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BECKER'S**ORTHOPEDIC, SPINE & PAIN MANAGEMENT****REVIEW**

Sept./Oct. 2011 • Vol. 2011 No. 4

*Business and Legal Issues for Orthopedics, Spine and Pain Management***Will There Be a Place for Orthopedic and Spine Surgeon Relationships With Device Companies in the Future? 6 Responses**

By Laura Miller

Six orthopedic and spine surgeons and industry members discuss the current state of surgeon relationships with device companies and what might be in store for the future.

continued on page 8**Robotics in Orthopedic Surgery: 6 Points on the Present and Future**

By Laura Miller

Robotic and computer-assisted technology is now available for use during orthopedic and spine procedures. There are many concerns associated with the efficacy and efficiency of this technology, especially since it costs hospitals a great deal of money to acquire. Here, orthopedic and spine surgeon leaders discuss six points on where the technology is now and where it will likely head in the future.

1. What robotic and computer-assisted technology is capable of now. Currently, there are only a few orthopedic procedures, such as partial knee and hip replacements, that have robotic or computer-assisted

continued on page 9**67 Outstanding Shoulder Surgeons and Specialists**

By Laura Miller

The following shoulder surgeons and specialists were selected for this list based on the awards they have received from major organizations in the field, leadership in those organizations, work on professional publications and positions of service held at hospitals and practices. The surgeons are listed in alphabetical order by last name. All physicians placed on this list have undergone substantial review from our editorial staff. Physicians do not pay and cannot pay to be selected as an outstanding leader. This list is not an endorsement of any individual's or organization's clinical abilities.

A full-length version of this list with full profiles is available at www.BeckersOrthopedicandSpine.com

Jeff Abrams, MD (Princeton Orthopaedic Association, Princeton, N.J.). Dr. Abrams was one of the first physicians to perform rotator cuff repairs and stabilization surgery using arthroscopy. Dr. Abrams is a member of American Academy of Orthopaedic Surgeons and American Shoulder and Elbow Surgeons.

Answorth Allen, MD (Hospital for Special Surgery, New York City).

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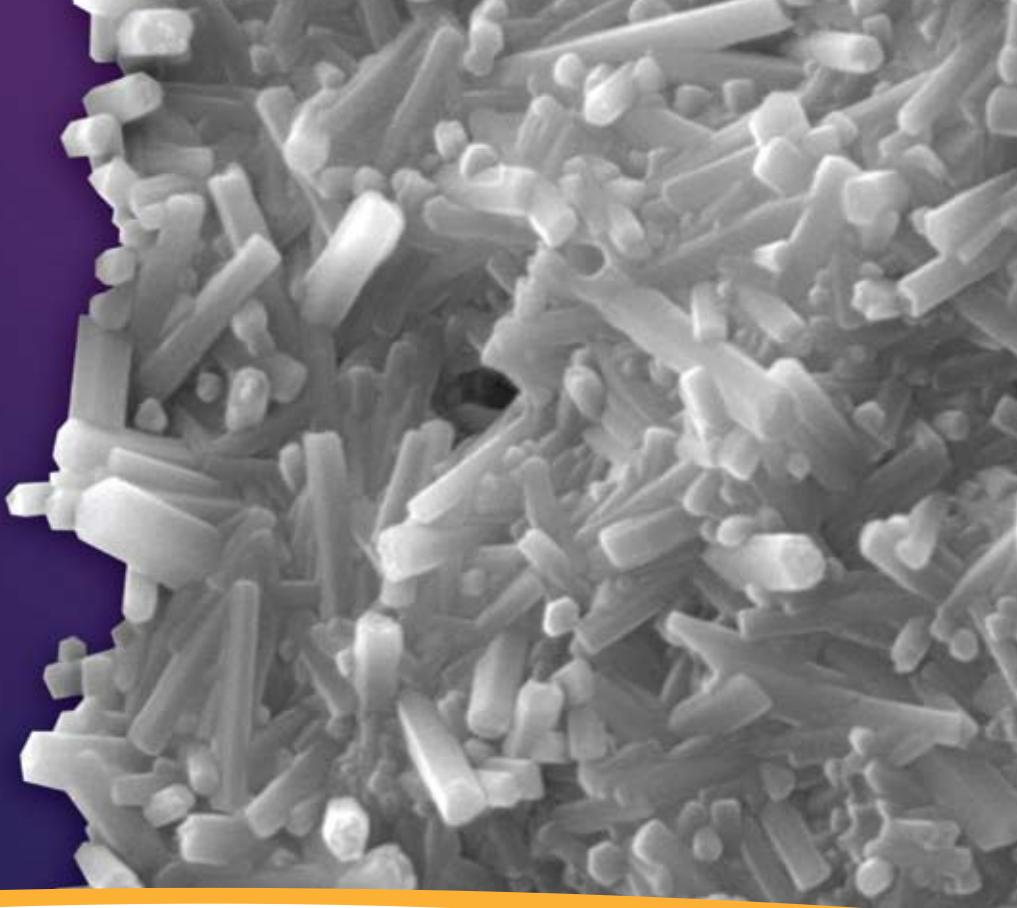
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Publisher's Letter

The Evolution of Physician Alignment; Becker's Hospital Review CEO/CFO Annual Strategy Webinar

1. The Evolution of Physician Alignment. Core options for alignment. Hospitals generally look at three core options for aligning with physicians. These include (1) practice acquisitions coupled with ongoing employment, (2) collaborative hospital financial relationships such as joint ventures, call coverage, recruiting assistance, service line management and (3) finding ways to work with physicians that have complete financial independence. However, the era of complete independence seems to be moving towards extinction. According to a recent study by Accenture, only 33 percent of physicians will remain truly independent by 2013. Thus, much effort is placed on the employment integrated model and hybrid relationships, of which there are a variety. Overall, though, more and more hospitals seem to be focused on executing a strategy that includes a vertically integrated delivery system, which can be achieved through acquisition and employment as well as residency hiring. However, building a strong bottom-up program through residency hiring can take a decade or more. As a result, systems are increasingly focused on employment and acquisitions, which impacts the future of all physicians, including those specializing in orthopedics, spine and pain.

Physician employment. While many systems today use a mix of both the employment and hybrid models to approach their physician alignment strategy, even more physician employment is on the horizon. A study by the Medical Group Management Association reported that 55 percent of

medical practices were hospital owned as of 2009. In 2005, the majority of practices (66 percent) were physician owned.¹ Additionally, a Merritt Hawkins survey of hospital leaders revealed the following:

- 74 percent say they plan to employ a greater number of physicians in the next 12 to 36 months
- 70 percent say they have received increased requests from physician group for employment
- 61 percent plan on acquiring medical groups in the next 12 to 36 months²

Alignment critical to hospital survival. It has been noted "Only hospitals that are tightly aligned or integrated with critical mass of physicians will be able to organize their delivery system to meet payer/consumer demands for price, quality, efficiency and community services. Hospitals that lack a strong relationship with a group of line doctors will not survive on their own."³

There continues to be increased scrutiny of such relationships from a federal standpoint. This comes in the form of cases that allege unreasonable compensation being paid by hospitals to employed physicians and situations where purchasers of practices were being viewed as paying more than fair market value. As such, it is important that physicians contracting with hospitals take care to ensure their contracts meet all legal requirements.



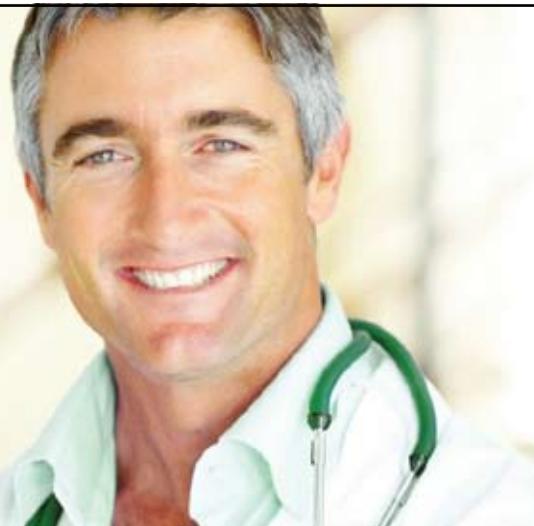
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Should you have any questions or can we be of any help, please contact Scott Becker, publisher of *Becker's Hospital Review*, at sbecker@beckershealthcare.com or call (312)750-6016.

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1 Medical Group Management Assoc., *Physician Compensation and Production Survey: 2010 Report Based on 2009 Data* 26 (2010).

2 Merritt Hawkins, Health Reform and the Decline of Physician Private Practice: A White Paper Examining the Effects of the Patient Protection and Affordable Care Act on Physician Practices in the United States (2010).

3 Aligning Hospitals and Physicians: Formulating Strategy in a Changing Environment, A Governance Institute White Paper (2008).

Will There Be a Place for Orthopedic and Spine Surgeon Relationships With Device Companies in the Future? 6 Responses (continued from page 1)

Todd Albert, MD, Spine Surgeon and President, Rothman Institute (Philadelphia). The short answer is there will be and there must be because this relationship is really important for innovation. We must figure out a way for surgeons to be involved and work in a compliant way with device companies. We acknowledge there is going to be a conflict of interest sometimes, but there's a difference between working with companies on innovation and being cheerleaders for a particular company. Many surgeons are developing devices that are a significant contribution and they hold patents on devices as their intellectual property.

Tom Hackett, MD, Sports Medicine Surgeon, The Steadman Clinic (Vail, Colo.). Absolutely, yes. I think the relationships are very important in terms of the development of new devices or improvements on old devices. I think those relationships, if they are managed properly, can be very fruitful, especially for patients. These relationships can also be beneficial for the surgeons and the device companies during product development. Many companies fund research and foster surgeon education. All of these relationships can be managed ethically by following the American Academy of Orthopaedic Surgeons standards of professionalism. If surgeons follow those standards and adhere to the concept of full disclosure, there shouldn't be a problem.

Eric Muehlbauer, Executive Director, North American Spine Society. Absolutely! Innovation cannot take place in a vacuum. Through thoughtful and ethical collaboration, medical professionals and device companies can continue to improve patient care and advance medical science, including the development of cutting-edge devices in spine care.

NASS believes so strongly in the value of this type of collaboration that it has created one of the most stringent mandatory codes of conduct for itself, its members and outside companies conducting business with NASS. With clear, ethical guidelines before them, physicians can continue to share their expertise as inventors, scientific advisors and consultants to industry and provide patients with the very best spine care.

Bill Kolter, Corporate Vice-President of Government Affairs, Public Affairs and Corporate Communication, Biomet. It's going to remain necessary for orthopedic manufacturers to continue to have working relationships with orthopedic surgeons because we can't do our jobs without their input. There are several key areas where the involvement of orthopedic surgeons is necessary in order to address unmet clinical needs. Orthopedic surgeons provide essential input into the development of new products.

Before the devices can be made available to orthopedic surgeons for use with their patients, we need their input on how to design products that perform as intended in their hands. We also need their help to evaluate that performance. The population of clinical studies is also important. The

Food and Drug Administration often requires clinical studies as part of submissions for clearance or approval to market new products. We need orthopedic surgeons who can conduct these studies and continue with post-market surveillance of those products.

Educating surgeons on the safe and effective use of the products is another critical area of interaction with surgeons. We frequently conduct cadaveric and other training on our products to teach surgeons about the safe and effective use of our products. In order to conduct these trainings, we need orthopedic surgeons to help lead these educational sessions. That's a critical part of our mission. We can't do our job without that kind of assistance and collaboration.

Bruce Darden, MD, Spine Surgeon at OrthoCarolina, Charlotte, N.C. I definitely think there is a place for orthopedic and spine surgeons to have a relationship with device companies in the future. There are a number of people in our group who work with companies and provide consultation. I think it's necessary to have physicians working with companies to design products because when we've had instruments designed by just engineers without a medical background, they don't always work well for physicians.

Where it becomes muddy is that some surgeons have consulting agreements where the guidelines aren't specific as to what they are doing with the company or whether they are adding value to the product. I think some of those relationships will die pretty quickly. At our practice, the basic premise that we use when we negotiate a consulting agreement is based on a numeric amount of what we generate — our value for one day of work. We document everything we are doing and we basically work on an hourly rate based on the number of hours we are working with the company, as opposed to some nebulous number. Everything is clean with that agreement and it's pretty clear what we are doing with the consulting firm. These are the types of relationships that will stick around in the future.

Bal Raj, MD, Orthopedic Surgeon, Beverly Hills (Calif.) Orthopedic Institute. Spine and orthopedic surgeons used to have a much closer relationship with device companies, but because of the potential bias these relationships have changed. There have been several issues in regards to these ongoing relationships, including surgeons who have benefitted from using the implants of companies they have a relationship with. We've seen a lot of these relationships dissipate and it's to protect patients.

I think surgeons and device companies will be able to have legitimate relationships in the future and we will get rid of the illegitimate relationships. Even when the relationship is legitimate, it is the surgeon's responsibility to disclose them publicly. The recent scrutiny on these relationships is great in the sense that it is protecting people. It's cleaning up the whole scenario — there are only a few bad seeds who have led to this problem. The surgeons in legitimate relationships with companies don't have anything to worry about. ■

**Robotics in Orthopedic Surgery:
6 Points on the Present and Future**
(continued from page 1)

technology to help facilitate the surgeries. As the technology advances, companies have gone from developing facilitating technology to enabling technology. "Up until now, a lot of the advanced techniques using computer assistance have been facilitating, which means they made the surgery more precise," says Andrew Pearle, MD, an orthopedic surgeon at the Hospital for Special Surgery in New York City. "Now, we are starting to see more programs that are enabling, which means making it possible to do surgeries that surgeons couldn't do before."

Robotic systems for orthopedic and spine surgery are surrounded by misconceptions, most notably that the robot performs the procedure. However, the robot is only able to follow the surgeons' preoperative plans and guide them perioperatively. "Some surgeons think that a robot will make a bad surgeon good," says Isador Lieberman, MD, a spine surgeon with Texas Back Institute in Plano and co-inventor of SpineAssist from Mazor Robotics. "If you don't understand the indications, biomechanics and musculoskeletal anatomy, it doesn't matter what tools you have in your hand, you won't do a good job."

Surgeons often use advanced technology in their every day lives, such as computers or iPads, but many are skeptical about bringing the robotic technology into the OR. Some surgeons might feel threatened by the idea of using the technology to enhance a procedure they already perform well while others fear the technology is industry-driven instead of evidence-based. "The argument about needing long-term data supporting better outcomes with robotic technology is good, but everything has to start somewhere," says James Ballard, MD, an orthopedic surgeon with Legacy Meridian Park Medical Center in Tualatin, Ore. "If a new idea comes out that you understand and like, you just might have to use it."

2. Applying evidence-based research to robotic technology. Strong, evidence-based studies showing that robotic technology produces better outcomes are lacking, and many orthopedic surgeons are unsure of spending the extra time and money to train on the systems. "We have to show using the robot is better than conventional techniques, and it's got a long way to go," says Dr. Pearle. "Up until now, robotics has been promoted and expanded mainly because of marketing successes of the robotic companies."

Strong evidence-based studies are rare in orthopedics because sorting patients and physicians

into randomized, double-blind groups is problematic, and patients often want to use the latest and greatest technology if it's available. Dr. Pearle is participating in research at the Hospital for Special Surgery using the technology on cadavers, but the best studies using humans take several years to complete. The short-term studies show that using the robot has very little impact on a patient's immediate outcome.

"A lot of computer surgery or robotics improves implant positioning, and the improved effects of implant positioning sometimes aren't seen for 10-20 years," he says. "A well-positioned implant may not mean the patient feels better in the first five years, but it could mean that the implant is more durable over the second five years. It's pretty clear, at least with total knee replacement, that implant positioning may not be as important in the short term as fixation strategies, surgical techniques and patient selection."

Additionally, measuring the success of precise incisions for joint replacement using robotic technology is difficult because surgeons don't have the outcome tools to define the precision. The kinematics aren't sensitive enough for patient performance outcomes to help depict improvements for implants that are placed within a millimeter of where surgeons want them.

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3. Marketing the technology. While the technology doesn't have hard clinical evidence to support its use, device companies have been able to sell their systems to hospitals across the country. Much of the success of these sales can be attributed to marketing by the company, but the sustained use of the technology could be a sign that hospitals and surgeons are seeing good results.

"Marketing can only take you so far, and now we have to show that the technology is better," says Dr. Pearle. "These systems cost so much that hospitals tend to create a marketing effort when they buy one of these products. That is a bad thing because it limits the substantive research that needs to be done for robotics."

Orthopedic and spine device companies are also seeing the marketing power of robotic technology and many may add robotics to their proprietary portfolio. "The companies will link implantable devices to robotic systems," says Dr. Lieberman. "I see a big market growing there and I think it's going to be subject to the typical supply and demand rules that we see in other emerging technology."

Before learning the MAKOplasty procedure, Dr. Ballard didn't perform partial knee replacements because he felt the instrumentation and technology was too finicky. "I had dealt with a lot of patients who had failed partial knee replacements, and that scared me away from performing it," he says. "When I used the robotic system, I have a reproducible way to place implants. I don't think the robotic technology makes the procedure any worse, and it stands the chance to create better outcomes."

4. Patient demand for robotic surgery. In some communities, patients are driving the trend toward robotic- and computer-assisted proce-

dures by demanding them from their physicians. "Patients see advertisements and hear a lot about robotic surgery, so there are a fair number of them who come into the office asking for it," says Scott Heithoff, DO, an orthopedic surgeon with Orthopedic Associates of Port Huron (Mich.). Healthcare is one of the last fields switching over to electronic technology and patients are often well-accustomed with the potential advantages robotics can bring to their every day lives before the need for surgery arises.

"Patients realize what the computer has done in their personal life, and if they are going to have an operation, they want the best thing going for them," says Lawrence D. Dorr, MD, medical director of the Dorr Arthritis Institute at Good Samaritan Hospital in Los Angeles. "Patients can find the information on the Internet and they know who in their community uses robotic technology. Then, when the physician down the street does robotic surgeries and has great results, you feel pressure to use the technology, too."

Dr. Lieberman has already witnessed patient demand for robot-assisted spine surgery. "There's a perception out there that the robot is more accurate and efficient, which could translate to better outcomes," he says. "If the patient wants robotic surgery, the hardest thing to tell them is that they don't need surgery or that the robot won't help them with their particular procedure. It's recognizable and appreciated, and patients want to use it."

5. Dealing with the technology expense. Purchasing the equipment and software for performing robotic or computer-assisted surgery places a great burden on the hospital or health-care provider. Some surgeons are partnering with hospitals that purchase the equipment, but

even taking the time out of daily practice to train and become proficient on the technology can be difficult, despite the potential benefits of using the systems. "Right now, I think cost is a limiting factor," says Dr. Heithoff. "For example, a robotic knee system can come close to costing a million dollars. But, as with any technology, the cost will come down with time."

For now, the initial staggering costs place pressure on hospitals to market their new equipment to patients, which can be problematic since the technology hasn't been proven at the strong evidence-based level yet. "Some of the issues with current research on the effectiveness of the robots comes because it's not independent, non-biased research," says Dr. Heithoff. "This might be difficult to achieve because the robot cost so much. Many surgeons need the company backing to complete the research."

However, once the hospital goes beyond the initial cost for the equipment, a more precise surgery could save money in the long run. "The fact of the matter is, if you get a good result with every surgery you do, you save time with the complications associated with failed surgery," says Dr. Dorr. "People look at it as a short-term expense, but you have to look at it in the long run. It could prevent revision surgeries and long hospital stays. I think if it's going to make the patients better, it's worthwhile."

6. Will robotic technology still be around in 10 years? With increased pressure to reduce the cost of healthcare and emphasis on evidence-based medicine, robotic technology must prove its efficacy to continue its increased use. The systems will need to come down in price, which will happen if more products come into the market. "Ten years from now, I think robotic technology will be pervasive among operations, including trauma, joint and spine," says Dr. Dorr. "There isn't much more that can be done with implants, fixation and articulation. The only thing we can do is improve our human performance."

While robotic technology for orthopedics may expand in the future, there will most likely be limitations to how far it will go. "I don't think we'll ever see completely active robots in orthopedic surgery because there is too much variation in the human anatomy and too many instances that need immediate human judgments," says Dr. Ballard. "I think you're going to see refinements to the preoperative planning software and limited robotic technology so you can see what you want to change and go through simulations until the surgery is perfect."

Dr. Lieberman predicts that robotics will become more of the standard of care for spine surgery as well. "Much like none of us would want to be without GPS in our cars today, in the future we'll want to have the robotic technology in the OR," he says. "We can still perform surgery without it, but we'll want the robot there because it's more efficient and will be the standard of care." ■

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67 Outstanding Shoulder Surgeons and Specialists (continued from page 1)

Dr. Allen is a team physician for the New York Knicks and former team physician for the New York Mets. His expertise is in arthroscopy, shoulder surgery and treating sports injuries.

Vivek Agrawal, MD (The Shoulder Center, Carmel, Ind.). Dr. Agrawal is director of The Shoulder Center in Carmel, Ind., which specializes in providing advanced care for shoulder problems. Dr. Agrawal has expertise in reverse shoulder replacement and uses arthroscopic techniques to repair complex shoulder tears.

David W. Altchek, MD (Hospital for Special Surgery, New York City). Dr. Altchek is co-chief of sports medicine and shoulder service at Hospital for Specialty Surgery and has special expertise in arthroscopic surgery of the shoulder. He has received the Charles S. Neer Award from the American Shoulder and Elbow Surgeons.

James Andrews, MD (Andrews Sports Medicine and Orthopaedic Center, Birmingham, Ala.). Dr. Andrews is the founder of Andrews Sports Medicine and Orthopaedic Center. He is a past president of the American Orthopaedics Society for Sports Medicine and has served on the board of directors for the Arthroscopy Association of North America.

Eric Berkson, MD (Orthopedic Surgery of Quincy, Quincy, Mass.). Dr. Berkson has a professional interest in arthroscopic techniques and rotator cuff repair. He conducts research on the biomechanics of pitching project, pediatric shoulder treatment and minimally invasive total joint replacements.

Louis Bigliani, MD (Columbia Orthopaedics, New York City). Dr. Bigliani is chair of orthopedic surgery and chief of the center for shoulder, elbow and sports medicine at Columbia University. He has previously served as the American Orthopaedic Association president and is a founding member of the American Shoulder and Elbow Surgeons.

Mark Bowen, MD (Northwestern Orthopaedic Institute, Chicago). Dr. Bowen is a team physician for the Chicago Bears. He is also an associate clinical professor of orthopedic surgery at Northwestern University and is a frequent instructor for the American Academy of Orthopaedic Surgeons.

James Bradley, MD (Burke and Bradley Orthopedics, Pittsburgh). Dr. Bradley is the team physician for the Pittsburgh Steelers and past president of the NFL Physicians Society. He has been president of the Herodicus Society and member of the American Orthopaedic Society for Sports Medicine.

John Brems, MD (Cleveland Clinic). Dr. Brems is the fellowship director for shoulder and elbow surgery post residency training program at the Cleveland Clinic. He is a review editor of the *Journal of Shoulder and Elbow Surgery*.

Stephen S. Burkhart, MD (San Antonio Orthopaedic Group). Dr. Burkhart has pioneered a number of arthroscopic shoulder procedures and invented or patented more than 20 surgical devices. He is a past president of the Arthroscopy Association of North America.

Wayne Burkhead, MD (The Carrell Clinic, Dallas). Dr. Burkhead created the modular replacement for the shoulder and developed techniques to improve results of rotator cuff repair and surgery for dislocated shoulders. He is the former shoulder surgeon to the Dallas Cowboys and past president of the American Shoulder and Elbow Surgeons.

Charles Bush-Joseph, MD (Midwest Orthopaedics at Rush, Chicago). Dr. Bush-Joseph is a team physician for the Chicago White Sox and the Chicago Bulls. He is a member of the American Orthopaedic Society for Sports Medicine and the American Academy of Orthopaedic Surgeons.

Michael Ciccotti, MD (Rothman Institute, Philadelphia). Dr. Ciccotti is director of the sports medicine division at Rothman Institute in Philadelphia. He is the head team physician and medical director for the Philadelphia Phillies and orthopedic consultant for Philadelphia Flyers and Philadelphia Eagles.

Robert Cofield, MD (Mayo Clinic, Rochester, Minn.). Dr. Cofield's research focuses on biomechanics and motion analysis. He has authored several publications on topics including total shoulder replacement for osteoarthritis patients and shoulder arthroplasty in paraplegic patients.

Brian Cole, MD (Midwest Orthopaedics at Rush, Chicago). Dr. Cole is the head of the Cartilage Research Program at Rush University Medical Center and the Cartilage Restoration Center at Rush. Dr. Cole serves as a team physician for the Chicago White Sox and Chicago Bulls and a member of the American Shoulder and Elbow Surgeons.

Geoffrey Connor, MD (Alabama Orthopedic, Spine & Sports Medicine Associates, Birmingham). Dr. Connor is a staff instructor at Jefferson County Clinic at Cooper Green Hospital in Birmingham and has an interest in arthroscopic knee and shoulder reconstruction. He also studies topics like ultrasound diagnostics for rotator cuff tears.

Michael Corcoran, MD (OAK Orthopedics, Bradley, Ill.). Dr. Corcoran serves as the director of OAK Sports Medicine, team physician for US Soccer and an orthopedic consultant for the Chicago Bears.

Frances Cuomo, MD (Beth Israel Medical Center, New York City). Dr. Cuomo is the chief of shoulder service and the director of the shoulder and elbow fellowship program in the department of orthopedic surgery at Beth Israel Medical Center. She is currently the president of American Shoulder and Elbow Surgeons.

Ralph "Bud" Curtis, MD (Sports Medicine Association of San Antonio). Dr. Curtis is the shoulder consultant for many professional sports teams, including the San Antonio Spurs, San Antonio Silver Stars and USA Swimming. He is a member of American American Shoulder and Elbow Surgeons.

Patrick M. Connor, MD (OrthoCarolina, Charlotte, N.C.). Dr. Connor counts all aspects of shoulder and elbow surgery among his professional interests with expertise in rotator cuff and shoulder replacement surgery. He is head team physician for the Carolina Panthers.

David Dines, MD (Hospital for Special Surgery, New York City). Dr. Dines is a past president of the American Shoulder and Elbow Surgeons and an orthopedic consultant for the US Open Tennis Tournament. He also developed the Biomet Biomodular Total Shoulder System and has won the Charles S. Neer Award for his research.

Xavier Duralde, MD (Peachtree Orthopaedic Clinic, Atlanta). Dr. Duralde serves as the assistant orthopedic surgeon to the Atlanta Braves. He is a member of the American Shoulder and Elbow Surgeons and the Major League Baseball Physicians Association.

Neal El Attrache, MD (Kerlan-Jobe Orthopaedic Clinic, Los Angeles). Dr. El Attrache is the director of the sports medicine fellowship. He is a team physician for the Los Angeles Dodgers, Anaheim Mighty Ducks, St. Louis Rams, Los Angeles Lakers and the Los Angeles Kings.

Blaine Farless, MD (Cleburne Orthopaedic and Sports Medicine Center, Cleburne, Texas). Dr. Farless has a professional interest in sports medicine and shoulder care. He is a member of the American Academy of Orthopaedic Surgeons and Texas Orthopaedic Association.

Stephen Fealy, MD (Hospital for Special Surgery, New York City). Dr. Fealy received a grant from Major League Baseball to evaluate common tendon injuries involving the shoulder, elbow and knee. He is a member of the American Orthopaedic Society for Sports Medicine and Arthroscopy Association of North America.

Evan L. Flatow, MD (Mount Sinai Medical Center, New York City). Dr. Flatow is chair of the orthopedics department at Mount Sinai School of Medicine and is past-president of the American Shoulder and Elbow Surgeons. He also helped to develop a comprehensive shoulder replacement system.

Leesa Galatz, MD (Washington University Physicians, St. Louis). Dr. Galatz has expertise in traumatic and degenerative disorders of the shoulder and rotator cuff disorders. Dr. Galatz has also published research on arthroscopic rotator cuff repair and frozen shoulder.

Gordon Groh, MD (Blue Ridge Bone and Joint, Asheville, N.C.). Dr. Groh holds memberships to both American Shoulder and Elbow Surgeons and American Society for Surgery of the Hand. His additional affiliations include the American Academy of Orthopaedic Surgeons.

Michael Gross, MD (Active Orthopaedics & Sports Medicine, Westwood, N.J.). Dr. Gross is a chief of the division of sports medicine at Hackensack (N.J.) University Medical Center. He is a member of American Academy of Orthopaedic Surgeons and the American College of Sports Medicine.

Stephen M. Gryzlo, MD (Northwestern University, Chicago). Dr. Gryzlo is an assistant professor at Northwestern University and has a professional interest in treating shoulder pain, SLAP tears and rotator cuff injuries. He is head team physician for the Chicago Cubs.

Brad Harman, MD (Cleburne Orthopedic and Sports Medicine Center, Cleburne, Texas). Dr. Harman is on the medical staff for the U.S. Water Ski Team and has served on medical staff for various professional and collegiate teams, including the Houston Texans.

Richard Hawkins, MD (Steadman Hawkins Clinic of the Carolinas, Spartanburg, S.C.). Dr. Hawkins is a founding member of the Steadman Hawkins Clinic of the Carolinas. He is also among the founding members of the American Shoulder and Elbow Surgeons as well as past president of the Canadian Academy of Sports Medicine.

Heinz Hoenecke, MD (Scripps Clinic, La Jolla, Calif.). Dr. Hoenecke is the head team physician for the San Diego Padres. He recently led a research team in developing a three-dimensional computer-animated shoulder stimulator to measure how much stress is put on muscles during various motions.

S. Wendell Holmes, Jr., MD (Moore Orthopaedic Clinic, Columbia, S.C.). Dr. Holmes is director of The Sports Medicine Center of the Moore Orthopaedic Clinic. He has made countless surgery-specific presentations, written for numerous publications and holds five patents.

Joseph Iannotti, MD (Cleveland Clinic). Dr. Iannotti is the chairman of the Orthopedic and Rheumatologic Institute at the Cleveland Clinic. He is a past-president of the American Shoulder and Elbow Surgeons.

Frank Jobe, MD (Kerlan-Jobe Orthopaedic Clinic, Los Angeles). Dr. Jobe is co-founder of the Kerlan-Jobe Orthopaedic Clinic and is credited with developing the modern ulnar collateral ligament repair. He is a founding member and past president of the American Shoulder and Elbow Surgeons.

James Kelly, II, MD (The San Francisco Shoulder, Elbow and Hand Clinic). Dr. Kelly is a member of a reverse shoulder replacement development team for patients with previously unsolvable arthritis and rotator cuff disease. He is a member of Arthroscopy Association of North America.

William N. Levine, MD (Columbia Orthopaedics, New York City). Dr. Levine is the director of sports medicine and assistant director for the Center for Shoulder, Elbow and Sports Medicine as well as head team physician at Columbia. He is a member of American Shoulder and Elbow Surgeons.

Scott Lintner, MD (OrthoIndy, Indianapolis). Dr. Lintner has a professional interest in arthroscopic surgery, shoulder repair, sports medicine and cartilage restoration. He is a member of the NBA Team Physician Society and serves as a physician consultant to the National Football League.



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Edward G. McFarland, MD (Johns Hopkins Medicine, Baltimore). Dr. McFarland is director of the division of adult orthopedics at Johns Hopkins University in Baltimore. He is a team physician for the Baltimore Orioles.

Augustus Mazzocca, MD (New England Musculoskeletal Institute, Farmington, Conn.). Dr. Mazzocca has three patents on devices and processes to improve the healing of rotator cuff repairs and has designed three products used to reconstruct shoulder injuries. His research has received the Richard B. Caspari Award for the best international upper extremity paper from the Society of Arthroscopy.

George McCluskey, MD (San Francisco Orthopaedic Institute). Dr. McCluskey directs the shoulder surgery center and shoulder fellowship program at San Francisco Orthopaedic Institute. He is a member of American Shoulder and Elbow Surgeons and the Columbia Shoulder Society.

Seth R. Miller, MD (Orthopaedic & Neurosurgery Specialists, Greenwich, Conn.). Dr. Miller has served as orthopedic consultant to the New York Mets and is a member of American Academy of Orthopaedic Surgeons.

Peter J. Millett, MD (The Steadman Clinic, Vail, Colo.). Dr. Millett has an expertise in complex and revision shoulder surgery. He is a member of American Academy of Orthopaedic Surgeons and American Shoulder and Elbow Surgeons.

Gregory P. Nicholson, MD (Midwest Orthopaedics at Rush, Chicago). Dr. Nicholson has a professional interest in shoulder and elbow surgery utilizing arthroscopic and open surgical techniques. He is a team physician for the Chicago White Sox and the Chicago Bulls.

Robert Nicoletta, MD (St. Elizabeth's Medical Center, Boston). Dr. Nicoletta was recently named the chief of orthopedic surgery and sports medicine at St. Elizabeth's Medical Center. He is also the Harvard Medical School Course Director for Sports Medicine Symposium, held annually in Boston.

Gordon Nuber, MD (Northwestern Orthopaedic Institute, Chicago). Dr. Nuber is a reviewer for the *Journal of Shoulder and Elbow*. He is a team physician for the Chicago Bears and a member of several professional organizations, including American Academy of Orthopaedic Surgeons.

Michael Pearl, MD (Kaiser Permanente, Los Angeles Medical Center). Dr. Pearl has a professional interest in anatomical shoulder repair and treating sequelae of brachial birth plexus palsy. He is treasurer of the American Shoulder and Elbow Surgeons.

Roger Pollock, MD (Valley Health System, Ridgewood, N.J.). Dr. Pollock has been a reviewer for *American Journal of Sports Medicine*, the *Journal of Bone and Joint Surgery* and *Journal of Shoulder and Elbow Surgery*. He is a member of American Shoulder and Elbow Surgeons.

Christopher Price, MD (Missoula Bone and Joint, Missoula, Mont.). Dr. Price has a professional interest in sports medicine, shoulder and joint replacement surgery. He has given several presentations throughout his career and served as staff assistant at the Annual NFL Combine in Indianapolis.

William D. Prickett (Tucson Orthopaedic Institute, Ariz.). Dr. Prickett has authored several articles on topics such as shoulder instability in athletes. He is a member of American Shoulder and Elbow Surgeons.

Matthew L. Ramsey, MD (Rothman Institute, Philadelphia). Dr. Ramsey has lectured on arthroscopic shoulder techniques around the country. He is the assistant editor of the *Journal of Shoulder and Elbow Surgery* as well as reviewer for *Journal of Bone and Joint Surgery*.

Anthony A. Romeo, MD (Midwest Orthopaedics at Rush, Chicago). Dr. Romeo has designed an advanced shoulder replacement system for treating arthritis. He is a member of the American Shoulder and Elbow Surgeons.

Marc Safran, MD (Stanford University School of Medicine, Redwood City, Calif.). Dr. Safran is the associate chief of sports medicine and sports medicine fellowship director at Stanford University School of Medicine. He serves as a member-at-large on the executive committee of American Shoulder and Elbow Surgeons.

Felix Savoie, III, MD (Tulane University School of Medicine, New Orleans). Dr. Savoie is the chief of sports medicine at Tulane University School of Medicine. He has received the American Shoulder and Elbow Surgeons' Charles Neer Award for his research.

Mark Schickendantz, MD (Cleveland Clinic). Dr. Schickendantz is the director of the Center for Sports Health at Cleveland Clinic and the head team physician for the Cleveland Browns. He has published research on topics such as ulnar collateral ligament repair and injury among professional baseball players.

Joshua Siegel, MD (Access Sports Medicine, Exeter, N.H.). Dr. Siegel is sports medicine director at Access Sports Medicine & Orthopaedics. He helped pioneer various procedures, such as a new resurfacing prosthesis and biologic rotator cuff repairs.

James Tibone, MD (Kerlan-Jobe Orthopaedic Clinic, Los Angeles). Dr. Tibone is past president of the American Shoulder and Elbow Surgeons. He has provided care for Los Angeles Dodgers and Los Angeles Lakers.

Nikhil N. Verma, MD (Midwest Orthopaedics at Rush, Chicago). Dr. Verma's research interests include healing of rotator cuff tendons after arthroscopic repair. He is a team physician for the Chicago Bulls and Chicago White Sox.

Jon Warner, MD (Boston Shoulder Institute, Boston). Dr. Warner is a physician at Boston Shoulder Institute and chief of the shoulder service and director of the combined shoulder fellowship at Harvard Medical School in Boston. He has received the Charles S. Neer Award of the American Shoulder and Elbow Surgeons.

Russell Warren, MD (Hospital for Special Surgery, New York City). Dr. Warren is a surgeon-in-chief with the Hospital for Special Surgery. He is a past president for the American Shoulder and Elbow Surgeons and team physician for the New York Giants.

Gerald R. Williams, Jr., MD (Rothman Institute, Philadelphia). Dr. Williams is director of the shoulder and elbow center at Rothman Institute. He has been president-elect of the American Shoulder and Elbow Surgeons.

Ken Yamaguchi, MD (Washington University Physicians, St. Louis). Dr. Yamaguchi has expertise in minimally invasive surgery, rotator cuff disorders and treatment of arthritis in the shoulder. He has published research on infection after total elbow arthroplasty and rotator cuff repair.

Austin Yeargan, MD (North Carolina Shoulder and Elbow Surgery, Wilmington). Dr. Yeargan has a professional interest in sports medicine and is among the pioneers of stem cell therapy in orthopedics.

Lewis Yocum, MD (Kerlan-Jobe Orthopaedic Clinic, Los Angeles). Dr. Yocum is the medical director of the Los Angeles Angels of Anaheim and an orthopedic consultant to several professional dance companies. He has performed ulnar collateral ligament repair on several professional athletes.

Joseph Zuckerman, MD (NYU Langone Medical Center, New York City). Dr. Zuckerman's professional interests include shoulder surgery and joint replacement. Throughout his career, Dr. Zuckerman has published several articles on topics including revision shoulder arthroplasty and healing rotator cuff repairs. ■



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Dr. John Caruso: Becoming a Champion of Change in Healthcare

By Molly Gamble

Some healthcare professionals might still be analyzing the Patient Protection and Affordable Care Act, but other physicians are making the legislation — and the ideas behind it — come to life.

John Caruso, MD, is one of those physicians. He has nearly 20 years of experience in neurological surgery and currently practices with Neurological Specialists, a private group in Hagerstown, Md. A physician advocate, Dr. Caruso believes it's time for physicians to become more involved in healthcare economics and policy. Here, he shares his insight on physician-hospital relationships, population health management, and why physicians should broaden their understanding of a hospital's bottom line.

On working with hospitals

Dr. Caruso says physicians' tenures in a community generally outlive those of CEOs. "Philosophies can change quickly in regard to healthcare," says Dr. Caruso. He mentions a friend who once told him CEOs are similar to ball players that frequently relocate and work for different organizations. Young and eager CEOs, however, can make a noticeable difference in a hospital's relationships with other providers in the area. "When you get a CEO that really wants to innovate, that's when you get a home run," says Dr. Caruso.

Tense relations with hospitals are nothing new to Dr. Caruso, who has battled a hospital in his market for the past four years. The hospital saw the private practice as a competitor, taking inpatients away from their spine services.

"The hospital saw us as a source of leakage. They fought us tooth and nail. Then they finally admitted that their inpatient volumes had been rising and they were improving their bottom line due to our practice," says Dr. Caruso.

He says hospitals often evaluate things from a service-line perspective, and need to widen their lens to focus on the large picture. His spine practice helped provide follow-up care for hospital patients, which could eventually lead to reduced readmissions. "Inpatient and outpatient care are married; you can't separate the two," says Dr. Caruso.



A sharpened focus on healthcare economics

Healthcare experts often speak on the gap in understanding between the head and the heart of healthcare — the people crunching numbers and the those providing care. As a physician activist, Dr. Caruso has made an initiative to educate himself on the economics, finances and business behind healthcare — the only way he thinks physicians can change the system. He encourages physicians to develop a deep sense of curiosity and become engaged in discussions, collaborations, meetings or other forms of activism to improve healthcare. "You have to understand that healthcare is at risk right now. You've got to realize you can't keep playing by the same rules. Become the champion of that change," says Dr. Caruso.

"It would be wrong for me to sit there and put my head in the sand," says Dr. Caruso. Physicians can no longer turn a blind eye to the cost of the care they provide. "You should become involved in your hospital, understand relationships with other physicians and maximize the economies of scale," says Dr. Caruso.

"You're a back-pain management specialist"

Dr. Caruso realized his field was evolving when one of his peers in the medical community told him he is not a spine surgeon, but a back-pain management specialist. "I thought he was nuts, but he was right," says Dr. Caruso. "He understood the concept that conservative care is the best way to go."

Dr. Caruso's change in mindset reflects a broader change in healthcare: population health management. The three-word term has become a buzzword in the industry, married to healthcare reform since it is believed to reduce spending while boosting efficiency. More physicians are extending the focus of their care to help manage chronic conditions — such as back pain — and serve across the continuum of care rather than episodically. As Dr. Caruso mentions, this can not only benefit the healthcare system but physicians' practice as well.

Less than five percent of people need surgery of the spine, which is why Dr. Caruso has expanded the musculoskeletal and neuromuscular health focus of his practice. As a result, Dr. Caruso's practice has also expanded its role in the marketplace. Sixty percent of all trauma patients have neuromuscular problems, which automatically ties the practice to inpatient hospital services. "That becomes an energy in and of itself," says Dr. Caruso. "We are forming a group that expands upon our ability to keep trauma services open." ■

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Dr. Brian Cole: Developing the Future of Cartilage Regeneration in Orthopedics

By Laura Miller

Biological solutions for cartilage regeneration in orthopedics are one of the fastest-growing areas of research and development fields in the specialty. While some solutions may seem beneficial in the early stages, evidence-based research trials are emerging to evaluate their longer term benefits. However, those that currently show clinical improvement could be the first step to revolutionizing the way orthopedic care is delivered.

"We're getting closer to biologically modifying the environment of our diseased joints so outcomes can be improved and we can spare patients from having surgery, which is the biggest goal in my mind," says Brian Cole, MD, head of the Cartilage Restoration Center at Rush University Medical Center in Chicago. "We at Rush, in many ways, are spearheading a lot of this research in collaboration with others in the Division of Sports Medicine headed up by Dr. Bernard Bach."

Dr. Cole discusses the clinical trials and developments at the forefront of biologics in knee and shoulder surgery today as well as four trials being conducted at Rush that could have a huge impact on orthopedics in the future.

Knee

Cartilage Autograft Implantation System (CAIS). In a recently published study titled "Mincing Cartilage Without Cell Culture Serves as an Effective Intraoperative Cell Source for Cartilage Repair," Dr. Cole and his team showed that using small bits of cartilage placed into a small resorbable scaffold can promote re-growth better than most currently available implants.

What sets this technique, the Cartilage Autograft Implantation System (CAIS), apart from the current autologous chondrocyte implantation procedures is the surgeon's ability to make the procedure a one-step process instead of two. Surgeons currently harvest cartilage tissue from the patient and prepare it for re-implantation as a two-step process, a very expensive process requiring two surgeries. Dr. Cole's team has overcome these challenges by preparing a cartilage-loaded implant in the operating room with immediate availability. In the study, chondrocytes grew into adjacently placed scaffold materials to produce neo-cartilage in a mouse model.

Since CAIS is simplified into a one-step process and emphasizes regeneration from the time the treatment is indicated or desired, the technique eliminates technical difficulties and high costs associated with alternative procedures such as

autologous chondrocyte implantation. In the future, more studies will identify the appropriate parameters of the procedure, such as the size and loading density of the fragments and method of harvest, to optimize the extent of successful cartilage repair.

Comparing CAIS to microfracture. Dr. Cole and a team of collaborating orthopedic surgeons also conducted research comparing CAIS to microfracture for patients with symptomatic chondral defects. In the study, titled "Outcomes After a Single-Stage Procedure for Cell-Based Cartilage Repair: A Prospective Clinical Safety Trial With 2-Year Follow-Up," the researchers found that CAIS shared comparable risks to performing microfracture and progressive improvements during the second year after surgery.

In the study, the average age of the patients in both groups was the same, which means the improvements associated with CAIS aren't dependent on age. Patients were given the International Knee Documentation Committee evaluation and Knee Injury Osteoarthritis Outcome Score at various increments after surgery and the CAIS group consistently showed improvements at 12, 18 and 24 months. From these results, the study's authors determined the procedure is safe and feasible for patients.

Shoulder

Minimizing re-tear rates. A broad spectrum of research regarding biologic solutions for shoulder injuries is now underway, particularly focusing on minimizing the re-tear rates among patients undergoing reconstructive surgery. Dr. Cole has participated in the development of a polyethylene-articulated sponge that promotes collagen in-growth to improve tissue regeneration. "We're looking at novel scaffolds that can ultimately improve the repair construct," says Dr. Cole. "There is currently a large propensity for re-tears after a patient undergoes rotator cuff repair, and these scaffolds can help promote re-growth. The exact clinical indications for their use continues, however, to be defined."

Utilization of soft biologics. Another area of biologic shoulder repair receiving significant attention is soft biologics. Dr. Cole is also currently investigating recombinant human growth factors that could help the body heal if they are injected into the injured region. Another option under consideration is the use of platelet-rich plasma to augment the healing of small tears, as this has been supported to date in basic science laboratory studies.



Current cartilage trials at Rush

1. Biologic implants. Both the Denovo Natural Tissue (NT) and Denovo Engineered Tissue (ET) are being studied at Rush. NT is human issue allograft consisting of particulate juvenile articular cartilage. The ET graft is a three-dimensional hyaline-like cartilage tissue developed by culturing allogenic chondrocytes from juvenile human donors. Both implants are surgically implanted and affixed to the bone at the base of a cartilage defect through a small incision in front of the knee. The NT procedure is currently available to treat symptomatic localized cartilage defects and the ET procedure, which was initially investigated in part at Rush, will be ready for further clinical study near the end of 2011.

2. Limited resurfacing implants. The HemiCAP implant is used for limited resurfacing arthroplasty and is designed to match the individual shape of the patient's cartilage surface. In the study, researchers are examining the use of the metallic implant for the treatment of specific focal femoral condyle defects to see whether it provides better outcomes than current treatment options.

3. Arthroscopic partial meniscectomy. In this NIH-funded, multi-center trial, researchers are comparing the use of arthroscopic partial meniscectomy to non-operative treatment for patients with symptomatic meniscal tears in the setting of concomitant knee osteoarthritis. The trial seeks to identify which, if any, patients would benefit from the surgical meniscectomy over non-operative treatment.

4. Platelet-rich plasma. Dr. Cole is looking at the effects of autologous conditioned plasma, or platelet-rich plasma, on patients who have osteoarthritis. He is comparing three ACP injec-

tions to three hyaluronic acid injections in patients who have painful arthritis of the knee. Before the injections, he draws out fluid from the joint to examine proteins related to cartilage breakdown and production. Gathering this data will help him determine if surgeons can use biologic markers to predict clinical outcomes.

Where the industry is headed

Studies on biologic solutions for cartilage regeneration associated with joint repair are increasingly prevalent as more orthobiologic companies push their way into the biologics market. In some cases, there are treatments approved for one indication, and the surgeon researchers are working on proving them for additional indications as well.

Although biologic solutions aren't always the golden ticket to pain relief, the media, lay press are patients pushing these types of solutions that gives the public a positive perception of their impact. Professional athletes have also contributed to this perception because they were the first people to seek out these treatments, often times with positive results for their overall performance.

"Some solutions, such as PRP, are easy to use, but you have to prove they work," says Dr. Cole. "Unproven solutions often have an extra cost associated with them since they aren't covered by insurance companies and that can be inconvenient for the patient. We need to prove these solutions in a more reliable way. One must never forget that in some studies, a 30 percent placebo effect exists which can be mistakenly believed to be due to the treatment itself." ■

Simplifying the Complexities of Being a Team Physician for Professional Athletes: Q&A With Dr. Doug Freedberg

By Laura Miller

A team physician for the Arizona Cardinals and Phoenix Coyotes and consultant with the Oakland Athletics, Douglas Freedberg, MD, discusses the finer points of being a sports medicine and team physician today. Dr. Freedberg is a sports medicine orthopedic surgeon with Arizona Sports Medicine Center in Scottsdale.

Q: How do you manage the sometimes complicated web of communication associated with treatment for professional athletes?

Dr. Doug Freedberg: There are a few things I do to make something that seems complex actually pretty simple. Beyond explaining the injury or condition and discussing options with the player and athletic trainer, I ask the player if there is anyone else to whom they want me to talk. Often this is the agent, and frequently also a family member. With other players, no calls are needed. This way, we have satisfied the player and adhered to HIPAA requirements.

In regards to communicating with the team, each has its own scenario. Always, I'm speaking with the athletic trainer and sometimes I speak with the general manager directly as well, whereas protocol may dictate the information flows through the trainer. Team physicians should know the preferred approach for their specific team. In some cases for particular players, the agents add to the confusion, but more often are helpful as a trusted advisor to the player.

Q: How do you handle athletes who seek a second opinion?

DF: We encourage the athletes to have second opinions — the last thing they want as a player is to feel steered in a direction they don't want to go. There are some players who have a history with a particular surgeon, whether from high school or college. Agents often have strong relationships

with surgeons and may push the player to travel across the country even for a simple procedure. If that's what they want, that's what they get.

In my experience, players will seek second opinions and we often ask if they desire one, but it is very rare that they have an interest in going elsewhere for surgery. The key is to have trust in the locker room and a good rapport with players. Being available and approachable is the best start. Over a period of time, your best advocates are often experienced players who trust you and have seen that you can produce good results, whether surgical or even difficult injuries treated non-operatively. They may tell an injured player, "Why would you travel away from your home and family to have surgery that you can do at least as well right here with our team doc?" This is a process and there will always be the occasional player that opts to travel.

Even if the player does go somewhere else for surgery, the team physicians are still going to take care of them during the rehabilitation and follow-up time. Sometimes, physicians worry about their athletes seeking second opinions, but think about a typical day in the office. Don't patients sometimes decide to seek second opinions, and aren't you often the second opinion? If the patient or player feels confident to undergo treatment with us, great, and if they want to see someone else, that's fine too.

Q: When the athlete is high-profile, what stressors do you encounter when choosing the right treatment path?

DF: For one, you oftentimes need to get more people involved, including agents and maybe additional layers of team management. Also as the perceived importance of the player increases, so too does the media scrutiny. We don't get directly involved with this, as the media relations staff interfaces with the media. Sometimes there are unique

issues, such as the NFL lockout, that are added stressors. On a regular year, we roughly know our entire schedule, save for possible postseason. Right now with the lockout, there are rough contingency plans, but nothing is settled. At the moment, we're just waiting to get the OK to be able to evaluate new players and perform preseason physicals on players under contract, but as soon as the lockout is resolved, we'll have to find time ASAP.

Q: What do you do to balance your team physician responsibilities with those of your regular practice?

DF: My time management involves being mindful of the calendar. In each sport, there are some very busy, hectic times and there are slower times. For example, in February during the offseason, the NFL Combine takes place in Indianapolis and team physicians are there for about five days. During that time, and other times requiring time away from the practice, we rely on partners to cover. Being a team physician for multiple sports, there is some overlap and it is essential to have your calendar in sync. We have it set up where between the different surgeons, there's always someone available. This is important because if there's an issue with an athlete, the player and team have the expectation that they will be treated right away.

There are significant benefits to seeing the athlete soon after an injury because it minimizes their down time. Perhaps it could allow them to play in a few extra games or make it back in time for an important post-season game. From the management perspective, a roster spot may need to be filled quickly. There is a certain level of frustration for the general population, because they often have insurance hoops to jump through which take time, whether for a referral or authorization for an MRI or surgery. This doesn't happen with professional athletes. ■



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PROGRAM SCHEDULE

Pre Conference – Thursday October 27, 2011

11:30am – 1:00pm	Registration
1:00pm – 5:30pm	Pre-Conference
5:30pm – 7:00pm	Reception, Cash Raffles, Exhibit Hall

Main Conference – Friday October 28, 2011

7:00am – 8:00am	Continental Breakfast and Registration
8:00am – 5:05pm	Main conference, Including Lunch and Exhibit Hall Breaks
5:05pm – 6:30pm	Reception, Cash Raffles, Exhibit Hall

Conference – Saturday October 29, 2011

7:00am – 8:10am	Continental Breakfast
8:10am – 12:20pm	Conference

Thursday, October 27, 2011

1:00 – 1:40 pm

A. Key Concepts to Fixing Physician Hospital Joint Ventures Gone South

Brent W. Lambert, MD, FACS, Principal & Founder, and Luke Lambert, CFA, CASC, CEO, Ambulatory Surgery Centers of America

B. Business Planning for Orthopedic and Spine Driven Centers

Jeff Leland, CEO, Blue Chip Surgical Center Partners

C. Benchmarking for GI Centers

Robert Estes, VP Operations, and Susan Kramer, Director of Clinical Support, Physicians Endoscopy

D. How Do You Value Your ASC For Sale? What is the Value in a Majority Sale Transaction? Can Hospitals Pay More if They can Convert to an HOPD or Apply Managed Care Contracts? What is the Value in a Sale of a Small Percentage to a Physician?

Jon O'Sullivan, Senior Partner, and Greg Koonsman, Senior Partner, VMG Health

E. Managed Care Negotiation Strategies - Using Transparency and Case Data to Show Payers How ASCs Save Them Money

I. Naya Kehayes, MPH, CEO & Managing Principal, and Matt Kilton, MBA, MHA, Principal and Chief Operating Officer, EVEIA HEALTH Consulting and Management

F. Infection Control in ASCs - Best Practices and Current Ideas

Phenelle Segal, RN, CIC, President, Infection Control Consulting Services, LLC

1:45 – 2:25 pm

A. Cost Reduction and Benchmarking - 10 Key Steps to Immediately Improve Profits

Rob Westergard, CPA, CFO, Susan Kizirian, COO, and Ann Geier, RN, MS, CNOR, CASC, Vice President of Operations, Ambulatory Surgery Centers of America

B. Developing a Spine Driven ASC: the Essentials for Success

Kenny Hancock, President & Chief Development Officer, Meridian Surgical Partners

C. Ophthalmology, ENT and Podiatry in ASCs - Key Thoughts and Trends

Jeff Peo, Vice President, Development & Acquisitions, Ambulatory Surgery Centers of America

D. Should You Sell Your ASC? - A Step by Step Plan for Selling Your ASC - How to Maximize the Price, Terms and Results and How to Handle the Process

Luke Lambert, CFA, MBA, CASC, CEO, Ambulatory Surgery Centers of America. Introduced by Scott Downing, Partner, and Gretchen Heinze Townshend, Associate, McGuireWoods, LLP

E. Should You Outsource Billing and Collections or Keep It in House?

Caryl Serbin, RN, BSN, LHRM, Executive Vice President and Chief Strategy Officer, Source-Medical Solutions, Revenue Cycle Solutions

F. Effective Clinical Benchmarking and Infection Control

Regina Robinson, Director, Peninsula Surgery Center

2:30 – 3:05 pm

A. 10 Statistics Your ASC Should Review Each Day, Week, and Month and What to do About Them

Reed Martin, Chief Operating Officer, Surgical Management Professionals

B. What Percentage of Key ASC Specialties Will be Employed by Hospitals Within 5 Years - Orthopedics, GI and Ophthalmology

Brian Mathis, Vice President, Strategy, Surgical Care Affiliates, Mike Lipomi, CEO, Surgical Management Professionals, Jimmy St. Louis, III, MBA, Chief Corporate Operations Officer, Laser Spine Institute and CEO, Advanced Healthcare Partners, and moderated by Amber McGraw Walsh, Partner, McGuireWoods LLP

C. An Introduction to a Retirement Concept Tailored to Physicians and Doctors Groups

Steven D. Schaumberger and Ken Crabb, JR Katz

D. Physician-Hospital Joint Ventures - How to Resolve Conflict and Keep the Venture Thriving

Dawn McLane, Regional VP, Health Inventures, and Tom Yerden, CEO, TRY Healthcare Solutions

E. Being a Great Administrator - Core Concepts to Develop Raving Physician Fans

Joe Zasa, JD, Managing Partner, ASD Management, and Stephanie Stinson, RN, BSN, CASC, Administrative Director, Strictly Pediatrics Surgery Center

F. How to Determine When To Go In-Network vs. Out-Of-Network

Rob Murphy, President, Murphy Healthcare Group

A. Assessing the Future Demand for ASCs, A Panel Discussion

Barry Tanner, President & CEO, Physicians Endoscopy, Brian Mathis, Vice President Strategy, Surgical Care Affiliates, and Vivek Taparia, Director of Business Development, Regent Surgical Health

B. Impact of Healthcare Reform on Physician Practices and ASCs

Charles "Chuck" Peck, MD, CEO, Health Inventures

C. Key Thoughts From Great Medical Directors - Managing Expenses and Managing Physicians

Alfred McNair, MD, Steven Schuleman, MD, and moderated by Nap Gary, Chief Operating Officer, Regent Surgical Health

D. Anti-Kickback and Stark Act Compliance - Common Issues for ASCs

Scott Becker, JD, CPA, Partner, Melissa Szabad, JD, Partner, and Lainey Gilmer, Associate, McGuireWoods LLP

E. What Can Be Paid for Co-Management? Should You Enter Into a Co-Management Relationship? Co-Management Arrangements Valuation and Other Issues

Jen Johnson, CFA, Managing Director, VMG Health

F. Meaningful Use, EMR and Other Key IT Issues for ASCs

Marion K. Jenkins, PhD, FHMSS, Founder, CEO, QSE Technologies, Scott Palmer, President & COO, Ambulatory Surgery Center Division, SourceMedical Solutions, Jeff Blankinship, President & CEO, Surgical Notes, Faris Zureikat, Administrator, North Texas Surgery Center, USPI, Holly Carnell, Associate, McGuireWoods LLP

Roundtable Discussion

Establishing and Operating Successfully in a Small Market

Joseph Zasa, JD, Partner, ASD Management, and TK Miller, MD, Associate Professor, Dept. of Surgery, VTC School of Medicine, Medical Director, Roanoke Ambulatory Surgery Center, Carilion Clinic Orthopaedics/Sports Medicine

3:55 – 4:30 pm

A. Orthopedics and Spine - Physician Payor Relationships and Evolving Changes

John Cherf, MD, MPH, MBA, President, OrthoIndex, Steven H. Stern, MD, MBA, Vice President, Cardiac & Orthopaedics/Neuroscience, and Michael R. Redler, MD, The OSM Center, moderated By Scott Becker, JD, CPA, Partner, McGuireWoods LLP

B. Private Equity's Role in and View of the ASC Market

Joe Clark, EVP & Chief Development Officer, Surgical Care Affiliates, David F. Bacon, Jr., CEO, Meridian Surgical Partners, Geoffrey C. Cockrell, Partner, McGuireWoods LLP

C. Revenue Capture for Endoscopy Centers - Best Practices and Great Ideas

Linda K. Peterson, CEO, Executive Solutions for Healthcare

D. ASC Litigation - Can Non-Competes be Enforced? What to Do When the FBI or OIG Calls? How to Work with Payors

Jeffrey C. Clark, Partner, and David J. Pivnick, JD, BBA, Associate, McGuireWoods LLP

E. What is Great and What is not Great Physician Leadership for Your ASC

Brad Lerner, MD, Summit ASC

F. Evaluating the Return on Investment: Outsourcing Key Business Office Operations

Kim Woodruff, Vice President Corporate Finance & Compliance, PINNACLE III

4:30 – 5:30 pm - KEYNOTE

Climbing Up the Mountain - One More Time

Bill Walton, Former ABC, ESPN, NBC Basketball Announcer, Hall of Fame NBA Basketball Player

5:30 – 7:00,

Networking Reception, Raffles and Exhibits

Friday, October 28, 2011

8:00 am

Introductions

Scott Becker, JD, CPA, Partner, McGuireWoods, LLP

8:10 – 8:45 am - KEYNOTE

The View from Washington: Politics, Healthcare Reform and the 2012 Election

Sam Donaldson, ABC News Veteran and former Chief White House correspondent for ABC News

8:50 – 9:30 am – General Session

ASCs, Healthcare and Washington DC

Brent W. Lambert, MD, FACS, Principal & Founder, Ambulatory Surgery Centers of America, Tom Mallon, CEO Regent Surgical Health, Michael E. Russell, II, MD, President, Physician Hospitals of America, Texas Spine and Joint Hospital, Tom Price, MD, U.S. Congressman, Moderated by Sam Donaldson, ABC News Veteran and former Chief White House correspondent for ABC News

9:35 – 10:20 am - KEYNOTE

A. KEYNOTE - How the Best Managers use Recognition to Accelerate Performance

Adrian Gostick, Author and Global Thought Leader on Workplace Strategy

B. The ASC Association Legislative Priorities - and What We Will See for the Next Five Years

William Prentice, JD, Executive Director, and Steve Miller, Director of Government and Public Affairs, Ambulatory Surgery Center Association

C. How to Evaluate & Implement New Profitable Services into an ASC

Robert Zasa, MSHHA FACMPE, Founder, ASD Management, and Kenneth Austin, MD, Orthopedic Surgeon, Rockland Orthopedics and Sports Medicine

D. ACOs in Action

11:25 – 12:10 pm

A. The State of the Unions for ASCs

Andrew Hayek, President & CEO, Surgical Care Affiliates and Chairman of the ASC Advocacy Committee

B. Interventional Pain Management - What the Next Few Years Will Look Like

Laxmaiah Manchikanti, MD, CEO & Chairman of the Board, American Society of Interventional Pain Physicians

C. Hospital and Physician Alignment in the Wake of Healthcare Reform - The Expectations for the Next Five Years

Kate Lovrien, Senior Manager, Kurt Salmon and Associates

D. What are the Key Issues Facing Great ASC Administrators

Kara Vittetoe, Administrator, Thomas Johnson Surgery Center, Tracey Hood, Administrator, Ohio Valley Ambulatory Surgery Center, Brooke Smith, Administrator, Maryland Surgery Center for Women, and moderated by Susan Kizrian, COO, Ambulatory Surgery Centers of America

12:15 – 1:00 pm

A. Developing a Strategy for Your ASC

Kenny Hancock, President & Chief Development Officer, Meridian Surgical Partners, Mike Doyle, CEO, Surgery Partners,

B. Endoscopy Centers - Key Trends and Issues

Frank Principati, COO and Frank Coll, VP New Business Development, Physicians Endoscopy

C. Orthopedics and Spine in ASCs - Key Trends and Ideas

John D. Atwater, MD and Richard A. Kaul, MD, Board Certified Minimally Invasive Spine Specialist & Owner, New Jersey Spine and Rehabilitation, Moderated by Jeff Leland, CEO, Blue Chip Surgical Center Partners

D. Anesthesia in ASCs

David Shapiro, MD, CHC, CHCQM, CHPRM, LHRM, CASC, Partner, Ambulatory Surgery Company, LLC

E. Accreditation 101, Everything You Need to Know About Accreditation

Bernard McDonnell, DO, Healthcare Facilities Accreditation Program

1:00 – 2:00 pm

Networking Lunch & Exhibits

2:00 – 2:40 pm

A. The Best Ideas to Improve Volume and Profits

Bryan Zowin, President, Physician Advantage, Inc., John C. Steinmann, DO, Renovis Surgical Technologies, Robin Fowler, MD, Executive Director and Owner, Interventional Management Services, and Keith Metz, MD

B. ASC Turnaround Case Study, From Zero to Wow!

Joseph Zasa, JD, Managing Partner, ASD Management, and Daniel C. "Skip" Daube, Jr., MD, FACS, Founder, Surgical Center for Excellence, Panama City

C. Is There Still Room for Joint Venture ASCs in the Physician-Hospital Integration Tool Kit - The Pros and Cons to ASCs

Allan Fine, Senior Vice President, Chief Strategy and Operations Officer, The New York Eye & Ear Infirmary, and Brandon Frazier, Vice President Development & Acquisitions, Ambulatory Surgical Centers of America

D. Should You Sell Your Practice to a Hospital? What Will the Agreement Look Like? What are the Key Issues?

Kristin A. Werling, Partner, Geoffrey C. Cockrell, Partner, and Gretchen Heinze Townshend, Associate, McGuireWoods LLP

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2:00 – 3:25 pm

E. Managed Care Contracting - 1) How Do You Align Your ASC with Physicians 2) Update on CMS Payment System and How it Impacts on Negotiations 3) Fee Schedule Numbers and Ensuring Revenue Collection from Contracts

I. Naya Kehayes, MHP, Managing Partner & CEO, and Matt Kilton, Principal and COO, Eveia Health Consulting and Management

2:00 – 2:40 pm

F. CMS Inspections Surveys; Are You Ready?

Tracy Hoeft-Hoffman, Administrator, Hastings Surgery Center

2:45 – 3:25 pm

A. The Best Ideas for Physician-Hospital Alignment

Allan Fine, Senior Vice President, Chief Strategy and Operations Officer, The New York Eye & Ear Infirmary, Charles "Chuck" Peck, CEO, Health Ventures, R. Blake Curd, MD, Board Chairman, Surgical Management Professionals, Robert Boeglin, MD, President, IU Health Management, and moderated by Scott Becker, JD, CPA, Partner, McGuireWoods LLP

B. Surgeon Hospital Partnerships Models

Jeff Simmons, Chief Development Officer, and Bo Hjorth, Vice President, Business Development, Regent Surgical Health

C. Developing an Outstanding ASC Quality Program That Can be Implemented and Makes a Difference

Linda Lansing, Senior Vice President of Clinical Services, Surgical Care Affiliates

D. Physician-Owned ASCs and Hospitals - The Best Strategies for the Next Five Years

Michael J. Lipomi, MSHA, President & Chief Executive Officer, Surgical Management Professionals

F. Governing Body Documentation, Meeting CMS and Accreditation Requirements

Sandra Jones, FHFMA, LHRM, CASC, Ambulatory Strategies, Inc.

4:00 – 4:30 pm

A. Extreme Makeover: Surgery Center Edition - Lessons Learned From a Dozen Turnaround Projects

Chris Bishop, Senior Vice President, Acquisitions & Business Development, Blue Chip Surgical Center Partners

B. Ophthalmology in ASCs, Key Issues

Edward Glinski, DO, Healthcare Facilities Accreditation Program

C. Endoscopy Centers - Taking Steps to Prepare an Endoscopy Center for Sale - How to Maximize Your Transaction

Jonathan Vick, President, ASCs, Inc.

D. Helping Large Specialty Physician Groups Navigate the Next Few Years

Marc Steen, Market President, USPI

E. Business and Financial Relationships with Hospitals - Co-Management, Joint Ventures and Employment - Key Valuation Issues

Todd J. Mello, ASA, AVA, MBA, Principal & Founder, HealthCare Appraisers, Inc.

F. Direct Marketing to Patients to Increase Case Volume

Jimmy St. Louis III, MBA, Chief Corporate Operations Officer, Laser Spine Institute and CEO, Advanced Healthcare Partners

4:35 – 5:05 pm

A. Q&A Panel: Will Evidence Based Medicine Kill Spine? Will Practice Acquisitions by Hospitals Kill ASCs? Should ASCs Employ Physicians? Where are the Profits in Pain Management?

Terry L. Woodbeck, CEO, FAHC, Tulsa Spine & Specialty Hospital, Thomas J. Pliura, MD, JD, PC, Physician & Attorney at Law, zChart, R. Blake Curd, MD, Board Chairman, Surgical Management Professionals and Thomas J. Chirillo, SVP Corporate Development, Surgery Partners

B. Physician-Owned Distribution Companies - Doing It The Right Way

John C. Steinmann, DO, Renovis Surgical Technologies

C. Urology Issues for ASCs

Herbert W. Riemenschneider, MD, Riverside Urology, Inc.

D. Trends in Buying and Selling ASCs: Mergers and Acquisitions of Surgery Centers

Patrick Richter, Vice President Business Development USPI, Blayne Rush, President, Ambulatory Alliances, Michael Weaver, VP Acquisitions & Development, Symbion, Inc.

E. Key Compliance Risks in ASC Billing

Bill Gilbert, Vice President, AdvantEdge Healthcare, and Brice Voithofer, Vice President, ASC Services

F. The Most Common Medical Staff Issues and How to Handle Them

Thomas J. Stallings, Partner, McGuireWoods LLP

Roundtable Discussions

2:00 – 2:40 pm

Physician-Owned Ancillaries - Device Companies, Anesthesia, Pathology and Pharmacy and More

Richard Kube, MD, CEO, Founder & Owner, Prairie Spine and Pain Institute, John C. Steinmann, DO, Renovis Surgical Technologies

2:45 – 3:25 pm

Capital Markets Update - Key Thoughts from Lead Investment Strategists/Managers

Gregory D. Miller, Senior Investment Advisor, and Beata Kirr, Senior Portfolio Manager, Sanford C. Bernstein & Co., LLC

4:00 – 4:30 pm

Metrics and Improving Performance

John Seitz, CEO, Ambulatory Surgical Group

4:35 – 5:05 pm

Are We Profitable? Driving ASC Performance Through Effective Financial Management

Rajiv Chopra, Principal & Chief Financial Officer, The C/N Group

5:05 – 6:30 pm

Networking Reception, Raffles and Exhibits

Saturday, October 29, 2011

8:15 – 9:00 am

A. The 5 Best and Worst Specialties for ASCs - An Outlook for the Next Five Years

Larry Taylor, CEO, Practice Partners in HealthCare

B. Improving Revenue Capture: Best Practices in Coding, Documentation and Charge Capture

Rosalind Richmond, Coding Compliance Officer, and Yvonda Moore, Director of Implementation, GENASCIS

9:05 – 9:45 am

A. The Role of the Medical Director and Physician Leaders in ASCs

John Byers, MD, Medical Director, Surgical Center of Greensboro, Orthopaedic Surgical Center

B. Optimizing Business Office Performance

Paul Davis, CPA, CMA, Ambilitel

C. Infection Prevention in ASCs: Looking Ahead - What Does the Future Hold

Marilyn Hanchett, RN, CIC, Senior Director, Clinical Innovation, APIC

D. What Should Great Medical Directors, Administrators and DONs be Paid?

Moderated by Rachel Fields, Managing Editor of Becker's ASC Review, ASC Communications, Inc.

9:50 – 10:30 am

A. The Best and Worst Procedures for ASCs and What an ASC Should Get Paid

Matt Lau, Director of Financial Analysis, Mike Orseno, Revenue Cycle Director, and Vivek Taparia, Director of Business Development, Regent Surgical Health

B. Determining the Exact Cost of a Procedure

Terry Woodbeck, CEO, FAHC, Tulsa Spine & Specialty Hospital

C. Infection Prevention and the CMS Infection Prevention Mandate for ASCs: Key Strategies to Enhance Performance

LoAnn Vande Leest, RN, MBA-H, CNOR, Chief Executive Officer, and Fawn Esser-Lipp, The Surgery Center, LLC

D. How to Improve Coding for ASC Procedures - A Discussion of Orthopedic, GI and Ophthalmology Procedures

Stephanie Ellis, RN, CPC, President, Ellis Medical Consulting

E. The Future Is Now, Preparing You and Your Practice for a Changing Environment

Pedro Vergne-Marini, MD, Founder and Managing Member, Physicians' Capital Investments

10:35 – 11:15 am

A. 3 Core Orthopedic and Practice Group Initiatives - Hospitals and Ancillaries Service Line Management Agreements and Becoming Leaner

John Martin, CEO, OrthoIndy

B. Examining Every Aspect of the Supply Chain to Develop Great Cost Savings

Scott Benglen, CEO, Via Novus Medical, LLC

C. Environmental Cleaning & Disinfection - Best Practices

Jack Wagner, President & Founder, Micro-Scientific Industries

D. Ophthalmology in ASCs - Current Trends and Issues

Michael A. Romansky, JD, Washington Counsel, VP for Corporate Development, Outpatient Ophthalmic Surgery Society

E. Advanced Benchmarking of Financial and Clinical Results

John Goehle, CASC, MBA, CPA, Ambulatory Healthcare Strategies, LLC

11:20 – 12:20 pm

Key Legal Issues and Legal Compliance Boot Camp - The Core Elements of a Successful Compliance Plan

Scott Becker, JD, CPA, Partner, Lainey Gilmer, Associate, and Amber McGraw Walsh, Partner, McGuireWoods LLP

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Kenneth Austin, MD, Orthopedic Surgeon, Rockland Orthopedics and Sports Medicine	Bill Gilbert, Vice President, AdvantEdge Healthcare	Tom Mallon, CEO, Regent Surgical Health	John Seitz, CEO, Ambulatory Surgical Group
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Thomas J. Chirillo, SVP Corporate Development, Surgery Partners	Tracy Hoeft-Hoffman, RN, MSN, MBA, CASC, Administrator, Hastings Surgery Center, Nuterra Health	Keith Metz, MD	Stephanie Stinson, RN, BSN, CASC, Administrative Director, Strictly Pediatrics Surgery Center
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What Minimally Invasive Spine Surgery Means and Why it Will Survive: 5 Points From Dr. Frank Phillips

By Laura Miller

Frank Phillips, MD, a spine surgeon and partner at Midwest Orthopaedics at Rush, discusses five points on minimally invasive spine surgery. Dr. Phillips is a founding member and past president of the Society of Minimally Invasive Spine Surgery (SMISS).

1. What defines a “minimally invasive” spine surgery? The definition of minimally invasive spinal surgery remains elusive. Although some physicians define “minimally invasive” surgery by the size of the incision or as a percutaneous procedure, the essential goal of minimally invasive spine surgery is to limit collateral damage to unininvolved structures, in particular the muscles, surrounding the spine. Patients seek out minimally invasive surgeries because of the perceived advantages associated with the procedures, but the tag “minimally invasive” doesn’t mean the procedure will necessarily work for all patients.

“Patients associate ‘minimally invasive’ with the size of the incision, but I consider it as a less-disruptive procedure, minimizing para-spinal muscle injury and damage,” says Dr. Phillips. “I think the minimally invasive procedures that are most effective are the same procedures for the same indications that have been proven to work when done in an open fashion. Ideally, you want to be able to do the same operations we have done open in a less invasive way.”

2. How minimally invasive surgery has evolved. Early on in the spine minimally invasive experience, most of the efforts were focused on smaller procedures, such as discectomies. Now, there are specialized instruments, retractors and microscopes that enable minimally invasive approaches to more complex procedures. “We can now do many open surgeries through a minimally invasive approach, particularly for degenerative conditions,” says Dr. Phillips. “For example, I routinely do a minimally invasive fusion procedure using screws and cages where the patients can leave the hospital the day after surgery.”

In addition to established procedures, there are newer types of fusion procedures that lend themselves to minimally invasive surgery, such as the lateral lumbar interbody fusion technique. For this procedure, surgeons access the spine through the side of the body to avoid disruption of the back muscles. They implant the cage and perform fusion through the lateral incision. Dr. Phillips was involved in the development of lateral lumbar interbody fusion and was one of the initial surgeons to perform the procedure. He says the “procedure has grown over the past six or seven years. It’s become widely performed and has data to support it being a safe and reproducible technique.”

3. Minimally invasive procedures need more clinical quality and cost-effectiveness data. In today’s healthcare environment, the spine community must show that at a minimum, minimally invasive techniques are safe with good clinical outcomes. In addition, it needs to show that any added costs associated with minimally invasive spine surgeries are commensurate with the clinical advantages of the procedure.

“It’s easy to sell minimally invasive surgeries to patients, but there needs to be quality evidence to support their effectiveness,” he says. “It’s been difficult to prove there is a difference between the minimally invasive and open surgeries because a lot of the standard outcome measures we use aren’t designed or validated to detect difference in clinical results during the early post-operative period (first three to six months).”



Payers may balk at the cost of minimally invasive spine surgery, especially since the data doesn’t yet show it is better than conservative treatment or the open procedure for certain conditions. However, when looking at the overall cost for conservative treatment versus a minimally invasive surgical procedure and considering the quality metrics associated with each treatment modality, the minimally invasive procedure may be beneficial and less expensive in the long term. “For solid indications, there is data showing that minimally invasive spine surgery works well,” says Dr. Phillips.

Conservative treatment can be less expensive than surgery in the short term; however if the treatments continue over a long period of time, they can exceed the cost of a single, effective surgical procedure. “There is a lot of good evidence for a lot of what we do in spine surgery, but we haven’t done a good job of getting the word out,” says Dr. Phillips. “In a study out of Europe comparing a number of orthopedic diagnoses and treatments, spine surgery has had the best improvement in quality of life, even compared to hip and knee replacement.”

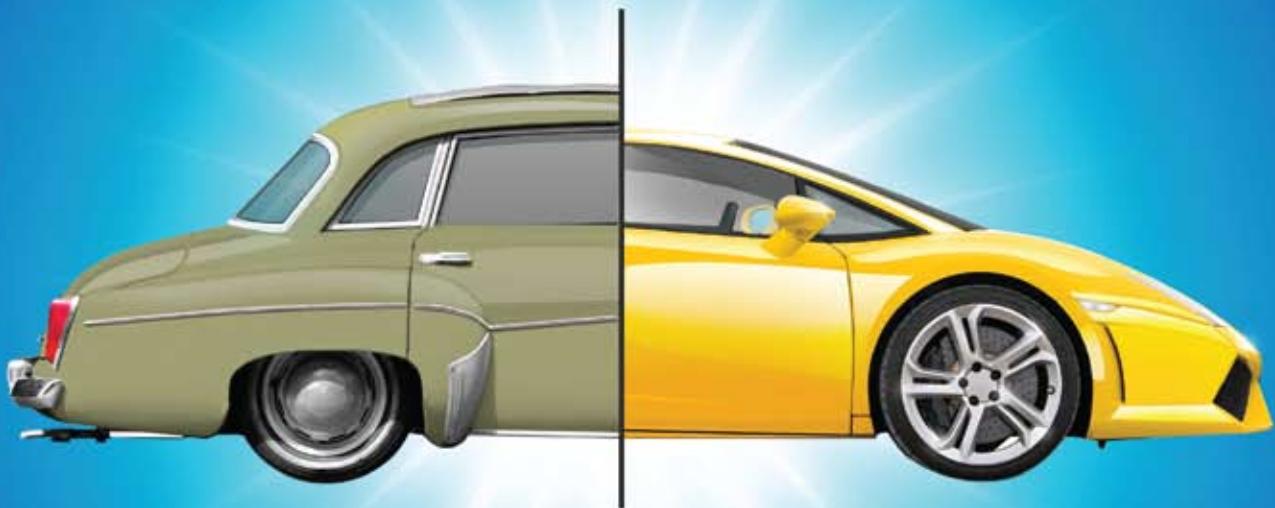
4. The media needs more information on positive outcomes. The commercial press has recently focused on negative clinical results and high costs associated with certain spinal procedures. The positive news about good and cost-effective outcomes hasn’t been as widespread. “Our professional societies need to play a role in spreading the message about positive outcomes of spine surgery, and they are trying to do that,” says Dr. Phillips.

Another way to combat the negative press associated with spine surgery is by encouraging patients to become involved in the advocacy efforts. “A number of patients and groups are starting to spring up to promote spine surgery when patients have done well,” he says. “I think it will take patients getting involved to change the way payors and society look at this issue.” Sometimes, patients come into the office and would benefit from surgery, but their insurance companies won’t approve the procedure. These patients become upset, and Dr. Phillips tells them to join him in the fight for broader coverage.

5. The improvements to look for in the future. Minimally invasive procedures, such as the lateral incision procedure, have become more so-

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phisticated than it was when surgeons first started performing it in the early days. However, there are still improvements that could be made. "In terms of achieving fusion, we do pretty well, but in the future some of the instruments or techniques will become more disease-specific," says Dr. Phillips. "Right now, we have the same instrumentation and implants for young patients with disc degeneration and older patients with spinal deformity. I think the surgical techniques will become tailored to the specific pathology, which could lead to a higher level of reproducibility and better results."

In addition to procedural advances, spine treatment algorithms need to incorporate perioperative pain management to expedite patient recovery and resumption of activities. "Right now the perioperative pain management side of minimally invasive spine surgery hasn't been emphasized as it has in other minimally invasive orthopedic procedures," he says. "The success of minimally invasive hip and knee replacement isn't all about the surgeries; it's also about the perioperative pain management. We haven't done as much with that in spine, and I think we could." ■

Dr. Frank Cammisa: 4 Points on Lateral Lumbar Interbody Fusions

By Laura Miller

Lateral lumbar interbody fusion, also known as extreme lateral interbody fusion, is a relatively new procedure that surgeons have found successful for treating patients with complex disorders such as spondylolisthesis and scoliosis. "Right now, I consider lateral lumbar interbody fusions to be the most successful procedure to accomplish what we set out to do in terms of surgical interventions for these complex procedures," says Frank Cammisa, MD, chief of spine service for the Hospital for Special Surgery in New York City. He discusses four points on the XLIF procedure.

1. Performing XLIF procedures. XLIF is a minimally invasive procedure where the surgeon makes an incision in the patient's side and accesses the spine laterally through the psoas muscle, referred to as the "trans-psoas" approach. Once the incision is made, a special tubular retractor is inserted and dilated. The lumbar plexus goes through the psoas and surgeons use neuromonitoring to identify the nerves. "We want to make sure we are between the nerves so we don't damage them," says Dr. Cammisa. "We're able to do complete corpectomies without making large flank incisions and damaging the patient's anatomy. It's a much less traumatic experience for patients, which really helps them mentally as well as physically."

Once the equipment is in place, surgeons can use cages filled with bone growth factors to

achieve fusion. Iliac bone graft can also be used, but this technique is falling out of fashion. "It's rare that I ever have to take a bone graft from the iliac crest," says Dr. Cammisa. "It just saves so much time and avoids patient pain when you don't have to take a graft from the patient."

2. Benefits of XLIF. Dr. Cammisa is able to perform complex surgeries, such as an adult degenerative scoliosis correction, through a smaller incision fusing fewer levels than with the open posterior approach. Less invasive procedures are beneficial because they allow a surgical intervention without significant blood loss or muscle and tissue damage, and patients with decreased hospital stays are able to begin rehabilitation quicker than with the traditional open procedure. When patients are able to rehabilitate quicker, they are able to return to work sooner.

3. Incorporating lateral lumbar interbody fusion into your practice. There are many device companies that now offer lateral lumbar interbody fusion devices, led by NuVasive's eXtreme Lateral Interbody Fusion. Surgeons can undergo training courses with their device of choice and then observe surgeons who are already proficient with the procedure. "It is less complicated for the surgeon if they are able to start performing a procedure without a steep learning curve," says Dr. Cammisa. "Most experienced surgeons will be able to pick it up



very quickly, incorporate it into their practice and be very happy with it."

4. Will it stick around in the future? The XLIF has a typical learning curve of a new spine procedure, but unlike other minimally invasive technologies, Dr. Cammisa sees it becoming more of a standard-of-care in the future. "I think it's going to be used very regularly by spine surgeons all over the country and the world," he says. "Other minimally invasive procedures won't stand the test of time because the outcomes won't be as good as people think they are. This type of procedure is different because it accomplishes the same goals as the traditional surgery through a less invasive approach." ■

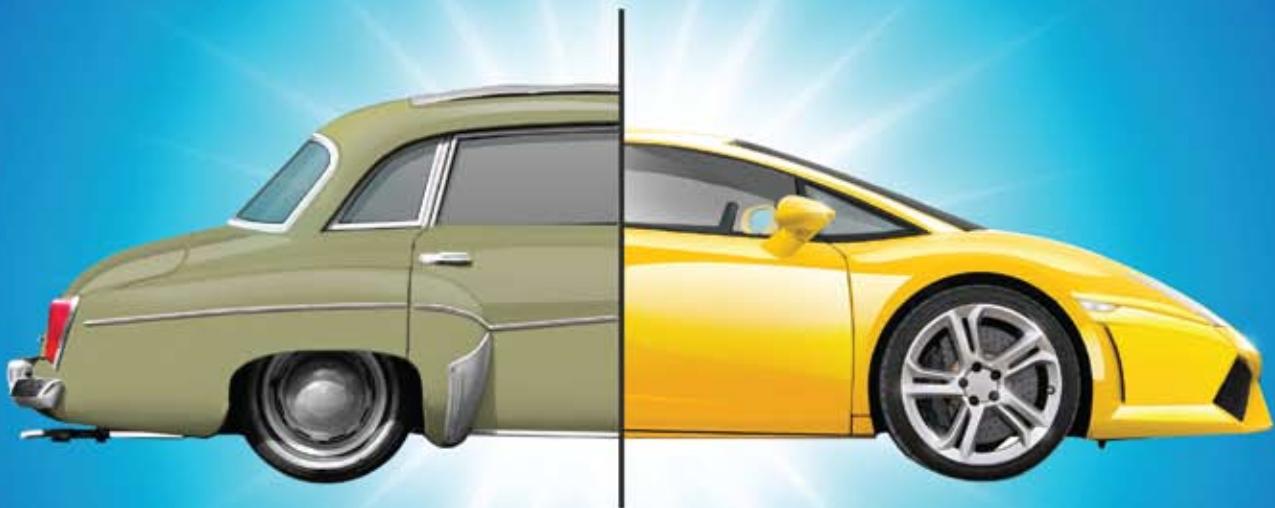
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Top 10 Things to Look for in a Teleradiology Group

By Doug Smith, MD, CEO, Musculoskeletal Imaging Consultants

In today's constantly changing healthcare environment, it's important for orthopedic and spine surgeons and practices to work with reliable radiologists who are experienced in reading musculoskeletal reports. Here are 10 key qualities to look for in a teleradiology group to ensure efficient and effective services.

1. Specialization and expertise in orthopedics, spine and pain management radiology. Limit your search to teleradiology companies focusing on orthopedics and spine. Your physicians need detailed, clinically relevant reports from experts in the field. The radiologists reading your studies should be seasoned, clinically oriented subspecialists with at least a decade of musculoskeletal imaging experience. Many large teleradiology companies farm studies out to lower cost, less experienced radiologists or outsource your studies to offshore radiologists in India.

Language and dialect differences among offshore radiologists can produce interpretive or contextual errors that can be costly to your group prestige and medical liability. Imprecise wording in reports can be a reason for insurance denying your surgical procedures. You and your patients deserve the best, and for a price, you can obtain readings from leaders in the field. Accurate detailed reports by experienced subspecialty radiologists can be priceless compared to the real costs of the lowest cost bidder.

2. Physician ownership and active management. Physician owners empathize with your clinical requirements and are more responsive to your needs as a practicing physician. Many of the largest teleradiology companies are publicly held corporations run by businessmen responding to the demands of the corporate stockholders rather than to your needs as only one of thousands of small clients. When you have a request or clinical need, having a fellow physician responding directly to your request rather than talking to a corporate board is often easier and more personal.

3. Radiologist accessibility. When you are busy with your clinic or in the operating room and have questions about a radiology study, you need an answer right now. Look for a teleradiology group that has online collaborative session capabilities so you can access the radiologist who read the imaging study. As you investigate a potential teleradiology company, call the corporate office and ask to speak with the owner/CEO. If the owner promptly takes your call, this is a strong indicator of the clinical response of this teleradiology company to your future concerns about clinical service.

4. Annotated key images attached to reports. Insist on having the radiologist annotate key images and attach them directly to the report. It makes your reports much more understandable and distinguishes your reports from competitors in your community. Surgical authorization rates increase with inclusion of annotated key images but very few teleradiology companies offer this service because it takes the radiologist more time. Patients really love this service and providing reports with the images attached will add prestige to your practice.

5. Dedicated radiologist(s) assigned to your group. Most teleradiology groups farm your studies out to a large pool of radiologists so you rarely know the radiologists reading your study. Insist on having the teleradiology company commit one to three radiologists to your group's studies so that you have a close working relationship with your teleradiology consultants. Insist on seeing CVs of the specific radiologists who will be reading your studies and ask for samples of their reports. Additionally, ask to speak with the radiologists before you sign a contract to get a feel for how well they interact with members of your group.

It is also reasonable to ask for an online interactive session between your physicians and prospective radiologists to review a test case before making this important decision. Demand that all radiologists be trained at leading U.S. medical

schools, undergo musculoskeletal radiology residency training and be American Board of Radiology-certified with participation in the ABR Maintenance of Certification program.

6. Universal access to your reports and images. Cloud computing and secure Internet-based radiology software can allow you to view your radiology reports and images from virtually anywhere. If you use handheld devices like the iPad in your practice, make sure that the teleradiology company uses a clientless or zero footprint image viewer so your patients' protected health information on the cloud is not transferred to your handheld device. Loss or theft of a handheld device with this information can result in a PHI security breach. If the PHI is viewed remotely on the cloud rather than the handheld, there is no PHI transferred to the handheld or potential exposure with device loss.

7. Capability of handling STAT examinations within 15 minutes. In sports medicine practices, having the ability to review the MRI report with the patient within minutes after the scan is a great medical and marketing advantage. With this ability, the report with annotated images can be submitted to the insurance company for surgical authorization and a treatment plan can be developed during a single office visit. Patients traveling from a distance can have a pre-scheduled MRI appointment with the follow-up office visit right after the MRI if the teleradiology company can generate a report within a few minutes using voice recognition technology.

The use of voice recognition can also allow immediate availability of an addendum to a report during an online collaboration session. Very few teleradiology companies offer this service but it can be a huge marketing advantage to your group.

8. Peer review process. The teleradiology company should actively participate in a peer review process such as RadPeer, administered by the American College of Radiology. The teleradiology company should have policies and pro-

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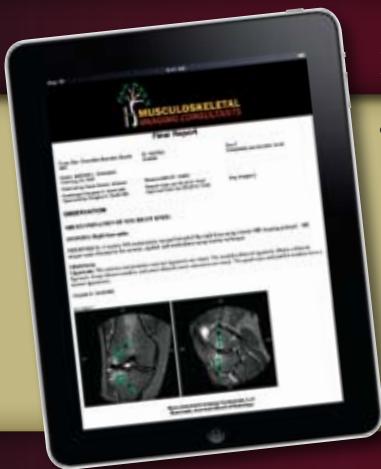
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cedures in place to notify you of any clinically relevant discrepancies or changes in the report content.

9. Experience with MIPPA/CMS mandates and MRI scanner accreditation procedures. If your orthopedic group owns or operates an MRI scanner, you must achieve accreditation by one of three Medicare-approved accreditation entities: the American College of Radiology, the Intersocietal Accreditation Commission and The Joint Commission before Jan. 1, 2012, in order to receive payment for the technical component of scanning under Part B of

the Medicare Physician Fee. Insist on using a teleradiology group that is familiar with Medicare Improvements for Patients and Providers Act and provide the “supervising physician” role required for continued MIPPA certification.

Medicare approval requires designation of a “supervising physician” with extensive training and documented experience with diagnostic imaging to monitor the required quality assurance and maintenance program. This is best addressed by a teleradiology group that can monitor and adjust your scanner’s performance and the peer review process of your radiology reports.

10. Reputation of the teleradiology group. Before you agree to a service contract, interview current clients including other physicians, practice managers and MRI technologists to learn what others think about the service they receive. Ask their MRI technologists if the radiologists are accessible for questions or suggestions on scanning protocols. Ask the practice manager if the reports are timely and if the service is consistent. Ask the physicians if they are happy with the reports they receive and if the radiologists are readily available for their questions. Finally, ask if the client sees the teleradiology group as an asset. ■

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Changes for CMS Imaging Reimbursement

By Laura Miller

Effective Jan. 1, 2012, all non-hospital providers of advanced diagnostic imaging services (ADIS) including CT and MRI examinations must be certified by one of three credentialing agencies in order to receive Medicare payment for technical fees under Part B of the Medicare Physician Fee. MIPPA eliminates any grace period so the entire certification process must be completed by the Jan. 1, 2012 deadline in order for orthopedic groups or musculoskeletal imaging centers to receive payment. The accreditation requirements are stringent and a minimum of 2-6 months is required to complete the accreditation process.

The American College of Radiology (ACR), Intersocietal Accreditation Commission (IAC) and The Joint Commission (TJC) are the only CMS-approved accreditation entities.. Ambulatory surgical centers typically bill Medicare under the Hospital Outpatient Prospective Payment System (HOPPS) rather than the Physician Fee Schedule and therefore are not affected by the MIPPA mandates.

"Many orthopedic groups are not aware of the potential impact of MIPPA on their practice" says Douglas K. Smith, MD, President of Musculoskel-

etal Imaging Consultants LLC. "If an orthopedic group owns or operates an uncertified MRI, the first time the group may become aware of MIPPA is when the group's Medicare claims are denied and the group is prevented from billing Medicare for months while it obtains MIPPA compliance. Medicare may even deny payment to orthopedic groups with a currently certified scanner if the group does not address new MIPPA quality assurance requirements. MIPPA may adversely affect orthopedic groups even if they don't own a scanner. They may suddenly discover that their favorite imaging center suddenly stops accepting Medicare patients after 1/1/12 because the scanner or center has failed to meet the 1/1/12 MIPPA certification deadline".

MIPPA is intended to ultimately improve the quality of imaging provided to all patients by requiring performance and safety standards for imaging devices and all personnel that use them to scan Medicare patients, says Dr. Smith. "At first these performance standards must only be met for Medicare patients but it likely that MIPPA certification standards will also be required by insurance carriers for all scanners." ■

Will Your Medicare Payments for MRI be "Safe" After January 1, 2012?



If you bill Medicare for MRI services under Part B of the Medicare Physician Fee Schedule, your MRI scanner must be accredited by one of three approved entities by January 1, 2012 in order to receive payment for the technical component of these services.

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Dr. Scott Glaser: 6 Points on Why Repeal of IPAB and PCORI is Necessary

By Laura Miller

As part of healthcare reform's initiative to lower the cost of health-care, the Independent Payment Advisory Board and Patient-Centered Outcomes Research Institute were formed to make decisions about the procedures Medicare will cover. IPAB will develop proposals guiding Medicare as to which treatment methods are necessary and acceptable for coverage while PCORI is charged with conducting evidence-based research for patients and physicians to enhance treatment pathways. Both IPAB and PCORI are led by a small number of people consisting of select medical and non-medical professionals.

For several reasons, physicians from across the board have issues with IPAB and PCORI, both of which stand on the chopping block of health-care reform. "These two groups are saying they are using science to prove effectiveness, but they are really ways of rationing care by reducing patient access," says Scott Glaser, MD, DABIPP, President of Pain Specialists of Greater Chicago and board member of American Society of Interventional Pain Physicians. He discusses six points on IPAB and PCORI, and how physicians can become part of the advocacy efforts for repeal.

1. Why IPAB and PCORI are troubling for physicians and patients. From the medical professional's perspective, IPAB and PCORI are particularly disconcerting because they take the decision-making process away from physicians and this will be done without oversight or recourse by legislators and legislation. Because neither organization would have legislative oversight as they are part of the executive branch, there wouldn't be any repercussions for mistakes and unintended consequences which may have drastic and direct effects on patient care. Mistakes, at least initially, will be inevitable because the groups are largely led by non-physician professionals, methodologists and very few subspecialists and practicing physicians, says Dr. Glaser.

"These groups are going to be drawing conclusions about what should be compensated and what shouldn't, and this is problematic because they aren't specialists in the field and don't understand the whole continuum of care," he says. "It's possible they will make recommendations that will have huge unintended consequences, especially for new and emerging subspecialties such as interventional pain management."

Interventional pain management has only been around for the last 15-20 years and has developed to fill a void in the treatment of pain between medications and other conservative treatment and the other end of the risk/benefit spectrum, invasive surgery. Many of the minimally invasive techniques these physicians perform were only developed in that time and although these interventions are based on sound scientific principles and there is significant proof of effectiveness, it is not like the kind of proof you have for treating a staph infection with PCN.

"These interventions are based on strong scientific evidence but you can't prove an intervention is effective until you have experience with it, and we are very concerned that elected officials will come up with recommendations that will stop innovation in its tracks," he says. "I tell legislators this: If you implemented IPAB and PCORI 20-30 years ago, you probably would never have had cardiac stents and angioplasties, which are standard for cardiac care now, because they were being developed and weren't proven procedures. These procedures which have dramatically improved quality of life for patients with coronary artery disease were developed because physicians were able to pursue the right thing to do for their patients and understood the shortcomings of the previous treatment paradigm — medications and surgery."

2. What worries physicians about the focus on comparative effectiveness research.

A major aspect of healthcare reform has been lowering the cost of care, especially for Medicare patients, and commercial payors have historically linked their payments to Medicare payment rates. However, recently and more audaciously, they are doing their own flawed analysis of the literature and are denying procedures that even Medicare pays for based on it, according to Dr. Glaser. "Every field that is searching for a better way to do things is going to be harmed by this, which is our greatest fear," says Dr. Glaser. "Blue Cross Blue Shield doesn't approve certain X-ray guided injections for spinal pain because they haven't been proven up to the company's 'standards.' In other words, it's not just Medicare, but everyone that will be affected by these decisions."



This has been extremely concerning to patients and physicians and has led to suffering and reduced access to care. "Insurance companies are driven by one overarching goal — to be profitable companies," he says. "That immediately disqualifies them from doing appropriate quality analysis of the scientific research because they are hopelessly biased. As interventional pain management physicians, we are driven by one overarching goal — to ensure access to care for our patients to scientifically proven procedures."

The grave concern is the knowledge that the insurance companies are waiting for PCORI to come out with proclamations about procedures that they can then use to further deny access to appropriate care. In other words, any potentially mistaken conclusions by this small group of "experts" without legislative oversight or recourse will affect all patients with pain, not just Medicare beneficiaries.

In the United Kingdom, PCORI's counterpart, the National Institute for Health and Clinical Excellence, came out with treatment guidelines for lower back pain in 2009, and those guidelines didn't include interventional pain management. Unsurprisingly, says Dr. Glaser, the group was led by expert surgeons, chiropractors, physical therapists and one pain management physician who didn't practice interventional pain management. Patients became unable to receive the treatments that had been helping them, and the government is now holding hearings to potentially change the recommendations.

"At the 2011 American Society of Interventional Pain Physicians meeting we had a speaker from the UK and the effect of these treatment guidelines has been dramatic and has significantly reduced access to procedures which help patients control their pain and reduce their need for narcotics and surgery," says Dr. Glaser.

3. How interventional pain management leaders are protecting the field.

Prior to the emergence of interventional pain management, the only options for patients were conservative physical therapy, pain medication and surgery. Interventional pain management was developed as a minimally invasive middle step between conservative treatment and surgery. "Our field has opened up through research, innovativeness and the use of technology," says Dr. Glaser. "This has completely revolutionized the treatment of spinal pain."

With some of what interventional pain management physicians do under fire, the American Society of Interventional Pain Physicians has been able to defend the procedures by conducting high quality studies for evidence

and systematic reviews. Led by Laxmaiah Manchikanti, MD, an interventional pain management physician in Paducah, Ky., ASIPP has released treatment guidelines based on these studies that describe whether there is scientific benefit for a procedure or not. These guidelines can be found on the National Guideline Clearinghouse website which is hosted by the Agency for Healthcare Research and Quality under the U.S. Department of Health and Human Services.

4. Why guidelines should focus on the algorithm of spine care instead of isolated treatments. Dr. Glaser says one of the biggest hurdles physicians are facing right now is steering the guidelines away from focusing on isolated scientific studies to incorporating different treatment methods into an algorithm of care. This may be the greatest concern about the makeup of the committees doing the research for PCORI and IPAB.

"If you are not an expert in the field you are evaluating and you don't have a perspective on the risks and benefits of all alternative treatments, then you may come to inaccurate conclusions about a particular treatment that falls outside your realm of expertise," he says. "In the human spine there are a certain number of specific places where the pain comes from. You try the first treatments in an algorithm, and if they don't work you go on through to the next pathway until you are able to relieve the patient of their pain." Although relief may not be complete and procedures may need to be repeated, this pathway of treatment is often a safer and more effective long-term treatment than narcotic painkillers or invasive surgery, the most utilized alternatives. These algorithms or treatment pathways are found on the National Guideline Clearinghouse website.

5. How to work your way around Washington. Dr. Glaser was recently a member of a large group that traveled to Washington, D.C., to advocate for the repeal of IPAB and PCORI. "When you are visiting Washington, D.C., you don't have much time but the legislators do pay attention," he says. "Our group was featured in the newspapers because we

went out there to speak with legislators about these and other big issues such as fighting prescription drug abuse."

All Republicans and some Democrats are making an effort to repeal IPAB and PCORI, but there is still opposition on Capitol Hill, which means more effort could be made to influence these decisions. Physicians and others involved in the care of patients in pain who can't travel to meet with the legislators can still become involved by calling their representatives' offices or sending messages to them about the importance of repeal.

"Tell them you don't want IPAB and PCORI to go through because it will affect your ability to care for patients," says Dr. Glaser. "Don't focus on how it might impact the physician, but how it could hurt the patients and limit their access to care. These representatives don't know what people think about these issues unless we call and talk to them, because they aren't going to come to us and ask."

A further way to become more involved in politics is by financially supporting candidates with similar values. Compared with other professionals, such as lawyers, physicians give much less liberally to the candidates they are backing and are less involved in the campaigning efforts. "It's hard to become involved because we are all so busy, but we have to make the time," he says.

6. What you can do with your patients to get them involved. One of the best tools physicians have for supporting advocacy efforts is the patients themselves. If a particular patient has experienced success with an interventional pain management procedure that may not be covered in the future, that patient has a vested interest in advocating for continued coverage.

"We are talking with patients about the possibility of losing access to care, such as the injections they receive for their spinal stenosis, and they get really nervous about it," says Dr. Glaser. "Patients are very upset once they understand what could happen." These patients can send messages to their representatives advocating the repeal of IPAB and PCORI. ■

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Impact on Pain Management of the New Outcomes Research Institute: Q&A With Dr. Laxmaiah Manchikanti

By Leigh Page

Laxmaiah Manchikanti, MD, is CEO and board chairman of the American Society of Interventional Pain Physicians.

Q: You recently co-wrote an article in the journal Pain Physician about the impact on pain management of a new federal entity, the Patient-Centered Outcomes Research Institute. Can you describe the institute?

Dr. Laxmaiah Manchikanti: The Patient-Centered Outcomes Research Institute was established by the Affordable Care Act of 2010 (the healthcare reform law) to promote comparative effectiveness research. It was created to assist patients, clinicians, payors and policymakers by advancing the quality and relevance of evidence on how certain health conditions can be treated.

Q: What are your chief concerns about this new institute?

LM: Its actions have to be approved by a board that is dominated by non-physicians, such as representatives from insurance companies. Many of them have an ax to grind and cannot look at these matters objectively. I think PCORI will have a difficult time making balanced, scientific determinations on important issues for pain physicians.

The field of pain management is a particularly vulnerable area for this. There has not been a lot of study, even of some pain processes that have been around for a long time. PCORI can start new studies, but they would take 10 years to complete.

Meanwhile, whatever PCORI says about any of these studies would have a significant impact on reimbursement. The insurers, for example, are looking for anything possible as a reason to deny coverage of a therapy.

Q: In your article you criticized a similar effort in the United Kingdom, called NICE, the National Institute for Health and Clinical Effectiveness. Can you describe NICE?

LM: NICE, which has been around for many years, is much better than PCORI, in that it compares therapies and has baseline data which should or should not be included for quality of life improvement. However, in the field of pain management, NICE has developed guidelines for early management of persistent non-specific low back pain that have been inappropriately applied for chronic persistent low back pain.

In the NICE evaluation, there were major misunderstandings of methodology, an inordinate focus on methodological assessment, lack of understanding of the study design, a lack of involvement of clinicians and misinterpretation of the evidence. These erroneous interpretations continue to be disseminated.

Q: You also criticized a similar effort in Washington State. Can you describe that?

LM: Another precursor of PCORI is the Health Technology Assessment Program in Washington State, which makes coverage decisions for state employees and their families. I was a peer reader for the program but they didn't take any of my comments.

In April, HTAP issued some important decisions on pain management that will directly affect reimbursements. It decided to continue paying for some spinal injections and made a preliminary decision to continue coverage for lumbar epidurals, cervical-thoracic epidurals and sacroiliac joint injections.



HTAP endorsed radiofrequency neurotomy, which uses heat generated by radio waves to damage specific nerves and temporarily interfere with their ability to transmit pain signals. However, an Australian study from several years ago says it doesn't work. Meanwhile, HTAP decided to stop payment for nerve block injections, intradiscal injections and facet injections.

Q: Getting back to PCORI, what stage is it at right now?

LM: The GAO announced the appointment of 19 members to the board of governors of PCORI in Sept. 2010. And in January, the GAO announced members of its methodology committee, which is supposed to develop methodological standards for evaluating various clinical therapies. But PCORI will hire a company to do the actual comparative effectiveness research. The federal stimulus bill set aside \$1.1 billion for comparativeness effectiveness research. PCORI just held their first meeting in New York but I did not attend.

Q: What do you think should happen to PCORI?

LM: It should be eliminated. I'm all for evidence-based medicine when it is done properly, but PCORI has the potential for doing a lot of actual damage. Rep. Joe Pitts [R-Pa.], chair of the House health subcommittee of the House Energy and Commerce Committee, is interested in eliminating PCORI. The bill might pass the House but it probably wouldn't pass the Senate at this time. ■

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50 Orthopedic and Spine Devices to Know

This is a list of 50 orthopedic and spine devices that have received FDA 510(k) clearance in 2011. This list is not an endorsement of any product or company chosen for inclusion.

Accolade II Femoral Hip Stem from Howmedica Osteonics. Howmedica Osteonics received FDA clearance for its novel tapered hip system in March. The system is a tapered non-porous coated femoral stem indicated for use in cementless, press-fit applications. The stem is designed to address variations in patient femoral morphology and length can be reduced to facilitate intraoperative insertion.

Aequalis Ascend Modular Reverse Shoulder System, Tornier. The Aequalis Ascend Modular Reverse Shoulder System received FDA clearance in June after more than 12 years of development. It is indicated for patients with a functional deltoid muscle and significant disability after arthropathy for massive irreparable rotator cuff tears. The system includes the Aequalis Reversed Shoulder G2 Baseplate, glenoid spheres and the lateralized polyethylene insert.

Aleutian Lateral from K2M. The Aleutian Lateral is comprised of anatomically designed interbody implants made of PEEK material and meant for use in conjunction with the company's Ravine Retractor. The implants have the potential to increase visualization of bone graft and aid in accurate fusion assessment. The device received FDA clearance in March.

AlloFuse Plus from AlloSource. AlloFuse Plus combines previous AlloFuse demineralized bone matrix capabilities with the osteoconductive properties of cancellous bone. The device received FDA clearance in January and allows for osteoinductivity and osteoconductivity in the same product. The device is used as an autograft extender and bone void filler in gaps that aren't imperative to the bony structure's stability.

Anatomical Shoulder System from Zimmer. The Anatomical Shoulder System's modularity and design allow for reproducible reconstruction of the glenohumeral joint to restore limb kinematics. During the procedure, the humeral head prosthesis is adjusted to the anatomical position on the humeral stem prosthesis and locked. The Anatomical Shoulder Combined System received FDA clearance in March.

Apex ARC Hip Stem from OmniLife Science. The Apex ACR Hip Stem received FDA clearance in June and is designed to allow the surgeons benefits of resurfacing without the disadvantages associated with metal-on-metal articulation. The stem minimizes the amount of bone resection necessary during surgery and allows the surgeon to dissect fewer soft tissues.

Arthrex BioComposite SutureTak from Arthrex. The Arthrex BioComposite Suture Tak is a 2 millimeter biocomposite suture anchor loaded on a driver and intended for use during suture or tissue fixation of the foot, ankle, knee, hand, wrist, shoulder and elbow. The device received FDA clearance in March and is equivalent to previously approved Arthrex anchors.

Ascent Posterior Occipital Thoracic System from Orthofix. Orthofix's Ascent Posterior Occipital Thoracic System received FDA Clearance in May. The system is designed for surgeons taking on complicated fusion cases from the base of the skull to the thoracic region. The system's multi-axial screw includes 66 degrees of angulation and biased angle screws are available to accommodate a range of patient anatomies.

Biomet Sports Medicine Juggerknot Soft Anchor from Biomet. In March, Biomet received FDA clearance for its Juggerknot Soft Anchor, used for soft tissue-to-bone fixation in the shoulder, foot and ankle, elbow, knee, hand and wrist and hip. The device consists of a coreless sleeve suture and suture.

Biomet Sports Medicine Sternal Closure System. The Biomet Sports Medicine Sternal Closure System is used in the stabilization and fixation of anterior chest wall fractures following sternotomy and sternal reconstructive surgical procedures. Implants for the application include Clips and ZipLoop constructs. The single-use device received FDA clearance in April.

BioSpine VBR System from Aesculap Implant Systems. Aesculap, a B. Braun Company, received FDA clearance for its BioSpine VBR System in June. The system is an adjustable vertebral body replacement device designed to improve spine stability. The device can be adjusted to the exact length of the patients' anatomy and locks in place at the desired length. The device is intended for use in the thoracolumbar spine for partial or total replacement of the unstable vertebral body.

Consensus Knee System from Consensus Orthopedics. The Consensus Knee System includes an oval patella and anatomical femoral and tibial component. The oval patella is designed to improve contact area flexion. The tibial inserts are designed to increase joint stability and contact area, which reduces wear. The system received FDA clearance in April.

CoRoent Small Interlock System from NuVasive. In February, NuVasive received FDA clearance for the CoRoent Small Interlock System. The system is a standalone anterior cervical interbody device that includes a PEEK implant cage with titanium alloy radiographic markers and wash-

ers. The devices are manufactured from PEEK-Optima and are intended for use in patients with degenerative disc disease at one level.

Cougar LS System from Johnson & Johnson from DePuy. The Cougar LS Cage was launched last October at the North American Spine Society annual meeting and the system received FDA clearance this past May. The cage has a self-distracting tip and bulleted nose for a streamlined insertion.

Cutting Edge Spine Interbody Fusion Device from Cutting Edge Spine. Cutting Edge Spine received FDA clearance for its interbody fusion device in April. The device is intended for use in patients with degenerative disc disease with Grade 1 spondylolisthesis at one or two contiguous levels. It is used with autologous bone graft to facilitate fusion and is implanted during a direct posterior, transforaminal retroperitoneal or anterior approaches.

Ellipse Occipito-Cervico-Thoracic Spinal System from Globus Medical. The Ellipse system received FDA Clearance in May. The system is designed for the swift installation of implants during complex spine cases. The system includes a non-treated locking cap and the ElliptiClick, a drop, click and lock feature that retains the rod for ease of placement.

Emerald Spinal System from Mazor Robotics. Emerald Spinal System consists of proprietary thoracolumbar implants and accessories guided with unmatched accuracy by Renaissance, Mazor Robotics state-of-the-art guidance system. Emerald provides comprehensive, flexible solutions that allows Intraoperative choice between detachable, interchangeable MonoAxial and PolyAxial Tulips and pedicle screws. Using Emerald allows soft- and hard-tissue sparing, facilitating recovery; it can also reduce intraoperative radiation.

Endofuse Intra-Osseous Fusion System from Wright Medical Technologies. Wright Medical Technologies received FDA clearance for the Endofuse Intra-Osseous Fusion System in May. The system includes titanium alloy rods and beams intended for surgical implantation in the bone for fixation of fractures. The rods and beams have a CP titanium spray coating to help achieve fixation.

Exactech Proliant Polyaxial Pedicle Screw System from Exactech. Exactech Proliant Polyaxial Pedicle Screw System is a top-loading spinal fixation system that includes several sizes of polyaxial screws, rigid rods and cross connectors for immobilization and stabilization of spinal segments in adjunct to fusion. The system includes instrumentation to assist the surgeon during the traditional open procedure. The system received FDA clearance in January.

Flexfusion Fixation Implant from Nextremity Solutions. Nextremity Solutions received FDA clearance for the Flexfusion Fixation Implant in March. The proximal and distal components of the device are provided as a set and the implant is fabricated from medical grade stainless steel. The implant is designed to establish a natural angulation of the fused inter-digital joint during inter-digital repair and fusion of the lesser toes.

Gladiator Plasma Classic Hip System from Wright Medical Technology. The Gladiator Plasma Classic Hip Stem is a straight, uncemented stem featuring a rectangular cross-section. The stem has a thick titanium plasma spray coating on the proximal third of the stem surface and is available in standard and extended neck offsets. The device is indicated for use in total hip arthroplasty and received FDA clearance in May.

IFuse Implant System from SI-Bone. The IFuse Implant System is designed for use during treatment of patients with sacroiliac joint problems. The system contains titanium implants and associated surgical instruments for the minimally invasive procedure. The implants are delivered using a cannulated delivery system and soft tissue protection.

InFill Intervertebral Body Fusion Device from Pinnacle Spine. Pinnacle Spine received FDA clearance for its InFill Intervertebral Body Fusion Device in April. The device is a radiolucent implantable manufactured from PEEK and tantalum. The system includes various implant sizes to fit the patient's individual anatomy and condition. It is designed for use with autogenous bone graft.

Integrity Spinal Care System from Integra LifeSciences. Integrity Spinal Care System received FDA clearance in April and is intended for use to manage pain and disability in patients with lower back and neck pain, including anatomical dysfunctions of the spine. The system includes a bed split into two cushions that both slide in the horizontal plane and are only on low friction runners. The sides have the ability to lock independently.

InterContinental Plate-Spacer from Globus Medical. The InterContinental Plate-Spacer is Globus Medical's second generation system in minimally invasive lateral fixation. The plate and spacer are contained within the disc space and the optimized screw design compressively loads the graft to promote fusion. The device received FDA clearance in May.

iTotal Cruciate Retaining Knee Replacement System from ConforMIS. ConforMIS received FDA approval for the iTotal patient-specific implant for total knee replacements in January and announced the first successful surgeries using the device in June. Computer modeling is used to build a three-dimensional image based on the

patients' CT Scans, and then the personalized implants and cutting jigs are created.

KneeAlign System from OrthoAlign. The KneeAlign is a small surgical navigational system for tibial alignment during total knee arthroplasty. The system is compatible with TKA implant systems and received FDA clearance in April. The device doesn't require capital expenditures and entails only a short learning curve.

Kyphon Inflation Syringe from Medtronic. Medtronic received FDA clearance for its Kyphon Inflatable Syringe in January. The device is intended for use to inflate and deflate devices, such as inflatable bone tamps, and to measure pressure within the inflatable device intraoperatively. The device is designed to generate and monitor pressure up to 700psi.

Kyphon Xpede Bone Cement from Medtronic. The Kyphon Xpede Bone Cement is a quick-to-dough polymethylmethacrylate bone cement that is indicated for use with the Kyphon Balloon Kyphoplasty minimally invasive procedure. The device is used for treatment of spinal fractures and reaches the doughy state twice as quickly as other Kyphon bone material.

Lanx Intervertebral Body/VBR Fusion System. Lanx received FDA clearance for a product line extension to the Lanx Intervertebral Body/VBR Fusion System in February. The system now includes additional cervical intervertebral body fusion device implants with increased graft volume, additional larger implant footprints, implants with convex superior endplates and the ability to accommodate a threaded inserter.

LP Cage from Medsysey Spine. The LP Cage is indicated for use with patients who have degenerative disc disease at one or two contiguous levels from L2-S1 for posterior lumbar interbody fusion. Medsysey received FDA clearance for the cage in April, and the company aims for a full commercial release of the product by the fourth quarter of 2011.

Maxfire MarXmen Meniscal Repair Device from Biomet. This device, cleared by the FDA in June, is the next generation for Biomet's all-inside, all-suture meniscal repair technology. The Maxfire MarXmen includes a one-handed trigger delivery system that requires a small amount of insertion force compared to other similar devices and using the rigid tube cannula can help protect the joint intraoperatively.

MIS Anterior Cervical Plating System from Life Spine. Life Spine received FDA clearance for its MIS Anterior Cervical Plating System in June. The system's components include temporary implants intended for anterior fixation of the cervical spine during fusion. The system has a variety of plate and screw sizes as well as associated instruments.

Mountaineer OCT Spinal System from DePuy Spine. Cobalt-Chromium Allo Rods, which received FDA clearance in April, are now available for the Mountaineer Occipito-Cervico-Thoracic Spinal System. These new rods are designed to maintain the sagittal and coronal alignment surgeons demand for deformity correction, without compromising imaging capabilities. The Mountaineer OCT Spinal System is indicated for use during rigid posterior fixation of the OCT spinal region and allows surgeons to anatomically place screws and rods with minimal contouring.

Multifit Total Hip System from Biotech. Biotech received FDA clearance for the Multifit Total Hip System in January. The system includes the option of cementless and cement collared stems and metal femoral heads. The system can be used to replace a defective hip joint in specific instances, such as congenital hip dysplasia.

Revere Sacral Plates from Globus Medical. Globus Medical received FDA clearance to add Revere Sacral Plates to the Revere Stabilization System in March. When used as a posterior pedicle screw system, the system is intended to provide immobilization and stabilization of spinal segments as an adjunct to fusion for patients with acute and chronic instabilities or deformities.

SeaSpine Spacer System from SeaSpine. Sea Spine received FDA clearance for its spacer system in May. The system is intended for use during intervertebral body fusion for patients with degenerative disc disease. The system can be used as a vertebral body replacement device in the thoracolumbar spine to replace a collapsed, diseased, damaged or unstable complete or partial vertebral body. It is intended for use with bone graft.

SIMmetry Sacroiliac Joint Fusion System from Zyga. Zyga Technologies received FDA clearance for SIMmetry Sacroiliac Joint Fusion System in January. The system is indicated for patients with degenerative sacroiliac and sacroiliac joint disruptions. The system includes several threaded, cannulated implants and associated instrumentation for the minimally invasive procedure.

Spartek Variable Angle Pedicle Screw Posterior Fusion System from Spartek Medical. The Spartek Variable Angle Pedicle Screw System received FDA clearance in April and is intended for use in the thoracic, lumbar and sacral spine. The single-use device can be used in one or more segment stabilizations to facilitate fusions during spine surgery.

Streamline TL Spinal Fixation System from Pioneer Surgical Technologies. The inclusion of the FixxSure Cross Link to Pioneer Surgical's Streamline TL Spinal System received FDA clearance in May. The system's components are intended for use during non-cervical spinal fixations as an adjunct to fusion. The Cross Link is designed to provide added fixation to the spinal construct.

Stryker Patient Specific Cutting Guide from Stryker. The ShapeMatch Cutting Guides received FDA clearance in May and are indicated for use with Stryker's Triathlon Total Knee System. The patient-specific three-dimensional data derived from MRI or CT scans is used to design the guidelines. The technology employs software to develop customized preoperative surgical plans for each patient.

Symmetric Total Knee Augments from Signal Medical. The Symmetric Total Knee Augmentation is intended to complement the Symmetric Total Knee System and consists of metallic wedges, stems, cones and sleeves for use during total knee arthroplasty. All components are for cemented use. Signal Medical received FDA clearance for the device in March.

Synthes Hemostatic Bone Putty from Synthes USA. Synthes received FDA clearance for its Hemostatic Bone Putty in May. The device is designed to stop bone bleeding by establishing a physical barrier along the edge of damaged bone. The HBP includes synthetic water soluble polymers which form a ready-to-use haemostatic agent, which is substantially eliminated from the defect site within 48 hours.

TranS1 AxiaLIF+ from TranS1. In March, TranS1 received FDA clearance for its AxiaLIF 1L+, the next generation of its original system launched in 2005. The system allows for more precise distraction capabilities and improved pull-out strength. The product is set for full commercial release during the second half of 2011.

Trinity Acetabular System from Corin USA. The Trinity Acetabular System received FDA clearance in March and is intended for use during total hip arthroplasty. It is indicated for use in patients with non-inflammatory degenerative joint disease and is intended for cementless use only.

Trio Trauma Spinal System from Stryker. The Trio Trauma Spinal System from Stryker received FDA clearance in March. The system includes cannulated pedicle screws in a variety of lengths and both straight and pre-bent rods, and components are manufactured from titanium alloy. The system is intended for percutaneous, posterior, non-cervical fixation of the spine with degenerative and traumatic conditions.

Total Shoulder System from Shoulder Innovations. The Total Shoulder System received FDA clearance in January and consists of modular humeral stems and heads and a glenoid component. The humeral stems and heads are manufactured

from cobalt chrome and the glenoid component from ultra high molecular weight polyethylene.

Vault ALIF System from Spinal USA. Spinal USA received FDA clearance for its Vault ALIF System in April. The system is designed for use with autograft to facilitate fusion of either one or two contiguous levels in the lumbar spine. The standalone system can be used for treatment of patients with degenerative disc disease and Grade 1 spondylolisthesis.

Zenith Pedicle System from Apollo Spine. In March, Apollo Spine received FDA clearance for its Zenith Pedicle System. The system is intended to provide immobilization and stabilization during thoracic, lumbar and sacral spine surgery. The temporary implant system is intended for removal after solid fusion and should only be used with components from the Zenith system.

Zimmer Periarticular Locking Plate System from Zimmer. The periarticular plates in this system were developed using digital laser one-scanning technology to design a device that closely mimicked the shape of the bone. The plates have decreased thickness toward the joint line which reduces soft tissue irritation. The system was developed for use during minimally invasive surgical procedures. ■

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30 Orthopedic and Spine Surgeons on the Move

Danville (Va.) Spine Center, a division of Danville Orthopedic Clinic, welcomed **Leon Abram, MD**, a traumatic spinal disorder surgeon.

Sports medicine physician **Frank Alberta, MD**, joined the Malo Clinic Health & Wellness in Rutherford, N.J.

Orthopedic surgeons **Dennis Anderson, MD**, **Todd Bankhardt, MD**, and **David Clark, MD**, voluntarily resigned from Racine, Wis.-based All Saints' orthopedic department.

Theodore Belanger, MD, an orthopedic spine surgeon, joined Texas Back Institute in Plano after years of practicing in North Carolina.

The Longstreet Clinic in Gainesville, Ga., welcomed sports medicine physicians **Amy E. Borrow, MD**, and **Stephen Fisher, MD**, to the clinic.

Samuel K. Cho, MD, a spine surgeon, joined Montvale (N.J.) Health Associates while retaining his practice at Mount Sinai Medical Center.

McCullough-Hyde Memorial Hospital in Oxford, Ohio, welcomed **Matt Daggiy, MD**, a sports medicine physician, as part of the hospital's strategic plan to expand outpatient services.

Thomas Dulaney, MD, a sports medicine, joint replacement, arthroscopy and traumatic injury surgeon recently joined Stewart Memorial Community Hospital in Lake City, Iowa.

Spine Surgeon **Keith Eugene Girton, MD**, joined Laser Spine Institute in Philadelphia.

After spending the past few years practicing in Wyoming, **Doug Hiller, MD**, an orthopedic surgeon, returned to North Hawaii Community Hospital in Kamuela.

Greg Hoover, MD, and **J. Mark MacNaughton, MD**, have joined Cumberland Medical Center in Crossville, Tenn., to provide emergency orthopedic service coverage.

Orthopedist **Ron Joseph, MD**, has joined Gulfcoast Spine Institute in Brooksville, Fla., and will head up the practice's conservative or non-operative care.

Orthopedic trauma and arthroscopy surgeon **Bradford Matthews, MD**, joined Sanpete Valley Hospital Specialty Clinic in Mount Pleasant, Utah.

St. Luke's Hospital in Columbus, N.C., recently welcomed spine surgeon **Mark L. Moody, MD**.

Rothman Institute in Philadelphia recently welcomed **Zachary Post, MD**, an orthopedic surgeon with a professional interest in hip and knee arthroplasty.

Orthopedic surgeon **Russ B. Rauls, MD**, joined Knox Orthopaedics in Mountain Home, Ark.

Sports medicine physician **Jesse Sandlin, MD**, joined Henry County Orthopaedic Surgery in Paris, Tenn.

Jeffrey Rosenberg, MD, a sports medicine physician, joined Summit Medical Group in Berkeley Heights, N.J.

Kevin Stanley, MD, a sports medicine and joint replacement surgeon, joined OrthoCarolina at the practice's Mooresville, N.C., location.

Sports medicine surgeon **William Sterett, MD**, recently left The Steadman Clinic in Vail, Colo., where he was a partner, and joined Vail-Summit Orthopaedics and Sports Medicine.

After serving as an orthopedic surgeon in the military for 11 years, **Kevin Strohmeyer, MD**, joined Laughlin Memorial Hospital and Laughlin Medical Group in Greeneville, Tenn.

Orthopedic trauma physician **Jonathan Swindle, DO**, joined Fayetteville (N.C.) Orthopaedics & Sports Medicine.

Ocean Beach Hospital in Ilwaco, Wash., welcomed orthopedic surgeon **Ronald Teed, MD**, to the hospital.

Pediatric orthopedic surgeon **Craig Shank, MD**, has joined Dayton (Ohio) Children's Orthopedic Center.

David A. Weimer, MD, an orthopedic surgeon with a special interest in knee and hip replacements, became partner at Youngstown (Ohio) Orthopaedic Associates.

Sports medicine specialist **Kurt Wohrab, MD**, joined Pinehurst (N.C.) Surgical after previously practicing at Womack Army Medical Center at Fort Bragg. ■

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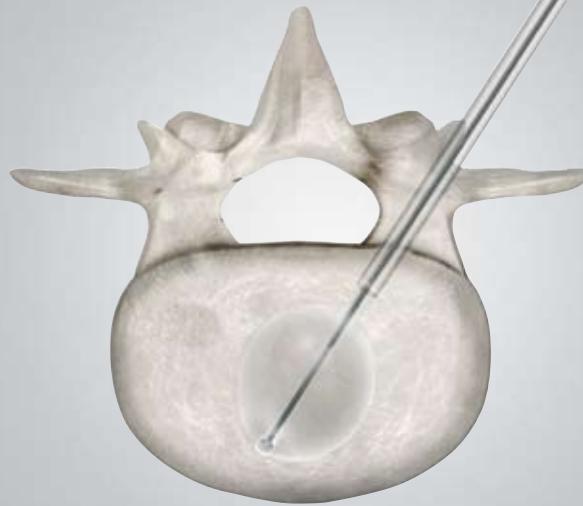
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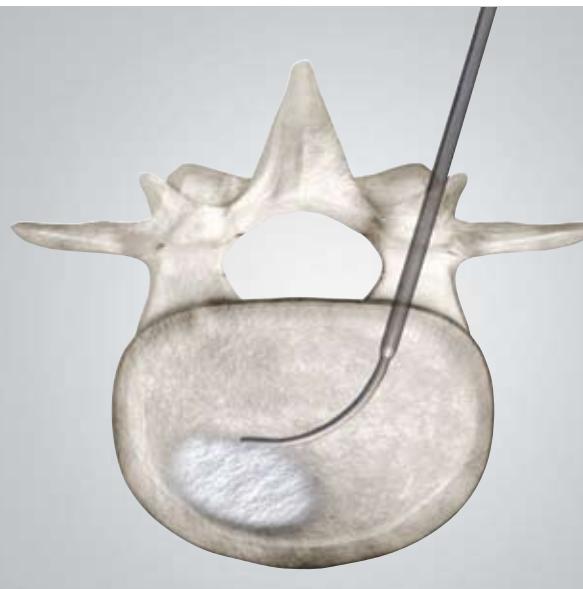
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