West Virginia Orthopaedic Society

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No Bones About It

Please Join Us for the WVOS Annual Meeting – And Bring the Family!

by Joe Prud'homme, MD
President, WVOS

My wife and kids actually miss me when I travel away for a meeting. I also miss them and feel guilty about leaving. There are so many specialty meetings and regional meetings within Orthopedic Surgery that I could be busy every weekend.

So…we have decided to include the family in our next Annual Meeting in April. We changed the venue to a fun location with lots of included amenities AND obtained very reasonable rates so that cost will not be an issue. The resort is centrally located so no one has a long drive. There will be organized children's activities and other kids for them to play with. That may even contribute to a little down time for the non-orthopedic spouse. We have canoes, peddle boats, fishing, tennis, a scavenger hunt, and a camp fire to make s'mores. Of course, we will play golf (but you do have to pay a little extra for that.)

On top of that, the meeting is going to be great. The theme will center around injections. The talks are to be cutting edge and evidence based. We will be looking at the evidence for all of the new and popular old types of injections in a body part specific format. There is a lot more out there than "cortisone"! Of all of the interventions done by Orthopedic Surgeons, injections overall offer the most bang buck for may ailments. They give the patient rapid relief of

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By WVOS Program Chair Jack Steel, MD

Register Now for 2012 MWM

Make your room reservation by March 14 to join the fun!

Registration is now open online at www.wvos.org for 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. **Registration and payment are due by April 1, 2012.**

The theme for the meeting is "Diagnostic & Therapeutic Injections in Orthopaedics." The schedule has been posted on the conference tab at www.wvos.org. You're invited to bring case presentations for the last session of the afternoon.

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. Please **call 304.269.8885 to make your tee time by March 14** and identify yourself with the WVOS.

There will be a cash bar reception from 5:00-7:00 p.m. 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. Call 888-278-8150 for the 5:00 or 6:00 p.m. seatings.

Saturday morning will begin with a continental breakfast, followed by our outstanding array of speakers.

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

The sleeping room rate will be $125 per person (plus tax) and incudes resort fee, high speed internet access and Wi-Fi, use of fitness equipment, pool and other amenities. Spa services can be arranged prior to the meeting. For those wanting to bring the family, rates are available for Saturday night. Please **call 888-278-8150 by March 14** and mention you are with WVOS to get our special rate.

By Bernie Deem, President, DeemHR

Are Your Personnel Files a Loaded Keg?

Expert witness work taught me one thing for sure. Don't EVER let your personnel files be the dumping ground for stuff you don't know where else to put. Not only are you running the risk of violating HIPPA and several other laws regarding privacy, you could also be setting your company up to lose an unlawful termination claim. And who ever thought we'd have to guard data against identity theft?

First some fundamentals: Are the files kept in a fireproof, secure location? Is it clear who has access to a file? Is there a consistent policy on whether an employee can see their own file? Is there set of guidelines as to what can be placed in a file? Can an employee bring documents to be put in the file? How long will information be kept? And that's the short list!

Employers keep at least two separate personnel files these days. The main personnel file contains employee performance information and the medical/ confidential file that contains protected, non-job-related or confidential information. Documents that include medical information, Social Security numbers, or other protected class information (including but not limited to age, race, gender, national origin, disability, marital status, need for religious accommodation) should be filed elsewhere. Any EEO collection data should be maintained separate from personnel files and I-9's should be kept together and in one place.

Here are some general guidelines for determining where documents should be filed. In the main personnel file, keep records such as the job application, the offer letter (remember this is required by the West Virginia Wage Payment and Collection Act), handbook acknowledgement, performance evaluations, and records certifying attendance for required training on subjects such as unlawful harassment.

Most experts warn against keeping these in the main file: I-9's and any copies of identification, investigation notes and reports, any drug test results, payroll records containing SSN's or other protected information including W-4's and garnishments, medical or confidential records, and anything that has protected information such as date of birth. And of course, benefit information and

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Don't EVER let your personnel files become document dumping grounds.

By Emily P. Walker, MedPage Today

Congress Passes 10-Month Fix

SGR 10-month fix not popular with all; funds coming from other services.

Congress has passed a compromise bill that would delay the impending 27% cut in Medicare pay rates for 10 months.

The House of Representative voted 293-132 Friday morning to pass the bill, and the Senate passed it by a 60-36 vote less than an hour later.

The compromise -- which also provides a year-long payroll tax cut extension and an extension of unemployment benefits -- would hold Medicare payment rates to doctors steady at 2011 rates through this year. Without legislative action, a 27.4% reduction in Medicare payments was scheduled to kick in on March 1.

The price tag on the "doc fix" is close to $18 billion and will be paid for by cutting other areas of the budget, including certain provisions in the Affordable Care Act (ACA). That includes taking $5 billion from a $15 billion fund designed to pay for programs to prevent chronic disease over the next decade.

Sen. Tom Harkin (D-Iowa), champion of the prevention fund, voted against the compromise bill.

Also opposed to the cut was The Partnership to Fight Chronic Disease. The group called cutting one-third of the prevention fund "short-sighted."

The compromise bill also cuts more than $4 billion in Medicaid disproportionate share hospital (DSH) payments, which are meant to compensate teaching hospitals for treating many of the sickest patients in the medical system.

The rest of the money to pay for the SGR fix would come from cutting payments to clinical laboratories and from reducing the amount Medicare pays hospitals for bad debt.

The bill also extends current payment rates for a number of programs, including ambulance services, but extra payments for bone density scans and for certain mental health services will be eliminated.

Doctor's groups were relieved the 27% cut wouldn't go into effect, but called the bill a missed opportunity to permanently repeal the SGR. Last month, the AMA and 109 other medical groups suggested using savings from cost projections for the war in Iraq to fund the SGR fix.

"When will Congress stop using short-term, last-minute 'doc fixes'? The SGR deficit will be over $600 billion in five years," Jack Lewin, MD, CEO of the American College of Cardiology said.

HHS Announces ICD-10 Delay

As part of President Obama's commitment to reducing regulatory burden, Health and Human Services Secretary Kathleen G Sebelius today announced that HHS will initiate a process to postpone the date by which certain health care entities have to comply with International Classification of Diseases, 10th Edition diagnosis and procedure codes (ICD-10).

The final rule adopting ICD-10 as a standard was published in January 2009 and set a compliance date of October 1, 2013 – a delay of two years from the compliance date initially specified in the 2008 proposed rule. HHS will announce a new compliance date moving forward.

"ICD-10 codes are important to many positive improvements in our health care system," said HHS Secretary Kathleen Sebelius. "We have heard from many in the provider community who have concerns about the administrative burdens they face in the years ahead. We are committing to work with the provider community to reexamine the pace at which HHS and the nation implement these important improvements to our health care system."

ICD-10 codes provide more robust and specific data that will help improve patient care and enable the exchange of our health care data with that of the rest of the world that has long been using ICD-10. Entities covered under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) will be required to use the ICD-10 diagnostic and procedure codes.

Visit cms.gov/ ICD10 for news and updates.

Loaded Keg

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absence documentation (FMLA and non FMLA) or anything related to Worker's Compensation.

Most companies find it best to develop an internal set of guidelines on the basics for personnel file management.

Deem will be speaking at the WVAOE MidWinter Meeting on April 14. Her topics will include "Ten Secrets About HR in WV I Wish Every Practice Manager Knew" and "Motivating Without Money." Please visit the conference tab at www.wvos.org and register for the WVAOE meeting to hear more from Deem.

By Retiring AAOS Councilor Jack Steel, MD

Fall Council Update

Orthopaedic surgeons receiving lower Medicare reimbursement rates now than in 1992.

This is a report of the fall meeting that was held in Seattle in October. This will be a summary of the symposia and other information received at the meeting.

Symposium 1: Reimbursement trends versus general economic trends and the impact on health care delivery.

Medicare is shifting from paying usual and customary fees to the sustainable growth rate formula. This sets the stage for the insurance industry to match lower government payments leaving physicians as the ones whose fees are cut. Additionally, the anti-trust relief bill still does not allow physicians to negotiate Medicare rates.

Ninety-seven percent of orthopedic surgeons treat Medicare patients. Medicare payments make up a significant portion of income for orthopedic practices but real dollar changes during the period from 1992 - 2010 have meant that orthopedic surgeons are receiving less today than in 1992. Although the consumer price index rose 53.21% during that period, the average real dollars received by orthopedic surgeons for select procedures fell by 57.51%.

Incomes for orthopedic surgeons have continued to increase however, in part because they have expanded their services and changed their payer mix.

Barbara Cataletto, CEO of the Business of Spine, LLC, indicated that there is a significant impact from for-profit insurers who continue to experience significant growth in earnings income. She noted a shift toward high deductible health plans which may keep patients from going for care they need. She also addressed the cost of doing business which has increased substantially over the years, even as reimbursements have fallen. She encouraged orthopedists to use the website fairhealthus.org to determine payments per procedure. This is a website that provides healthcare reimbursement data for consumers, insurers, healthcare providers, researchers, analysts, and policy makers. Her conclusion was that orthopedists most basic obstacle is the domination of the marketplace by for profit insurance companies.

Symposium 2: Payment and delivery systems engaging orthopedists in innovation.

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By Sanford Emery, MD, MBA

MOC Highlights, Reminders, Help

Remember, MOC = Maintainence of Certification! Recertification became a requirement for Orthopaedics in 1986, and approximately 2005 the name and details were changed to Maintainence of Certification. The goal is to ensure that we as professionals keep up with our own education as an ongoing process. This MOC process has four components:

1. Evidence of professional standing – this requires licensure with state medical board and admitting privileges. This is nothing new.
2. Evidence of lifelong learning and self assessment – this consists of CME credits and a self assessment exam. To be exact, 120 credits of category 1 CME during years 1-3 and again in years 3-6 prior to application of the written or oral examination. Twenty (20) credits of this 120 total must be from a legitimate self assessment test or tests. Practically speaking this means taking one of the AAOS self assessment exams and sending it in to be scored. This has to be done well in advanced of deadlines so beware! Details are on the web site – read on for clarification.
3. Evidence of cognitive expertise – this is either an oral examination or a computer examination within the required ten (10) years since your last certification. There are now hand sub-specialty certificates, sports medicine sub-specialty certificates, spine sub-specialty examination for an orthopaedic surgery certificate, and adult reconstructive sub-specialty examination for an orthopaedic surgery certificate. You can actually take this exam in any of the last three (3) years of your existing certificate, which means you could actually fail it twice and pass it on the third try without losing your certification. It does make sense to take it a year or two early to get it out of the way and it does not shorten the ten year timeframe for the validity of your certificate.
4. Evaluation of performance in practice – Currently the American Board of Orthopaedic Surgery(ABOS) does peer reviews of everyone recertifying which is effective for

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Maintenance of certification has four components.

By AAOS Councilor Greg Krivchenia, MD

The View from K2

The SGR patch won't fix the problem. The next proposed cuts are steeper!

I am greatly disappointed by the recent agreement of Congress in regards to the Medicare Sustainable Growth Rate (SGR). This outdated formula has once again been pushed forward with another short-term "patch" that doesn't solve the real problem of how physicians are paid under Medicare. For the past nine years, Congress has "passed the buck" instead of making the hard decisions necessary to enact serious payment reform.

Now they have punted the verdict to January 1, 2013, at which time the cuts become even steeper, an estimated 32 percent. This perpetuation of indecision continues to threaten the ability for Medicare patients to access quality care. Patients and physicians will now again feel the insecurity of the double-digit SGR cuts that are looming less than 10 months from now.

We must unify. We must become vocal. We must appeal to Congress to take action and permanently repeal the SGR before December 2012.

Also on the horizon is the Maintenance of Licensure (MOL) requirement that is currently being proposed by the Federation of State Medical Boards (FSMB). The final details and implementation won't occur for a few years, although pilot projects are supposed to begin within the next 12 months. When implemented, this will result in us completing additional compliance activities. Even though the Maintenance of Certification (MOC) will likely be linked with the ABOS and their current requirements, it is designed to demonstrate to our patients and peers that we are staying current with our medical knowledge and skills. The MOL, though only being in the preliminary phases, is rapidly catching favor nationwide and Ohio and West Virginia are seriously considering this requirement. Only time will tell how onerous this new hurdle will be to our practice of medicine.

Please keep in mind that in November, there will be an election that may have a significant impact on our ability to take care of patients. Thanks to the bureaucrats in D.C., taking care of patients is not the main concern. More time and effort is being spent charting than with the patient. This reversal of priorities is being felt not only by physicians, but other health care personnel such as nurses, therapists, PCA's, etc.

We need a strong voice for orthopaedic patient care.

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ethical behavior and professionalism. We also require case lists in order to sit for the recertifying exam- this case list is due almost two years before you take the exam, so check out the web site or you can get caught by surprise!! The ABOS is working on feedback loop processes such as PIMS (Performance Improvement Modules) that will allow each of us to look at outcomes on some of our patient groups compared to national norms, enabling us to continue to improve our practice over time.

This all seems more complicated than it is, but it certainly is different than 20 years ago. Times have changes however and both the public and healthcare entities expect more from the medical profession in updating our knowledge and skills with a more substantial process than a solo written exam every ten (10) years.

The first step is to make sure you are signed up for MOC. Many hospitals and systems are requiring this now, and this trend is expected to continue. Go to the web site and click on the blue star on the upper right. It will instruct you to sign in and check the "ABOS status" and "MOC" tabs. You can register for MOC which I believe is one click – check the web site or call the ABOS if questions.

Here is the question you really want to ask me: What are my deadlines?!

Go to the ABOS.org website, sign in with your username and password (upper right). It may ask you to verify your current information. Hit "confirm". The next page is "ABOS status section". This has your name and it tells you when your certificate expires. Click on the third tab labeled "MOC". This page also shows your certificate expiration date and allows you to keep a running list of your CME acquisitions. It has the due date for the three (3) year CME cycle. In the upper left hand corner, click on the "ten year cycle grid" link. This takes you to a very important page listing your requirements for MOC in the first three (3) years, the second three (3) years and the last four (4) years of your ten (10) year cycle. This colored page lists due dates! Note there is a computer examination pathway on the top half of the page and an oral examination pathway on the bottom half of the page, since you can choose your type of exam.

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Everyone expects more from physicians in updating their knowledge and skills.

Don't let the deadlines get away from you. When in doubt...ask!

Don't miss the fun...or the family! Join us at Stonewall in April!

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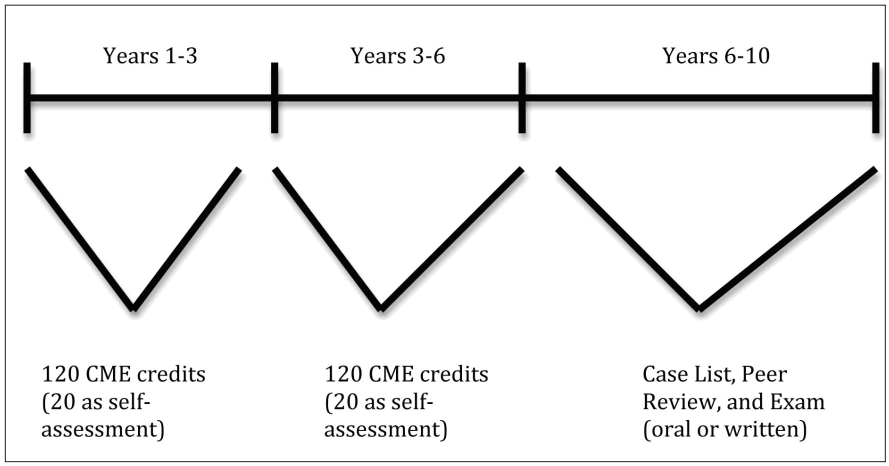
Here is the MOC timeline in graphic form:



The confusing/dangerous detail is that the application for the oral or written exam is due almost two years before you sit for the exam !! This is where a percentage of diplomates are missing their deadline!

If there are any questions please call the staff at ABOS (919-929-7103), they are very knowledgeable !!

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symptoms at low cost and low risk with very high satisfaction. Did you know that based on time and resources spent that they are also the highest re-embursing procedure that most surgeons perform? Sounds like a win-win to me.

So come join us at Stonewall Jackson Resort April 13 and 14 and learn about the latest evidence for orthopedic injections. AND bring the family so that they can have fun and not miss you!

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David Halsey, M.D. of Vermont indicates that the Patient Protection and Affordable Care Act (PPACA) is the greatest change to US health policies since the passage of Medicare and Medicaid in the mid 1960's. The plan is to transform the national infrastructure from a volume base to a value based model that better aligns the incentives and needs of all stake holders. CMS, which is the Centers for Medicare and Medicaid Services, has proposed both delivery changes i.e. accountable care organizations or ACO's and payment reforms in the form of bundled payments. The payment reform package with bundled payments is anticipated to begin in 2013. This phase one would probably include total hips and knees and allow gain sharing with the potential for up 150% increase in reimbursement. Groups could consider, either prospective or retrospective payment plans, but to be involved the group would need to submit a letter of intent to CMS and then DRG data would be provided to them.

A group in Connecticut called Connecticut Joint Replacement Institute developed and has implemented a bundled payment plan for primary total hip and total knee arthroplasty's. They presented a fairly complicated plan that has a potential to reach that 150% increase in reimbursement. They've spent a lot of time and money developing this program but to date they only have five patients enrolled.

The last portion of this symposium was presented by a director of the Pacific Business Group on Health and the California joint replacement registry. She presented the purchaser's viewpoint indicating that orthopedists were employers' biggest customers. The purchasers were implementing a variety of programs that affect benefit design. This included caps on payments, bundling of payments, outcome measurements, and third party evaluations of effectiveness. Their goal was to improve health outcomes at sustainable cost. Essentially they wanted to know how much they were going to have to pay up front.

This was a somewhat complicated plan that, in all likelihood, would not be implemented in West Virginia.

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PPACA is greatest change to US health policy since Medicare and Medicaid.

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More entities requiring participation in MOC programs.

Symposium 3:

Maintenance of certification.

The basic MOC process was developed in 2005 and will not change through 2017. The MOC covers four competencies: professional standing, lifelong learning, cognitive expertise, and performance in practice. The lifelong learning component is addressed within a 10 year cycle by requiring 2-three year cycles of 120 CME credits including 20 CME credits from scored and recorded self assessment exams. There will also be three opportunities to pass the exam. The cognitive expertise component is addressed by a written (computer) or an oral exam. The written exam pathway requires a case list not to exceed 75 cases for three months and will be modified to provide feedback to those taking the exam. The oral exam pathway requires a six month case list. Performance and practice components simply means that one reviews one's practices, educates one's self on change, implements improvements, and conducts a second practice review. The differences between MOC and MOL, which is Maintenance of Licensure, were discussed. MOC is a professional program which is administered by the American Board of Orthopedic Surgeons and MOL is a government/ state run function. Medical licensure is undifferentiated and is the same for all physicians regardless of practice or specialty. Medical licensing boards, however, are looking for proof of confidence and professional development which MOC provides. Hospitals and the joint commission are also requiring participation in MOC.

The ABOS website is being upgraded and the ABOS hopes to push information to diplomats as well as to provide credit for participation in quality improvement programs such as joint registry.

Symposium 4:

Orthopedic physician manpower.

There is anticipated to be a deficiency in orthopedic providers. This will be at least partly a function of what the orthopedists do as opposed to the sheer number of orthopedists. An example would be the number of sports medicine trained fellows versus those orthopedists who are competent and interested in caring for hip fractures and other general orthopedic conditions. Suggestions were presented to consider

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workforce alternatives such as a "musculoskeletal home" that would enable orthopedic surgeons to spend more time in the operating room while other medical professionals handle non-surgical treatment. It was concluded that the orthopedic surgeon had to be the leader of the non-physician provider such as PA's, NP's, PT's and athletic trainers.

Symposium 5: Help to optimize your organizational talent to prepare for health care reform.

This was presented primarily by orthopedic executives. It was emphasized that physician time is most valuable but staff compensation accounts for about a quarter of overhead in most practices so their time should be optimized as well. It was recommended that orthopedic surgeons establish standards within their practices to push every task down to the lowest level.

This gives people appropriate responsibility and authority and will result in a high performance team. The most important role of the staff was to support the billable provider. Increased efficiency in the office and tracking of the efficiency were felt to be the keys to success.

Symposium 6: The spread of state health care initiatives.

This was presented by an MBA who is a CEO of a large orthopedic group in Oregon. He pointed out the evolution of accountable care organizations and health care exchanges mandated by the Patient Protection and Affordable Care Act. He was primarily concerned about issues at the state level due to anticipated budget deficits with the addition of thirty million Medicaid patients. It was encouraged that orthopedists be involved at the state level because (if you're not at the table you're on the menu). He advised working together with other physicians and hospitals to be seen not as an adversary but as a solution.

Symposium 7: POD's for Orthopods?

POD's are physician owned distributorships. This is a concept by which physicians basically are the distributors of implants, braces, and other durable goods. The orthopedic industry is opposed to this as it could certainly affect their sales support staff. Also, there is significant concern about the legal and ethical considerations including stark anti-kickback regulations.

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Deficiency anticipated in orthopedic manpower levels. Organizational talent should be optimized.

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National medical liability reform not expected any time soon.

A staff member of a US senator from Wisconsin expressed concern about the impact of POD's on medical decision making.

She felt there was potential for financial inducements affecting medical decisions. She was interested in the fact that POD's may result in cost savings, but concerned about utilization and legal concerns as well as investment issues. She was not particularly enthusiastic about the concept. The final speaker, a corporate vice president for Biomet, saw significant potential pitfalls. He expressed his belief that POD's were anti-kickback traps. He made the point that implant costs are flat not increasing and that hospital profits are not declining. He indicated orthopedics is the most profitable service line. He called POD's a controversial service model.

Symposium 8:
Alternatives to traditional medical liability reforms.

This was a discussion regarding the potential for tort reform on the national level. There was some thought that the new health care law could potentially lead to medical liability reform on a national level but there was not much confidence that this would occur in the near future. There was one proposed measure called the Patient's Safety and Compensation Act that included everything except CAPS and would potentially generate enough bipartisan support for passage. It was felt that tort reform would improve patient access to care, quality of care, and safety while lowering cost. It sounded somewhat like the plan that we have in place currently in West Virginia which currently and fortuitously includes CAPS.

I will provide my last councilors report after the academy meeting in February. As of this date, the Medicare cuts, as we all know, have been pushed back again at least two months. It's not likely that any permanent fix will occur until after the election. The Obama care bill is slated to go into effect, as mentioned in the report, initially in 2013. This law, however, will be evaluated by the Supreme Court to determine if it is constitutionally legal sometime in the next few months.

I would again continue to suggest that you each become members of the orthopedic political action committee. They are very

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much involved on a daily basis in Washington covering our backs. $25.00 is an insignificant amount that would at least increase the numbers of othropedists participating in the PAC which is influential when approaching congress. The AMA is the group that congress tends to look toward to represent medicine. The AMA, as we know, does not represent us well and in fact it only represents about 17% of physicians.

It has been an honor, privilege and pleasure to serve as your councilor for the last six years.
Sincerely,

Jack R. Steel, M.D.

It's been a pleasure to serve WVOS for six years.

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Our Ortho PAC is making great strides to get our voice heard so that we can take better care of our patients. I encourage all of us to make a contribution during this election cycle to make our voice heard. The best place to keep informed is the three times per week email from AAOS. Sign up today for this way to stay on top.

In closing, I would like to thank Jack Steel, M.D., for his years of service as an AAOS Councilor. I can only hope to follow in his footsteps with as much pride and dignity as he has shown. I'm also optimistic that we can continue his fight in the coming months on issues such as tort reform, the SGR, IPAB, ACO's, and patient care. If you have any questions with what is happening in our Academy or at the federal level, please do not hesitate to contact me (k2bones@hotmail.com).

Beware confusing motion with progress--- Aiden Tozer

Jack Steel is leaving large shoes to fill as AAOS Councilor.

By Sandy Gordon, AAOS

AAOS collecting patient stories

AAOS telling story of a nation in motion through patient experiences.

Your Academy is launching a new public awareness campaign called "A Nation in Motion: One Patient at a Time." This campaign will tell the stories of patients across the country whose lives have been saved or restored by orthopaedic care.

As you know, our strongest ambassadors are our patients, whose lives are forever changed by our care. With this in mind, we ask that you identify patients who are willing to share their stories of restored independence, productivity and improved quality of life.

Here's how you can help us make this initiative a success:

1. Choose patients whose stories embody "A Nation in Motion: One Patient at a Time."
2. Talk to them—or ask someone in your office to do so—and invite your patients to submit their stories on our website, www.anationinmotion.org, or alternatively, ask them for permission to use their story. Then you or someone on your staff can then submit the stories on their behalf.
3. We would like to have these responses as soon as possible, but before Friday, March 23, 2012.

AAOS staff members will contact some of these patients to develop more comprehensive profiles. In April, selected stories will be shared on the Academy's new "A Nation in Motion" website as part of a national media outreach campaign launch.

Thank you in advance for your leadership and participation. If you have any questions or would like additional information about this campaign, please call or email Sandra R. Gordon, 847-384-4030 or gordon@aaos.org.