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No Bones About It

Why You Should Care (More Than You Do) About Medicare

by **Joe Prud'homme, MD**
President, WVOS

Medicare is the cancer that is about to kill the host. It is multiplying out of control. It is one of the most expensive government programs, and one of the fastest growing. More than any other single thing, Medicare has shaped the face of modern medicine in the US. It de facto sets the reimbursement rates for almost everything medical from hospital admissions and surgeries to medications and DME. Nursing homes, home health, physical therapy, physician office visits, ambulance transport, chemotherapy, imaging studies - all are reimbursed according to a Medicare fee schedule. Increasingly,

as costs have risen, the Medicare fee schedule has become a template for all of the other payers to follow as they lower their payments, essentially setting the overall medical payment rates for most of medical treatments in the US. Medicare also pays a significant portion of the costs for graduate medical education in the US.

This has not been all bad for patients or doctors. For many years, doctors' incomes grew every year largely due to Medicare. They got paid dollars for patients who they previously treated for free, or for chickens and eggs. Older patients got access to the newest therapies that they previously would not have been able to afford

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MOC: Reminder of Highlights

Have MOC
questions?
Call
(919)
929-7103.

Requirements – the big Four:

1. **Evidence of professional standing:
i.e. your license**
2. **Evidence of lifelong learning and self
assessment:**
 - Years 1-3: 120 category I CME credits with 20 of these from a legitimate ABOS approved self assessment type test. (Most common one is the AAOS self assessment exam – several subspecialties available).
 - Years 3-6: Same as above (again).
3. **Evidence of cognitive expertise:**
 - A computer exam or oral exam sometime in the three years prior to your certificate expiring!
4. **Evaluation of performance in practice:**
 - Currently a case list needs to be submitted as part of the application for the computer or oral exam.
 - Peer reviews are obtained by ABOS to evaluate your practice.

Check the website (ABOS.org) for DEADLINES!! CME credits and self assessment exam results are due over a year in advance of deadlines!!

**If questions, call the ABOS at
(919) 929-7103!**

Letter to Congressman Shared

October 17, 2011

Congressman David McKinney
313 Cannon House Office Building
Washington, D.C.

Congressman McKinney,

It has come to my attention that MedPac is going to recommend an 18% cut in reimbursement and then a 7 year freeze for surgical specialists. As an orthopaedic surgeon practicing in Appalachia, this would have a devastating effect on giving care to my patients. If this would go thru, all insurance carriers would inflict upon me the same reduction. Wages to my employees could not be cut 18%. I could not reduce my utility bills by this amount to make up this deficit.

There are much better ways to control the spiraling costs of Medicare. Possible solutions include:

1. Tort reform. With this, there would be a significant reduction in ordering unnecessary tests.
2. When an orthopaedic injury occurs, have them seen by an orthopaedist before unneeded tests and therapy are ordered by primary care physicians.
3. Physician reimbursement only makes up about 20% of total Medicare expenditures. This would not address the major costs of healthcare.
4. Address palliative care options with end of life patients to help avoid costly surgical procedures.
5. Stop Medicare fraud. In 2010 alone, Medicare made \$47.9 Billion dollars in improper payments.

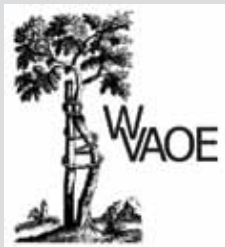
After the billions of dollars saved by following the above recommendations, any additional cuts that have to be made, should be done across the board. Let every Medicare provider (doctors, hospitals, DME providers, pharma, and the patients) share equally in trying to make the system whole. To solve this and other problems in Washington, compromise is essential.

Sincerely,
Dr. Gregory Krivchenia II

**Congress
needs to hear
from their
constituents
on medical
issues.**

Testing Readiness: What to Know

**Test now
to ensure
there are no
interruptions
in your claim
remittances or
payments.**



On January 1, 2012, the Version 4010/4010A electronic transaction standards used to send administrative transactions will be replaced with the upgraded Version 5010 standards. After this time, the Centers for Medicare & Medicaid Services (CMS) will no longer accept transactions in the Version 4010 format.

All health care providers that are covered entities under the Health Insurance Portability and Accountability Act (HIPAA) are required to comply with the new standards. This means providers, payers, vendors, and clearinghouses must be ready to implement the Version 5010 transaction standards on January 1, 2012. Unlike the current Version 4010/4010A1, Version 5010 accommodates the ICD-10 codes, and must be in place first before the changeover to ICD-10. Version 5010 has the ability to tell your practice management or other system that you are using an ICD-10 versus an ICD-9 code. The Version 5010 change occurs well before the ICD-10 implementation date to allow adequate time for Version 5010 testing and implementation.

A key step in preparing your office for this upgrade is testing transactions in the

new Version 5010 format. Testing transactions using Version 5010 standards will assure that you are able to send and receive compliant transactions effectively. Testing will allow you to identify any potential issues, and address them in advance of the January 1, 2012 compliance date.

Who Should Test?

All HIPAA covered entities that submit transactions electronically are required to upgrade to the Version 5010 transaction standards, and should conduct testing both internally, and with external business partners in preparation for the January 1, 2012 compliance deadline.

Who is a Covered Entity?

- Providers- physicians, including alternate site providers
- Payers
- Health care clearinghouses
- Pharmacies
- Health plans

Where to Start?

Level I: Internal Testing
(Take Action Now)

The first step in testing can begin as soon as your software has been upgraded. CMS suggested completing a thorough internal testing of your upgraded transaction systems by December 31, 2010. Internal testing allows you to identify and address

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Version 5010 Continued from page 4

any potential issues that may arise in advance of testing with external business partners. If you have not yet done so, take action now to complete your internal testing as soon as possible to ensure a smooth transition and begin external testing. Level II: External Testing (12 months)

After you have completed internal testing, you can begin sending test data to your external business partners to ensure a smooth transition. Identify the partners you currently conduct transactions with, and create a schedule and timeline for external testing with each partner. Identify priority partners to conduct testing with if you trade with a large number of business partners.

Which Business Partners Would be Included in External Testing?

- Billing services
- Clearinghouses
- Pharmacies
- Entities responsible for coverage and benefit determinations
- Payers

Confirm that your business partners are also engaged in testing with other external partners with whom they may work. This is crucial to completing comprehensive testing. Allow for sufficient time to train,

and practice with staff using the new transactions.

Which Transactions to Test?

Test transactions that you currently use on a daily basis such as:

- Claims
- Eligibility determinations
- Remittances
- Referral authorizations

CMS has resources available to help you in the transition process – even help you get the conversation started with your business partners if you haven't already. Go to our Web site, www.cms.gov/ICD10, for Provider and Vendor Resource pages that include fact sheets with tips on asking each other the right questions.

Testing with Medicare

The Medicare Fee-for-Service (FFS) program is accepting claims in both test and production mode using the errata Version 5010 standard (an X-12 updated version featuring corrections). You can begin to test your transactions with Medicare now, and up until the January 1, 2012 mandatory compliance date.

After January 1, 2012, Medicare will no longer accept transactions using Version 4010 standards. Begin testing as soon as possible to help reduce risk and avoid rushing tests.

Visit
cms.gov/
ICD10 for
news and to
sign up for
Version 5010
and ICD-10
email updates.



Orthopaedic Practice in US: 2010

Every two years, the American Academy of Orthopaedic Surgeons conducts the Orthopaedic Practice in the US survey. Demographic (e.g., age, gender, race, work status) and orthopaedic practice-related information (e.g., practice setting, degree of specialization, fellowship, work hours, etc.) collected through the census are used to ensure that Academy programs and products are designed to address AAOS members' professional needs

and interests.

2010 was a census year. How did your state compare to others?

The top five states with the highest orthopaedic surgeon densities were Montana, Wyoming, Alaska, Vermont, and DC (10 or more per 100,000 population). Conversely, Texas, Arkansas, Mississippi, Michigan, and West Virginia had the lowest density of orthopaedic surgeons (6 or fewer per 100,000 population).

**West Virginia
has lowest
density of
orthopaedists,
according to
AAOS 2010
Census.**

Highest Density States Surgeons Per 100,000 Pop.		Lowest Density States Surgeons Per 100,000 Pop.	
Montana	13.44	Texas	6.19
Wyoming	13.41	Arkansas	6.13
Alaska	12.31	Mississippi	6.06
Vermont	12.06	Michigan	6.04
District of Columbia	11.84	West Virginia	5.88

2012 WVOS MidWinter Meeting



Make plans now to attend the 2012 MidWinter Meeting of the West Virginia Orthopaedic Society (WVOS) and the West Virginia Association of Orthopaedic Executives (WVAOE) on April 13 and 14 at Stonewall Resort in Roanoke, W. Va.

The theme for the meeting will be "Injections in Orthopaedics." Please contact WVOS CME Chairman Jack Steel, MD, President Joe Prud'homme, MD or Executive Director Diane Slaughter, CAE, APR, with topics of interest and speakers you would like us to consider for this upcoming meeting.

The fun begins Friday with golf tee times starting at 11:00 a.m. We have reserved eight tee times for foursomes. The golf fee is \$89, and includes green fees, a shared golf cart and unlimited use of the practice facility.

After golf, there will be a cash bar reception in the exhibit hall, giving you a new opportunity to visit with our

exhibitors. Dinner is included in your room rate and will be on your own that night in the Stillwaters Restaurant.

Saturday morning will begin with a continental breakfast, followed by our outstanding array of speakers. The final topics for the meeting will be announced early in 2012.

The meeting is open to physicians, physician assistants, physical therapists, allied health professionals and exhibitors.

The sleeping room rate will be \$125 per night single/\$75 per night double and includes your sleeping room, meals, resort fee, onsite parking, in-park shuttle service, high speed internet access and Wi-Fi, use of fitness equipment, indoor/outdoor pool and many other amenities.

The spa and other services can be arranged prior to the meeting. For those wanting to bring the family, rates are available for Saturday night.

See you in 2012!

**Make plans
now to attend
the 2012
MidWinter
Meeting at
Stonewall
Resort.**

By AAOS Councilor Jack Steel, MD

Medicare Tops Council Agenda

**Expected 2012
Medicare cuts
likely to be
hot topic at
AAOS Council
meeting.**

This is an abbreviated Board of Counselor's report as the Fall Meeting will not commence until October 27 in Seattle. The most pressing topic will be the Medicare cuts expected to be instituted in 2012.

The state of the economy, Obamacare, and the "Jobs Bill" have dominated the news for the past several months leaving the long-delayed Medicare SGR update in the background. The latest proposal involves cuts of 5.7% per year for EACH of the next 3 years to specialists. That is 18% over the next 3 years. This certainly pales in the face of the previously proposed 29.5% cut mandated by the SGR bill from the past. Regardless, this will significantly impact our practices when you also consider that the commercial payers typically base their payment schedules on medicare payments. I anticipate much discussion at the Fall Meeting regarding the effect on our practices and the ultimate effect on patient access to care. I will keep you posted.

My term as Counselor ends at the AAOS meeting in San Francisco. The WV Orthopedic Society elected Greg Krevchenia as our new Counselor at the August meeting at The Greenbrier. Greg will be an excellent,

enthusiastic representative for our Society. He attended a number of Washington meetings over the past several years during his tenure as president of the WVOS. He is well prepared to step in and do a great job.

I will keep you posted on the upcoming meeting.



**Mark your
calendar for the**

**2012
AAOS Meeting**

www.aaos.org

February 6-11, 2012

San Francisco, CA

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unless they were wealthy. There have always been squabbles here and there about Medicare costs, benefits and reimbursement rates. In decades past these were a minor issue from a public policy perspective. The total number was not that big. Over the past 20 years, explosive growth in expensive new medical imaging and expensive new medicines and cancer treatments, combined with an ever increasing percentage of the population that are over 65, made it impossible to ignore. Every month the government has to write a bigger check to pay for Medicare. It is now in the running to become the single largest installment payment. In fact, Medicare and the federal contribution to Medicaid, combined, made up 23% of the entire 2010 federal budget. Medicare alone came in at about 20%. That is currently equal to Social Security and Defense spending which were about 20% each in 2010. In 2011 Medicare is on track to be number one with its annual costs growing twice as fast as the other two.

When Medicare was first introduced in the 1960s, the AMA hired then-actor Ronald Reagan as its spokesperson to denounce Medicare as a communist threat to

the American way of life. Strangely, fifty years later, that prophecy seems very appropriate. Medicare is the program in the US that most closely resembles the bankrupt socialist systems of the Euro zone that we hear about everyday in the news. These western European countries are now in the position of the hiker who became famous several years ago after he cut off his arm to save his life. If they don't do something equally painful, their economies will not survive. We are not too far behind.

We as doctors do need to tell congress to get rid of the SGR and to repeal IPAB. These types of mechanisms should not be used to make medical decisions. At the same time we need to offer an alternative solution. The current system is on a death spiral. As physicians we should be the ones to make the tough medical decisions about how to best utilize the truly available resources to do the greatest good for the most people in a sustainable system. I challenge each of you to ponder the magnitude of this problem and to offer the best overall solution that you can come up with. We should all think about this and actively pursue a solution on a daily basis. It

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There have
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This problem
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unsolved.

should be a priority for us all. To ignore it threatens the lives of our patients as well as our livelihoods. This problem is too huge to leave unsolved. If we don't provide the solution, and it will take a fairly radical one, then someone in Washington who does not have to worry

about getting elected is going to do it. I am pretty certain that you will not like the results, and neither will your patients.



OMG

**GET THE MESSAGE.
TEXTING WHILE DRIVING IS A DEADLY DISTRACTION.**

ota.org/donttext [aaos.org/donttext.](http://aaos.org/donttext)

 |  AMERICAN ACADEMY OF ORTHOPAEDIC SURGEONS