federation. http://my.clevelandclinic.org

University of Florida Orthopaedics & Sports Medicine Institute (Gainesville, Fla.). Patients at UF Orthopaedics & Sports Medicine receive full orthopedic care, rehabilitation and radiological services at the practice. The physicians have expertise in several areas of orthopedics, including joint replacement surgery and adult reconstruction, minimally invasive spine surgery and pediatric orthopedic care. The practice offers a running medicine clinic including patient access to a biomechanical analysis of gait and muscle imbalances, joint fluid therapy for knee pain management and a sports performance center which includes performance assessment and injury prevention. Patients also have access to the SpineCare center, aquatic therapy and medical massage. Practice physicians are affiliated with the Florida Gators athletics program and include Peter Idelicato, MD, who has received four Gators championship rings during his career for his work as head team physician. www.ortho.ufl.edu

Illinois Bone & Joint Institute (Chicago). Physicians at the Illinois Bone & Joint Institute have expertise in all types of sports medicine treatment and surgical solutions. In addition to fulfilling their patients' surgical needs, the physicians provide pre- and peri-operative programs for learning exercises and helping patients deal with symptoms of asthma, diabetes, osteoporosis, arthritis and obesity. The primary care sports medicine services include assessment and management of acute and chronic injuries, care for overuse injuries and sports physicals. The practice includes a training room

and medical tent coverage for sporting teams and events. The physicians are affiliated with a wide range of athletes and teams, including the Chicago Bulls, Chicago Bears, Chicago White Sox, Chicago Blackhawks and the Philadelphia Eagles. www.ibji.com

OrthoCarolina Sports Medicine Center (Charlotte, N.C.). In addition to providing full orthopedic care to their patients, physicians at OrthoCarolina Sports Medicine Center are involved with the Cartilage Restoration Institute, performing cutting-edge techniques for knee cartilage repair and restoration. The practice includes urgent care services for patients requiring immediate attention after office hours. Coupled with the orthopedic treatment programs, OrthoCarolina includes a sports performance program for post-procedural and preventative care. This program trains athletes from all sports to avoid injuries and optimize individual potential. Additional therapy programs at OrthoCarolina include aquatic therapy and underwater treadmill, back therapy, hand therapy and sports therapy promoting a safe return to activity after sustaining a sports-related injury. Physicians at OrthoCarolina are affiliated many local teams, including the Carolina Panthers. www.orthocarolina.com

Fairfield's Orthopedic Specialty Group (Fairfield, Conn.). This team of physicians provides comprehensive sports medicine services to patients ranging from recreational to professional athletes. Treatment options include onsite orthopedic surgery, physical therapy and pain management. Physicians are trained to use minimally invasive techniques for knee and shoulder surgery. Among the practice physicians is Robert Stanton, MD, the recently named president of the American Orthopaedic Society for Sports Medicine. The practice includes team physicians for the U.S. Alpine Ski Team, U.S. National Soccer Federation, Bridgeport Sound Tigers minor league hockey team and Fairfield University. www.osgpc.com

OrthoIndy Bone, Joint & Muscle Care (Indianapolis). Sports medicine physicians at OrthoIndy understand athletes at all levels are interested in returning to their active life as soon as possible. As a result, the physicians are focused on providing services to ensure patients a quick recovery while minimizing the risk of re-injury. The practice includes fracture care and outpatient physical therapy as well as digital radiography, MRI and CAT scan. OrthoIndy offers a walk-in clinic for immediate access to bone, joint, spine and muscle condition treatment. The practice is affiliated with the Indiana Pacers, Indiana Fever WNBA team, Indianapolis Indians minor league baseball team and Indiana Ice tier one ice hockey team. www.orthoindy.com

Stanford Sports Medicine (Stanford, Calif.). In addition to Stanford Sports Medicine's medical clinic, the practice includes a rehabilitation suite and a human performance lab staffed by physicians, physical therapists and sports scientists to help athletes learn the best practices for optimizing performance and minimizing the risk of injury. The services include biomechanical analysis, exercise physiology testing and coach-athlete counseling. Additional practice programs include nutrition guidance and psychological services. Physicians at Stanford Sports Medicine are involved in extensive orthopedic and sports medicine research projects as well as serve as team physicians for the San Francisco 49ers. http://sportsmedicine.stanford.edu

The San Antonio Group Sports Medicine Institute (San Antonio). The physicians at the Sports Medicine Institute provide comprehensive orthopedic care in prevention, treatment and rehabilitation for injured athletes. Patients can receive diagnostic services at the imaging center, equipped with a CT scan and MRI, as well as treatment in the onsite outpatient operation room. Physicians have experience in arthroscopy of the knee, arthroscopic repair of complex shoulder injuries and minimally invasive hip and knee replacements. The practice is currently involved in the STOP Sports Injury campaign to promote injury prevention among young athletes. Team physician affiliations include associations with the World Wrestling Entertainment and the University of Texas at San Antonio. www.tsaog.com

Cincinnati SportsMedicine and Orthopaedic Center (Cincinnati). The Noyes Knee Center, the cartilage repair and regeneration center, the complex shoulder and elbow center and the sportsmetrics knee injury prevention program are all programs at the Cincinnati SportsMedicine and Orthopaedic Center. Practice physicians have affiliations with the Cincinnati Bengals and several Olympic athletes. In addition to clinical work, the practice is affiliated with the Cincinnati Sports Medicine Research and Education Foundation created by practice physician Frank R. Noyes, MD, to promote clinical, biomechanical, bioengineering and neuromuscular research. Dr. Noyes is among an elite group of physicians who have been named to the American Orthopaedic Society for Sports Medicine's Hall of Fame. www.cincinnatisportsmed.com

Minnesota Orthopedic Sports Medicine Institute (Edina, Minn.). Having just opened in July 2010, the nine physicians at Minnesota Orthopedic Sports Medicine Institute collaborate in order to ensure all levels of athletes can return to the playing field after an injury. In addition to standard orthopedics, physicians perform a variety of sports medicine procedures, including arthroscopy of the shoulder, hip and knee as well as ACL and PCL repair and reconstruction. The practice houses a fellowship program for future physicians as well as a research and education team. MOSMI is affiliated with several local teams as well as the U.S. men's and women's national soccer teams, the Minnesota Vikings and the U.S. Cup for mountain biking. www.mosmi.org

Diagnostic and Interventional Sports Care & Orthopedics (DISC) (Marina del Rey, Calif.). Patients at DISC's 7,200-square-foot practice receive orthopedic surgery, non-surgical injections and alternative medicine treatment for sports-related injuries. The practice supports an onsite MRI and spinal surgery equipment, including the Seiss OPMI pen-

tero microscope. DISC physicians focus on performing minimally invasive procedures and utilizing cartilage preserving surgical techniques. DISC is the official medical practice for the U.S.A. Men's Volleyball Team, the Los Angeles Kings, the Los Angeles Clippers and the U.S. Olympic Team. Frederic Nicola, MD, director of the practice's sports center as well as the knee and hip institute at DISC, served as team physician for teams during two Super Bowls and two NFL Pro Bowls. www.discmdgroup.com

Panorama Orthopedics & Spine Center (Golden, Colo.). Several physicians at Panorama Orthopedics & Spine Care are fellowship trained sports medicine physicians with the ability to treat injuries from concussions to rotator cuff damage. The practice includes centers for surgery and convalescents, imaging and physical therapy as well as an orthopedic research foundation. The practice recently joined the STOP Sports Injuries campaign, a national campaign affiliated with the American Orthopaedic Society for Sports Medicine to raise awareness about injury prevention for young athletes. Practice physicians have affiliations with several professional teams, including the Chicago Bears, Chicago Blackhawks, Oakland Raiders and the U.S. Ski Team. Panorama Orthopedics & Spine provides the team physicians for several local college teams and soccer clubs. www.panoramaortho.com

Indianapolis' Methodist Sports Medicine/The Orthopedic Specialists (Indianapolis). As the official team physicians for the Indianapolis Colts since 1984, the fellowship-trained physicians at Methodist Sports Medicine have a long history in treating sports and activity-related injury. In addition to providing orthopedic surgery, the practice offers pediatric sports medicine, rehabilitation and sports performance programs. Physicians have experience treating several conditions, including rotator cuff tendonitis and ACL tears. In addition to their affiliation with the Colts, the physicians treat athletes from several local teams. In 2003, Methodist's Art Rettig, MD, was named the Jerry "Hawk" Rhea Outstanding NFL Team Physician of the Year. www.methodistsports.com

Atlanta Sports Medicine Orthopedic Surgery & Physical Therapy (Atlanta). Physicians at Atlanta Sports Medicine focus on treatment for athletic injuries and cartilage repair. Services include an onsite MRI, operating room and physical therapy center. The physicians perform arthroscopic and open surgery for sports medicine procedures, including knee and shoulder arthroscopic surgery. In addition to their clinical work, practice physicians do extensive research to develop new methods for ligament reconstruction, cartilage restoration and meniscus repair and transplantation. Atlanta Sports Medicine serves as the team physicians for the Atlanta Falcons and Atlanta Thrashers. www.atlantasportsmedicine.com

Access Sports Medicine & Orthopaedics (Exeter, N.H.). Access Sports Medicine & Orthopaedics is active in its community, offering workshops on sports injury prevention and pre-participation sports physical examination clinics for young athletes. Additional services include a concussion and osteoporosis program, physical and occupational therapy and an athletic training department. Rehabilitation staff members are trained in the Graston technique for mobilizing soft tissue as well as administering the Functional Capacity Evaluation. Access Spine Care physicians utilize minimally invasive techniques for correcting cervical and lumbar spinal disorders. Access Sports Medicine & Orthopedics is home to the first open MRI center accredited by the American College of Radiology. Practice physicians are affiliated with the U.S. Ski Team. www.accesssportsmed.com

Nashville's Baptist Sports Medicine (Nashville). While the team at Baptist Sports Medicine is focused on rehabilitation, the physicians also offer preventative programs and general orthopedic and sports medicine services. The practice physicians provide sports participation screening and free injury assessments. Other programs at Baptist Sports Medicine include aquatic therapy, sports psychology and the Dart Fish program to identify and measure abnormal movement patterns. Baptist Sports Medicine also employs professionals to assist with sports nutrition, work hardening and sports physical therapy. In addition to associating with several local athletic programs, Baptist Sports Medicine physicians are affiliated with the Tennessee Titans. www.baptistsportsmedicine.com

Beacon Orthopaedic & Sports Medicine (Sharonville, Ohio). Physicians at Beacon have a wide range of expertise, including unicondylar knee replacement, regenerative and biologic orthopedics and reconstructive orthopedics. Among the four Beacon facilities there are two ASCs, imaging centers including a hologic delphi scanner, physical therapy services and a spine center for non-surgical treatment. The practice also includes 23-hour stay suites for patients undergoing complex operations. The clinic partners with a high endurance training facility, D1, offering athletes training in such as strength, flexibility and agility. For young athletes and weekend warriors, the practice includes Saturday clinic hours. Beacon physicians are affiliated with the Pittsburgh Steelers, Cincinnati Reds and the Cincinnati Cyclones. www.beaconortho.com

Advanced Orthopedic and Sports Medicine Specialists (Denver). In addition to treating recreational and youth athletes, the physicians at this facility have past and present affiliations with the Colorado Rockies, U.S. Soccer teams, Denver Broncos, Colorado Ballet, U.S.A. Wrestling and several local high schools. The practice includes imaging and diagnostic technology as well as physicians with expertise in arthroscopic and minimally invasive surgery for the hip, knee, shoulder and ankle. For adult patients, physicians have access to the MAKOplasty Partial Knee Resurfacing equipment and RIO Robotic Arm Interactive Orthopedic System at the practice to increase incision accuracy when performing surgeries. www.advancedortho.org

Santa Monica Orthopaedic and Sports Medicine Group (Santa Monica, Calif.). In addition to providing orthopedic treatment for their patients, physicians at SMOG are continuously involved in research to develop new techniques and treatment for orthopedic medicine. The practice includes digital x-ray, extremity MRI, physical therapy and an outpatient surgery center near the clinical building. SMOG patients have access to skilled trainers, nutritionists and athletic performance specialists. The practice recently launched a children's sports medicine program. SMOG is team physicians for the Los Angeles Galaxy and Chivas USA soccer team as well as affiliated with the LPGA. www.smog-ortho.com ■

Contact Laura Miller at laura@beckersasc.com.

4 Issues Which Will Shape the Future of Orthopedics

By Rachel Fields

Peter Mandell, MD, chair of the American Academy of Orthopaedic Surgeons Council on Advocacy, discusses four issues currently affecting orthopedics.

1. The development of appropriate use criteria. According to Dr. Mandell, AAOS is currently developing "appropriate use criteria" to phase out procedures that are no longer as useful or appropriate as previously thought. "Cardiologists have had appropriate use criteria for a long time, and they've found that one way to save money is to do procedures that work and phase out those that looked promising years ago but might not work anymore," he says. Over the next few years, AAOS will gather data to determine which procedures are most appropriate for each patient population and which should be discontinued by the specialty as a whole.

For example, he says total joint replacement in younger adults has become more popular over the last decade, raising a discussion over whether the procedure is appropriate for people in their 40s. "As a general rule, you're implanting a piece of metal and plastic that won't last 30 or 40 years in most people," Dr. Mandell says. "If you shift those resources to older people who don't have access because of insurance and other medical problems, you may not save money, but you're going to be using the money more appropriately."

2. Medical liability reform. According to Dr. Mandell, the practice of "defensive medicine," or procedures and tests ordered to offset the likelihood of being sued, costs the United States over $50 billion every year. He says physicians should focus on using resources to treat patients appropriately rather than fend off lawyers.

In order to reduce the use of defensive medicine, AAOS is developing guidelines to protect physicians from lawsuits. For example, AAOS has published a guideline instructing surgeons on how to prevent symptomatic pulmonary embolism in patients undergoing total hip or knee arthroplasty, emphasizing the importance of assessing the patient's risk for bleeding. While physicians can currently only use the guidelines to argue a malpractice case, AAOS hopes the guidelines will eventually be "enshrined in law" so that physicians who follow the guidelines will not be sued in the first place.

"It's a tragedy [when a patient dies or is harmed during surgery], and the individuals or family should be appropriately compensated, but if you've done everything right and follow the guidelines and it was just bad luck, you shouldn't have to worry about getting sued," he says.

3. Influx of newly insured patients. Dr. Mandell says that over the next few years, orthopedic surgeons, like all physicians, will be tasked with handling a large influx of newly insured Americans, some of whom have lacked medical care for many years.

He says orthopedic surgeons will have to increase their focus on preventive care and patient responsibility by managing patient expectations about where and how often patients should receive care. As providers are stretched thin by the influx of new patients, he says many people will no longer be able to go to the emergency room for non-emergency situations because the waits will simply be too long. "They're going to have to take care of themselves more by watching their weight and taking responsibility for their health," he says. "A lot of problems, such as knee arthritis and hip arthritis, are caused by carrying that extra weight." He says orthopedic surgeons can help by encouraging their patients to lead healthy lifestyles and directing them to resources that will help them lose weight and stay active.

While the impending provider shortage is a problem for orthopedics as well as other specialties, Dr. Mandell says the specialty is still gaining quality orthopedic physicians every year. "We are getting very high quality folks coming into orthopedic surgery," he says. "We're working hard to have the best and the brightest, the most diverse and the most interested group."

4. Phasing out fee-for-service compensation models. Dr. Mandell says that while the push towards pay-for-performance and away from fee-for-service "looks good on paper," AAOS is concerned from a specialist perspective that the change may severely impact access to high-quality specialty care. "We do procedures like total hip replacement, total knee replacement and arthroscopy, that add a lot to quality of life but aren't inexpensive procedures," he says.

He says AAOS wants more expensive orthopedic procedures to be performed on those patients who need them and not rationed because of an unfeasible expense. "The models being proposed — ACOs, episodes of care and bundling services together — are looking pretty good right now, but the long-term results are [still unclear]," he says. ■

Contact Rachel Fields at rachel@beckersasc.com.

5 Best Practices for Physicians to Develop a Successful Sports Medicine Practice

By Laura Miller

Orthopedic practices around the country are adding sports medicine to the list of services they provide, sometimes even including the phrase in their practice name. However, not all of these new practices provide the services necessary to become a truly successful sports medicine practice. Walter Lowe, MD, of the University of Texas Health and Science Center and team physician for the Houston Texans, Houston Rockets and the University of Houston Cougars, discusses what it takes to succeed with sports medicine.

1. Develop a good relationship with athletic trainers. While a physician's surgical skill is important in creating great outcomes, the outcomes are also dependent on the post-surgical care the patient receives. Sports medicine practices should employ good athletic trainers and physical therapists, or have positive working relationships with an outside rehabilitation team in order to prepare the patient for returning to his or her normal activities. Athletes are particularly interested in returning to their former level of performance as quickly as possible, which means a better rehabilitation experience translates to higher patient satisfaction.

2. Be available on the sidelines. Commit to being a team physician for local youth sporting events and stand at the sidelines for each home event. If an injury occurs, the physician can make an assessment on the sidelines and treat the athlete as soon as possible. If the athlete has a good experience, he or she will relay that information to other players.

"You do have to build a good reputation because your patients are out there playing with other people who are your future patients," says Dr. Lowe. "The marketing dollars that are spent trying to promote physicians through advertising at the stadium for the most part are wasted." He says very few of his patients come to him as referrals from other physicians; most learn of his work through word-of-mouth.

3. Stay educated on latest procedural technology. Sports medicine is one of the most rapidly growing orthopedic subspecialties, which means treatment solutions are constantly evolving to better suit active patients. Physicians should stay aware of the newest procedures and technology that can help their patients heal quickly and have better outcomes, which often means learning about treatment for overuse injuries and ACL repair.

Dr. Lowe says anatomic placement of ACL grafts in single or double bundle procedures and repair using platelet rich plasma are the latest trends in ACL treatment. While these methods are effective for immediate treatment, researchers are unable to tell whether the solutions are effective in preventing arthritis.

"One thing that's a little frustrating for patients in sports medicine is that they want to be better immediately," says Dr. Lowe. "We are definitely getting very good at restoring immediate function. However, it's frustrating because we'd like to know these changes are going to prevent further conditions (such as arthritis) but really the only thing that's going to prove it is to assess the patients 20 years from now."

4. Commit to saying "yes." Athletes involved in school sports and after-school activities are often injured during the weekends or after clinic hours, yet they require immediate attention. Dr. Lowe says a successful sports medicine physician should always be available for his or her patients, regardless of the time or a busy schedule. "It takes a commitment of answering your phone and saying 'yes'," says Dr. Lowe. "The patients are usually young and highly motivated. If you want to survive in the sports medicine world, you have to have the mentality of service to your patients." If the physician turns a young athlete away, he or she will find another facility willing to offer immediate treatment.

5. Pay attention to the regular clinic. While serving as team physician for college or professional teams is prestigious, the bulk of the orthopedic work takes place in the regular clinic. "The professional and college world doesn't even make up 10 percent of the surgical cases I do," says Dr. Lowe. "The bread and butter of the practice happens in the clinic." There are very few athletes from one team who need orthopedic surgery every season, which means the physician must also build a reputation among all members of his or her community. ■

Learn more about Dr. Walter Lowe at www.drwaltlowe.com.

Top 5 Orthopedic Device Companies Based on 2009 Revenues

By Leigh Page

Stryker Corp. (Kalamazoo, Mich.) — $7.0 billion in revenues. Products from Stryker's Orthopaedic Implants division include artificial joints, spinal rods and screws, bone cement, artificial vertebral discs and OP-1, a biological product to grow bone. In April, the company manufactured its 1 millionth Exeter hip stem, developed 40 years ago by an orthopedic surgeon and an engineer. In February, Stryker released its Rejuvenate Modular Primary Hip System, developed to optimize anatomic restoration. Last year, the company agreed to buy Ascent Healthcare Solutions, the largest reprocessor of single-use medical devices in the country, for $525 million. www.stryker.com

DePuy (Raynham, Mass.) — $5.4 billion. A subsidiary of Johnson & Johnson, DePuy is said to have been the first orthopedic manufacturer in the world, creating a fiber splint in 1895 to replace wooden barrel staves to set fractures. The company is involved in orthopedic joint reconstruction, spinal care products and neurosurgical devices. Its products include hip replacements, internal and external fixator products, operating room equipment as well as knee, shoulder and spinal implants. In May, DePuy Spine launched the EXPEDIUM Vertebral Body Derotation Set to help correct spinal alignment and decrease rib rotation in patients with scoliosis. In 2009, the company announced it would fund 25 graduate medical education fellowships in spine care. www.depuy.com

Zimmer Holdings (Warsaw, Ind.) — $3.9 billion. Zimmer produces knee and hip replacements, spinal stabilizers, shoulder implants, tissue grafting materials, spinal implants and products for trauma and orthopedic surgery. About 8,500 Zimmer employees work in more than 25 countries. In August, the company announced the first implantation of its NCB Periprosthetic Plating System to address complex femoral fractures around hip or knee implants. In July, Zimmer announced it would acquire Beijing Montagne Medical Device Co. to gain a foothold in the Chinese orthopedic implant market. Zimmer Patient Specific Instruments, using MRI technology and pre-operative planning tools to create customized cutting guides, were released in March. www.zimmer.com

Smith & Nephew (London) — $3.7 billion. The company's orthopedics division makes hip, knee and shoulder replacements as well as fixation and bone-growth devices. Its endoscopy division makes arthroscopes, blades, digital cameras and other surgical products. Smith & Nephew operates in 32 countries. In 2008 it invested $152 million in research and development activities, focusing on novel bioresorbable polymers, tissue or cell engineering, and non-invasive stimulation. The company's new products include OXINIUM material for hip and knee implants, BIRMINGHAM HIP Resurfacing and the JOURNEY DEUCE knee. http://global.smithnephew.com

Synthes (West Chester, Pa.) — $3.3 billion. The company employs 5,600 people worldwide. It specializes in spinal devices, including disc replacement and cranio-maxillofacial implants. Synthes works closely with the AO Foundation, a research organization specializing in osteosynthesis. In 2010, the company's trauma division launched the TFN Lag Screw and the LCP Periarticular Proximal Humerus Plate. Synthes has seen increased adoption of its Matrix facial plating line and of thoracic products such as Titanium Sternal Fixation System. www.synthes.com ■

Contact Leigh Page at leigh@beckersasc.com.

DePuy Orthopaedics Recalls ASR Hip System

By Caitlin LeValley and Laura Miller

DePuy Orthopaedics has voluntarily recalled the ASR XL Acetabular System and DePuy ASR Hip Resurfacing System used in hip replacement surgery due to the number of patients who required a revision surgery, according to a DePuy news release.

The company posted a recall of the ASR 100 and 300 series Acetabular hip implant cups sizes 44mm to 70mm on the FDA website on July 17. The recall includes the ASR Hip Resurfacing system and the ASR XL Acetabular System.

DePuy Orthopaedics issued an Urgent Safety Notice to physicians in March warning of high revision rates in patients receiving the system and announced at that time the company would withdraw the implant from the market at the end of 2010. Reports of the metal-on-metal interface creating metal debris which caused inflammation of the surrounding tissue prompted the Notice.

The majority of ASR hip replacement surgeries have been successful, but DePuy is encouraging patients with ASR devices to have their implant performance evaluated. DePuy is providing comprehensive recall information to hospitals, surgeons and patients to help them determine how to proceed, according to the release. ■

Contact Laura Miller at laura@beckersasc.com.

6 Key Questions to Ask When Considering an Ancillary Physical Therapy Program at Your Practice

By Lindsey Dunn

Physical and occupational therapy services, along with athletic training, make up one of the most profitable ancillary service lines offered by orthopedic practices. As pressures mount against physician fees, especially for specialists, ancillary service lines are increasingly important to maintaining the financial success of practices. Physical therapy services, however, can be challenging to establish in markets that already have a large presence of private physical therapy providers.

Jeff Goldberg, director of operations for Resurgens Orthopaedics, a 90-plus physician orthopedic practice with 20 locations in and around Atlanta, shares six considerations for developing a rehabilitation program within your orthopedic practice.

Recruitment challenges

Mr. Goldberg, who is a licensed physical therapist and previously served as Resurgens' director of rehabilitation services, says that practice-owned rehabilitation programs provide more collaborative care for patients but are often looked down upon by the physical therapy industry. "The American Physical Therapy Association disapproves of physical therapy services owned by physician practices, so PT students are commonly discouraged from going to work for physicians," he says. "The ones that do, however, recognize early on that they are able to provide a higher quality of care with this type of relationship. Physical therapists and physicians can easily communicate, and medical records are shared. That's not the case in a private PT practice." Prejudices against working for physicians are not held by the national organizations for occupational therapists, certified hand therapists or athletic trainers, who are also valuable members of a rehabilitation team, notes Mr. Goldberg.

While a bias against physician-owned PT services and an overall PT provider shortage may make recruiting more difficult for some practices, Mr. Goldberg says recruitment and start-up concerns are outweighed by the benefits of a having a program, as long as the physicians have enough referral volume to support the group. "Some physicians do have concerns about dedicating resources to get a program started, but often physicians can use their existing relationships with local physical or occupational therapists to recruit those therapists or their colleagues to the practice," he says. "Even though we are seeing a decrease in the volume of therapy because of increasing deductibles and co-pays, it still provides a very good revenue stream for physician practices in addition to making care more accessible to the patient. Patients continually express to us how much they appreciate the fact that they can see their physician and rehab provider at the same location."

Start-up considerations

Practices exploring adding this ancillary service should consider the following questions.

1. Will your physicians create enough demand? Generally, two to three physicians will produce enough referrals to sustain one physical therapist, although this can vary by subspecialty, says Mr. Goldberg. Practices should ensure they have enough demand for services before hiring a therapist or developing a program. "In our practice, we find about 10-12 percent of our physician visits end up being therapy patients," he says. In addition to covering therapist salaries, the expected revenue will also need to cover the cost of space to house the program and necessary equipment.

2. What are the expectations for profitability? PT programs increase in profitability as they grow in size. "It is really difficult to be profitable with a low number of therapy providers and almost impossible with only one provider," says Mr. Goldberg. "Two or more therapists in one location are really needed to become profitable." While on-site physical therapy may be provided as a convenience to patients, practices with a goal of increasing profits through PT will need to ensure it can produce the volume needed to support several therapists.

3. Will commercial insurers contract with your practice? The access your patients will have to your physical therapy services can vary greatly by region. "High managed care areas may present a challenge because they often have exclusive contracts with private therapy providers," says Mr. Goldberg. "You need to look at your payor mix and the access that mix will have to your services. If you know that 60 percent of your volume is from a payor that won't contract with you, it may not make sense to add PT."

4. Will your therapists see Medicare patients? Another consideration for practices is whether or not its PT program will see Medicare patients. Resurgens decided not to see these patients because of the additional regulations on documentation requirements CMS places on therapy providers. "It can be a full-time job to manage the administration involved in treating and receiving reimbursement for these patients in a large practice," says Mr. Goldberg. "We weighed the risks and the benefits and in the end determined that referring our Medicare patients to the quality private therapy providers in our communities was the best model for our practice." This decision actually helps generate goodwill in the community because the practice continues to refer a number of its patients to these private PT providers, Mr. Goldberg notes.

5. Who will manage the program? The development of a rehabilitation program should be overseen by an experienced physical therapy program manager. In most cases, this will be a licensed physical or occupational therapist who has managed another program and ideally has developed a program at another practice. This way, he or she will be familiar with recruitment and the regulatory and financial issues involved in a start-up. For smaller practices, this person can also see patients in addition to his or her administrative duties. However, if the program grows to include multiple locations (more than five locations would be an appropriate guideline, according to Mr. Goldberg), a dedicated manager will likely be required

6. Who will manage the billing, coding and collecting? Finally, practices will need to consider if the existing business office staff will be able to support the billing, coding and collecting processes for the PT program. Practices may need to train existing office staff on supporting this service line, or if the program is big enough, dedicated business office employees may be needed, says Mr. Goldberg. ■

Learn more about Resurgens Orthopaedics at www.resurgens.com.

PRP Use for Orthopedics: Updates and Standards from AAOS

By Laura Miller

Surgical solutions using platelet rich plasma have recently begun making headway in orthopedic surgery, and physicians should have a good understanding of the how the technique works before using it, according to reports published in *AAOS Now*.

For orthopedic use, the physician harvests the venous blood and transfers it to the centrifuge. After the centrifuge processes, the physician extracts PRP according to device instructions. After cleansing the injection site, the physician administers local anesthesia (if necessary) and uses real time image guidance and sterile technique to inject the PRP.

When using PRP, the physician can have a centrifuge in the operating room that utilizes different levels of automation and platelet concentration techniques. Once the blood is in the centrifuge, processing usually takes between 15 and 20 minutes and a sterile barrier may be necessary, depending on automation and centrifuge processing protocols. The current recommendations state that the platelet concentration should be raised between four and six times above the baseline concentration.

The major components of PRP include transforming growth factor-beta, platelet-derived growth factors, insulin-like growth factor, vascular endothelial growth factors and fibroblast growth factor-2, which stimulate the proliferation of mesenchymal cells. These factors stabilize tissue during initial stages of tissue repair, though they can lead to fibrous connective tissue and scar formation.

Physicians thinking about using PRP in their practices should consider the time commitment it takes to learn and employ the technique, insurance coverage and informed consent, according to a report. The American Medical Association recently introduced a new category III CPT code for performing PRP injection procedures which includes harvesting the blood, spinning the blood and injecting the plasma. It can only be used when PRP is performed separately from the patient procedure.

More recent studies suggest that PRP could significantly improve tendon repair. Currently available data suggests that PRP could enhance soft tissue repair, particularly for tendons and wound healing.

Read "Practical guidelines for using PRP in the orthopaedic office" at www.aaos.org/news/aaosnow/sep10/clinical3.asp.

Read "Update: PRP in Orthopaedics" at www.aaos.org/news/aaosnow/sep10/cover2.asp. ■

Contact Laura Miller at laura@beckersasc.com.

8 Statistics About Orthopedic Surgeon Compensation

By Rachel Fields

Here are eight statistics about compensation of orthopedic surgeons, based on spring 2010 data, according to the Locum Tenens 2010 Orthopedic Surgery Salary Survey Report.

1. Average salary of orthopedic surgeons in spring 2010 was $397,879.
2. Average salary of male orthopedic surgeons was $405,185.
3. Average salary of female orthopedic surgeons was $365,000.
4. Average salary of orthopedic surgeons with less than five years of experience was $295,555.
5. Average salary of orthopedic surgeons with 6-10 years of experience was $434,545.
6. Average salary of orthopedic surgeons was more than 10 years of experience was $386,389.
7. Average salary of orthopedic surgeons who were salaried employees was $404,210.
8. Average salary of orthopedic surgeons who owned or partnered with a practice or group was $389,286.

Read the Locum Tenens orthopedic surgery salary survey report at www.locumtenens.com/surgery-careers/2010-orthopedic-surgery-salary-survey-report.pdf. ■

Advertising Index

Note: Ad page number(s) given in parentheses

Healthcare Reform Act's Impact on Orthopedic and Spine Device Companies

By Laura Miller

Hospitals, physicians and surgery centers are all preparing for the immediate impact of the Healthcare Reform Act on the healthcare industry. As these changes occur, medical device companies should also prepare for market and industry changes. Kristian Werling, JD, MBA, healthcare attorney with McGuireWoods, discusses how new regulations will impact orthopedic and spine device companies.

Q: What drives the major trends in medical device companies today?

Kristian Werling: A lot of companies are looking at different industry sectors post-healthcare reform. Not many changes about healthcare reform have come out for device companies. It's been business as usual, for now. However, in a few years there's going to be more cost-control initiatives, and when these initiatives are implemented the medical device companies will be impacted. It could be comparative effectiveness or cost controls coming from commercial payors servicing more patients than they are now or from the Medicare program itself.

Q: Which types of orthopedic and spine device companies have the best chance of success in the future market?

KW: The smart companies are looking down the road three, five, 10 years at where the products and specialties are going to be. Mousetrap companies (companies offering products without a clinical benefit over other products on the market) are usually offering the most expensive and least differentiated products. These types of products will have trouble moving forward because Medicare is only going to pay for or use the device that is the most cost-effective to get the job done. Some of the fancy devices or devices that have minimal physician preference might not see the light of the market in future years. Overall, good medical devices that are designed to help patients, cost effective and provide clear clinical benefits are going to be funded by venture capitalists and get the market.

Q: How will current and future changes in FDA regulations impact medical device manufacturers?

KW: There have been a variety of different controversies recently. The current administration is focused on heavily regulating big business. A key change is that many devices will require more clinical data before they will be approved. In the past, the devices could be approved through referencing clinical data. Now, the companies will need to provide device-specific clinical data regardless of whether a similar device has already been introduced. This will most likely mean going through a longer process to receive FDA 510k clearance and it could have the affect of weeding out weaker devices.

Q: What major changes from the Healthcare Reform Act should orthopedic and spine device companies be aware of?

KW: In the next two years, all companies will be required to disclose their relationships with physicians. A few years back there were some major settlements that happened with hip and knee companies (Stryker, Zimmer Holdings, Smith & Nephew, Biomet) and the outcome was to require those companies to disclose their relationships with physicians. If a physician is a marketing consultant for the company or helped develop a product that was licensed to the company, the companies must post that information as well as physician payments on their website. The concern was the companies were making these payments as kickbacks for referrals. That idea got a lot of steam and was included in the healthcare reform bill as a requirement.

Q: Will disclosing payment information discourage physicians from working with medical device companies?

KW: When the previous investigations first started, a lot of physicians were hesitant to work with the companies because they were worried there would be some taint. The physicians worried others would think they were accepting kickbacks. Now that every company will have to disclose this information, there could be less of a taint. I think physicians will continue to work with companies, though some may think twice about it.

Q: The current trend in hospital reimbursement is to utilize cost-effective equipment and compensate based on quality instead of quality. How does this impact medical device companies?

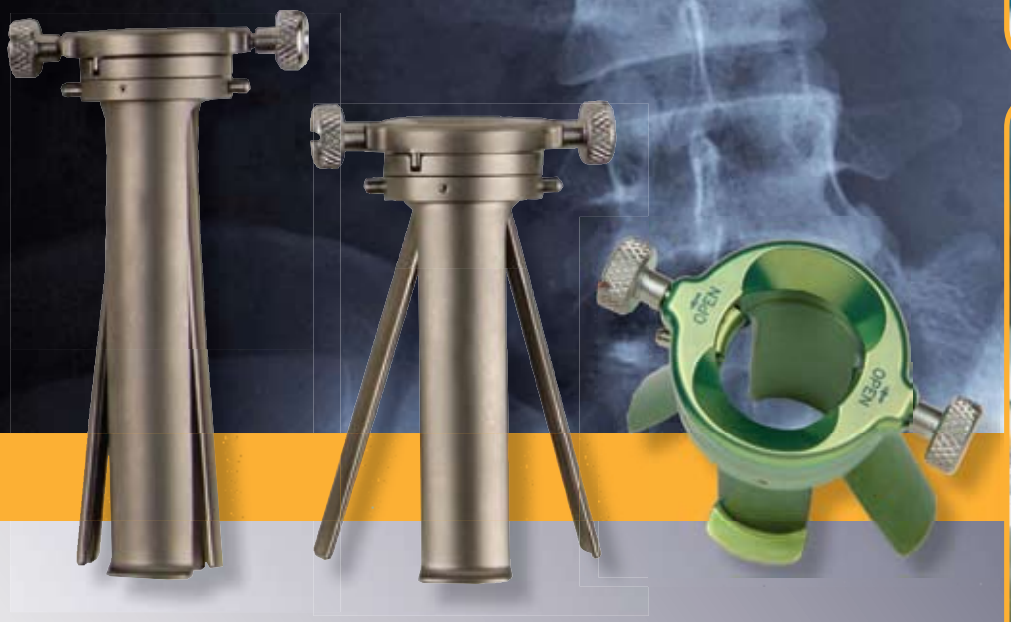
KW: A hospital right now might receive $8,000 for a surgery that uses three or four devices as major components. In the future, if the hospital only receives $5,000 for the same surgery, the hospitals will have to ask the device companies for lower prices. It's a trickle down effect.

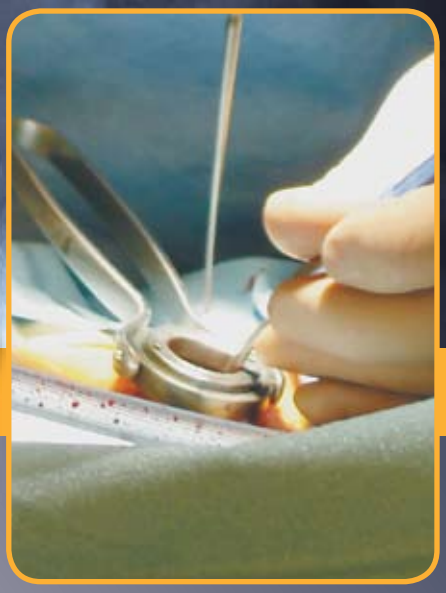
Additionally, some reimbursement organizations, such as accountable care organizations, have the possibility of limiting the number of devices a physician uses. The physicians could be financially incentivized to improve their quality and reduce their costs. One of the ways a lot of physicians reduce their costs is by reducing MRI scans and reducing supplies. If it catches on for orthopedic groups to become part of ACOs, that change could really have an impact on the device companies. ■

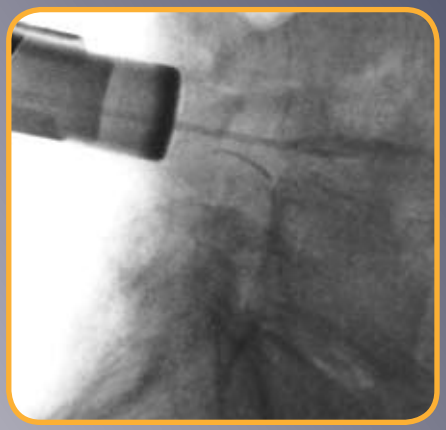
Contact Laura Miller at laura@beckersasc.com.

Swivel Port for Spine:

- ☑ Simple
- ☑ Safe
- ☑ Fast & Cost Effective







Swivel Port Systems:

- Excellent visibility and stability
- Budget friendly
- Made in USA and sold directly to you
- No expensive disposable or consumable expense

Spine Surgical Innovation

Call **1.800.350.8188** today or visit **www.SpineSurgicalInnovation.com** to learn more about the patented Swivel Port System. We offer no pressure, no-charge evaluations and training support.