

Orthopaedic

PRACTICE MANAGEMENT

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SPECIAL REPORT:

Hunker down, manage debt to protect your practice during economic turbulence

Nationwide, the number of consumers who are skimping on medical care is rising. Unemployment is up, and more individuals are losing health care insurance. Even those who are employed with health benefits are facing sticker shock during open enrollment as employers force more of them into expensive high-deductible health plans. Minnetonka, MN-based UnitedHealth Group, Inc. -- the nation's top health insurer by revenue -- last month reported a 28% decline in third quarter profit as employers burdened by the slowing economy shifted more health care risk to their workers. Similarly, Louisville, KY-based Humana reported a nearly 40% decline in profits during

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Innovative financial strategy protects accounts receivable from legal judgments

No matter how tough economic conditions may seem inside a medical practice, orthopaedic surgeons expect their medical liability carriers to pay claims in the event of a legal judgment. But with the financial industry battered by losses, that's no longer a given, says **Benjamin F. Renzo**, JD, president and CEO of ARLIS, LLC in West Des Moines, IA.

"The carriers that provide medical liability coverage for physicians need to be monitored and critically analyzed by a medical group's advisers," Renzo says. If a physician purchases malpractice insurance but the insurer becomes insolvent, the physician's ability to rely on indemnity payments in the event of a legal judgment is compromised.

In addition, a growing number of physician practices, especially in orthopaedics and other surgical specialties, participate in captive insurance companies. Typically, consortiums of two or three large practices pool their money to self-insure their liability risk, Renzo explains, but these arrangements also can face financial stress during economic downturns.

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Coding Spotlight

Code appropriately for hospital E/M services and boost revenue

Most orthopaedic practices pay enormous attention to the documentation of a physician's work effort in the operating room, ensuring that his or her operative notes support the codes selected for procedure-based care. However, breakdowns in compiling and submitting hospital encounter data can occur in other areas, says **Carol Hanschke**, RHIT, CCS-P, a coding and compliance professional with OrthoLink Physicians Corporation, based in Brentwood, TN.

"So many orthopaedic patients are seen under a global service that physicians often forget that they may code other hospital evaluation and management (E/M) services for patients not in a global period," Hanschke explains. "They may see a patient who is nonsurgical or a surgical patient who develops a new problem unrelated to the surgery, yet they don't bill those encounters. Some have the impression that they should not bill hospital E/M services, and that's simply inaccurate."

Hanschke worked with one large orthopaedic practice that for many years neglected to bill for physician E/M services in the hospital, including billing for patients seen in the emergency department, costing the practice tens of thousands of dollars in lost revenue.

"They were very disappointed to find out that for many years, they could have been billing for

hospital E/M services when patients were seen in the hospital, not as part of a global service," Hanschke says. "Once the coding education was provided and the differences were explained, they adjusted."

Both the CPT initial hospital care and subsequent care E/M services have three levels of service, she explains. Since physicians are more familiar with outpatient E/M services, including new patients, established patients, and outpatient consultations -- all with five levels of service -- many physicians select the wrong level of service in the hospital setting.

"I always include this subject when providing coding education to physicians so that they don't make this mistake and bill those services incorrectly," Hanschke says.

"The physician practice coding staff often misses these errors because their focus is primarily on the office or clinic environment," she adds. "Also, the clinic practice does not have trained staff who fully understand the hospital E/M services well enough to advise physicians regarding the documentation rules with respect to hospital E/M services."

Provide more intensive coding education

For example, patients who are hospitalized following a spine or hip replacement surgery and covered under a global payment often question their orthopaedic surgeon about an unrelated medical problem. Physicians typically address these concerns by providing treatment and advice for the medical problem. Physicians can bill for such services unrelated to the surgical problem, such as treatment for an underlying condition or an added course of treatment not related to the surgery, by using modifier 24 (unrelated E/M service during a global period) appended to the E/M service, as appropriate. If

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the physician performs a procedure unrelated to the surgical global service, modifier 79 (unrelated procedure/service during a global period) should be appended to the CPT procedure code.

Due to the complexity of coding hospital services and the risk of missed revenues, Hanschke recommends that a professional coder meet periodically with each orthopaedic surgeon to review the services he or she provides and examine whether the physician's dictation and documentation support the services provided and capture all of the work effort performed outside the office and OR setting.

"Many practice administrators have coding consultants come in and speak to the physicians, but often this occurs in a group format," Hanschke says. "Meeting with physicians one-on-one adds more value to their time allowed for education about coding hospital encounters as well as many other servic-

es they provide." In Hanschke's experience, orthopaedic surgeons often extend a scheduled 30-minute face-to-face coding education session to a one- or even two-hour lesson, once they learn how much revenue they may be letting slip away.

Meetings between physicians and coders also provide an opportunity to identify specific gaps in a physician's knowledge of coding, she says.

For example, "I've found that most orthopaedic surgeons are not aware that they can bill for discharge services (CPT 99238-99239) for patients not in a global period," Hanschke points out. "Many surgeons are not even aware that discharge E/M services exist. I've talked with orthopaedic surgeons nearing retirement who didn't know about the hospital discharge E/M services, although these are billed routinely by other specialties such as internal medicine."

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the third quarter because of investment losses associated with the credit crisis and anticipated lower premiums in Medicare prescription drug plans.

These trends have orthopaedic surgeons worried.

"There's a lot of ink on the economic turbulence going on around us with the stock market and credit crunch, and these are important issues," confirms **William R. Pupkis**, CMPE, CEO of Capital Region Orthopaedics in Albany, NY. "But there are other issues that are affecting the business of medicine. With more and more employers moving to health savings accounts (HSAs) for employees to pay their out-of-pocket expenses, for example, if you don't adjust your billing and collection procedures you can expect a dip in your bottom line."

Orthopaedic practices can avoid economic meltdown by refocusing on the basics: monitor contracts vigorously, plug gaps in collections, manage debt, and market services systematically. The key is to examine both sides of the profit equation: revenues and expenses.

"When there's a storm, the natural inclination is to cut costs," says **Pamela Waymack**, CHSP, managing director of Phoenix Services Managed Care Consulting, Ltd., in Evanston, IL. "But that's often the wrong inclination. This economic crisis is begging for practices to step back and look at how they manage their business."

"A group that's meeting best practice procedures for collections, looking at volume, identifying outlier physicians within the group, capturing internal referrals, and minimizing leakage from ancillaries has a good foundation to work from," adds **Scott Ferguson**, vice president of finance for Southern Orthopaedic Specialists, LLC, an Atlanta-based practice with 15 physicians at five sites. But practices that ignore these basics will be swimming upstream if the economy continues to tank.

Start with collections

Start by examining collections, a practice's most important metric, to ensure you have effective processes in place to collect patient balances at the time of service -- especially as higher percentages of collections shift from payers to patients through HSAs, health reimbursement accounts (HRAs), and increased co-pays and deductibles. "Some of the new HSA programs don't even want you to collect from patients at the time of service," Pupkis points out. "They require that you file a claim and wait for an explanation of benefits before you can bill the patient."

Orthopaedic surgery practices receive up to 25% of their revenue directly from patients, so it's essential to move collections to the point of service, Waymack says.

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“Create the expectation that payment is expected at the time of the visit,” she advises. “Identify the co-pay amount through electronic eligibility on the payer’s web site, and remind patients of that amount when scheduling the visit. When patients check in, ask how they plan to pay for the visit. And expand opportunities for payment by taking cash, check, and credit cards.”

Implement a plan to manage patients who aren’t prepared to pay at the time of service, Waymack adds. Instead of putting a bill in the mail, provide them with a copy of the bill in a pre-addressed envelope and ask them to return their payment as soon as they return home. Even better, send them to an ATM on the premises.

Practices should monitor additional financial metrics to guide strategic decision-making, Pupkis adds. For example, check payments against contractual rates to ensure that payers don’t skimp on reimbursement. Is the practice seeing more patients this year than last? Did it submit more charges to payers? Are revenues growing proportionately? Are days in accounts receivable (A/R) stable or growing?

In a tight economy, cash flow is king, so “create monthly, quarterly, and annual financial goals, and monitor your financial data regularly,” Pupkis says. “If you’re not on pace to meet your goals, make some adjustments.”

Practices also should liken their contracts and payer mix to an investment portfolio, he tells *OPM*, “and the more diverse they are, the better.”

Try these tips to close the cash flow gap

William R. Pupkis, CMPE, CEO of Capital Region Orthopaedics in Albany, NY, suggests adopting the following strategies to ensure continued cash flow in the face of uncertain economic times and changing health care benefits products:

- Verify benefits before patients arrive for visits or procedures
- Encourage patients to authorize automatic health savings account debits
- Collect past-due amounts at the time patients arrive for follow-up visits
- File electronic claims every day instead of once a week
- Establish a strict financial policy and adhere to it, even if the practice needs to release some slow-paying patients to accommodate quicker-paying patients.

“Physicians didn’t go to medical school to make money, but they need to collect money to stay in business,” Pupkis says. “They can’t buy groceries with accounts receivable.”

Like investments, payers and contracts demand careful management. If you calculate the percentage of each payer’s charges to your total charges, then calculate the collection ratio of each payer, you can examine each payer’s impact on your total revenues and identify your worst payer, Pupkis points out. By dropping your lowest payer and filling those appointment slots with higher-paying patients, you shift your payer mix and create an opportunity to raise your total reimbursement. You can also use the results of this analysis to force your lowest payer back to the negotiating table with the goal of increasing its rates.

“This is a great time to reevaluate payer contracts and think strategically about whether you can afford to participate in all of these plans,” Waymack agrees.

Measure practice from top to bottom

Waymack also advises orthopaedic practices to examine both revenues and expenses by profiling their processes -- staffing, imaging, ancillary services, information technology -- against comparable practices by size, region, and patient demographics. For benchmarks look to the Medical Group Management Association, which publishes annual survey data on orthopaedic practices. Practices that measure themselves from top to bottom can plug any gaps in efficiency and ensure they’re performing like a well-oiled machine.

Otherwise, “practices may cut the wrong process -- something that will help to maintain revenue,” Waymack says. For example, reducing staff FTEs by eliminating the person who precertifies in-house CTs and MRIs is likely to lead to higher denial rates and ultimately reduce collections.

Don’t overlook physicians as a key driver of the revenue/cost analysis. Compared to other subspecialists in orthopaedic practices of similar size and composition, are your surgeons generating the same volume of services proportionate to their time in the office? Is their compensation equivalent? If not, what’s the best mechanism to improve their productivity? Are physicians performing mundane functions that should be handled by a physician assistant or technician?

“Once you have data, you can drill down and take action,” Waymack says.

New technology, such as an EMR, might be one part of the answer, but staffing improvements -- the addition of a nurse or medical assistant on the clinical side or billing staff on the business side -- often

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pay off more quickly.

"Practices often are under-staffed, not over-staffed," Waymack says. "Many practices believe that their goal is to meet the average, but MGMA data show that best-performing practices staff at a higher level per physician. The biggest asset you have is the physician's time, so whatever enhances that time is worth the investment."

Don't overlook other tools to increase cash flow, she suggests. For example, use an appointment recall service to automate reminders for patients who are due for follow-ups or who previously underwent one hip or knee replacement and may be ready to schedule the other. Only after you're satisfied that you're maximizing patient volume, practice revenues, and operational efficiency should you consider whether to invest in new technology or add ancillary services, Waymack says.

"It's time for most practices to step back, evaluate the health of their business operations, and see what they can do to expand their bottom line without a significant financial outlay," she observes. "Given the tools you have in place and the people you have on staff, what can you do to improve?"

Protect cash through debt management

If your practice already operates using sound business principles, your next challenge is to protect your cash on hand through sound debt management. In light of turmoil in the stock market and the financial industry, all business organizations -- including physician practices -- will be hard-pressed to maintain their lines of credit in the coming months, Ferguson says. Orthopaedic practices that are tapping out their credit lines each month aren't managing debt judiciously.

"A line of credit should be used to cover the cash flow cycle that occurs to meet basic operating expenses, and it should come back down to a zero balance each month," Ferguson explains. "A line of credit isn't meant to fund start-up or development costs."

Orthopaedic practices that have bundled all of their expenses into their line of credit should consider rolling long-term debt into a note and reducing the line of credit to an amount that's sufficient to cover cash flow cycles. In fact, "in today's environment, the bank is probably going to come to you and ask when you expect to see that line of credit come to a zero balance for 20 or 30 days," Ferguson says.

When a practice is increasingly reliant on its

credit line to meet monthly expenses, it's time to examine some key financial indicators. For example, does the draw calculation for owners account for principal payments to lenders?

"After the practice has paid employees and vendors and accounted for these payments in the income statement, the balance sheet needs to account for principal payments," Ferguson explains. "Principal payments normally don't show up on compensation models because they're not an income statement item. But to the degree the owners have developed the practice, invested money, and purchased capital-intensive equipment such as MRIs, they can expect to make a principal payment each month. That amount needs to be removed from the draw calculation so that lenders are paid before the owners."

Banks that are under financial pressure also may ask for accelerated payments on notes payable so long-term debt can be paid down more quickly, Ferguson says. To prevent your bank from making such a move, he advises, meet with the bank proactively discuss your practice's debt structure, and determine what portion could reasonably be rolled into a note payable over a five-year term. A balloon payment at the end of the loan period may seem too large for the practice to absorb, but it's reasonable to expect the group will be able to restructure its long-term debt at that time.

The key is to negotiate a manageable financial arrangement that allows the practice to pay down long-term debt while maintaining a reasonable line of credit to manage cash flow.

"If you don't have a financial plan in place and the bank has problems, it can come to the owners and call the line of credit," Ferguson says. "An orthopaedic group doesn't want to be in that position, so it's better to get your balance sheet in line with the bank's expectations."

With large and small bank failures in the news almost daily, now is also an opportune time for the practice administrator to meet with bank officers to discuss the bank's portfolio and lending philosophy -- especially if that relationship hasn't been developed over time through periodic face-to-face meetings.

"Do some due diligence and ask for their numbers so you can make an assessment about their debt," Ferguson suggests. Ask bank officers about the institution's current foreclosure rate, the one-year trend in foreclosures, its exposure to various equity and debt instruments, and the impact of its holdings on its liquidity. While the Federal Deposit Insurance Corporation covers federally insured

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deposits in the event of a bank failure, a bank that goes belly up could potentially disrupt your cash flow, restrict or eliminate your access to credit, and generally inconvenience your practice.

Right-size your marketing plan

Marketing is another area where orthopaedic practices should avoid making a knee-jerk reaction. "If you cut expenses that actually drive revenue, you'll see a savings on your income statement the next day, but six months down the road you'll realize that you needed that marketing plan," Ferguson says.

Orthopaedic practices are increasingly nervous about the impact of a slowing economy on discretionary and elective surgeries, says **Bill Champion**, president of Orthopaedic Marketing Group in Omaha, NE. In response, some are implementing marketing programs in an effort to drive volume while others are halting their marketing effort altogether. "Rarely does a practice benefit from either of these approaches," Champion says.

In a survey of orthopaedic practices conducted last year by Champion's firm, fewer than 50% acknowledged they had a strategic business plan, "and experience tells me it's more in the range of 25%," he says. Consequently, marketing dollars are rarely tied to a group's business plan or financial goals, and that's a huge tactical mistake.

"Marketing is a long-term strategy," Champion says. "It takes time -- in some cases several years -- to position an orthopaedic practice properly in its market. You can go to the bank and borrow money, but you cannot go out and borrow marketing. So when times are slow, you can't make something happen overnight."

On the other hand, orthopaedic practices with entrenched marketing programs probably have some fat in their budgets, Champion concedes. He cites sponsorships as one ingredient in a marketing program that may produce a meager return on investment.

"It's easy to write a check, but that doesn't mean those funds will drive business," Champion points out. "Practices should look at sponsorships on a line item basis. They should be good community citizens and support certain activities, but they need to be selective."

He advises practices to allocate a portion of their marketing budget to sponsorships either on a flat dollar amount or as a percentage of receipts,

and to focus on relationships that support their business plan. Thus, supporting the local hospital fundraiser might be a productive strategy to drive referrals, but "if you give \$1,000 to a local fun run with 40 other logos on the t-shirt, that's a negative return," Champion says. "You won't get a single patient based on a logo on a t-shirt, and you're not supporting a relationship that's going to consistently send you referrals."

How much to spend on your marketing budget during an economic slowdown is the \$60,000 question, he admits. MGMA survey data indicate that orthopaedic surgeons with earnings in the top quartile spend an average of 1.33% of practice receipts on marketing. Although that's a good benchmark, a marketing budget should be driven largely by the amount of competition in the community and the aggressiveness of the group's objectives, Champion says.

"If you don't have a lot of competition and you don't have big, major initiatives, your marketing budget could be at half a percent," he observes. "But if you're in a very competitive market and you've got new physicians coming on board or you're adding new satellite offices, you're probably looking at closer to 2% or 3%."

Don't forget importance of customer service

Orthopaedic practices that emphasize good customer service and advocacy for patients also can counteract the effects of a recessionary environment. Access is critical when new patients are scarce. If physicians are booking three weeks out, develop a plan to reduce that backlog.

"Find a way to get patients in the door," Champion says. "If your market is hit hard and elective surgeries go down, and if other providers in the market have open slots, find a way to improve access or you're going to lose some of those patients."

Losing one or two patients to another practice might not hurt your bottom line much. But the problem with leakage is that an orthopaedic practice's best referral source is its existing patients. "Once you send a current patient -- who initially chose your practice -- elsewhere because they couldn't get in to see you quickly enough, their friends, co-workers, and family members will also be referred to that other practice," Champion says.

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On top of these factors, patients treated by orthopaedic surgeons are more likely to have their own financial woes during a recession, which may include the loss of a home, job, or business. Personal financial stress increases the likelihood that an unexpected event -- perhaps an infection or complication -- will prompt a patient to seek monetary compensation from the physician even when a surgical outcome is satisfactory, Renzo says.

"The patients for whom orthopaedic surgeons provide services during an economic downturn may actually increase the practice's exposure to liability," he points out.

ARLIS, for Accounts Receivable (A/R) Leveraged Insurance Strategies, is a risk management tool designed to mitigate some of the financial exposure associated with medical malpractice litigation. A/R represents a significant ongoing revenue stream that provides a physician practice with future liquidity for overhead and personal income. When a physician is hit with a jury verdict that exceeds the amount of his or her malpractice insurance coverage or the medical liability carrier is unable to pay, the plaintiff's attorney typically seeks to attach the physician's business and personal assets to settle the judgment. Because A/R represents the cash flow of the practice, it's a prime target.

When that attachment occurs, "every dollar that comes into the practice goes immediately to the judgment's creditor," Renzo explains. "As a result, the practice can't pay its overhead, its creditors, and its bank loans. Basically, this type of judgment squeezes the practice to death."

Use scheme to deter frivolous claims

That's where A/R financing comes in. According to Renzo, here's how it works:

Dr. Smith obtains a favorable business loan equal to 100% of his average one-year A/R collections -- let's say \$2 million. A third-party bank provides the loan at the most competitive interest rates available. As collateral for the loan, the lender files a lien against the practice's assets.

The orthopaedic practice then distributes the loan proceeds to Dr. Smith. As a non-liquidating distribution, which is less than Smith's basis in the practice, no taxable event occurs. Smith invests the loan proceeds in an asset protection vehicle, such as an indexed universal life insurance policy. The funds deposited into the policy grow tax-deferred, with

loan interest paid annually, and the physician uses the proceeds from the loan to pay for the policy.

In the meantime, if a creditor sues the physician successfully and tries to attach a medical malpractice judgment to the practice's A/R, it must first pay off the \$2 million lien to the bank, Renzo explains. "This is a very effective technique to remove low-hanging fruit that might be subject to a frivolous claim, because no plaintiff has the financial capacity to pay off that large note to the third-party bank before collecting the judgment," he says.

In nine of 10 cases, plaintiffs in a medical malpractice suit who are confronted with an A/R financing plan settle for policy limits -- accepting what the liability carrier pays -- or a "diminutive amount above that," Renzo says. In the end, "you preserve the practice and the cash flow." The physician cashes in the policy at retirement and pays off the loan, whose proceeds also can be used to augment the physician's retirement income or create a deferred compensation plan.

Equity stripping augments risk mitigation

Creating an A/R financing plan, also known as equity stripping, is gaining popularity among professional service providers, including physician practices, Renzo says. The technique requires collaboration among a knowledgeable financial planner, tax adviser, attorney, and financial institution.

In today's market, the financial institution is the weakest link. "Fewer banks are in a position today to make these loans compared to a year ago," Renzo concedes. "But keep in mind that, prior to the current credit environment, rates and loan terms were extremely aggressive and weren't necessarily in a client's best interest. Now, rates are low and terms are very client-friendly, with no prepayment or settlement fees."

Equity stripping is only one component of a holistic financial risk mitigation strategy, Renzo insists. Orthopaedic surgeons also should take advantage of homestead protections offered in their state, Renzo says, and make sure their investments are not owned personally but through corporations.

"The primary purpose of accounts receivable financing is to protect in one fell swoop against a variety of medical liability issues," he says. The practice administrator and outside attorneys and/or CPAs also should meet with the group's medical liability carrier to conduct due diligence on its financial strength and its ability to meet its insur-

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ance obligations. Even the hint of a red flag should compel the practice to move its medical liability coverage to another carrier, Renzo says.

A/R financing is no substitute for a comprehensive risk management program that includes physician education and coaching on physician-patient communications. Orthopaedic practice administrators should work with their liability carrier or outside consultants to tailor the risk management program to the subspecialty with the highest exposure, such as spinal surgery, and work down the pecking order from there, Renzo advises. But all surgeons in all subspecialties should understand that, based on the economy, they'll likely provide care to many patients facing significant financial problems. As a result, they may see an increased number of meritless lawsuits.

"Having a risk management program in place -- especially during a downturn in the economy -- can help to mitigate many issues related to miscommunications between physicians and patients, particularly for practices in high-risk specialties such as orthopaedics," Renzo says.

Include personal affairs in risk mitigation

Beyond implementing a strategic internal plan to protect the group's assets from legal judgments, practice administrators also should ensure that surgeons are using qualified advisers to handle their personal affairs. This isn't an invasion of privacy, Renzo says, but a defensive business move for a physician practice.

For example, an orthopaedic surgeon's own financial troubles may seep into the practice if an outside business investment goes sour. A physician who's burning through cash in his or her personal life, facing a foreclosure, or involved in personal litigation related to a bad business deal won't perform at an optimal level in the orthopaedic practice, Renzo points out. Moreover, physicians with large personal financial exposure tend to respond poorly to medical malpractice lawsuits.

"When physicians are unprepared for a lawsuit, their behavior can be somewhat irrational and their judgment can be skewed," Renzo maintains. "When they go into a lawsuit knowing that they have proper documentation and risk management tools, adequate liability coverage in place, and protection for their personal assets, they're more confident."

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CMS raises the stakes for preventing DVT, PE

Beginning with discharges on October 1, 2008, the Centers for Medicare & Medicaid Services (CMS) stopped paying hospitals for additional care resulting from "reasonably preventable" adverse events unless the conditions exist and are properly documented as present on admission (POA). Among the 10 hospital-acquired conditions (HACs) that CMS has targeted are two of major concern for orthopaedic surgeons:

- surgical site infection following certain orthopaedic procedures;
- deep vein thrombosis (DVT) or pulmonary embolism (PE) following total knee or hip replacements. (See the full list of conditions in the box on p. 117.)

In addition to losing CMS reimbursement for these HACs, hospitals are precluded from billing patients for any fees resulting from the preventable errors. And professional fees are on the line too, since Medicare will no longer pay for physician and other services required to treat the 10 categories of HACs, including costs of post-acute care prompted by one of these events.

CMS will still pay to treat the primary diagnosis and other complications, and the rule will not alter payment to physicians who provide that care.

The new policy was mandated by section 5001(c) of the Deficit Reduction Act of 2005, which requires the Secretary of Health and Human Services to identify conditions that "could reasonably have been prevented through the application of evidence-based guidelines." The policy cuts across multiple issues confronting orthopaedic surgery practices, including patient safety, coding, and contracting. To respond proactively, orthopaedic groups need to evaluate their standing orders, develop more rigorous educational policies for surgical patients, and improve communications with hospital staff, sources tell *OPM*.

Private payers follow suit

Private payers already are following CMS's lead and even going beyond the Medicare policy. A growing number of payers are withholding reimbursement not only for the 10 HAC categories but also for an expanded list of 28 so called "never events" that were established in 2002 by the Washington, DC-based

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National Quality Forum (NQF) and served as the framework for the CMS list. In January, Hartford, CT-based Aetna, Inc., and Indianapolis-based WellPoint revealed they would seek to eliminate payment for the NQF's 28 never events as they renew or negotiate contracts with hospitals. Other plans, including some in the nationwide Blue Cross Blue Shield network, subsequently adopted similar policies.

"Medicare is taking on the doctors last, but private payers won't do that," warns **Robin Fisk**, a health law attorney and principal with the Fisk Law Office in Ashland, NH.

"We are all very concerned about these changes," adds **Nina Walker**, CMPE, practice administrator at Raycraft & Jones Orthopaedics in Decatur, IL. "We know that the commercial payers follow CMS, but they certainly aren't wasting any time."

In addition, CMS has encouraged states to coordinate their Medicaid payment policies with Medicare's HAC policy to ensure that public funds don't pay for these preventable adverse events, and several state Medicaid agencies have already complied. On top of these payer initiatives, more than a dozen state hospital associations have established policies concerning the events for which member institutions will voluntarily forego payment from insurers and patients.

Document and follow best practices

True never events are rare, experts agree, and it's not clear how much money they represent in the healthcare system since they've never been systematically tracked on a national basis. In 2006, under its mandatory reporting law, Minnesota facilities reported only 154 adverse health events out of more than eight million patient visits. But CMS maintains that the 10 HACs for which Medicare has stopped paying represented nearly \$22 billion in hospital charges last year -- the vast majority related to pressure ulcers and falls.

And never events take a toll on the bottom line of health care institutions and physician practices in the form of costly lawsuits. The *2008 Hospital Professional Liability and Physician Liability Benchmark Analysis*, released in September by insurer Aon Corporation and the American Society for Healthcare Risk Management, both in Chicago, reveals that never events account for one of six medical malpractice liability claims in the United States.

"The increased awareness surrounding these

nonreimbursable conditions may cause a rise in the frequency of related hospital professional liability claims, not to mention other hospital-acquired conditions not currently addressed by CMS regulations," says **Greg Larcher**, director and actuary of Aon Global Risk Consulting and author of the analysis.

"This initiative is part of Medicare's value-based purchasing system," Fisk says. "CMS is starting with acute-care hospitals and looking to see how they can expand to other types of providers. They're using the stick with the hospitals and the carrot with the physicians, through pay-for-performance initiatives."

But physicians -- who aren't the specific target of these policies -- will likely be drawn into the fray as insurance contracts seek to disallow payment for HACs and never events. Since CMS is linking its denial of payment for HACs to situations where an event was preventable, contracts with private payers should reflect the same set of circumstances, Fisk says.

"If an orthopaedic surgeon has a patient come in other than through the normal course of care and his or her standing prep orders can't be followed, that patient's care has been taken outside his or her control," she points out, noting that physicians should not be denied payment for the care of these patients. "To the extent physicians can document that they've adopted and they're following best practices, they're in the best position to push back against private payers who attempt to disallow payment."

"If it's a nursing care issue -- hospital staff didn't ambulate the patient on schedule, for instance -- that's not the surgeon's fault," agrees **Cynthia L.**

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CMS hospital-acquired conditions that result in nonreimbursement

1. Foreign objects left in the body following surgery
2. Air embolism
3. Blood incompatibility
4. Stage III and stage IV pressure ulcers
5. Falls and trauma that result in fractures, dislocations, brain injury, crushing injuries, burns, and/or electric shock
6. Poor control of blood sugar levels that results in serious complications of diabetes, including diabetic ketoacidosis and hypoglycemic coma
7. Catheter-associated urinary tract infection
8. Vascular catheter-associated infection
9. Surgical site infection following coronary artery bypass graft, bariatric surgery, and orthopaedic procedures of the spine, neck, shoulder, and elbow
10. Deep vein thrombosis or pulmonary embolism following total knee or hip replacement

Source: Centers for Medicare & Medicaid Services

Dunn, RN, FACMPE, senior consultant in the Cocoa Beach, FL, office of the Medical Group Management Association's Health Care Consulting Group.

Examine policies and procedures

To prevent counterproductive finger-pointing, orthopaedic practices should work proactively with hospitals to implement patient safety standards and appropriate thromboembolic prophylaxis protocols for orthopaedic patients, sources tell *OPM*. Dunn advises orthopaedic practices to use an existing tool, such as MGMA's patient safety assessment (www.physiciansafetytool.org), to conduct a baseline assessment of existing treatment protocols for surgical patients.

"Look at your policies and procedures for preparing patients for hip replacements, knee replacements, and scopes," she says. Because each orthopaedic surgeon has a unique practice style, standardizing orders for a variety of surgeries across a group of eight or 10 doctors is a formidable challenge -- one that might require a year or more of spirited discussion. But given today's practice environment, it's not prudent for a practice with eight surgeons to have eight sets of standing orders, Dunn insists.

Orthopaedic surgeons also should work more closely with hospitals to educate patients who will undergo joint replacement surgery.

"Many hospitals offer educational classes about joint replacement surgery," Dunn says. "Practices should go out of their way to ensure that their patients attend those classes so they're prepared for the surgery, the recovery, and the rehab -- the whole experience. Often, orthopaedic surgery practices hand information to patients and tell them the hospital offers a class, but they don't do any follow-up to make sure that patients attend."

Medicare's new rule could tempt orthopaedic surgeons to select patients for hip and knee replacements more cautiously, since patients with certain genetic factors, a history of prior blood clots, obesity, and comorbidities such as diabetes or tobacco use are at heightened risk for DVT or PE. But the quick fix -- shutting the door to Medicare patients, who are most likely to have these higher risk factors -- won't work because some commercial payers have already adopted even more stringent policies.

"It's important for practices to keep up with other payers and see how they're responding to never events," Dunn says. "Many private payers are jumping on this bandwagon, and I think it's a

very short jump from 'We're not going to pay the hospitals' to 'We're not going to pay the surgeons.'

"If surgeons find that they're not going to get paid, at some point they're going to start telling their patients, 'We need your height and weight before we can make an appointment,'" Dunn predicts. "We're not there yet, but I can easily see practices start to move in that direction. How will that affect the care that people need?"

Efforts by payers to reject payment for never events "also make it very unattractive for orthopaedic surgeons to take patients from the ER," Dunn acknowledges. "With all of the new present-on-admission codes, nursing has to do a very good assessment before a surgeon accepts a patient. Otherwise, an elderly person who fell and broke a hip could have a [urinary tract infection] the surgeon knows nothing about, yet the surgeon could be penalized for that."

Work with hospital on surgical protocols

Both physicians and hospitals are eager to prevent HACs, but communication between the two often is lacking. Regular conversations between the clinical nurse manager on the hospital's orthopaedic unit and a designated member of the practice staff, such as a nurse practitioner or physician assistant, can help to close these communication gaps. Working with the hospital to develop a mechanism so practices are alerted when an orthopaedic-related HAC occurs is another good strategy. Ultimately, practices need to work collaboratively with local hospitals to identify and fix systemic shortcomings that could lead to preventable adverse events.

"I've worked with surgeons who've encountered problems with infection in the OR that no one bothered to share with them until their patient was affected," Dunn says.

"Through the practice administrator or CEO, physicians need to have some kind of communication with the hospital to share information about never events," she adds. "What's happening on the orthopaedic floor? What happens when orthopaedic patients are moved to a step-down unit? Physicians want to help as much as they can, but they're often unaware of issues that are occurring on the hospital floor. They'll need to pay much better attention to these."

Orthopaedic practices also need to work with hospitals -- and, in some cases, practices in other specialties -- to ensure that pre- and post-op protocols are conducive to orthopaedic patients and follow appro-

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priate clinical guidelines, says **Mary O'Brien**, MBA, CMPE, CEO of Fox Valley Orthopaedic Institute in Geneva, IL. For example, her orthopaedic surgeons are being asked by hospitals to use enoxaparin (Lovenox) as a DVT prophylaxis -- a protocol established mainly by cardiothoracic surgeons.

"If a patient has a history of blood clots following surgery, an orthopaedic surgeon might use a combination of Lovenox, Coumadin (warfarin), and a screen to prevent the formation of clots during a total joint replacement," O'Brien points out. "But if a patient has no family history and no predisposing conditions, the surgeon might choose a more conservative protocol."

Even when warfarin is appropriate for an orthopaedic patient, the orthopaedic surgeons at Raycraft & Jones choose an international normalized ratio (INR) of 1.7 to 2.1 -- a more conservative approach than internal medicine and other physicians typically use, says **Julie A. Maley**, the practice's CNP. The practice's electronic medical record includes a warfarin flow sheet from the hospital system that physicians can check with the click of a button. The flow sheet graphs the patient's INR and dose over a specified time period, "so that information is always documented," Maley explains.

Carefully document preexisting conditions

When they round, orthopaedic surgeons also have greater responsibility to ensure that their orders have been followed. In the past, surgeons might have been annoyed if a patient didn't receive TED hose after surgery or didn't use the deep breathing machine, but they rarely bothered to learn why those breakdowns in orders occurred, Dunn says. Physicians now have a bigger incentive to ensure that hospitals don't drop the ball, potentially resulting in a patient with a PE or DVT.

Orthopaedic surgeons also must carefully document preexisting conditions, such as infection at a surgery site or indication of pressure ulcers, before patients are admitted. Hospital staff will rely on these notes to validate that the preventable adverse conditions were not hospital-acquired.

In fact, coding issues and the definition of "reasonably preventable" conditions have been a challenge for CMS in the early weeks

since the HAC policy took effect. CMS is tracking whether Medicare patients experienced an HAC by using a present-on-admission indicator for each principal diagnosis and other diagnoses codes reported on UB-04 and 837 institutional claim forms. CMS is reimbursing diagnoses on the HAC list that are correctly coded as present or clinically undetermined at the time of inpatient admission. But payment is being withheld for HACs that are coded as not present on admission, that are insufficiently documented on admission, or that are unreported.

'A blunt instrument'

"Medicare is using a blunt instrument," Fisk says. "Generally speaking, if a code is missing indicating that a condition was present on admission, they're denying payment to the facility. The policy is less strict against the doctors, so physicians have more room to negotiate the conditions under which they accept responsibility for these events."

Orthopaedic surgeons should insist on being consulted before a hospital develops any public policy with respect to billing for never events. Such statements could be misleading to patients and expose physicians to lost revenue.

"If you're talking about a piece of equipment left in a patient during surgery, that's one thing," O'Brien says. "But if a patient who is hospitalized for some other reason falls in the hospital and

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Use AHRQ resources to help develop DVT, PE policies

In addition to clinical guidelines developed by professional societies such as the American Academy of Orthopaedic Surgeons, a new guide developed by researchers at the Agency for Healthcare Research and Quality (AHRQ) in Rockville, MD, may help orthopaedic practices examine and tweak prevention policies with respect to deep vein thrombosis (DVT) and pulmonary embolism (PE).

The clinician guide, *Preventing Hospital Acquired Venous Thromboembolism: A Guide for Effective Quality Improvement*, is based on quality improvement initiatives undertaken at the University of California-San Diego Medical Center and Emory University Hospitals in Atlanta. The guide is designed to assist quality improvement practitioners in leading efforts to improve prevention of hospital-acquired venous thromboembolism.

"Deep vein thrombosis -- collectively referred to as venous thromboembolism -- is the most common preventable cause of hospital death," the researchers write. "Pharmacologic methods to prevent venous thromboembolism are safe, effective, cost-effective, and advocated by authoritative guidelines, yet large prospective studies continue to demonstrate that these preventive methods are significantly underused."

The free guide is available at <http://www.ahrq.gov/qual/vtguide/>. ♦

breaks a hip, is the orthopaedic surgeon supposed to come in and take care of that hip without charging anything?

"Then there's the liability issue," she adds. "If the patient hears that the hospital won't get paid by Medicare and isn't going to charge the patient, there's going to be a pipeline to the lawyers."

In fact, implementation of Medicare's HAC policy represents an opportune time for orthopaedic practices to talk with their malpractice carriers and state medical societies to learn what, if any impact, orthopaedic surgeons are feeling from heightened scrutiny of never events and what strategies might mitigate their risk.

Most HACs and never events result from a combination of system and human errors, including changing technologies, poor communications, inadequate staffing, and insufficient documentation. There's no quick and easy fix to these problems. And sometimes, even with the best preventive and clinical care, an orthopaedic patient still can develop an infection, PE, or DVT in the hospital, sources agree. Therein lies the rub.

"How far will this go?" Fisk asks. "Will these policies remain restricted to truly heinous events that should never occur? Or will this give insurers another excuse to get involved in medical decision-making and punish providers by not paying them at all?"

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