



Pennsylvania Orthopaedic Society

**Testimony of Gerald R. Williams Jr., MD
before the Pennsylvania House Insurance Committee**

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Chairman DeLuca, Chairman Micozzie, committee members, thank you for the opportunity to speak today regarding legislation prohibiting physician referrals to services in which they have a financial interest. I am Gerry Williams, president of the Pennsylvania Orthopaedic Society. Although this hearing is specifically on HB 247, our Society's comments apply to HB 1405 as well.

On the surface, prohibitions on physician self-referrals seem to be a method to control rising healthcare costs. Unfortunately, this is a false premise that leads to a reduction of patient safety, patient convenience and satisfaction as well as increased healthcare costs. Please let me explain.

Several independent studies show physician owned facilities provide better care with fewer infections and complications and with greater patient satisfaction. We can provide higher quality care with fewer complications because we can bring better focus and more resources to the type of procedures we perform. And our patients prefer the heightened attention and greater convenience they receive in our facilities as opposed to the service they may receive in a hospital setting.

In addition, healthcare insurance reimbursement for surgical and other procedures performed in ambulatory surgical centers (ASC) is less than reimbursement rates for the same procedures performed in hospital settings. Under Medicare's payment system, ASCs are paid a facility fee intended to cover the costs associated with performing surgical procedures. In general, however, ASCs are only paid a portion of what hospital outpatient departments (HOPDs) receive for the exact same services. In 2008, ASCs were paid only 63% of what HOPDs received for providing the exact same services. The 2009 Medicare estimated ASC reimbursement will only be 59% of HOPD reimbursement for like services. And as you know, commercial healthcare insurers generally base their reimbursement rates on the Medicare fee schedule, therefore, commercial insurers likewise discount ASC reimbursement.

In addition, because ASCs have substantially less overhead than hospitals, the cost of care in ASCs is dramatically lower than like services provided in an inpatient hospital setting. Again, this cost difference is reflected in the lower reimbursement rates for ASC procedures versus those performed in an inpatient hospital setting.

When additional cost savings due to fewer ASC infections and complications are factored into this equation, it is easy to understand that care provided in a physician-owned ASC is clearly a lower cost option that must remain for the Commonwealth citizens.

According to a recent report prepared for the Ambulatory Surgery Center Coalition, surgeries performed in ASCs parallels the historic shift away from hospital inpatient surgeries toward outpatient settings. A number of factors account for the growth in ASCs including population health guidelines for disease screening, shift in site of services away from the hospital outpatient setting, payer incentives to pay for care in the most cost-effective setting, demographic changes, and consumer and physician preferences.

Much of the growth in outpatient surgeries was made possible by technological improvements that have allowed for faster patient recovery times. These advances include improved surgical techniques, anesthesia, and pharmaceuticals to better manage post-operative pain.¹

These are facts, not opinions. As you can see, the presumed benefits of the proposed prohibitions simply do not exist.

Imaging – A Means to Increase Patient Safety and Reduce Costs

Timeliness

For optimal patient care, imaging studies should be performed and interpreted in a timely manner. Most orthopaedic imaging procedures are performed when the patient is in the orthopaedic office so that judgments can be made without delay at the time of clinical

¹ Koenig, L; Doherty, J; Dreyfus, J; Xanthopoulos, J, An Analysis of Recent Growth of Ambulatory Surgical Centers, June 5, 2009, available at: <http://www.ascassociation.org/study.pdf>

decision making. If patients are required to leave the orthopaedic surgeon's office to obtain imaging studies at another facility, more than one physician office visit may be required to assess the condition and make appropriate treatment decisions. A prohibition against physicians using their own imaging services places a significant burden on all patients, but it is particularly burdensome to patients who are poorly mobile, ill or elderly. In such cases, transport by family members or by ambulance service will be required, especially if the outside facility is located blocks or miles away, thus adding to the total cost of care.

Patient inconvenience is not the only consideration. The quality of patient care is a major concern in this situation. For example, fracture treatment and post-operative management require skillful radiographs, often done just after immobilization is removed, but before subsequent casting or splinting. To have the patient leave the controlled office environment for radiographs elsewhere under these circumstances is dangerous, ill-advised, and places the patient at unnecessary risk. Furthermore, additional and sometimes special views may be needed for adequate patient care at the time of the office visit thus making the use of outside facilities untenable and a compromise of patient care.

Quality of Care

Orthopaedic surgeons are expert in the utilization and interpretation of imaging studies of the musculoskeletal system. Often, specialized radiographs require the presence of the orthopaedist to ensure proper positioning of the limb or stressing of the joint or bone. In fact, in many instances the orthopaedist is the only qualified or knowledgeable caregiver to perform such maneuvers. The ability of the orthopaedist to correlate the image with the living anatomy also plays a critical role in the interpretation of CT or MRI studies.

Technological innovations are rapidly transforming the practice of orthopaedics. Advancements in imaging have led directly to the reduction in invasive procedures that were previously used as diagnostic tools. Today, if a radiological report provides inconclusive information for a definite diagnosis, an orthopaedic surgeon may order additional images such as CT, bone scan or MRI to properly assess and diagnose the

patient without the need for an invasive procedure. Patients have greatly benefited from these advances in terms of higher quality care and safety, more convenience and reduced costs. Patients no longer need to be subjected to invasive procedures with the associated risk of infection as well as the pain and inconvenience of recovery. And our patients' experience is enhanced when these technological advances can be applied in their physicians' offices. This one stop approach to quality care serves our patients' needs and desires while providing the highest quality care in the lowest cost environment.

Better Quality Physical Therapy

Physical therapists have become an integral part of health care teams that improve patient outcomes and there are a number of models that exist for the collaborative delivery of physical therapy. These models include free-standing physical therapy centers, physical therapists acting as independent contractors within physicians' office, and physical therapists working as employees of physicians providing physical therapy as an in-office ancillary service Physician Owned Physical Therapy Services (POPTS).

POPTS gives physicians a greater role in the physical therapy services provided to patients. In-office therapy allows therapists and physicians to work together as a team, exchanging information and sharing ideas. The frequency and immediacy of feedback allow for the fine-tuning of therapeutic protocols that serves to improve patient outcomes. A study comparing on-site physical therapy delivered in physician offices versus other sites concluded that patients who receive on-site physical therapy lose less time from work and resume normal duties more quickly.²

Frequent and timely feedback between therapists and physicians also reduces over-utilization of services. For example:

- If the doctor deems the desired outcome to have been achieved, then services can be immediately discontinued;

² Hackett, GI; Blundred, P; Hutton, JL, O'Brien, J; Stanley, IM, Management of Joint and Soft Tissue Injuries In Three General Practices: Value of On-Site Physiotherapy, Br J Gen Pract. 1993 Feb; 43 (367): 61-64.

- If the doctor determines another therapy modality is appropriate, then a shift can be made in a timely manner;
- If it appears that physical therapy is not yielding desired results, other therapeutic techniques, including surgery, can be considered.

Finally, the ability to exchange information on a patient in a frequent and timely fashion serves to reduce errors. According to a study, 70 to 80 percent of medical errors are related to interpersonal interaction issues. Interpersonal interaction is critical to patient safety.³

POPTS offers patients direct and immediate access to physical therapists after the physician has seen them. Moreover, patients have the ability to schedule physician and physical therapy appointments at or near the same time and in the same office. This eliminates the need for patients to travel to two different appointments. Prohibiting POPTS would substantially reduce patient options regarding where to receive proximate care. In some rural locations, closing down physician-owned physical therapy facilities may eliminate access completely to physical therapy services causing patients to have to travel long distances to receive needed care. Fewer physical therapy facilities will also result in treatment delays.

The Myth of Cherry Picking

The vast majority of POS members treat Medicaid patients. We treat these patients in our offices; we treat them in our imaging centers; we treat them in our surgical centers. We do so because they are our patients and it is the right thing to do.

Hospitals would have you believe that physicians who own and operate their own ancillary services will only treat those patients with the highest likelihood of good outcomes. This is simply not true. According to Merritt Hawkins and Associates' 2009

³ Interdisciplinary Teamwork is a Key to Patient Safety in the Operating Room, ICU, and ER, Agency for Health Care Research and Quality, available at 222.ahcpr.gov/research/jan04/0104RA25.htm.

Survey of Physician Appointment Wait Times, 63% of Philadelphia orthopaedic surgeon respondents stated that they treat Medicaid patients.⁴ In fact, many of our Medicaid patients come to us as a direct result of our work within hospitals.

To receive an emergency room or trauma center license, hospitals are required to demonstrate that orthopaedic surgeons are available to provide care in those settings. To meet these rules, most hospitals require orthopaedic surgeons to take ER call (be available in the hospital or nearby location) as a condition of receiving practice privileges. In a recent survey of POS members, we found that over 75% of our members who are required to be on ER call receive no compensation from their hospital for that service.

As you know, a major cost driver for the Medicaid program is Medicaid patients presenting at the ER for non-emergent conditions. In most orthopaedic cases, Medicaid patients who present in an ER receive appropriate care and treatment in that setting, but follow-up procedures and care are more likely to occur in the physicians' offices or other ancillary facility. Orthopaedic surgeons do not dump these patients on hospitals; they care for their patients throughout the treatment process in the highest quality and lowest cost setting available.

Defensive Medicine as a Healthcare Cost Driver

Although medical liability is not this hearing's subject matter, Pennsylvania's liability environment cannot be ignored as one of the major healthcare cost drivers in the Commonwealth. The need for defensive medicine leads physicians and hospitals to utilize diagnostic tools that might otherwise not be necessary save for the fear of lawsuits. Again, this cost driver is the same for physician-owned ancillary services and hospital-based settings.

⁴ Merritt Hawkins and Associates; 2009 Survey of Physician Appointment Wait Times; available at: <http://www.merrithawkins.com/pdf/mha2009waittimesurvey.pdf>

The General Assembly made great strides over the past decade in dealing with medical liability reform. Act 13, Venue Reform and the Mcare Program helped to stabilize the physician community and to curtail the sharp increases in liability insurance. But more can and should be done.

Recently, a POS member shared with the Society a response he received from a prospective new partner. This Altoona-based practice has been desperately attempting to recruit a new, young surgeon for some time now. In his response, the prospective partner stated, “Thank you for your invitation to visit with you about your practice. Pennsylvania is a very pretty state, with many things to do outdoors, which is what I am looking for. Unfortunately, I am not interested in Pennsylvania because of the malpractice environment and the attorney's slush fund created by the state. Please feel free to send this to your local and state representatives.”

The Mcare Fund needs to be retired in a manner that will allow specialty physicians to again recruit the best and brightest young physicians to the Commonwealth. Currently, the General Assembly is considering proposals to appropriate hundreds of millions of taxpayers' dollars to programs designed to ensure patient access to services, but without physicians, no care will be provided.

Conclusion

We have heard the rhetoric that physician ownership of ancillary services leads to greater utilization because physicians have an economic interest in ordering unnecessary diagnostic tests or treatment procedures. This rhetoric belies two facts: first, all payors, whether commercial or governmental, will only reimburse for medically necessary tests and procedures. Any physician who orders unnecessary tests or procedures risks incurring the expense of such services without receiving reimbursement for those services rendered. And that is a risk most private practice physicians are unwilling to take. It is simply not in a private practice physician's economic interest to incur expenses with no reasonable expectation of payment.

Second, if this “economic interest” argument is to be applied to physicians, it must also be applied to hospitals. If private practice physicians have an incentive to order unnecessary tests and procedures simply to generate more revenue, then hospital administrators and employed physicians must have the same incentive to direct patients to hospital-owned ancillary services simply to generate more revenue. Yet the various legislative proposals do not prohibit what I will term as “hospital self-referral”. In fact, the bills before this committee seemingly accept that “hospital self-referral” is appropriate while physician self-referral is somehow tainted. If you truly believe that “self-referral” is inherently mired with conflict and abuse, then the logical conclusion would be to prohibit all self-referral and allow patients to choose the venue in which they wish to seek services. At least with this regulatory scheme, all players would be on a level playing field and patients will control their own medical destiny.

As a final thought, I believe it is important for this committee to understand that this self-referral issue ultimately boils down to an economic dispute between private practice physicians who wish to remain in private practice and large, monolithic hospital systems who wish to own and control all the means by which patients receive care. Private practice physicians are the backbone of the healthcare delivery system in that they are generally the entry point for most patients. We have expanded our treatment offerings to better serve our patients and to remain economically viable in a state with traditionally high liability costs and lower than average reimbursement levels. Private practice physicians provide patients better care with fewer complications at less expense than care provided in hospital settings. Please do not stifle competition and limit patient choice and treatment options by enacting a regulatory structure that gives unnecessary advantages to only one player in the healthcare delivery system. Please allow private practice physicians to remain vital and viable players in the medical community.

Thank you for the opportunity to testify today.