West Virginia Orthopaedic Society

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No Bones About It

Alas, no permanent fix to the SGR formula

President Greg Krivchenia, M.D.

Congress again has failed to give physicians a permanent fix to the way we are reimbursed for providing medical services to Medicare patients.

As of March 31, we will be taking a 21.3% pay cut. Before the two week Congressional recess, another temporary patch failed to overcome a filibuster by physician Senator Clyburn of Oklahoma. This patch is tied to extending unemployment benefits and other fiscal matters that have not been funded and will add to our deficit.

No one in Congress has shown "Profiles In Courage" (by John F. Kennedy) in dealing with impending financial disaster in America. When it comes to healthcare reform, it is imperative to tackle the issue head on NOW. Every minute the government is borrowing $1.7 million to finance our national debt. Presently, each taxpayer is on the hook for $100,000.00 for our debt.

The solutions to these problems will be tough and EVERYONE is going to have to sacrifice for our country. From healthcare, all interested parties (pharma, insurers, medical device companies, hospitals, healtcare providers, and PATIENTS) need to step back and see how we can make changes that will be WIN-WIN for all of us. And it can be done.

First of all, we do not need 2700 pages of complex regulations and another 153 pages of "corrections" to make our healthcare delivery system fair for everyone.

No SGR Fix Continued on page 6

WVOS Intern Hallie Sampson

MidWinter Meeting now June 5

The MidWinter Meeting was moved to June 5 after Gov. Manchin's February state of emergency due to extreme snowfall.

This year we have had one of the most brutal winters that West Virginia has seen in quite a few years. Inches upon inches of snow fell during this past winter season, and tremendous amounts of snow accumulated across the state. The MidWinter Meeting had to be cancelled on February 5 when Governor Manchin declared a statewide state of emergency. The new date for the "MidWinter" meeting is now set for June 5, 2010.

The "MidSummer/ MidWinter" meeting will take place at the Marriott Town Center Hotel on 200 Lee Street, East, in Charleston, West Virginia. Registration will begin at 7:30 AM and the conference will adjourn at 4:00 PM. The program chairmen for this year's MidWinter meeting are Jack R. Steel, MD, Tony C. Majestro, MD, and Greg Krivchenia, MD.

The theme for June's meeting is "Orthopaedic and Athletic Injuries in Children and Adolescents." This year's program is co-sponsored by both CAMC Health Education and Research Institute and the West Virginia Athletic Trainers Association. The participants at the MidSummer/MidWinter meeting will be given useful, practical information about the prevention, treatment, and rehabilitation of athletic injuries in children and adolescents.

The WV Association of Orthopaedic Executives will have a separate meeting including a discussion of benchmarking and practice issues.

If possible, please bring any interesting and relevant cases to discuss with your peers with films on compact discs that can run on Microsoft PowerPoint 2003.

Registration is now open and payment can be made through PayPal on our website at http://www.wvos.org/ or by check. You may also send your payment in by May 21st, 2010 to:

Diane Slaughter,
CAE, APR, Fellow PRSA
WV Orthopaedic Society
PO Box 13604
Charleston, WV
25360-0604

Hotel reservations for the Marriott should be made by May 14th, 2010. Please call 304.345.6500 and ask for the WVOS room block (using code DSL). The rates for the Marriot are $103 per night plus the applicable taxes. If you have any questions please contact the WVOS office at 304.984.0308.

Please join us June 5 at the Marriott.

We hope to see you there!

AAOS Councilor Jack Steel, MD; Chair AAOS BOC Resolutions Committee

Medicare cuts made; times tough

March madness has come and gone and the West Virginia University and other basketball fans among us were in heaven for a long time. The other madness of March is ongoing in into spring in Washington, DC.

Congress delayed the implementation of the 21% Medicare cuts until March 31. Our academy has been lobbying on our behalf to permanently fix the problem. Our position is opposed to that supported by the AMA and American College of Surgeons. They support avoiding the 21% cut by implementing a "no increase" in Medicare rates approach.

This means no increase in rates indefinitely. This is projected to equal a much greater than 21% cut with inflation over 5-10 years. This issue resided on the back burner as the health care overhaul bill reached a vote.

No one can predict where this will end, but the 21% cut is currently in place.

The future is worrisome, to say the least. Our academy's Washington office is busy advocating for our patients (access to care) and our members. Near daily updates are available on the AAOS web site. We can help our cause by keeping informed and informing our patients. Our patients can be our best advocates.

Lastly, joining the orthopedic PAC will add numbers to the cause. The current percentage of membership is just under 25%. The amount of money is not as important as the number of AAOS members represented. This adds clout to our message.

Remember this is the organization that was instrumental in blocking last year's reimbursment cuts for total joints and hip fractures. Tougher times are ahead.

Please continue to educate yourself and your patients on these issues, let your voice be heard in the offices of our Congressional delegation and share your voice (and your contribution) with the AAOS PAC.

Be sure to make plans to attend the MidSummer/ MidWinter Meeting on June 5 in Charleston. Visit www.wvos.org for details.

Congress delayed Medicare cuts – but tough times are still ahead.

WVAOE President David Proctor, MBA, ATC and WVAOE Secretary Clint Welch, JD

Benchmarking survey coming

Once data is collected, practices will be able to rate their own outcomes.

With the just passed healthcare legislation and the looming cuts in Medicare, it will be more important than ever for administrators to have a firm grasp of their practice's financial position. An important step in improving the performance of an orthopaedic practice is benchmarking against others within a common geographical region. Our current national benchmarking surveys through the MGMA and AAOE haven't yielded enough data specific to our region. Benchmarking, according to the AAOE, is important for the following reasons: Identifies practices' strengths and weaknesses, improves operations, trims costs, enhances practice value, and it is a key element to strategic planning.

Below is a list of data points that could be gathered from member practices:

- Practice Demographics (# of FTE physicians, & non-physicians, type of practice, and # of office visits)
- Revenue, expenses, and accounts receivable (gross billed charges, net collections, mid level provider charges & collections, total expenses, A/R, and overhead %)
- Expenses-People (mid-level providers, staff, admin/management)
- Payer Mix (by charges and by % of collections)

The benchmark survey would be accessed by member practices on the WVOS website. Members would be given a secure login and password. They would enter their data online into the prepared survey. After a certain date, they would be able to login to the website and compare their practice against other WV orthopaedic practices. Executives can retrieve a summary report that helps identify their practices' strengths and weaknesses, improve operations, trim costs, and enhance practice value. All data would be anonymous.

In addition, members will be able to access a portal where they could enter data regarding their medical supply and DME costs. Once members fill out this data, they would be able to compare prices paid by WV orthopedic practices on individual medical supplies, injectables, and DME products.

It was hoped to have the survey operational by this point in time. We were hoping to solicit administrator feedback at the Mid-Winter meeting. With the delay of the meeting till June, the start of the survey has also been postponed.

Matthew Twetten reprinted from "AAOS in the States "

GSD gets total content overhaul

Thanks to a lot of work by the AAOS Coding, Coverage and Reimbursement Committee the 2010 AAOS Complete Global Service Data for Orthopaedic Surgery Guide (GSD) might have the same name as it did in 2009, but that's just about the only part of the book that will look the same to users. Almost everything else, from the font to the binding (the 2010 version will be spiral bound), and especially the actual content will look much different in 2010. The new GSD guide will be available in early February, and the 2010 Code-x product, an electronic coding aide, is available now, and contains the 2010 GSD revisions.

The GSD guide has been published annually by the AAOS since 1991 and was conceived as a tool to help orthopaedic surgeons and their office staff to code and bill providers appropriately for the services they render. The guide is edited by members of the AAOS Coding, Coverage and Reimbursement Committee, chaired by Blair Filler, MD.

For those unfamiliar with the GSD guide, it has individual entries for virtually every integumentary, musculoskeletal, and nervous system CPT code. It then instructs users on what procedures are considered included, or bundled, and what procedures are considered excluded, or unbundled. The value of the GSD guide is that it tells users what intra-operative services they can bill separately and what intra-operative services they cannot bill separately for. If a user follows GSD recommendations he or she should be able to significantly improve their revenue by reducing the number of denials they get from payors for services considered bundled and by having a resource to use in appealing inappropriate payor denials.

The biggest change is the elimination of the generic templates so that every entry in the new guide is tailored to the specific CPT code and does not contain any extraneous or potentially contradictory inclusions or exclusions. Having inclusions and exclusions tailored to a specific procedure and nothing additional helps make the book much more logical since previously listing services associated with open treatment for non-open treatments, while making the publishing process easier, also made the guide

GSD Guide Continued on page 6

The GSD font, binding and content will change for 2010.

New GSD Guide will be available in several formats for ease of use.

GSD Guide Continued from page 5

harder to use. In place of the generic inclusions and exclusions will be inclusions and exclusions based on the work done in performing the specific procedure.

The guide also sought to standardize language throughout the guide. This may seem relatively unimportant to the naked eye, but payors rely on a standard language when it comes to determining payment policies and something as minor wording inconsistencies can change how a payor interprets an individual claim. This effort at standardization is also consistent with efforts by the American Medical Association (AMA) to standardize wording throughout the master Current Procedure Terminology (CPT) guide.

You can find out more information and see samples from the AAOS Complete Global Service Data for Orthopaedic Surgery, as well as AAOS Code-x at http://www4.aaos.org/product/productpage.cfm?

Five solutions offered to make system financially viable.

No SGR Fix Continued from page 1

My solutions to make our system financially viable:

1. Eliminate Medicare fraud. In the age of computer technology, this should be a fairly easily fix.
2. Meaningful tort reform. If we just enact on a national level California's tort laws of 1975, the problem would be solved.
3. Eliminate the burdensome federal regulations on healthcare providers that do nothing to improve delivering care to our patients. (ie. how important is that we sign our orders within 48 hours).
4. Common sense end of life issues. The reason why we are only the 18th healthiest nation in the world (even though we spend more than 50% than other countries) is that the rest of the world does not extend life needlessly.
5. If ALL stakeholders in delivering health care, took 5% to 8% less in reimbursement, we can start to put Medicare and OUR government on the road to recovery.

Finally, if the United States of America is EVER going to put our financial house in order, the individual must be held accountable for their own bad behaviors. We will never get a handle on the costs of healthcare until this is addressed.

HIPPA Breach Interim Rule Out

The American Recovery and Reinvestment Act of 2009 ("the Act") made several changes to the HIPAA privacy rules—including adding a requirement for notice to affected individuals of any breach of unsecured protected health information. On August 24, 2009, the Department of Health and Human Services (HHS) published an interim final rule (the "Rule") that lays out the specific steps that HIPAA-covered entities and their business associates must take. This Management Alert will summarize the Rule, which became effective September 23, 2009. HHS has stated that while it expects covered entities to comply with this Rule as of September 23, it will not impose sanctions for failure to provide the required notifications for breaches discovered through February 22, 2010. Instead, during such period it will work with covered entities to achieve compliance through technical assistance and voluntary corrective action.

Summary of Interim Rule

The new requirements apply if all of the following are present:

- There is a "breach." The Rule defines "breach" to mean (subject to exceptions discussed below) the unauthorized acquisition, access, use, or disclosure of protected health information ("PHI").
- The PHI is "unsecured." The Rule defines "unsecured protected health information" to mean PHI that is not rendered unusable, unreadable, or indecipherable to unauthorized individuals through the use of a technology or methodology specified by HHS guidance.
- The breach "compromises the security of the PHI." Under the Rule, this occurs when there is a significant risk of financial, reputational, or other harm to the individual whose PHI has been compromised.

What is Secured PHI?

On April 27, 2009, HHS issued the HITECH Breach Notification Guidance specifying the technologies and methodologies that render PHI unusable, unreadable, or indecipherable to unauthorized individuals. That guidance creates a safe harbor so that covered entities and business associates would not be required to provide

HIPPA Continued on page 8

HIPPA Rule deals with breaches discovered through February 22.

PHI can be encrypted or destroyed to comply with new rules.

HIPPA Rules Continued from page 7

the breach notifications required by the Act for PHI meeting these standards. PHI is rendered unusable, unreasonable, or indecipherable to unauthorized individuals only if one or more of the following methods are used:

(1) Encryption. Electronic PHI is only secured where it has been encrypted. The HIPAA Security Rule specifies encryption to mean the use of an algorithmic process to transform data into a form in which there is a low probability of assigning meaning without use of a confidential process or key. The Rule identifies the various encryption processes which are judged to meet this standard. Further, such confidential process or key that might enable decryption must not have been breached. To avoid a breach of the confidential process or key, decryption tools should be kept on a separate device or at a location separate from the data they are used to encrypt or decrypt.

(2) Destruction. Hard copy PHI, such as paper or film media, is only secured where it has been shredded or destroyed such that the PHI cannot be read or otherwise cannot be reconstructed.

Determining Whether a Breach of Unsecured PHI Has Occurred

The Rule envisions that covered entities and their business associates will analyze the following in determining whether a breach of unsecured PHI has occurred:

(1) Determine whether the use or disclosure of PHI violates the HIPAA Privacy Rule. For an acquisition, access, use, or disclosure of PHI to constitute a breach, it must constitute a violation of the HIPAA Privacy Rule. For example, if information is de-identified in accordance with 45 CFR 164.514(b), it is not PHI and any inadvertent or unauthorized use or disclosure of such information will not be considered a breach under the notification requirements of the Act and the Rule.

(2) Analyze whether there is a use or disclosure that compromises the security and privacy of PHI. HHS clarifies that a use or disclosure that "compromises the security and privacy of PHI" means a use or disclosure that "poses a significant risk of financial, reputational, or other harm to the individual." Thus, in order to determine whether a breach has occurred, covered entities and business associates will need to conduct a risk assessment to determine whether the potential breach presents a significant risk of harm to individuals as a result

HIPPA Continued on page 9

HIPPA Rules Continued from page 8

of an impermissible use or disclosure of PHI. The Rule provides a number of factors which should be taken into account when conducting a risk assessment. A covered entity should consult its legal counsel with respect to the impact of the presence of such factors.

(3) Assess Whether any Exceptions to the Breach Definition Apply. The Rule discusses a number of exceptions to the definition of breach. The following three situations are excluded from the definition of "breach" under the Act:

(i) The unintentional acquisition, access, or use of PHI by any workforce member or person acting under the authority of a covered entity or business associate, if such acquisition, access or use was made in good faith and within the scope of authority and does not result in further use or disclosure in a manner not permitted by the Privacy Rule.

(ii) The inadvertent disclosure of PHI by an individual otherwise authorized to access PHI at a facility operated by a covered entity or business associate to another person at the same covered entity or business associate, or at an organized health care arrangement in which the covered entity participates, and the information received as a result of such disclosure is not further used or disclosed in a manner not permitted under the Privacy Rule.

(iii) An unauthorized disclosure where a covered entity or business associate has a good faith belief that an unauthorized person to whom PHI is disclosed would not reasonably have been able to retain the information.

The covered entity or business associate has the burden of proving why a breach notification was not required and must document why the impermissible use or disclosure fell under one of the exceptions. Covered entities should document the risk and other breach assessments accordingly.

Breach Notification Requirements

The breach notifications required by the Act and the Rule are significant and are triggered by the "discovery" of the breach of unsecured PHI. A breach is treated as "discovered" by a covered entity as of the first day the breach is known, or reasonably should have been known, to the covered entity. Given that knowledge of a breach may be imputed, a covered entity should implement reasonable breach discovery procedures.

Notification to People. A covered entity must send

HIPPA Continued on page 10

There are specific ways to determine if a breach has occurred.

Notification guidelines spelled out for individuals, media, HHS.

HIPPA Rules Continued from page 9

the required notification to each individual whose unsecured PHI has been, or is reasonably believed to have been, accessed, acquired, used, or disclosed as a result of the breach, without unreasonable delay and in no case later than 60 calendar days after the date the breach was first discovered by the covered entity. The Act and the Rule specify the content requirements and the methodology required for providing such breach notices.

If a covered entity has insufficient contact information for 10 or more individuals, then substitute notice must be provided via a posting for a period of 90 days on the home page of its web site or conspicuous notice in major print or broadcast media in geographic areas where the individuals affected by the breach likely reside. The covered entity is also required to have an active toll-free number for 90 days so that individuals can find out whether their unsecured PHI may be included breach.

Notification to Media. If a covered entity discovers a breach affecting more than 500 residents of a state or jurisdiction, it must provide notice to prominent media outlets serving that state or jurisdiction without unreasonable delay and in no case later than 60 calendar days after the date the breach was discovered by the covered entity.

Notification to HHS. If more than 500 individuals are involved in the breach, the covered entity must notify HHS concurrently with the individual notifications. For breaches involving fewer than 500 individuals, the covered entity must maintain an internal log or other documentation of such breaches and annually submit such log to HHS.

Notification by a Business Associate. Following the discovery of a breach of unsecured PHI, a business associate is required to notify the covered entity of the breach so that the covered entity can, in turn, notify the affected individuals. To the extent possible, the business associate should identity each individual whose unsecured PHI has been, or is reasonably believed to have been, breached. Such notice should be given without unreasonable delay and no later than 60 days following discovery of a breach.

Delay Required by Law Enforcement. The Act provides that a breach notification may be delayed if a law enforcement official determines that such notification would impede a criminal investigation or cause damage to national security.