



Pennsylvania Orthopaedics

Newsletter of the Pennsylvania Orthopaedic Society

Summer 2008

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President's Message . . .

This has been a pivotal year in the political struggle for healthcare in Pennsylvania. Much to the detriment of our patients, two separate measures designed to facilitate Pennsylvanian's access to healthcare have been linked together in what has been described by many as mere political wrangling. The connection of medical liability premium subsidies to health insurance expansion has led to a political impasse which could cost Pennsylvania healthcare providers billions of dollars and dramatically impair efforts to recruit physicians to the state for years to come.



For months, POS leadership and our members have vigorously advocated for an end to the political stalemate at press conferences, through statewide opinion pieces in various newspapers, through a grassroots effort aimed at the state Senate, and by lobbying at the Capitol. I personally have been to the Hill and met with legislative leaders of both parties several times. Many in the POS leadership and I have kept our Society focused and engaged in advocacy efforts to guarantee that state revenues are committed to provide abatement and to ensure that state revenues committed to completely retire the Mcare fund. Despite our continued grassroots efforts throughout the spring and early summer, the General Assembly broke for their recess without resolving these and other healthcare related issues.

Under current law, POS members are facing a \$250,000 increase in primary medical liability insurance level on January 1, 2010 along with another \$250,000 increase in primary medical liability insurance level on January 1, 2013. The burden of retiring the Mcare Fund's estimated \$1.8 BILLION DOLLAR tail through continued physician assessments persists well beyond 2013; and non-renewal of the Mcare Abatement Program also remains.

POS previously estimated that each \$250,000 step will impose at least a 25% increase in liability insurance costs. Therefore, under current law primary liability insurance levels will be \$1 million by 2013. And given the current stalemate in the General Assembly, abatement may no longer be available for any portion of medical liability insurance. In addition, under current law the Mcare Fund's unfunded liability – which is currently estimated at \$1.8 billion – will be paid by continued assessments on physicians.

We plan to renew our advocacy efforts in the coming weeks as negotiators from the four legislative caucuses and the Governor's Office begin to discuss the details of a comprehensive healthcare package to be enacted in the fall session. It's time for our legislators and Governor Rendell to hammer out a solution that gives patients greater access to healthcare services and preserves access to quality specialty medical care. That means expanding health insurance options and other programs for the uninsured and underinsured. But it also means helping physicians with unaffordable medical liability costs, so they can continue practicing here and providing care to Pennsylvania's citizens.

I encourage each and every one of you to contact your legislators and explain how important the Mcare Abatement Program has been to your practice. Also remind them that if the program is not renewed this year, the incentive to remain in the Commonwealth will vanish with the expiration of this program. Most physicians have paid their 2008 surcharges and are no longer

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CMS Issues Final Inpatient Prospective Payment System (IPPS) Rule

The US Centers for Medicare and Medicaid Services (CMS) issued its final inpatient prospective payment system (IPPS) rule that finalizes three of nine proposed conditions for the list of hospital-acquired conditions (HAC). The three new conditions added by Medicare in the Final Rule are:

- surgical site infection (SSI) following certain elective procedures (including orthopaedic procedures)
- deep vein thrombosis/pulmonary embolism (DVT/PE) in total knee (TKR) and total hip replacement (THR)
- manifestations of poor glycemic control

The HAC payment policy states that Medicare will not provide additional payment to hospitals for complications/co-morbidities that are selected conditions on the list of HACs if they are not present on admission. However, Medicare continues to pay for the primary procedure or service.

This hospital inpatient policy does not affect physician payment, it only effects payment to the acute inpatient hospital setting.

The policy will begin on October 1, 2008, since the hospital inpatient setting is on a fiscal year cycle.

The American Association of Orthopaedic Surgeons (AAOS) met with CMS multiple times and submitted comments on SSI in TKR and DVT/PE as HACs. AAOS also proposed changes to the musculoskeletal Medicare severity diagnosis-related groups (MS-DRGs). CMS, however, did not accept any of AAOS' proposed MS-DRG changes for calendar year 2009.

The AAOS shares CMS' goal of promoting high quality, safe, and effective care,

but is concerned that including complications that are not always reasonably preventable to the HAC list may have unintended consequences that could negatively affect patient access and quality of care. Of primary concern is the inability to adjust the HAC policy for condition/procedure and patient specific risk factors.

The AAOS will respond with a strong comment, form a coalition with other physician organizations, and meet with CMS to discuss the potential threats on patient access to orthopaedic care. More information on this important ruling will be available in the September issue of AAOS NOW.

Opportunity for Practice Administrators: 13th Annual Bones of PA Meeting September 11-12 in Harrisburg

Practice Administrators, Office Managers, and Supervisors can attend a low cost meeting and gain exposure to topics that affect physician practices on a daily basis. This meeting provides the opportunity to network with peers from other practices and is a valuable resource for all types of information, such as current trends with Medicare and other insurances, staffing benchmarks, employee benefits, policies and procedures and much more. An exhibit hall also features approximately 25-30 exhibit booths where attendees can meet with vendors regarding new or existing services.

Registration is only \$50 for Bones of PA members. Non-members can attend for \$100, however new members can join for \$35, making the total cost only \$85.00! Visit www.bonesofpa.com for more information.

FREE WEBINAR:

“Telling the Whole Truth: Orthopaedists as Expert Witnesses and the Grievance Process”

Register now for a 90-minute live, interactive webinar on September 10, 2008, which includes the Standards of Professionalism on Orthopaedic Expert Witness Testimony and the Grievance Process, your professional responsibilities when providing orthopaedic expert witness testimony, and the AAOS Professional Compliance Program. For more information visit: http://www3.aaos.org/education/courses/course_detail.cfm?course_number=0809322.

US Senate Panel Reviews Proposed Merger

In late July, two US senators said they were concerned that mergers among health insurers were leading to higher premiums for consumers—and questioned whether a proposed merger between Pennsylvania’s two largest health insurance companies was a good idea.

The comments by US Senators Arlen Specter, R-Pa., and Herbert Kohl, D-Wis., came during a Senate Judiciary subcommittee hearing on a proposed merger in Pennsylvania that would create the state’s largest health insurer.

Kohl, chairman of the subcommittee that oversees antitrust matters, said the number of health insurers nationally has fallen 20 percent since 2000 and he questioned whether the Justice Department has done enough to enforce antitrust law in the industry. He said he planned more hearings on the issue and has sought an investigation by the Government Accountability Office.

Similar to hearings in Pennsylvania, the chief executive officers of the health insurance companies testified that the merger in Pennsylvania would save more than \$1 billion over six years by reducing overhead expenses. The companies have said \$650 million of that savings would go to assist uninsured Pennsylvanians.

Specter said he wanted to know what immediate benefits there would be for consumers and where exactly the anticipated savings would go. The Senator has questioned how much of the billion dollars that is claimed to be saved over six years is going to go into reserves and how much is going to go to reduce premiums. And he also feels that reduced premiums are much more attractive proposition. Based on annual premiums, the new company would become the nation’s No. three health insurer behind UnitedHealth Group of Minneapolis and Wellpoint Inc., of Indianapolis.

Witnesses from many healthcare organizations such as American Medical Association, Pennsylvania Medical Society, Pennsylvania Orthopaedic Society, Pennsylvania Physicians for the Protection of Specialty Care, and Harrisburg Association of Pennsylvania, have voiced

opposition to the proposed merger and their comments video of the recent public hearings can be viewed at the PA Department of Insurance website: <http://www.ins.state.pa.us/ins/site/default.asp>. Public comment is still being accepted and can be submitted via the website.

Lawmakers May Get Blues Merger Input, But Insurance Commissioner Gets Final Say

Governor Ed Rendell signed legislation in early July that will give the state Insurance Department the final say on the proposed merger of Independence Blue Cross and Highmark Inc. If approved, the combined Blues entity would control more than 65 percent of Pennsylvania’s health care market. During that same time-frame, three public hearings by the state Insurance Commission were held in Harrisburg, Philadelphia, and Pittsburgh. Lawmakers have said for months that a strong oversight bill was needed, but negotiations stalled for more than a year with the Rendell administration over just what role the Legislature should have. Everyone agreed that the state should have some regulatory role in approving the proposed merger. Existing law gave that oversight to the Insurance Department when for-profit entities merged, but not for nonprofit companies, like Independence and Highmark.

With the signing of House Bill 1150, which also mandates autism insurance coverage and amends other insurance laws, Rendell agreed to allow the House Insurance Committee and the Senate Banking and Insurance Committee to give its input.

The new law says those committees will have 45 days after the public comment period closes to review the filings and issue recom-

mendations. The insurance commissioner will then have to wait at least 60 days after receiving the legislative comment to make a final determination on the merger. In that final ruling, the insurance commissioner is obligated to include a “detailed written response” to the legislative recommendations, according to the bill.

This legislation gives the insurance commissioner the ability to hold this merger to a higher standard, while at the same time giving the Legislature the unprecedented ability to comment, review and recommend approval, rejections or conditions on a merger of this magnitude.

The bill achieves two important objectives: First, it puts the consolidation squarely within the scope of the Insurance Department’s review under the laws that have long applied to all other insurers (prior to this, the Blues themselves were not covered - only their for-profit insurance subsidiaries were). Second, it provides for meaningful legislative input into this by allowing the Senate and House Insurance Committees to provide comments and recommendations that the Insurance Commissioner has to consider and specifically address as part of any order. Given the unprecedented size of the consolidation, having legislative input, while also unprecedented, is important.

Frequently Asked Coding Questions

Mary LeGrand, RN, MA, CCS-P, CPC

The following represent frequent questions asked by orthopaedic physicians or staff.

Loose /Foreign body in the Presence of Other Arthroscopic Procedures

QUESTION: Our surgeons does a “wash out” of 100 loose bodies during the same session as an arthroscopic knee procedure. Can we report CPT code 29874 in addition to the knee procedure?

ANSWER: No, this would not meet the requirements of reporting CPT code 29874. Arthroscopy, knee, surgical; for removal of loose body or foreign body (eg, osteochondritis dissecans fragmentation, chondral fragmentation) in addition to the other arthroscopic procedures. When loose or foreign bodies are removed during the same session as other arthroscopic knee procedures, the surgeon must document that one of the two following criteria have been met:

- The loose/foreign body was removed through a separate incision
- The loose/foreign body was greater than 5 mm (and not collectively)

Unrelated Visit and Procedure During the Global Period

QUESTION: Our physician saw a patient who is in the global period of a knee replacement. The patient fell and broke the right wrist. The surgeon saw the patient in the ER at the request of the ER physician and did a closed reduction of the fracture. How do we report this service?

ANSWER: Because the patient is in a global period, modifier 24, Unrelated E&M during the post op period must be appended. Modifier 57 must also be appended because the surgeon made a decision for surgery. So append the physician would report 9924x-24, 57 and then append modifier 79, unrelated surgical procedure during the global period, to the appropriate closed reduction with manipulation CPT code.

Submuscular Transposition of the Ulnar Nerve

QUESTION: The surgeon performed a ulnar nerve neuroplasty and documented a submuscular transposition of the nerve. She is asking if we can bill anything additional for the submuscular versus anterior transposition of the nerve?

ANSWER: Yes, the key here is the submuscular transposition which must be clearly documented. The surgeon may report:

24305—Tendon lengthening, upper arm or elbow, each tendon

64718-59—Neuroplasty and/or transposition; ulnar nerve at elbow

CPT code 64718 which describes a transposition was created and valued for an anterior transposition. Thus if the surgeon performs and documents the submuscular transposition, CPT code 24305 may be reported in addition.

Revision Hip or Conversion to Total Hip Replacement

QUESTION: Patient who had a THA approx 6 yrs ago by a different practice began to develop pain in June 2008 and after complete work-up by our surgeon, the prosthesis was removed and a spacer was placed in July 2008. At that time, we reported CPT code 27091. This week the patient was returned to the OR and the surgeon removed the cement spacer and put in a new total hip prosthesis. The surgeon coded this as a “revision” and we are saying it is a “conversion”. How should this be reported.

ANSWER: First, you are still in the global period, thus a modifier 58 would be required. There is no mention of an antibiotic spacer being placed, so we will assume that the surgeon did not place an antibiotic spacer. You are correct that this is a conversion to total hip , CPT code 27132 Conversion of previous hip surgery to total hip arthroplasty, with or without autograft or allograft and not a revision. A revision CPT code is reported when the surgeon removes the prosthesis and places a new prosthesis at the same operative session.

Hemiarthroplasty for Femoral Neck Fracture

QUESTION: The surgeon documented a “hemiarthroplasty” for the treatment of an intertrochanteric neck fracture. Do we report CPT code 27125 or 27236?

ANSWER: CPT code 27125, Hemiarthroplasty, hip, partial (eg, femoral stem prosthesis, bipolar arthroplasty) would be reported for hip surgery for the treatment of a condition such as arthritis. Because the surgeon is treating a fracture, the correct code is 27236, Open treatment of femoral fracture, proximal end, neck, internal fixation or prosthetic replacement.

PA Orthos Meet with Senator Specter During NOLC in Washington

Several POS members joined more than 200 orthopaedic surgeons in visits to members of Congress to address issues such as Medicare reimbursement and medical liability reform. Drs. Hummer, Snyder, Baum, Schmaltz, Hughes, and Perricelli discussed the flawed Medicare reimbursement system and physician concerns with the planned merger between Highmark and Independence Blue Cross. Sen. Arlen Specter, direct from Senate Judiciary meetings, personally met with the group to discuss these issues. The visits were part of the National Orthopaedic Leadership Conference and through support from the AAOS State Orthopaedic Society Assistance Fund, we were able to provide sponsorship for resident representative, Brett Perricelli, MD. Resident participation will help educate and familiarize residents on how legislation affects the practice of orthopedics and to define issues facing young orthopaedists today.



POS members Brett Perricelli, MD; Thomas Hughes, MD; Barry Snyder, MD; Jeffrey Baum, MD; Chip Hummer, MD; and Harry Schmaltz, MD, take time to pose during Hill visits.

Make Sure Your CME File is Up to Date: Licensure Period Ends December 31, 2008

During the past decade, an emphasis has been placed on patient safety and what doctors can do to improve methods that protect patients. In most states, CME credits are required in the area of patient safety/risk management for license renewal.

The Pennsylvania State Board of Medicine requires 100 total credit hours of CME in the two-year license cycle:

- Medical Doctors (*January 1, 2007–December 31, 2008*)
- Osteopathic Doctors (*November 1, 2006–October 31, 2008*)
- A minimum of 20 of the total credit hours in Category 1
- 12 credit hours in the areas of patient safety/risk management (*Category 1 or 2*)

Category 1 and Category 2 are defined by the American Medical Association (AMA):

There are two categories of AMA credit. Generally speaking, Category 1 activities are designated by an accredited provider. Examples include attendance and presentations at a conference where Category 1 will be given. Physicians may also earn credit for publishing an article in a peer-reviewed journal and meritorious learning experiences that have been pre-approved for credit.

Category 2 activities, by contrast, have not been formally designated by an accredited provider for category 1 credit. Individual physicians may claim Category 2 credit for learn-

ing experiences that have improved the care they provide their patients. Category 2 activities include reading journal article and consulting colleagues.

Physicians may claim Category 2 Credit for such learning activities as:

- Teaching residents, medical students or other health professionals
- Unstructured online searching and learning
- Reading authoritative medical literature
- Consultation with peers and medical experts
- Participating in live activities not designated for Category 1 Credit

Physicians determine the number of credits by claiming one (1) Category 2 Credit for each 60-minute hour engaged in the learning activity. Physicians may claim credit in 15 minute increments, or .25 credit hours, and should round to the nearest quarter hour. Category 2 credit hours can be documented a physician journal or log.

If any of the patient-safety credit hours that a have been earned as Category 1, they can be counted toward both the Category 1 requirement and the patient safety/risk management requirement.

Having Difficulty Getting Timely and Correct Payment for Workers' Comp Services?

The Bureau of Workers' Compensation will provide training sessions in fall 2008 to help insurers, self-insured employers, providers and vendors understand workers' compensation medical billing and payment processes, as well as the workers' compensation fee schedule. The training sessions provide valuable information for all parties involved in the medical billing and payment aspects of workers' compensation. Provider Training Seminars, being held September 30 and October 2, 7, 9, 2008, are designed to assist medical providers to bill correctly, document charges, understand payment and de-

nial issues. Attendees will also receive information on the fee review process, learn how to utilize it, as well as gain an overall understanding of workers' compensation and its function. This seminar is an excellent source of information for providers who are frustrated with workers' compensation or providers who find it cumbersome. The information will provide you with a clearer understanding of the law and its requirements. For more details, visit: <http://www.dli.state.pa.us/landi/cwp/view.asp?a=138&q=246151>.

Member Data Update

It's that time of year again. Please look in the mail for POS's annual member data update and if you have any new information, please return the sheet so we can update our records accordingly. Thanks to those who have already responded.



New POS headquarters.

POS Is Movin' On Up ... the Street

The Pennsylvania Orthopaedic Society moved into its new office this past month and as we reorganize we want to make sure you have our new address: 510 North Third Street, Floor 3, Harrisburg, PA 17101. All phone numbers, fax numbers, and email addresses will remain the same, but please make the address change in your records.

Calendar

BONES of PA Annual Meeting

September 11-12, 2008
Harrisburg Hilton and Towers, Harrisburg, PA

POS Fall Scientific Meeting:

Innovations in Orthopaedics: New Tricks for Old Dogs

November 20-22, 2008
Philadelphia Park Hyatt at the Bellevue, Philadelphia, PA

2009 POS Coding Seminar

Dates in March/April TBD

POS Spring Scientific Meeting: Trauma

April 23-24, 2009
Nemacolin Woodlands Resort, Farmington, PA

Fall Meeting Offers New Technologies and Plenty of CME

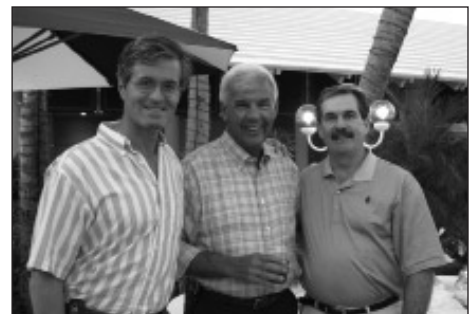
The Pennsylvania Orthopaedic Society is back in Philadelphia for its 2008 Fall Scientific Meeting, *Innovations in Orthopaedics: New Tricks for Old Dogs*, November 20-22, 2008. Program Chair, Hari P. Bezwada, MD, has worked all summer to put together an outstanding and wide-stretching program, encompassing some of the most exciting new trends and techniques in orthopaedic surgery today. There were so many great papers that we extended the meeting through Saturday for a total of 18.5 Category 1 CME credits. Be sure to sign up for the Thursday Night Reception and help celebrate the end of the term for President Jon B. Tucker,

MD, and the start of a new one for Gerald R. Williams Jr., MD. Make your reservations at the Philadelphia Park Hyatt at the Bellevue at 1-800-778-7477 and contact Colin Gabler at 717-909-8901 for more information. Please talk to your industry representatives about not only exhibiting, but finding other ways to support the Society with its educational endeavors.



Spring Meeting a “Key” to POS Success

The Pennsylvania Orthopaedic Society enjoyed a successful 2008 Spring Scientific Meeting, and anyone familiar with the Beach Boys 1988 hit single, “Kokomo,” knows why. Just south of Miami, amidst swaying palms and billowed sails, eighty POS members and 23 vendors gathered to teach, learn, and catch up with friends. President Jon B. Tucker, MD, chose the Ocean Reef Club in Key Largo for its beautiful views, sandy beaches, and award-winning golf courses, but program chair Jon K. Sekiya, MD, ensured it was as educational as it was relaxing. Sekiya brought in top speakers from across the state, as well as guests Ned Amendola, MD, Richard P. Kidwell, Esq., and Charlene MacDonald for his program, *Sports Medicine: Current Concepts and Controversies*. Many enjoyed fishing, boating, and snorkeling, while everyone partook in great seafood and sunbathing at the resort’s secluded spots. Over 150 people traded their shoes for sandals to attend the POS Party on the Beach. Tropical drinks and island mentality ruled the evening, with John D. Kelly IV, MD, providing the entertainment. Thank you to all our vendors, and a special shout out to Genzyme, our lone silver supporter for this meeting. We look forward to seeing everyone in Philadelphia.



Above photo: Brian Begor, Pat Smith, and Tom Muzzonigro. Top right photo: Greg Gallant and Mike Gratch enjoy the reception with their lovely wives. Center right photo: Comedian John Kelly with golf pros Jack Smith and Jim McGlynn. Bottom right photo: President Jon Tucker and Program Chair Jon Sekiya.



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President's Message

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beholden to their commitment to remain in state for another year. Therefore, doctors in Pennsylvania are now "free to move about the country..." just like the Southwest Airlines ad says.

I remain optimistic and hopeful that reasonable minds will prevail; I am hopeful that our Governor and the leadership of the General Assembly will pass a compromise bill that preserves patient access to care by funding the unfunded li-

ability and phasing out the Mcare abatement over ten years. The money is there, waiting to be disbursed by the state government. Each and every one of us needs to make it known that we consider the retirement and phase-out to be akin to a covenant between the state government and medicine. For that reason alone, failure to enact this long-promised legislation is tantamount to a betrayal of Pennsylvania's physicians' trust in our state government and also a betrayal by the state of our least fortunate citizens who have no or little health care insurance.