After attending our recent board meeting and listening to the variety of legal, public policy and business challenges facing orthopaedic surgeons, one of our former TOA presidents said, “I am glad that I am retired. I can’t imagine dealing with all of these challenges.”

For those of us in orthopaedic practice, our TOA membership is now more critical than ever. As you have seen in our email newsletters and magazines, TOA is involved in dozens of public policy and socio-economic issues at both the state and national levels. Our board members and staff work to represent Texas orthopaedic surgeons on many fronts.

At no other time in America’s history has the health care system been under such threat. Whether it is from the political failures of Obamacare, the greed of the insurance industry or stringent governmental hyper-regulation, American medicine is under assault. Patient access to traditional excellent orthopaedic care is in jeopardy. If orthopaedic surgeons do not participate in public policy processes, our opponents will take advantage of our issues and redefine them in their own terms. It is critical that we all support the only organization in Texas that is dedicated to preserving the delivery of orthopaedic care in the state – TOA.

The continued pursuit of scope of practice expansion by allied health providers is one of TOA’s agenda items. As you will read in this publication, TOA has been actively working on issues concerning physical therapists who want direct access to patients and podiatrists who believe that they have authority under state statues to operate above the foot. Our patients will suffer if orthopaedic surgeons allow legislators and policy makers to re-define medical qualifications. Providers without qualified training should not be able to perform surgery nor should they diagnose patients’ medical conditions.

I hope that you find our newsletters and the upcoming 2014 TOA Annual Meeting to be useful to you. These efforts highlight the outstanding advocacy work that TOA does on behalf of Texas orthopaedic surgeons. In 2014, our annual meeting will be held in San Antonio. The Westin Riverwalk Hotel is an ideal location for our academic and social activities. April 10-12, 2014 will be a special time in San Antonio. This year’s meeting has been planned to coincide with some of the early activities of Fiesta San Antonio. Please plan to bring your family to San Antonio to enjoy one of the best events that Texas and TOA can offer.

Our meeting co-chairmen, Joel Jenne, MD and Matt Morrey, MD, have assembled an outstanding panel of speakers that will include Drs. Rockwood, Morrey Sr., Parsons, Yaszemski, Dickson, and many others. Our topics will include current concepts in shoulder management, a young hip symposium, a trauma symposium, a sports medicine symposium and many other subjects of current interest. Also, we have planned an outstanding resident education program and the lively competition of the resident Quiz Bowl. We look forward to seeing you in San Antonio in April 2014. Plan to enjoy one of the best orthopaedic meeting experiences ever.

I thank you for your membership and contributions to our outstanding Texas state orthopaedic society. As a member-driven organization, the Texas Orthopaedic Association values the support of all Texas orthopaedic surgeons.

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**Want to stay connected with orthopaedic news and events in Texas?** Subscribe to our bi-monthly e-mail newsletter, eConnect. Contact Bhillert@toa.org if you are not receiving it.
Over the last several years, there has been an increase in the number of hospitals employing physicians and more and more physicians are starting to wonder whether they should join the crowd and become employed by a hospital or health system. According to the Medical Group Management Association, more than 50 percent of physicians are now employed by organizations affiliated with health systems, and in some specialties, the number is much higher.

The reasons health systems may employ physicians can vary, however common reasons may include shoring up potential referral bases, improving quality, clinical integration and care coordination, and better positioning the hospital for recent payment reform provisions that have eroded the current fee-for-service payment system for quality-based payments. Physicians often find hospital employment attractive because of declining reimbursement rates, higher costs and administrative burdens of operating a private practice, and because such arrangements can potentially create a more stable working environment.

What considerations should a physician ponder as he or she decides whether to become employed by a hospital or health system? This article will attempt to answer that question, both from the perspective of an individual physician considering employment by a hospital or health system and from a physician group considering being acquired by a hospital or health system. We will discuss how the employment relationship will likely be structured, covenants not to compete, potential compensation and other questions physicians should ask prior to becoming employed by a hospital.

Due to the prohibition on the corporate practice of medicine in Texas, the employment of physicians in Texas by a hospital is almost always through a non-profit health organization (also referred to as a 5.01(a)) that is certified by the Texas Medical Board. Non-profit health organizations (“NPHOs”) are organized as nonprofit corporations, and must be incorporated and directed by physicians licensed by the Texas Medical Board who are actively engaged in the practice of medicine. The administrative side of the NPHO may be handled by non-physician officers, but all medical decisions and the overall medical policies of the organization must be made by physicians. A NPHO may be owned by non-physicians if all statutory requirements are met with regard to the NPHO’s formation and operations, however physicians still make all medical decisions. Because physicians can maintain their independence with regard to their medical decisions, but allow a hospital or other non-physician to assume the administrative duties of the organization, some physicians find employment by a NPHO attractive.

Most often, physicians who are employed by NPHOs enter into employment agreements with the NPHO. These employment agreements often look like any other physician employment agreement between a physician and an independent group practice. Careful consideration should be given by physicians to certain key provisions of these agreements, including compensation provisions, and any non-competition, insurance and indemnification provisions.

With regard to non-competition provisions, in Texas, a covenant not to compete is enforceable if it is ancillary to or part of an otherwise enforceable agreement at the time the agreement is made, and any limitations as to time, geographical area, and scope of activity to be restrained are reasonable and do not impose a greater restraint than is necessary to protect the goodwill or other business interest of the employer. In addition to the above requirements, in order for a covenant not to compete to be enforceable against a physician, the covenant must (A) not deny the physician access to a list of his or her patients whom the physician had seen or treated within one year of termination of the contract or employment; (B) provide access to medical records of the physician’s patients upon authorization of the patient and any copies of medical records for a reasonable fee as established by the Texas Medical Board; and (C) provide that any access to a list of patients or to patients’ medical records after termination of the contract or employment shall not require such list or records to be provided in a format different than that by which such records are maintained except by mutual consent of the parties to the contract. Additionally, in order to be enforceable against a physician, the covenant must provide for a buy-out of the covenant by the physician at a reasonable price or, at the option of either party, as determined by a mutually agreed upon arbitrator or, in the case of an inability to agree, an arbitrator of the court whose decision shall be binding on the parties; and the covenant must provide that the physician will not be prohibited from providing continuing care and treatment to a specific patient or patients during the course of an acute illness even after the contract or employment has been terminated. It should be noted that these latter requirements do not apply to a covenant not to compete related to a physician’s business ownership interest in a licensed hospital or licensed ambulatory surgical center.

If there is a non-competition provision in a proposed employment agreement, physicians should negotiate key portions of the provision, such as the scope of the non-compete, the length of time the non-compete will be in place, the geographical restriction and the amount of the buy-out. Competent legal counsel can assist with this negotiation.

With regard to compensation, once employed by a hospital, the type of compensation under physician employment agreements can vary greatly. Nearly all physicians employed by hospitals receive some...
sort of productivity-based compensation. Additionally, physicians employed by hospitals may see that their compensation is also based, in part, on quality metrics that normally would not be the basis of their compensation in a private practice. This is due to some federal programs that penalize hospitals for poor quality, such as the Value-Based Purchasing Program, the Hospital Acquired Conditions Reduction Program, and the Hospital Readmissions Reduction Program.

With regard to productivity-based compensation, often the compensation is based on Relative Value Units (RVUs). RVUs reflect the relative level of time, skill, training and intensity required of a physician to provide a given service. A RVU-based compensation structure can vary greatly, both within a practice and among different specialties, and can be quite confusing. Physicians considering employment by a hospital must understand the compensation structure completely prior to becoming employed.

Other compensation structures may be based upon performance and offer performance “bonuses” upon meeting certain thresholds. A performance-based structure often takes into account the gross revenue received and gives the physician a bonus or calculates the compensation based upon the gross revenue attributable to the physician’s services less particular expenses.

No matter the compensation structure, due care should be followed that the employment relationship meets the Bona Fide Employment Relationship Exception to the Stark Law and the Employment Safe Harbor to the Anti-Kickback Statute.

Hospital Acquisitions of Physician Group Practices

Often, health systems will purchase a practice prior to employing a physician. This trend is driven by healthcare reform, reimbursement pressures, physician shortages and capital constraints. Purchasing a physician practice can be complex and involve significant risk, both from a business and a regulatory perspective. Physicians considering selling their practices should consult qualified health law counsel to assist the physician in carefully considering regulatory hurdles, valuation, pricing, escrows and indemnities. Any amount paid by a health system should be consistent with fair market value and should not be based on the volume or value of referrals the physicians can bring to the hospital or health system. A valuation company is one option parties can utilize in determining fair market value. Once a physician practice is sold and a physician becomes employed by a hospital or health system, the physician will have the same considerations outlined above for employment of physicians.

Initial Evaluation Show Rate

The initial evaluation show rate is the percentage of patients referred for therapy that show for their initial evaluation. This rate is tracked and reported separately from the follow-up visit show rate and should be 92 percent or higher. An initial evaluation show rate that is less than 92 percent may be due to scheduling patients for therapy more than 2 or 3 days after the physician’s order. If new patients cannot be scheduled for a week or more, the initial evaluation show rate will likely be significantly lower than 92 percent. For each initial evaluation no show, you lose not only the initial evaluation visit, but also all the follow-up visits for that patient.

Summary

Becoming employed by a hospital can be a big decision for a physician. Prior to taking the leap, physicians should talk to their colleagues who are currently employed by the hospital (especially those physicians who came from private practice) to determine their level of happiness with hospital employment. A physician should determine, to the extent possible, exactly how their day to day practice of medicine will change. Some key questions to answer may be:

- Will there be a new electronic health record?
- Will your staff, who know your preferences, be able to come with you?
- Do you understand how you will be paid?
- How do you terminate your employment if it does not work out and where can you practice if you terminate?

Physicians should also carefully review their proposed employment agreements and fully understand the compensation structure, any non-competition provisions and other key provisions such as professional liability insurance and indemnification provisions. A competent health care attorney can explain these provisions and also assist a physician in negotiating his or her agreement.

About the authors: Josh Weaver and Ashley Johnston are health care attorneys who advise doctors, hospitals, surgery centers and other health care providers on day-to-day operational and regulatory matters, including physician group practice acquisitions and physician employment arrangements. Both Ashley and Josh are Board Certified in Health Law by the Texas Board of Legal Specialization. Josh can be reached at (214)661-5514 and his e-mail address is jweaver@polsinelli.com. Ashley can be reached at (469)320-6061 and her e-mail address is ajohnston@lrmlaw.com.

This material is provided for informational purposes only. The material provided herein is general and is not intended to be legal advice. Nothing herein should be relied upon or used without consulting a lawyer to consider your specific circumstances, possible changes to applicable laws, rules and regulations and other legal issues. Receipt of this material does not establish an attorney-client relationship.
Q: How did you choose your fellowship at the Southern California Orthopaedic Institute?

A: With so many residents going on to fellowships these days, we’re fortunate to have a lot of good programs to choose from. Within the subspecialty of sports medicine, programs have a variety of focuses that fit the interests of different trainees - from high profile team coverage, to research, to clinical training and surgical skills. I was attracted to SCOI because of their focus on clinical and surgical training. Also, for me, a program like SCOI that includes substantial hip and ankle arthroscopy training (in addition to knee and shoulder) is a good compliment to my residency experience. And if we were going to leave Texas for a year, southern California is not a bad place to live.

Q: What is your plan when your fellowship concludes?

A: We’re hoping to make it back to central Texas next summer.

Q: We hear a lot about the issue of physicians becoming “employed.” How have you and your colleagues from your residency program approached the issue of being independent or being employed?

A: With the recent and anticipated future changes in healthcare, the solo or small group private practice model has become less appealing and those of us in training recognize that. I consider hospital/institutional employment to be a safer alternative in the short run, with relatively predictable lifestyle, attractive initial offers, and insulation from the effects of healthcare reform. But in the long run, a lot of us worry about things like loss of autonomy, declining compensation, etc. For the time being, I still see a lot of upside to large private practice entities, like big single specialty ortho groups and multispecialty groups.

In my limited experience, when it comes to searching for a job, the process seems to differ depending on what model you’re looking for. There are a good number of employed opportunities advertised or offered by physician recruiters. The good private practice opportunities, on the other hand, are a little harder to find and require a more personal approach with networking through mentors, surgeons in the community, friends, reps, etc. This difference could be a reflection of the trend toward hospital employment.

Q: As somebody who is about to enter your orthopaedic career, how do you view the future of orthopaedics?

A: I try to stay positive, but sometimes it’s not easy. At 17% of our GDP in recent years, our country’s rise in healthcare spending over the past few decades is clearly unsustainable. I don’t know what to expect any more than the next guy, but a couple of things are almost certain: regulatory burdens will continue to increase and compensation for procedures (in real dollars) will continue to decline – both aimed at reversing the persistent rise in healthcare spending.

With this in mind the future may seem bleak, but I think that those of us finishing our training now still have reason to be optimistic – especially those of us from Texas, where we benefit from tort reform, a strong economy, and rapid population growth. As orthopedic surgeons, we’re fortunate to practice in what I consider the best specialty in medicine. We offer tremendous value to our patients as individuals and to society at large. We have exceptionally strong advocacy groups like the TOA locally and the AAOS on a national level, led by intelligent, highly capable surgeon advocates. Finally, rapid changes like those affecting healthcare right now bring not only difficulties, but also opportunities for those willing to seek them out.

Q: What will you specialize in it and how did you choose it?

A: I really had fun with almost every subspecialty in residency and I have tremendous respect for the general orthopedist. As the body of orthopedic knowledge and complexity of our surgical procedures increase, I think that subspecialization is a practical way to maintain a high level of proficiency in a particular area. I was attracted to sports medicine because of the minimally invasive nature of the procedures – which is the direction we’re headed with all surgical specialties - and the opportunity to work with motivated athletes. I also like the fact that arthroscopic techniques are constantly evolving, and the opportunities for innovation that come along with that.
**Q:** Why were you involved with the Texas Orthopaedic Association during your residency?

**A:** The TOA makes it easy for residents to get involved – offering free membership, free admission to the annual meeting, and even a socioeconomic meeting with a series of speakers recruited to educate residents on business aspects of orthopedic practice. Attending TOA events is also a good opportunity to meet residents from other programs and surgeons in the community.

I also think that we have an obligation to be involved in organized medicine to look out for the interests of our patients and our profession, particularly at a time like this. The TOA welcomes clinician involvement in advocacy, even during residency. For example, Bobby Hillert let me tag along at the capitol one day during the legislative session this spring to speak with lawmakers and get an idea of what goes on behind the scenes. I’m looking forward to being involved with the TOA again when we get back to Texas.

Matthew Driscoll, MD, who is currently serving his fellowship at the Southern California Orthopaedic Institute in Los Angeles, was one of the most active residents within TOA. During his residency at Scott & White Memorial Hospital from 2008 to 2013, Dr. Driscoll competed in several TOA quiz bowls, presented papers, and even lobbied lawmakers at the Capitol with TOA.

The Dallas native finished at the top of his class at the University of Texas at Austin’s Business Honors Program and then graduated medical school from Baylor College of Medicine in Houston. He has plans to return to Texas after his fellowship concludes.

**TOA Member News (continued)**

**Kyle Dickson, MD Nominated as Third Vice-President**

The TOA Board of Directors confirmed the TOA Nominations Committee’s choice of Kyle Dickson, MD as TOA’s Third Vice-President. He will assume the presidency in April 2016.

Dr. Dickson is part of the Southwest Orthopaedic Group in Houston. He was formerly a Professor and Chairman of Orthopaedic Surgery at the University of Texas Medical School at Houston. His education, extensive training and many years of experience uniquely qualify him to treat complex orthopaedic trauma and orthopaedic reconstructions. Dr. Dickson was a Regent’s Scholar at the University of California, San Diego School of Medicine where he received his medical degree. He completed his orthopedic residency at the University of California, San Francisco, followed by a fellowship in Trauma and Pelvic and Acetabular surgery at the University of Southern California. Dr. Dickson went on to complete an AO trauma fellowship in the trauma centers of Hanover, Augsburg, and Bern. He became a Tenured Professor of Orthopaedics at Tulane University. He received an M.B.A. from Tulane’s Freeman School of Business. Dr. Dickson is board certified by the American Board of Orthopaedic Surgery and was a past President of both the New Orleans Orthopaedic Society and the Houston Orthopaedic Society. In the field of Orthopaedic Trauma and Complex Reconstructions, Dr. Dickson has published numerous peer reviewed papers, written many textbook chapters, and given lectures all around the world.

**Future TOA Presidents**

Marc DeHart, MD of Texas Orthopedics in Austin is slated to assume TOA’s presidency in April 2014. Howard Epps, MD of Texas Children’s Hospital in Houston will become TOA’s president the following year.

**New Committee Members**

TOA is pleased to announce that a number of orthopaedic surgeons who have recently completed fellowships are now serving on TOA committees. If you would like to participate in TOA committees, please contact TOA.
5+ million square feet of healthcare space master planned or designed by Kirksey Healthcare
Texas Orthopaedic Association’s 2014 Annual Meeting

April 10-12, 2014 | San Antonio
Westin Riverwalk

Exploring the Future of Orthopaedics in a Changing Health Care Environment

- Learn about the latest clinical, legal, and business issues and trends within orthopaedics.
- Outstanding information for orthopaedic surgeons, sports medicine physicians, physician assistants, and orthopaedic staff.
- Situated in the heart of Downtown San Antonio, the Westin Riverwalk is a great facility for your entire family.

Five sessions that will cover the latest issues and trends affecting orthopaedics:

- All-day ICD-10 seminar for physicians and their staff (Thursday, April 10).
- A look at new payment models and how they will impact our future reimbursement: ACOs, bundled payments, gain-sharing, and other global payment models.
- Total joint presentation by the new AAHKS president, Brian Parsley, MD.
- Young Hip Symposium.
- Total joint presentation by the new AAHKS president, Brian Parsley, MD.
- Shoulder Overuse Symposium.
- Total joint presentation by the new AAHKS president, Brian Parsley, MD.
- Sports Medicine Symposium, which will include both clinical and legal information for sports team coverage.
- A look at the future of independent practices and hospital employment.
- Legal seminar on physician employment contracts and Stark/anti-kickback issues.
- Special session for orthopaedic staff on Friday, April 11.
- New resident session on the afternoon of Saturday, April 12. Outstanding networking opportunities.
- New physician extender course on Thursday, April 10 for physician assistants, nurse practitioners, and other providers interested in orthopaedics.
- Much more to be announced soon.

Confirmed faculty (as of October 3, 2013):

- Kyle Dickson, MD – 2014 LeRoy C. Abbott Visiting Professor at the University of California, San Francisco
- Warren Kadrmas, MD – United States Air Force, San Antonio, TX
- Bernard Morrey, MD – Mayo Clinic
- Brian Parsley, MD – 2014-2015 AAHKS President
- Theodore W. Parsons, MD – Henry Ford Hospital
- Casey Tober, MD – The San Antonio Orthopaedic Group
- Michael Yaszemski, MD – Mayo Clinic
- Michael Zucker – Senior VP & Chief Development Officer for Baptist Health System (San Antonio), which led some of Medicare’s first new payment model initiatives.
- More to be announced soon.

For hotel reservations and more information, please visit www.toa.org.
**Upcoming Meetings**

**Upcoming TOA Events:**
**Visit www.toa.org for more details**

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**December 1 Abstract Submission Deadline**

TOA will be accepting abstract submissions for the 2014 Annual Meeting until December 1, 2013. Please visit our Web site (www.toa.org) to submit an online form.

This year, paper presentations by residents and other orthopaedic surgeons will occur on the morning of Saturday, April 12. Prizes will be presented to the top papers.

**Make Plans to Join Us at the Westin Riverwalk Today**

We are pleased to hold the 2014 Annual Meeting at the San Antonio Westin Riverwalk. As an added bonus, there is a strong possibility that San Antonio officials will move up Fiesta San Antonio to the weekend of April 11th, which is when we will be holding our conference.

There is no better place to experience Fiesta than in the middle of the festival at the Westin Riverwalk. Our incredible conference rate of $219 will expire on March 10. Please reserve your room today because our allotment will sell out quickly.

You can make reservations online by visiting our Web site (www.toa.org) or calling the San Antonio Westin Riverwalk at 210.224.6500 and asking for the “Texas Orthopaedic Association” rate.

**All-Day ICD-10 Seminar for Physicians & Staff: April 10**

TOA is pleased to offer an all-day ICD-10 seminar for TOA members and their staff on Thursday, April 10. This low-cost CME event will be presented by Karen Zupko and Associates and will provide you with all of the information necessary to prepare for the ICD-10 changes.

Please make plans to join us on April 10th. A low-cost fee and registration details will be announced in January.

**Courses for Your Orthopaedic Staff: April 11**

Once again, TOA will present courses for TOA orthopaedic administrators and staff on Friday, April 11. The day-long event will look at socioeconomic and legal issues that face orthopaedic practices.

Mark your calendar to join us. More details will be announced soon.

**New Physician Extender Course Announced: April 10**

Several physician assistants have contacted TOA with a desire to become more involved within the organization. As a result, TOA will be holding a physician extender course during the 2014 Annual Meeting on Thursday, April 10 in San Antonio.

More details will be announced soon. If you would have an interest in serving as the a course faculty member, please contact TOA.

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**ICD-10 Events**

**ICD-10 Orthopaedic-Style with Margie Scalley Vaught**

*Wednesday, November 20, 2013 | 12:00 p.m. - 2:00 p.m. CST*

*$35 cost per attendee. Visit www.toa.org for registration*

Margie Scalley Vaught, one of the most popular speakers in the orthopaedic coding world, will present this two-hour course.

**T-Bones Fall Meeting for Administrators**

*November 7-8, 2013 | Hyatt Lost Pines Bastrop*

This annual event is a great way for orthopaedic administrators to network with their colleagues and learn more about the latest business and legal issues impacting orthopaedics.

**Physician Employment & Stark/Anti-Kickback Legal Seminar**

*November 13, 2013 | 6 p.m.-7 p.m.*

**Polsinelli Office | 2501 N. Harwood, Suite 1900 Dallas, Texas 75201**

**RSVP required - visit www.toa.org to register**

Attorneys Josh Weaver of Polsinelli and Ashley Johnston of Looper, Reed & McGraw will provide TOA members and their staff with a free legal seminar concerning the latest legal issues surrounding employment contracts and Stark/anti-kickback considerations.

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**Texas Orthopaedic Association**
Physical Therapists Continue Pursuing Direct Access to Patients Without a Diagnosis

The Texas Physical Therapy Association (TPTA) is preparing to make a strong push for direct access to Texas patients in the 2015 Texas Legislature. The TOA Board of Directors recently sat down with TPTA officials to listen to TPTA’s reasoning for expanded access to patients.

Background

Over a decade ago, the state’s physical therapy statute was amended to allow physical therapists to evaluate a patient and allow a patient to return to a physical therapist within a specific time period if a physical therapy script had already been signed off on by an approved provider.

In 2009 and 2011, TPTA pushed legislative initiatives that would have allowed all physical therapists (whether they have a graduate degree or not) to have direct access to patients for an unlimited time period. TPTA then pushed legislation (HB 1309) in 2013 that would have allowed direct access for physical therapists for doctorates for a time period limited to 20 sessions or 45 calendar days.

Ultimately, TOA led a coalition that included the Texas Medical Association, Texas Academy of Family Physicians, Texas Pediatric Society, Texas Association of Health Plans, and other medical specialty societies to oppose the 2013 measure. TOA argued that it would be irresponsible to allow physical therapy direct access if a medical diagnosis is not in place.

HB 1039 from the 2013 Legislature was voted out of the House Public Health Committee. Three lawmakers opposed HB 1039: Sarah Davis (R-Houston), Nicole Collier (D-Fort Worth), and JD Sheffield, DO (R-Gatesville). Meanwhile, the measure to expand direct access for physical therapy was supported in committee by: Chair Lois Kolkhorst (R-Brenham), Jodie Laubenberg (R-Murphy), Susan King (R-Abilene), Phil Cortez (D-San Antonio), Bill Zedler (R-Arlington), and Bobby Guerra (D-McAllen). Ultimately, the bill died after leaving the House committee.

Legislation Moving Forward

We are expecting the physical therapists to push hard for expanded direct access in 2015. The TOA Board of Directors has expressed strong concerns with the expanded direct access concept and questioned how it would actually increase the quality of health care in Texas.

The two greatest concerns include:

- If physical therapists are not able to diagnose a condition, how will they be able to know what they are treating?
- A physician has completed medical school, a residency, a fellowship, and other training. How will a physical therapist with a doctorate and one year of practice experience be able to replace the physician’s training?

We will continue updating you on this and other important issues that involve the musculoskeletal health of Texans. Please continue reading the eConnects and other TOA communications for more information.

Abilene Court Delivers Ruling on Podiatry Ankle Case

In early October, a Texas district court granted the Texas Podiatric Medical Association and two podiatrists an interlocutory judgment on the scope of podiatry at an Abilene hospital. The bigger question in the case involves whether or not Henrick Medical Center could drop privileges for certain procedures, which involved podiatrists operating on the ankle.

Keep in mind that an interlocutory judgement is temporary and cannot be appealed. Because it is temporary, the judge can change his mind at any time. At the moment, we do not have a strong understanding of the judge’s temporary ruling because trial judges (unlike appellate judges) do not necessarily have to explain their ruling.

We will have more information on this case and what it means in one of our upcoming e-mail newsletters. If you do not receive a copy of our e-mail newsletter, please subscribe by visiting our Web site or e-mailing Bobby@toa.org.

The procedures that were in question and granted to the podiatrists in the interlocutory judgment include:

1. Ankle fusion
2. Pantalar fusion
3. Open reduction – internal fixation (ORIF) of ankle fracture to treat unstable talus
4. Ankle arthroscopy to treat talus
5. Tibial/fibular osteotomy to treat talus
6. Calcaneal osteotomy
7. Cuneiform osteotomy with bone graft
8. Gastrocnemius recession
9. Tendo-Achilles lengthening
10. Detachment and re-attachment of Achilles tendon with resection of posterior calcaneal exostosis
11. Lector hallucis tendon transfer
12. Tibialis posterior tendon transfer
13. Decompression posterior tibial nerve
Uncertainty Surrounding the New Exchanges Remains

While enrollment in the Affordable Care Act’s exchange has been up and running for over a month, much uncertainty remains for providers.

A Smaller Network of Providers?

Since the ACA’s passage several years, many analysts have speculated that the exchange will result in “narrow” networks of providers to keep costs low. At the moment, we are not sure if this has happened. It is difficult for providers to determine whether or not health plans have placed them on the new exchange plans.

While there has been a lot of confusion surrounding which providers will be in the exchange networks, it does appear that existing BCBS of Texas in-network providers are part of BCBS of Texas’ Gold Plan. However, the Silver and Bronze plans appear to be HMO networks.

The Texas Tribune recently analyzed the concern:

“Many insurance companies participating in the marketplace have created health plans with provider networks based on existing contracts with physicians and hospitals, and did not contact those providers to sign new contracts or ask if they were willing to participate in the new health plans, according to the associations. As a result, many providers do not know which of the health plans offered in the marketplace will pay them for services.

[The Texas Medical Association’s Lee Spangler] explained that many physicians sign contracts that allow insurance companies to include the physician in the provider network for any of their health plans. Often, the insurer is not required to notify the physician which of the health plan networks include the physician.”

In other states, we are witnessing exchange plans in which a number of providers have been excluded. Seattle Children’s Hospital has filed a lawsuit claiming that most exchange plans are excluding the provider from most exchange plans’ networks.

Ninety-Day Grace Period “Short Coverage Gaps”

Orthopaedic societies in Texas and other states are concerned about the 90-day grace period spelled out in the exchange plans. If an enrollee fails to pay their premiums with the 90-day period, health plans are required to give them a grace period (“short coverage gap” in which individuals will not be subject to the individual mandate).

However, it will be unclear to providers if the patients have been paying their premiums. As a result, it may be up to the provider to pursue any co-pays from the patients if they failed to pay their premium.

The Basic Health Plan

This exchange plan is for uninsured individuals whose income falls between 133 and 200 percent of the federal poverty level. This is the plan in which we are likely to see much more limited networks of providers in the coming years.

While a patient under the Basic Health Plan may present with an insurance card of a large health plan, the health plan’s logo will not necessarily mean that the provider network in the Basic Health Plan will be the same as the insurance carrier’s typical network.

Some Unanswered Questions

We are watching the following questions, which have led to confusion in the health care industry:

- Can providers (physician-owned hospitals, physicians, etc.) that do not take federal patients (Medicare and Medicaid) work with patients who are in the exchanges? Some in the health care industry have asked that questions.
- Will reimbursement be a blend of Medicare/Medicaid rates or a separate fee structure?
- Will reimbursement and patient liability/out-of-pocket depend on exchange tier (Bronze, Silver, Gold)?
- Will coordination of benefits be applied if the patient has other health insurance coverage? For example, will the exchange be the last payer of resort (similar to Medicaid)?
- Will a patient be allowed to apply retroactively for an exchange plan? For example, an admission date of January 5, 2014 if the patient is uninsured and does not qualify for Medicaid or any other entitlement program. Can the patient then apply for coverage retroactive to January 1, 2013 with the help or a hospital or other provider?
- Is the exchange plan making a payment to the provider directly or is it being subsidized by the federal government? For example, Novitas, which is the Medicare contract in Texas, administers the claims. However, the funds are coming from CMS.
- How often will exchange eligibility rosters be updated and who will be responsible for it?
- Will this be an HMO-based plan or will the applicant be allowed to select POS, PPO-type of plans? We believe that one plan’s basic plan for low-income patients will not allow...
patients to go out-of-network (the network will be very small). This could be a problem for orthopaedic surgeons taking emergency call when patients think that they have a large network of providers because they have a card with a well-known plan.

- How often can a member switch exchange plans.
- Will the exchange plans use a re-pricing company to adjudicate claims or handle it internally?

We will continue updating you on this and other important issues that involve the musculoskeletal health of Texans. Please continue reading the eConnects and other TOA communications for more information.

The Early Exchange

October 2013 data supplied by the Texas Department of Insurance (TDI) indicates:

- Out of 254 Texas counties, 74 counties will have one carrier and 18 plan options.
- The Central Texas counties of Williamson, Hays, and Travis will have the most options in the marketplace with seven carriers offering 80 different plans.
- Harris County residents will have 42 plan options offered by six carriers.

The carriers represent several traditional plans, a couple hospital system offerings, and a traditional Medicaid plans. A number of plans are on the sidelines waiting to see if they would like to participate in the future. In the broader market, 19 carriers have filed rates for new 2014 products.

Q: What kind of network access do Texans have through Blue Cross and Blue Shield of Texas products offered on the Health Insurance Marketplace?

A: We are proud to say that Blue Cross and Blue Shield of Texas is offering products on the Health Insurance Marketplace that will serve all 254 counties in the state. In an effort to offer a broad portfolio of products to meet the diverse needs of potentially new customers, we chose to create new, lower cost products that will be available both on and off the marketplace. Our goal is to expand access to cost-effective health care to as many people as possible in every part of the state. Those who choose Blue Cross and Blue Shield of Texas will also have added benefit of quality customer service from the company that ranked highest in member satisfaction for three consecutive years according to the J.D. Power 2013 Member Health Plan Study.

Q: With so much uncertainty surrounding the health insurance marketplace, why did Blue Cross and Blue Shield of Texas put so much effort into participating in the marketplace?

A: To put it simply, we believe offering products on and off the Health Insurance Marketplace is the right thing to do. Expanding access to high quality, cost-effective coverage is part of our mission. We’ve been committed to serving Texans for more than 80 years, and the Health Insurance Marketplace is yet another avenue for us to prove this commitment.

Q: Do you all have any projections that you all can share showing what percentage of Texans do you all think will eventually receive their health insurance coverage through the new marketplace?

A: While we can’t speculate on how many Texans may eventually receive their health insurance coverage through the Health Insurance Marketplace, we do know that 2.5 million Texans will be eligible for tax credits and financial assistance through the marketplace.

A: In March, BCBSTX launched the “Be Covered Texas” – a non-branded, grassroots education and outreach initiative. It works with Texas’ uninsured residents as they begin to understand how the new health care law impacts them. Since its inception, Be Covered Texas has been partnering with organizations including community groups, direct service agencies, advocacy groups and churches. The initiative has provided more than 140 partners with access to educational tools in both English and Spanish.
You may have started to see a decrease in your reimbursement for many of the most common shoulder procedures, especially when performing arthroscopic procedures. As of Jan 1, 2013 the Correct Coding Initiative (CCI) updated their guidelines in Chapter 4 and it now reads:

“22. CMS considers the shoulder joint to be a single anatomic structure. An NCCI procedure to procedure edit code pair consisting of two codes describing two shoulder joint procedures should never be bypassed with an NCCI-associated modifier when performed on the ipsilateral shoulder joint. This type of edit may be bypassed only if the two procedures are performed on contralateral joints.”

This means that if the CPT codes you are wanting to report hit up against a given CCI edit you can’t use modifier 59 to bypass unless it is the other shoulder. They key is knowing which codes are impacted and which of your payers/carriers following the CCI guidelines.

The majority of the issues deal with the arthroscopic debridement codes 29822 and 29823 when also performing an arthroscopic Mumford (29824) or arthroscopic RCR (29827). Even if you are debriding unrelated structures, such as the labrum or the biceps or performing a chondroplasty.

But the edits don’t just affect the shoulder arthroscopy procedures it also affects the open shoulder procedures. The most common is total shoulder arthroplasty (23472) and biceps tenodesis (23430) and as of Jan 2013, CCI says you can’t report 23430 as it is considered bundled into 23472 and they won’t allow modifier 59 to bypass unless opposite shoulder.

To help clarify this here are some examples:

Surgeon does 29827, 29828, 29824, 29822 and 29826 - per CCI you should only report 29827, 29828, 29824 and 29826 as 29822 is bundled into 29827 and 29824 and CCI states you should not append modifier 59 unless it is the other shoulder.

Surgeon does 29824, 29822 and 29826 - per CCI you should only report 29824 and 29826 for the same reason of 29822 being bundled.

Surgeon performs 29822 and 29826 - per CCI you should report both as there are no bundling issues.

Surgeon does 23472 (total shoulder) and 23430 (biceps tenodesis) - per AAOS they state you can bill, but per NCCI they are bundled and now they are saying modifier 59 should not be appended. So again issues of who follows NCCI edits and guidelines. Per NCCI you should just report 23472

Surgeon does 23120 and 23130 - Acromioplasty and Mumford open - per NCCI there are no bundling issues so both codes can be reported.

In checking with CCI they have stated if there are more comments asking for changing of these edits then they will look into it further. If you would like to voice your opinion with supporting documentation showing that anatomically they should not be bundled together (i.e., Mumford and debriding the humeral head) you can contact them at:

National Correct Coding Initiative
Correct Coding Solutions, LLC
P.O. Box 907
Carmel, IN 46082-0907
Fax: 317-571-1745

All articles in Connect that mention the Texas Orthopaedic Association’s stance on state legislation are defined as “legislative advertising” according to the Texas Government Code. As a result, the law requires the disclosure of the name and address of the individual who contracted with a printer to publish the legislative advertising:

Bobby Hillert, Executive Director,
Texas Orthopaedic Association,
401 W. 15th, Suite 820 | Austin, Texas 78701
Contact Bhillert@toa.org if you are not receiving it.
In General

Q: What is Functional Limitations Reporting (FLR)?

A: In 2012, Congress passed a law requiring CMS to implement a claims-based data collection system for outpatient therapy services, including PT, OT, and SLP, to collect information on patient function during the course of therapy in order to better understand patient conditions, outcomes, and expenditures.

Patient functional information is reported using non-payable functional G-codes and severity/complexity modifiers reporting the patient’s functional status at the outset of therapy, including projected goal status, at specified points during treatment and at the time of discharge.

Q: What types of providers are subject to FLR?

A: TReporting applies to Part B outpatient PT, OT, and SLP provided by:
- Private offices of therapists, physicians and non-physician practitioners
- Hospitals
- Home health agencies
- Skilled nursing facilities
- CORFs, rehabilitation agencies

Q: Does FLR apply if Medicare is primary or secondary?

A: WFLR applies in either case

Q: Does FLR apply to Medicare Advantage patients?

A: ICMS has stated that FLR does not apply to Medicare Advantage patients; however, plans can impose reporting requirements by contract/policy

G-Codes and Modifiers

Q: What are the function-related G-codes?

A: There are 42 functional G-codes, 14 sets of three codes each. However, only six of the G-code sets are generally for PT and OT functional limitations.

The following G-codes are for functional limitations typically seen in patients receiving PT or OT services. The first four of the sets describe categories of functional limitations and the final two sets describe “other” functional limitations, which are used for functional limitations not described by one of the first four categories.

Q: What are the severity/complexity modifiers that must be used with the functional G-codes?

A: If a patient’s functional limitations are not defined by one of the other four categories, or
- If therapy is not intended to treat a functional limitation (e.g., lymphedema, wound care), or
- If a patient’s composite score from an assessment tool is used and does not clearly fall into one of the four categories

Q: Can you report more than one functional limitation at a time?

A: No, providers are not allowed to report more than one functional limitation at a time. You should report on the patient’s primary functional limitation that is the most clinically relevant functional limitation at the time of the initial evaluation and establishment of the plan of care (POC). You should use the G-code that best describes the functional limitation that is primary to the POC.

Q: When do you use the “Other PT/OT Subsequent Functional Limitation” G-codes?

A: If treatment continues after the primary treatment goal is achieved and reporting ended on the primary functional limitation, reporting will be required for another functional limitation. If you need to report on a second condition after reporting on the first has ended, use the G-code set for “other subsequent” functional limitation (G8993, G8994, G8995).

Frequency

Q: When do you need to report?

A: When an initial evaluation or reevaluation (97001-97004) is furnished and billed:
- At least once every 10 treatment days, which corresponds with the progress reporting period; however, if you complete a progress report sooner than the 10th visit, the next reporting period begins with the following visit, not the 10th visit;
- At the time of discharge from the therapy episode of care – (i.e., on the date services related to the discharge report are furnished); however, no discharge reporting is required if therapy is discontinued by the patient prior to the planned discharge visit (i.e., therapy ends without the planned discharge taking place); or
- At the time reporting is begun for a new or different functional limitation within the same episode of care (i.e., after the reporting of the prior functional limitation is ended)

Q: Has the timing for progress reports changed to coincide with FLR?

A: Yes, CMS modified its rules to establish the same timing requirement for progress reports effective 1/1/13, so progress reports are now re-
**Practice Issues**

Required every 10 treatment days. However, keep in mind that your state PT or OT Act may have a different progress reporting requirement. For example, if your PT Act requires a progress report every 30 days, then you will need to do a progress report at the lesser of every 30 days or every 10 visits to comply with both your PT Act and Medicare requirements. If you need to do a progress report at the 7th visit because this is when you meet the 30-day requirement, you will need to report the FLR G-codes and modifiers on or before visit 17 because that is 10 visits after visit 7.

**Q:** Do you need to report if you are only doing a custom splint and not billing any therapy code?

**A:** No, you do not need to report if you are only providing a splint.

**Q:** How do you report the functional information when you provide an evaluation only and determine that the patient does not need further therapy services?

**A:** For one-time visits, you report all three G-codes for the functional limitation being evaluated, along with the corresponding severity modifiers for each.

**Q:** How do you report an evaluative procedure when it is for a different functional limitation than you are currently reporting?

**A:** You should report the evaluative procedure furnished for a second/different functional limitation other than the primary functional limitation for which ongoing reporting is occurring as a one-time visit (i.e., report all three G-codes in the code set for the functional limitation that matches the evaluation). Your ongoing reporting of the primary functional limitation is not affected by the reporting of this one-time visit. However, the G-codes and modifiers for this one-time visit cannot be reported on the same day as ongoing reporting.

**Q:** How do you report functional information when the patient has two plans of care from two different physicians for separate conditions?

**A:** Assuming the same provider submits the claim for services under both POCs, only one functional limitation can be reported at a time per discipline. You will need to decide which POC functional reporting is most appropriate. Treatment days for both conditions are counted towards the reporting frequency – counting each treatment day towards the total number of days the patient received services under both POCs. When services are received on the same date of service under both POCs, this counts as one treatment day.

**Q:** Do you need to report for each discipline?

**A:** Yes. If, for example, a patient is receiving both PT and OT, the providers will need to report G-codes and modifiers for both PT and OT.

**Q:** Can therapists use any of the G-code sets or are they limited to those corresponding to their discipline?

**A:** The G-code sets are not discipline specific. The G-code set that best describes the functional limitation being treated should be used, regardless of the provider’s discipline.

**Q:** If improvement is expected to be limited, can current function and goal be reported using the same modifier?

**A:** Yes.

### Reporting on Second/Subsequent Functional Limitations

**Q:** Can you document the G-codes and modifiers for the second functional limitation? Do you need to report if you are only doing therapy for the second limitation or is it just for evaluation?

**A:** Yes, you need to end reporting on the first functional limitation when a new functional limitation develops, e.g. a new condition, before reporting on the second functional limitation.

**Q:** Can you document the G-codes and modifiers for the second functional limitation by reporting the appropriate goal and discharge status codes before reporting on a second functional limitation can begin.

**A:** Yes, you need to end reporting on the first functional limitation by reporting the appropriate goal and discharge status codes before reporting on a second functional limitation can begin. Discharge reporting applies in all situations, except when the patient unexpectedly does not return to therapy and discharge information is not available.

### Assessment Tools

**Q:** Does CMS recommend any assessment tools?

**A:** Yes, CMS recommends any of the following four tools:

- Patient Inquiry by Focus On Therapeutic Outcomes, Inc. (FOTO)
- OPTIMAL by Cedaron through the American Physical Therapy Association
- National Outcomes Measurement System (NOMS) by the American Speech-Language Hearing Association
- Activity Measure – Post Acute Care (AMPAC)
**Practice Issues (continued)**

**Q:** Are you required to use an assessment tool?  
**A:** No. CMS is not requiring the use of a particular functional assessment tool or even the use of any tool to determine the severity/complexity modifier. When assessment tools are not used, CMS requires the use of objective measures to document functional status.

**Q:** What do you need to do if you use a functional assessment tool where 100 means no disability and zero (0) means totally disabled to obtain the severity modifier? Can you directly crosswalk the score from the tool to the CMS severity modifier scale?  
**A:** You will need to convert the score from the “wellness” scale, a scale in which 100 means no disability, to the CMS “disability” scale in which zero (0) means no disability. For example, if a patient scored 60 (out of 100) where 100% means no disability), this score converts to a 40 on a scale where 100% means totally disabled. To make this conversion, the wellness score of 60 is subtracted from 100 to yield a score of 40 on the disability scale.

**Q:** Should you report the “other” PT/OT G-codes when using a functional assessment tool that yields a “composite” score?  
**A:** A PT/OT categorical G-code set should be reported when it best describes the functional limitation being treated – even though the assessment tool used surveyed the patient’s overall functional abilities, such as the ability to carry out his/her daily routine and other quality of life measures. There may be times, however, that the “other” PT/OT G-code sets will be appropriate, especially when the patient’s functional limitation is not described by one of the four categories of functional limitations or the patient is not being treated for a functional limitation.

**Documentation**

**Q:** Do providers need to note the FLR G-codes and modifiers in the patient’s medical record?  
**A:** Yes. CMS expects individual therapists to continue to document objective measures (range of motion, strength, special screening or functional tests) and to develop objective and measurable impairment and functional goals as part of the treatment plan.

**Billing/Claims Submission**

**Q:** What needs to be added to the claims?  
**A:** For each visit that requires FLR G-codes, the claim form should include a line that includes each reportable FLR G-code, the associated severity modifier, the corresponding GP or G0 modifier, DOS and nominal charge.

**Q:** Should you include a charge on the G-code line?  
**A:** Yes. A charge of $0 or $.01 should be added.

**Q:** What if the claim is for an amount above the therapy cap and qualifies for an exception to the cap?  
**A:** The KX modifier should be included on the line with the CPT codes that result in charges above the cap, not on the FLR line.

**Q:** Does the -59 modifier go on the G-code line?  
**A:** No.

**Q:** Do claims for dates of service that do not require FLR G-codes need to include a code, modifier or any other signal that reporting is not required?  
**A:** No.

**Q:** Does the “units” field need to be completed for the functional G-code line of service?  
**A:** Yes. The “units” field is required to be completed. Use “1” to complete the "units" field.

**Q:** Do the FLR G-codes and other lines need to be in any specific order?  
**A:** No. G-codes and other information can be listed on the claim in any order.

**Q:** Are there any other claim requirements?  
**A:** No. Except for the addition of the G-codes and modifiers as noted above, the FLR rules do not modify requirements for the submission of therapy claims.

**Effective Date**

**Q:** What is the effective date for reporting?  
**A:** From January 1-June 30, 2013, CMS permitted a testing period when providers did not receive denials for missing G-codes (but might have received remittance messages requesting codes).

For dates of service on and after 7/1/13, providers must report to be paid.

**Q:** If you have been submitting FLR data during the testing period, do you just continue or do you need to do something different?  
**A:** If you have been submitting FLR data during the testing period, you can continue reporting and will not need to restart reporting on the first date of service on or after July 1, 2013 for episodes of care for which reporting began during the testing period. You just continue reporting on and after July 1, 2013 at the next regularly scheduled reporting visit.

**Q:** If you have not been reporting prior to July 1, 2013, when do you need to report for a patient that began treatment before July 1?  
**A:** If a patient started treatment prior to July 1 and you did not report for that patient, you will need to report current functional status and goal for the first visit on or after July 1, every 10th visit thereafter and at discharge. In this case, you should complete the required FLR assessment and a progress note so that you can assign the proper G-codes and modifiers for the first visit on or after July 1, but you should not do a re-evaluation unless medically necessary for non-FLR purposes.

**Sources**

Medicare Claims Processing Manual, Ch 5, Section 10.6-Functional Reporting.


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