West Virginia Orthopaedic Society

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No Bones About it

Orthopaedic Economics: Supply and Demand

by Brett Whitfield, MD
President, WVOS

In my first article, I highlighted the changes that are facing orthopaedic surgeons. Between the insurances and the hospitals, it seems more difficult for doctors to "find a place at the table." This situation will become more problematic for surgeons as insurance companies begin lumping reimbursement and paying hospitals directly. Surgeons will be forced to negotiate with hospitals for fair compensation. In this this article I will explain why we have increasing power to negotiate in West Virginia.

West Virginia has the second lowest number of orthopaedic surgeons per capita in the US with only Michigan being lower. West Virginia has 4.5 orthopaedic surgeons per 100,000 persons. This lack of supply will be further decreased by retiring surgeons. The AAOS cites that one-third of practicing orthopaedists are over the age of 55. The 600 orthopaedic residency graduates a year will not be able to make up for the number of retiring surgeons.

It is projected that the demand for orthopaedic surgeons will be 20-45% over supply by 2020. The demand is increasing with the aging baby boomer generation, the healthier and more active aging population and the increasing obesity rates. Sixteen percent of West Virginians are over the age of 65, the highest percent in the US. In addition, West Virginian was ranked #1 in obesity (BMI > 30) in 2013. The obesity rate was 35.1%. The rising rate of obesity will increase the need for musculoskeletal surgery, including joint replacement.

By simple economic measures, it is clear that in West Virginia we have a significant imbalance between the supply of orthopaedic

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In This Issue:

By Greg Krivchenia, MD

The View From K2...

"Simplicity is the ultimate sophistication."

Leonardo Da Vinci

The electronic health record has unfortunately hindered the care of our patients. In theory, the seamless use of a computer with shared data between providers is a wonderful idea. However, in the real world this has not been attained. The only people that have benefited with the mandate of EHR's are the IT contractors (the helpless desk).

For example, at one of the hospitals where I practice, the initial cost was estimated at $14M, however after implementation it ballooned to over $30M. That is a lot of money that could have been used for treating patients. Today, the medical record is given more attention than the patient. The implementation of meaningless use was launched without adequate testing. Every hospital was a guinea pig and this has not improved healthcare in the slightest. The July 13th issue of Becker's Hospital Review gives an excellent summary of meaningless use and what one needs to know. The author notes that as of March 2015, 353,350 eligible professionals and 4811 eligible hospitals participated.

The article also notes that over 257,000 professional face a 1% reduction in payment due to noncompliance. With the advent of meaningless use Stage 3, providers could face up to a 9% reduction by 2019. The major problem with the EHR today is the lack of compatibility between systems. Unless the physician is employed by only one healthcare system, the communication of vital patient information may be nearly impossible. In my dealings with the EHR at the hospital, it now takes me three to four times longer to get information that is important to my patients' care. In closing, the EHR is great for collecting data, but when it comes to trying to improve outcomes, it has a long way to go. Further beta testing must be performed and perfected before a nationwide release. Also, reimbursement to IT contractors must be capped to avoid needless cost overruns and wasted time.

The Real Steel

By Jack Steel, MD

Three Important Subjects from Jack Steel:

1) The 2016 West Virginia Orthopedic Society Spring Meeting will take place at Stonewall Jackson Resort on Friday, April 15 and Saturday, April 16. This meeting will be orchestrated by the Orthopaedists in the Morgantown area with the subject to be determined in the near future. The format for the meetings beginning in 2014 was to have rotating planners from at least three areas of the State. The meeting in 2013 was organized by Scott Orthopedics and Marshall University and this year's was Brett Whitfield from Beckley and Aaron Sop from CAMC. Morgantown will be the next host, with the rotation resuming in 2017 with Huntington area orthopaedists planning the meeting. This format encourages a more broad participation in the meetings. We would like to encourage the Northern and Eastern panhandle members to plan the meeting for 2017 which would form a four-year rotation. Please let Diane or me know of your interest. Be sure to mark your calenders for April 15 and 16. Golf on Friday will be available along with possibly another Texas Hold'em Tournament. This year's Texas card tourney provided a nice donation to the OREF from our Society.

2) The Orthopedic Research and Education Foundation is the leading grant making resource for new investigators. This includes residents, attendings and clinicians who are not affiliated with academic programs. OREF was founded in 1955 and has awarded more than 4,700 grants providing more than $142 million in support of orthopaedic research. Donors are recognized in the OREF brochures, AAOS meeting displays and on the OREF website oref.org. West Virginia has about 3-4 regular donors yearly with Doyle Sickles leading the way for 22 years as an Order of Merit donor. Owen Nelson from nearby Uniontown, PA has been doing so for 26 years. I have been a donor for 16 years and I encourage your consideration at any level of giving. Consider your donation as a gift to our profession which has been very good to us all.

3) Orthopedic PAC of the American Association of Orthopaedic Surgeons. This is my last solicitation for the summer! We have the largest medical PAC in the country. Our representatives have the ears of the leaders in congress and have been successful in supporting our issues in Washington. On the local front, the PAC donated $2500 to Evan Jenkin's successful campaign and consider his victory a great accomplishment. John Gill, MD a private practice orthopedist from Texas has assumed the

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Did you know Doyle Sickles is an OREF Order of Merit donor? He has given to OREF for 22 consecutive years! Have you made your contribution?

By Scott McCarus, Intern

Diagnosis: ICD-10 & Your Patients

ICD-10 code set is like a dictionary; some words are very commonly used, while some are never spoken.

The World Health Organization's (WHO) International Classification of Diseases has served the healthcare community for over a century. The United States implemented the current version (ICD-9) in 1979. While most industrialized countries moved to ICD-10 a number of years ago, the United States is just now transitioning to ICD-10 with an anticipated final compliance date of October 1, 2015. ICD-10 is a classification system for diagnosis codes only. The system does not contain a procedural code set. The U.S. is adopting a modified version of ICD-10 known as ICD-10-CM. Any references to "ICD-10" throughout this paper refers to ICD-10-CM. ICD-10 provides greater specificity in coding injuries than ICD-9. While many of the coding guidelines for injuries remain the same in ICD-9, ICD-10 does include some new features, such as seventh character extensions and the concept of reporting laterality.

In ICD-10, injuries are grouped by body part rather than by category. In ICD-9, sprains, dislocations and fractures are all labled in their own seperate categories with location being irrelevant. ICD-10 will label the injuries to specific parts of the anatomy. Such as, the head (S00–S09), injuries to the neck (S10–S19), and injuries to the thorax (S20–S29).

Other differences existing between ICD-9 and ICD-10 include:

- Codes for osteoarthritis of the knee, pain in the hip, and degenerative meniscus all begin with the number 7 in ICD-9. Those same conditions, when not the result of an acute injury, will be found in the musculoskeletal chapter in ICD-10, but will begin instead with the letter "M."
- In ICD-10, acute injuries will still be found in the "Injury" chapter but will start with the letter "S."
- In the new classifications, a single code is used to report both the exact location of the pathologic fracture and the cause (age- or drug-induced, neoplasm, or other).
- Under Health Insurance Portability and Accountability Act (HIPAA), impatient coding and diagonis will have to comply with ICD-10; that means it doesnt just apply to people submitting Medicare or Medicade claims.

It seems like a lot but is qiute simple once you've adjusted. In fact, if you use books to do your coding you can purchase an ICD-10 code book or access the ICD-10 codes online. If who or whatever machine is responsible for coding in your practice—cannot identify codes accurately using the code book

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By WVAOE President David Proctor, MBA, ATC

Top Ortho ICD-10 Codes Cards Out

The West Virginia Association of Orthopaedic Executives (WVAOE) is pleased to offer orthopaedic surgeons a tool to help you and your staff transition from ICD-9 to ICD-10.

These comprehensive ICD-10 Reference Cards have been developed on nearly 500 of the most common orthopaedic conditions in the following areas:

- Shoulder and Elbow Fractures
- Other Shoulder and Elbow Conditions
- Hip and Knee Fractures
- Other Hip and Knee Conditions
- Wrist and Hand Fractures
- Other Wrist and Hand Conditions
- Ankle and Foot Fractures
- Other Ankle and Foot Conditions
- Spine Fractures
- Other Spine Conditions

A must for a busy orthopaedic practice, the 10 reference cards were developed for viewing at a glance and are laminated for durability, but they also still allow you to write on the cards to add your notes or additional orthopaedic conditions. These Reference Cards will be a quick reference for you and your staff and save you valuable time as you transition to ICD-10.

The Reference Cards were distributed at the California Orthopaedic Association (COA) 2014 Annual Meeting and they were well-received by orthopaedic practice managers and surgeons. COA worked with Newport Medical Solutions to develop the Reference Cards. Newport Medical Solutions retains copyrights to the Reference Cards and they are responsible for their content. We urge you to consider these Reference Cards.

ICD-10 is coming in days. Let us help you prepare!

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or 'look-up' functionality in your software, explore their ICD-10 training options and determine if formal training is necessary. CMS has developed a tool called the General Equivalency Map (GEMS) to help with the crosswalk from ICD-9 to ICD-10. This tool is not a substitute for learning ICD-10. GEMS should not be used to code patient encounters. GEMS is a tool that you can use to help convert data from ICD-9 to ICD-10 and vice versa and most often used by software vendors for developing transitional products.

Helpful References

- American Health Information Management Association (AHIMA)
  Coding Injuries in ICD-10-CM
  ICD-10-CM/PCS
  Documentation Tips

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By WVAOE President David Proctor, MBA, ATC

Place Your ICD-10 Card Order Today

Place your order today by using this form.

ICD-10 Reference Cards

WVOS/WVAOE Members: $60 USD per set
Non-members: $75 USD per set
Reference cards are needed by: ___ ASAP ___ Specific date

Name: _____

Phone: (_____) _____

Practice Name: _____

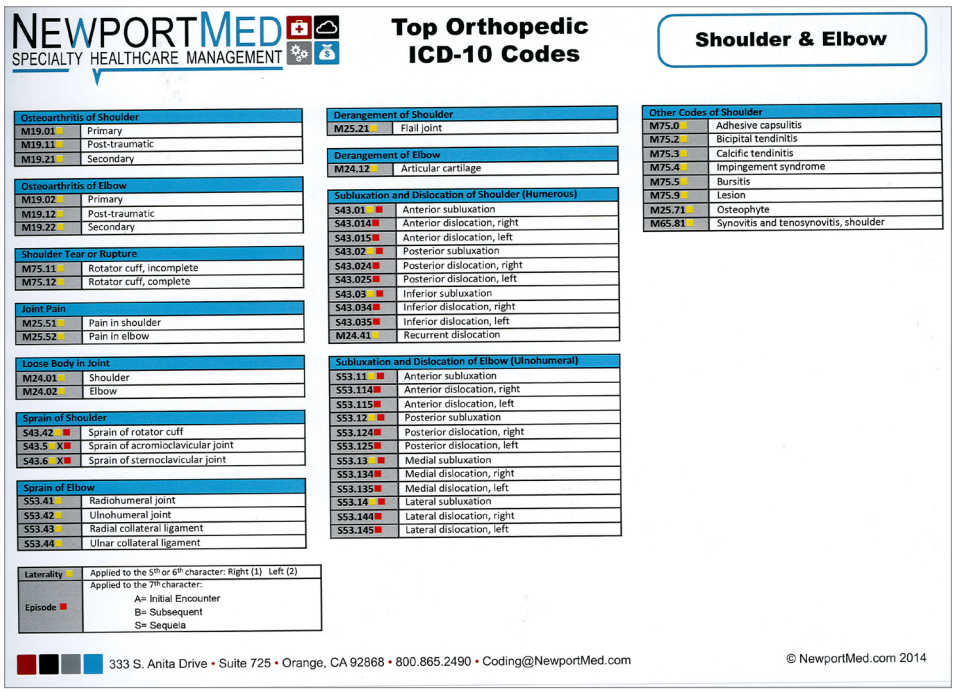
Address: _____

City: _____ State: _____ Zip: _____

E-Mail: _____

Method of Payment:
☐ Check enclosed for $_____

Email or mail completed order form to: WVAOE, PO Box 13604, Charleston, WV 25360. Email: wvaoe@frontier.com



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- Electronic Documentation Templates Support ICD-10-CM/PCS Implementation
- ICD-10-CMS/PCS Transition: Planning and Preparation Checklist
- ICD-10 Experts Push Back on Physician Concerns
- Medicare CMS/AMA Frequently Asked Questions – http://www.coa.org/docs/CMSAMAFAQ.pdf
- Medicare Clarifying Questions and Answers Related to the July 6, 2015 CMS/AMA Joint Announcement and Guidance Regarding ICD-10 Flexibilities
- Medicare CMS- ICD-10 - http://www.cms.gov/Medicare/Coding/ICD10/ProviderResources.html
- Medicare CMS – Road to ICD-10 - http://www.roadto10.org/
- AAOS - http://www3.aaos.org/member/prac_manag/ICD-10.cfm
- ICD-10: The Documentation is in the Details, "AAOS Now," March, 2014
- Medscape article "Preparing for ICD-10: Now is the Time" by Joseph Nichols, M.D.
- California Medical Association "ICD-10 Transition Guide"

ICD-10 references

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surgeons and the demand for our specialty. It is imperative that we use this imbalance when we are faced with negotiations with hospitals and insurance companies. Hospitals are hoping that physicians do not realize one simple truth: Without physicians, hospitals are just really expensive empty buildings!

Sincerely,
Brett Whitfield, MD
President

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chairmanship of the PAC from Stuart Weinstein. I know John well from my days on the Board of Councilors and feel he will perform to level established by Dr. Weinstein. I encourage all WV orthopedists to support our PAC as it is a strong voice for us. No sum is too small. Go to the AAOS website and go to the PAC link to learn more and to donate.

4) I hope you all have a great summer and are ready for ICD-10! Oh my!!

Sincerely,

Jack Steel, MD

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