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Pennsylvania Orthopaedics

Newsletter of the Pennsylvania Orthopaedic Society...**Fighting For You!**
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Fall 2003

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President's Message

Richard G. Schmidt, MD

The revolution has begun.

Several weeks ago our dedicated staff, asked me to prepare my presidential address. I wondered how I could possibly summarize all my feelings and our efforts? So much has happened in a short period of time. We remember and honor our past president, Paul Burton, who did his best to serve our society only to move to California before his term ended. I assumed Presidency of the Society four months ahead of schedule and thanks to everyone it has been a smooth transition.

Paul Burton's departure was painfully re-emphasized when my own brother, a board certified urologist at Northeastern Hospital, also left Pennsylvania. I remember the feelings of anger as he left with his family. This state has been home to my family since the time of the American Revolution.

His departure caused me to reminisce about the collective pains felt by orthopaedic surgeons. We endured long residencies averaging three or four nights per week of call for five years. Many of us went the extra mile and completed fellowships in distant cities. Recently, we have had to endure strenuous governmental mandates of DRGs and HIPPA guidelines that transform us from doctors to "healthcare providers". We sign Medicare attestation sheets with the carefully placed governmental warning of criminal prosecution. Our patients have been transformed to "potential plaintiffs". I am saddened when I think of all the orthopaedic surgeons who have left Pennsylvania.

A physician's life is not easy. We have often had to place our patient's well being above that of our own family. How many of you have missed your child's birthday or a wedding anniversary because duty called to take care of a patient who needed us? Today, many over-burdened physicians are taking too much call and working long hours due physician shortages. One never sees stories of this nature in the newspaper.

As your president I can tell you that I am not the kind of person who goes quietly into the night. I have made a personal decision to stay in Pennsylvania and fight. Like our founding fathers, I can no longer tolerate the actions that have been levied upon us. It is time for a revolution and the revolution has begun.

POS has achieved much success thanks to the hard work and dedication of our Board of Directors. We have been instrumental in recent political

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"Recently, we have had to endure strenuous governmental mandates of DRGs and HIPPA guidelines that transform us from doctors to healthcare providers."

Need the address of your state Representatives and Senators?

visit

www.paorthosociety.org
and click "Find Your Legislator"

Supreme Court Allows States More Leeway in Regulating HMO's

Earlier this year the U.S. Supreme Court struck a victory for medicine. They unanimously ruled that Kentucky has the power to require HMOs to accept into their network any willing provider who accepts the HMO's terms. In doing so, they rejected the view that the Employee Retirement and Income Security Act (ERISA) places a road block on states who wish to regulate HMOs. The Supreme Court's opinion has great implications for a state's ability to effectively legislate on issues such as prompt pay, external review and insurer liability.

The ERISA law is one of the most complex areas of federal law. ERISA lawyers will tell you that if someone says they understand ERISA they are lying. ERISA was drafted to protect workers' pensions. At the last minute it was amended to include other "employee benefits," which include health benefits. ERISA provides that any state law that "relates to" employee benefits is preempted by ERISA. This broad preemption has an exception allowing states to pass laws regulating insurance. However, under this exception a state cannot

regulate a self-funded employee benefit plan (since, technically, it is not insurance).

Forty-four percent of people get their health insurance from self-funded plans. Insurance companies almost always administer self-funded plans for employers. In these cases the insurers are not "insurers" under ERISA, but are third party administrators. They are not insuring against risk, but they are managing the health care benefits. All the money that is at risk is supplied by the employer. Historically courts have considered third party administrators and the employer plan itself as one entity having the same rights under ERISA.

This has great implications for laws such as the prompt pay law. A patient may visit your office with a Humana card and the claim may be covered by the prompt pay law. The next patient you see may also have a Humana card, but is employed by a self-funding company whose plan is administered by Humana so the prompt pay law does not apply.

However, the Supreme Court has recently been narrowing the reach of ERISA. They ruled that HMO medical

necessity decisions affect the quality of care and therefore ERISA does not prevent a state from requiring that HMO medical necessity decisions go through an independent review. As mentioned previously, this year the court ruled that "any willing provider" (AWP) laws regulate insurance and therefore are saved from preemption.

There is an extremely important footnote in the Kentucky case that could have huge implications for state regulation of health care. The footnote states that the Kentucky AWP law applies to HMOs who act as administrators for self-insured plans and not as traditional insurers. The Court seems to imply that this application of the AWP law is appropriate and does not provide a reason for ERISA preemption.

If the lower courts understand the implication of this footnote a prompt pay law would apply to any patient who walks in your office with a Humana card. States will be able to provide more effective and encompassing regulation of insurer/provider relations. Look for more litigation in the years to come as the states push to see how far they can legislate. ■

CMS's Guidance To Payers Regarding HIPAA TCS Regs Leave Physicians In Limbo

CMS has announced that it won't penalize health plans that pay claims that don't meet the HIPAA transaction and code sets (TCS) standards, but that it will not force them to pay claims either. Specifically, CMS said that it will not fine "otherwise compliant" payers that choose to pay noncompliant or partially-compliant physician claims after the Oct. 16 deadline - as long as the payer is giving physicians help testing claims. At the same time, however, the agency emphasized that paying such claims would technically violate HIPAA regulations, and it explained that it "has no authority" to delay or otherwise

change the Oct. 16 deadline.

While the latest guidance removes the immediate threat of fines for "otherwise compliant" health plans and other payers, it puts physicians at the mercy of those same organizations. While some payers have publicly said they want to keep paying providers who are struggling to meet the new standards, others may see little incentive to violate the statute in order to help providers. (After all, by not making payments, they can make money on the "float.")

AAOS was one of more than 30 medical groups that collaborated in writing a

letter to DHHS Secretary Tommy Thompson expressing concern about this matter. The letter explained that many payers, software vendors and clearinghouses are simply not ready to start testing claim submissions from providers, and that they very possibly will not be ready until shortly before the October deadline. (This is occurring for many reasons, a primary one being that the TCS "Addenda" were not even issued until February, 2003.)

As a result, many physicians will not be

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On a recent visit to Harrisburg, President, Richard G. Schmidt, MD met with political leaders to discuss the medical liability crisis and the plight of high risk-specialists in Pennsylvania.



Senator Jeffrey E. Piccola with Dr. Schmidt



Representative Ellen M. Bard (R-Montgomery County) and Dr. Schmidt



Beth Weachter, Governor Rendell's Deputy Chief of Staff, David Myers, MD, Richard Schmidt and Kathy DeWittie



Richard Schmidt, MD with Indiana County Representative Sam Smith

Medicare Questions Arthroscopy for Osteoarthritis of the Knee

AN EARLIER VERSION OF THIS ARTICLE APPEARED IN THE AUGUST 2003 AAOS BULLETIN

In July 2002, the New England Journal of Medicine (NEJM) published, "A controlled trial of arthroscopic surgery for osteoarthritis of the knee" by Moseley et al. This article presented the results of a randomized, placebo-controlled trial that evaluated the efficacy of arthroscopic lavage and arthroscopic debridement for osteoarthritis of the knee. The authors concluded the outcomes of patients who underwent these procedures were no better than the outcomes of those patients who underwent placebo surgery.

In response to the NEJM article, the Centers for Medicare and Medicaid Services (CMS) announced its intent to begin a national coverage analysis and determination to "evaluate the scientific evidence to determine the indications for which arthroscopic lavage and/or debridement for the treatment of the osteoarthritic knee is reasonable and necessary." CMS noted that "recent evidence published in the New England Journal of Medicine suggested that arthroscopic lavage and/or debridement

in patients with osteoarthritis of the knee without other specific indications is no better than placebo surgery."

Medicare relies on a network of local Medicare carriers to run and manage the Medicare program within their respective jurisdictions. These local carriers usually provide services to a particular state, although some carriers process claims for physicians in several states. Although the number of carriers changes often, there are approximately 35 carriers in the United States.

Local Medicare carriers are responsible for processing claims, computing and making payments for physician and other practitioner services, determining whether claims are for covered services, denying claims for non-covered services, and denying claims for medically unnecessary services. Local carriers will only pay for medical items and services that are "reasonable and necessary." Determination of whether or not a service is reasonable and necessary is based partly on whether or not it is safe and effective and com-

monly accepted as a standard of practice in the medical community.

In most situations, Medicare relies on its local carriers to make coverage determinations. However, in certain instances, CMS will issue national coverage decisions to ensure that consistent coverage policies are applied nationwide. CMS is authorized to make national coverage decisions for the Medicare program because the laws that govern Medicare do not explicitly list the medical devices, surgical procedures, or diagnostic services that are covered or excluded under the program. When CMS makes a coverage decision, it issues a national coverage determination (NCD). These NCDs affect the entire Medicare program and are binding on all local Medicare carriers. Early in October 2002, in response to CMS's coverage analysis, the AAOS assembled a group of representatives from various musculoskeletal societies to develop a unified orthopaedic response. Over the course of the past year, this coalition of musculoskeletal specialty societies has worked with

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Fall Meeting Highlights

In October 2003, POS conducted a very successful meeting at Nemaocolin Woodlands Resort and Spa with 125 physicians in attendance. The meeting, entitled "Sports Medicine", included guest speakers: Stephen Howell, MD, University of California at Davis, Daniel McKernan, MD, Medical College of Ohio, Jon J.P. Warner, MD, Harvard Medical School and AAOS President, James H. Herndon, MD. Congratulations to Josh Port for developing a great program. Danielle Walters, Executive Vice President, Californians Allied for Patient Protection, was featured as a luncheon guest speaker and the social highlight of the meeting was a Roman Feast. ■

New Officers Step Up

Richard G. Schmidt, MD took office as the President of the Society in August 2003 following Paul Burton's departure. Dr. Schmidt will serve his term as President through November 2004. He earned his medical degree in 1980 from the Milton S. Hershey Medical Center and completed his orthopaedic residency at the Hospital of the University of Pennsylvania in 1985. He completed his orthopaedic oncology fellowship in 1986 at Shands Teaching Hospital at the University of Florida. Dr. Schmidt was Board Certified by the American Board of Orthopaedic Surgery in 1988 and serves on the medical staffs of nearly a dozen hospitals in the Philadelphia area and southern New Jersey. He enjoys membership in numerous medical professional organizations and is a fellow of the American Academy of Orthopaedic Surgeons. Dr. Schmidt will be succeeded next year by First Vice President, P. Christopher Metzger, MD, followed by newly nominated Second Vice President, Joshua Port, MD. ■

Exhibitors

The Pennsylvania Orthopaedic Society extends sincere appreciation to the following companies for their support of the 2003 meeting at Nemaocolin:

American Red Cross, Arthrex, Inc, ArthroCare, Aventis, Benchmark O&P/Prosthetic Orthotic Solutions, Bledsoe Brace Systems, DeLaTorre Orthotics, DePuy/Johnson & Johnson, DJ Orthopedics, EBI, Elsevier Science-Saunders/Mosby/Churchill, Exactech, Hapad, Hitachi Medical Systems America, Inc, Image Radiology Group, Jetstream Medical/Centerpulse, Orthopedics/Medaphor, LifeNet, Linvatec, Merck, Mitek, Musculoskeletal Transplant Foundation, ONI, Inc, Organon Sanofi-Synthelabo LLC, PA Medical / Hand Innovations, Pfizer, R & B Medical, Sanofi Synthelabo Inc - Hyalgan, Shilling Medical Supply, Inc, Smith & Nephew Endoscopy, Smith and Nephew - Kohut and Assoc, Inc, Stryker Howmedica Osteonics, Synthes USA, The Retirement & Financial Planning Education Center, Wright Medical, Wyeth, Zimmer

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POS Welcomes New Members Approved at October Board Meeting

Active

Robert H. Baker MD, Greenville, PA
Barry Berger MD, Allentown, PA
Michael A. Catino MD, Greensburg, PA
Anthony Jon Ferretti DO, Erie, PA
Robert L. Friedman MD, Easton, PA
Chad Ghigiarelli MD, Scranton, PA
Susan Palmer Harding, MD, Philadelphia, PA
Neil Kahanovitz MD, Philadelphia, PA
John D. Lehman MD, Beaver Falls, PA
James J. Purtill MD, Philadelphia, PA
James A. Shaer MD, Camp Hill, PA
Paul S. Sherbondy MD, University Park, PA
Chris Vasilakis MD, New Castle, PA
Lawrence E. Weiss MD, Philadelphia, PA
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Nicholas A. Grimaldi DO, York, PA
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Asif Ilyas MD, Philadelphia, PA
Joel C. Klena MD, Danville, PA
Raphael Klug DO, Philadelphia, PA
Daniel Krenk DO, Erie, PA
John Todd R. Lawrence MD, Philadelphia, PA
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Mark Pollard MD, Erie, PA
Rachel S. Rohde MD, Pittsburgh, PA
Gary L. Schmidt MD, Pittsburgh, PA
Anjan R. Shah MD, Philadelphia, PA



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CMS to develop an appropriate coverage policy for arthroscopic surgery and osteoarthritis of the knee for the Medicare program. Below is a brief summary of their activities to date.

First Meeting

In November 2002, musculoskeletal representatives met with CMS to provide them with clinical and scientific information on specific arthroscopic procedures and osteoarthritis of the knee. The representatives asserted several important points. First, they emphasized there are many patients with osteoarthritis of the knee that can be significantly helped by arthroscopic surgery. An overly broad change in Medicare policy would deny many patients a valuable treatment option. Second, they discussed the indicators for arthroscopic debridement in patients with osteoarthritis of the knee, and the well-established teaching in the orthopaedic community that pain alone is not a specific indicator for arthroscopy. Finally, the representatives outlined the patient selection process on the basis of a combination of variables, such as mechanical symptoms, limb and knee joint alignment, and severity of arthritis. All of these are important factors that can lead to positive responses to arthroscopic surgery and significantly better patient outcomes.

Second Meeting

In January 2003, musculoskeletal representatives met again with CMS to specifically discuss the NEJM study, in light of the publicity and media attention surrounding this issue. The representatives addressed the article's conclusions and applicability to Medicare coverage policy.

The representatives acknowledged the design strengths of the study and encouraged further high-quality, evidence-based studies. However, they also emphasized the risks of basing CMS coverage policy on the results of one study. The representatives expressed their beliefs as to the drawbacks of the NEJM study: use of an unpublished instrument to measure pain

outcomes, potential selection bias due to the number of patients who did not participate in the study, lack of well-defined specific indicators as inclusion and exclusion criteria, and flaws in the statistical analysis of data from the study.

Furthermore, the representatives argued it would be wrong to create policy that extended beyond the scope of the NEJM study. The authors of the study concluded that arthroscopic lavage and debridement for patients with osteoarthritis of the knee, without other specific indications, was no better than placebo surgery. The NEJM article examined the outcomes of arthroscopic lavage and debridement in patients with osteoarthritis of the knee. The study did not analyze the outcomes of the subgroup of patients who had specific mechanical symptoms in addition to osteoarthritis. Representatives argued that any coverage decision by CMS should not extend beyond the scope of the study.

Report

In order to provide CMS with current information and to further assist in the coverage determination process, the musculoskeletal societies submitted the report, "Arthroscopic Surgery and Osteoarthritis of the Knee." (<http://cms.hhs.gov/mcd/viewtracking-sheet.asp?id=7>) The report provided current scientific evidence that supported the indications of arthroscopic debridement for the treatment of the osteoarthritic knee. It provided definitions, treatment options, and detailed information on the specific indicators for arthroscopic surgery. The report also included a bibliography of recent clinical and scientific articles on the arthroscopic management of osteoarthritis, along with an AAOS evidenced-based document, "Improving Musculoskeletal Care in America (IMCA) Project: Osteoarthritis of the Knee."

Current Situation

In July 2003, CMS posted a decision memorandum that outlined its coverage position on arthroscopy for the osteoarthritic knee. (<http://cms.hhs.gov/mcd/viewdecisionmemo.asp?id=7>) CMS determined "arthroscopic lavage alone is

not reasonable and necessary for patients with osteoarthritis of the knee." CMS also determined "arthroscopic debridement is not reasonable and necessary for patients presenting with knee pain only or with severe osteoarthritis (Outerbridge classification III or IV)." The memorandum was based on CMS's review of the existing literature, the two meetings with the musculoskeletal representatives, and the report submitted by the musculoskeletal societies.

The coverage decision was similar to the position of the musculoskeletal societies because CMS recognized arthroscopy is appropriate in virtually all circumstances in which the orthopaedic community now employs this technology. CMS's decision limited the use of arthroscopic lavage or debridement only in the subgroup of patients that present with knee pain only or in more severe cases of osteoarthritis.

The musculoskeletal societies have already contacted CMS to discuss next steps in the NCD process. Although CMS's decision was largely in line with the musculoskeletal societies position, it does raise some concerns. First, there are specific problems with the use of the Outerbridge system as a method of determining the severity of arthritis since it is a post-operative classification system. Second, the musculoskeletal societies believe local Medicare carriers will need specific and detailed instructions to appropriately implement the coverage decision. The instructions should clearly reflect the limited applicability of the policy decision – the decision affects the subgroups of Medicare patients who suffer from knee pain only or who present with severe cases of arthritis in the knee.

Because of the importance of this issue, the AAOS and the other musculoskeletal specialty societies have agreed it is necessary to continue to work with CMS on this coverage issue. They will work with CMS to develop specific carrier instructions to ensure the appropriate implementation of this coverage decision. ■

Workers' Comp Medical Fee Review

Enclosed with this newsletter is the updated brochure on Medical Fee Review recently published by the PA Bureau of Workers' Compensation. Medical Fee Review is the process by which a provider can dispute the amount or timeliness of the payment made by an employer or insurer for a workers' comp bill. A provider must first have submitted the proper bills along with the Bureau's Medical Report form (LIBC 9) to the insurer before they can seek a review by the Bureau. The form used to dispute the amount or timeliness of a payment is the LIBC 507 - Application for Fee Review.

Samples of the LIBC-9 and LIBC-507 are also enclosed with this newsletter. You may obtain the LIBC-507 in quantity by contacting the Bureau at 717/772-1900. The LIBC-9 may be copied. ■

New Software Eases Workers' Comp Medical Fee Review Process

A new software package is now available which assists with the automation of the Medical Fee Review process through the PA Bureau of Workers' Compensation.

Urling's Electronic Forms enables you to complete the following Bureau forms and then print them as needed:

- LIBC 9** Medical Report Form
- LIBC 344** Report of Industrial Injury
- LIBC 497** Affidavit of Recovery
- LIBC 507** Application for Fee Review
- LIBC 767** Impairment Rating Determination Face Sheet

Orthopaedic practices using systems which are ODBC* compliant can import the necessary patient data directly to *Urling's Forms* without re-entering it. (Millbrook, Medent, and MedEvolve are all ODBC compliant as is the software in which *Urling's Electronic Forms* is written.)

If you are using a non-ODBC compliant system such as Medic (manufactured by Misys), the data cannot be imported; however, you can "copy and paste" from the Medic window to the *Urling forms* window.

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President's Message **continued from page 1**

victories such as venue reform and the election of Supreme Court Justice Eakin. For the first time in our history, we have taken the next step and endorsed a candidate who will challenge an incumbent senator who has not favored liability reform in Pennsylvania. On November 18th, the OrthoPAC officially endorsed Congressman Pat Toomey.

My message to you is clear. Our goal is to improve the practice environment for orthopaedic surgeons. By proposing creative and innovative solutions to Pennsylvania's medical liability problems such as venue and the Auto CAT Fund provision of Act 13 — we

promote, direct, and implement change. In addition, the American Academy of Orthopaedic Surgeons has selected Pennsylvania as one of two model states for which to create its public relations "tool kit" for medical liability reform.

I am asking each and every orthopaedic surgeon to get involved. Each of you must become a physician warrior. The definition of a warrior is a soldier who is committed to the content of the cause. Winning is a byproduct of that commitment. To support our fight you can do the following:

- Create a personal relationship with your legislator

- Contribute to the OrthoPAC
- Get qualified orthopaedic surgeons to join the Society
- Call me or POS to see how you can help with the campaigns of our friends in elected office and those running for office

Lastly, I want to hear from you. If you have an idea of how to improve the Society, I want to know about it. The POS will only be as strong as its members.

I look forward to seeing all of you at our spring meeting in Las Vegas! ■

Orthopaedic Surgeons Wanted

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Orthopaedic Calendar

POS Spring Scientific Meeting
Shoulder Surgery - State of the Art
April 15-17, 2004
Four Seasons at Mandalay Bay

AAOS Annual Meeting
March 10-14, 2004
San Francisco, CA

Philadelphia Orthopaedic Society Programs

December 15
Gill Lecture
Congressman James C. Greenwood

January 12, 2004
Corn Lecture
Scott Streater Kelley, MD
Clinical Professor, Orthopaedic Surgery
Duke University
“Implications of Diameter in Total Hip Arthroplasty”

February 9
Moore Lecture
Gary Gruen, MD
Professor and Vice chairman
Department of Orthopaedic Surgery
University of Pittsburgh
“Controversies in Orthopaedic Surgery The Pilon Fracture”

No meeting in March

April 12
Rechtman Lecture
Michael Hausman, MD

May 10
Sixth Annual Resident Bowl

HGSA.com – A Useful Site

HGSAdministrators (HGSA), is the organization responsible for managing the Centers for Medicare & Medicaid Services (CMS) Medicare Part B benefits in Pennsylvania. Located in Camp Hill, these are the folks who process 37 million Medicare claims annually for Pennsylvania patients and answer questions about Medicare benefits when you call their provider relations line at 1-866-488-0548. (Make sure you have your provider number handy when you call.)

www.hgsa.com is the web site for HGSAdministrators. A large portion of this site is dedicated to Health Care Professionals. For instance, on the HGSA site you can:

Access the Medicare Part B Reference Manual

- View Medicare Reports, Letters, Specialty Billing Guides, and Medical Policy Bulletins
- Obtain a listing of HGSA's educational events
- Search the current year Medicare fee schedule by code number
- Download CMS and HCFA forms
- View Reason and Remark code descriptions
- View Comparative Billing Reports

At HGSA.com you can also find links to the CMS site such as:

- CMS Quarterly Provider Update
- The new on-line CMS Web-Based Manual System
- CERT Program (CMS's Comprehensive Error Rate Testing Program)

HGSA offers a web-based interactive training module system. With a catalog of twenty (20) modules, this application is offered free of charge and allows physicians and office staff to access an interactive multimedia training system, which includes topics such as Introduction and Advanced Evaluation and Management Services, Incident To, The Medicare Coverage Process, Consultations, Drugs and Biologicals and the list goes on.

A number of List Servs are also available which allow you to receive electronic notification directly in your email. Topics include:

Ambulance • Anesthesia • Ambulatory Surgical Centers • Chiropractic
Clinical Diagnostic Labs • Consolidated Billing • Eye Care • General Independent Diagnostic Testing Facilities
Non-physician Practitioners • Physicians • Podiatry • Psychiatric Services • Therapy/Rehab

CMS's Guidance re: HIPAA continued from page 2

in a position to finish testing their practice systems by that time. HIPAA experts agree that, depending on a given practice's specific circumstances, this could require weeks or even months; that is, far longer than the time between now and the October deadline.

Signatories to the letter asked the government to make sure physicians who make good-faith efforts to meet the HIPAA deadline but fall behind will continue to be paid for their services after October 16th. Unfortunately, CMS's latest "guidance" sidesteps all of the issues set forth in our letter. AAOS therefore urges members to take immediate action to minimize payment disruptions. The Academy suggests the following steps:

- Contact your software vendor, clearing house, and payers. Demand that they help you begin external testing now and continue to follow up with them until they do. Pay particular attention to your Medicare intermediary, BC/BS, etc.
 - Ask your vendor very specific questions about what they are doing to meet your HIPAA TCS needs. See the following list of questions: www.cms.hhs.gov/hipaa/hipaa2/Questionsforproviderstoaskvendors.pdf.
 - If any vendors don't agree to begin testing your claims, report the difficulty to the CMS hotline at <http://www.cms.gov/hipaa/hipaa2/support/correspondence/complaint/securitychoice.asp>. In your communication, document your compliance efforts. Such documentation could be a mitigating factor if/when CMS later considers enforcement actions against non-compliant practices.
 - If your vendor won't help you, start searching for a substitute vendor immediately.
 - Finally, arrange a line of credit for your practice to cover anticipated payment interruptions after Oct. 16. Plan on disruptions of 60 to 90 days for payers with whom you have not already completed testing.
- For more information, the CMS guidance is online at www.cms.hhs.gov/hipaa/hipaa2/guidance-final.pdf. ■



Pennsylvania Orthopaedic Society

**500 North Third Street, 11th Floor
Harrisburg, PA 17101-1111**

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April 15-17, 2004

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