

Orthopaedic

PRACTICE MANAGEMENT

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◆ **CODING SPOTLIGHT: Use the right codes for these confusing cases.** Various CPT coding rules, complex anatomy, and frequent changes to codes and definitions often confuse coders in orthopaedics, says Cynthia L. Dunn, RN, FACMPE, Cocoa Beach, FL-based senior consultant for the MGMA Health Care Consulting Group. She cites these examples that can stymie coding staff, and offers the correct codes for each p. 13

◆ **NCQA Back Pain Recognition Program designed to standardize care.** Orthopaedists are among the specialty physicians who have felt the heat from payers, including the Centers for Medicare & Medicaid Services, about potential overuse of studies and procedures -- especially MRIs, CT scans, and X-rays -- to treat back pain and other conditions. Now, the National Committee for Quality Assurance in Washington, DC, thinks it has built a better mousetrap to promote a standardized level of care for patients with low back pain p. 14

Practices share their data analysis strategies

Put orthopaedics benchmarking data to good use in your practice

Findings from the Medical Group Management Association's (MGMA) most recent *Cost Survey for Orthopedic Practices: 2007 Report Based on 2006 Data* show that orthopaedic group practices continue to battle rising costs that are outpacing increases in gross charges and revenues. The report and others like it offer a treasure trove of data, but practice executives say they have little real-world value unless you use them to benchmark your group's performance and use the results of that process to reveal problem areas and improve operations.

The report from Englewood, CO-based MGMA, based on 102 responses, reveals that orthopaedic practices saw median operating costs per FTE physician rise by 2.4%, to \$516,359, in 2006 while revenues per FTE physician increased by 2.2%, to

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Build a proactive marketing plan for your practice

Orthopaedic practices have some terrific options for marketing their services to build volume and generate incremental revenues -- often without major increases to their existing capacity. But, like many other businesses, they often put the cart before the horse by establishing bottom-line objectives before evaluating the market's needs, says **Bill Champion**, president of Orthopaedic Marketing Group, Omaha, NE.

For example, practices often tell Champion that they want to increase volume by 5% and increase total receipts by 7% -- in essence, not only seeking to drive volume but also attract patients for higher-paying services. When Champion examines the market, however, he may find that PCPs are simply looking for greater accessibility from orthopaedic practices. Under these circumstances, you could waste every penny thrown at an ill-equipped marketing campaign.

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Use these tactics to lower your medical liability premiums

Medical liability insurance rates have stabilized nationwide, with nearly 84% of company-reported rates holding steady or declining in 2007, according to the *Medical Liability Monitor* survey, the largest of its kind to track how much insurance carriers charge physicians.

Despite a slight respite from soaring liability premiums, orthopaedic groups still can take some steps to reduce their exposure and, correspondingly, their premiums, according to **John B. Davis, MBA**, president of Goshen, CT-based Medical Practice Consulting. Here's how:

- **Learn which of your state's insurers favors the orthopaedics specialty.** In most states, physicians have a choice of only two or three liability carriers, so they have little negotiating leverage.

However, each tends to favor different specialties due to fewer claims and lower indemnity payments for those specialties during the previous few years. In Connecticut, for example, Connecticut Medical Insurance Company has offered orthopaedists the lowest rates in recent years, Davis says. The differences between the highest and lowest cost insurers in a given state could be as much as 30%, he adds.

- **Be proactive with insurers and ask for loss-free credits.** If your practice has been claim-free for several years, use that positive history to shop your business around and ask for loss-free credits.

"Most insurance companies have a formula -- for example, a percentage point for every year that each doctor has not had a claim," Davis says. In a practice where none of the doctors has had a claim for multiple years, the savings can be significant, "but the medical group only gets as razor-sharp service as it demands."

- **In a larger practice, consider self-insuring.** A practice of five to 10 physicians is too small to accept the risk involved in self-insurance, but a larger single- or multispecialty group should check out risk retention groups -- corporations or limited liability associations owned by their members that spread the risk and results among members. The Liability Risk Retention Act in 1986 allows risk retention groups to be licensed in one state but to operate in every state. RRGs only insure third-party liability coverage.

A captive insurance company operated by the local health system might be another option for reducing liability insurance costs. Captives are wholly owned insurance subsidiaries of organizations that insure all or part of the risks of the parent company. Many health care systems have started captives to gain more control over the millions of dollars in premiums they pay annually. Typically, these programs self-insure against lower-dollar claims and purchase reinsurance to protect from catastrophic claims. More are opening their doors to physician practices in the community. The downside is that such arrangements often represent a one-way street, Davis cautions.

If something goes awry in your relationship with the local hospital, "the concern is that traditional insurers won't want you back."

- **Attend the risk management seminars offered by your liability insurer for physicians, office staff, or both.** The seminars usually cover topics such as the quality of the medical record when faced with a potential claim, strategies for responding to requests for medical records, and the use of interpersonal skills to placate patients and families. Often, insurers offer premium discounts of 1% to 3% when physicians from a practice attend these seminars.

- **Ask your insurer to audit your practice.** Let them visit your office, look around, and advise you

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on your registration paperwork and practices, including HIPAA compliance, Davis suggests. Allow them to pull some random charts and advise you on the thoroughness and accuracy of the medical records. During these audits, insurance reps also will help you to remedy any potentially dangerous conditions in the office. These visits, which might occur every two or three years, are worth another 2% to 3% discount off your premium.

• **Seek pro-rated premiums for part-time providers.** If you have a semi-retired physician who performs or assists with orthopaedic surgery several days a week, for instance, check with your broker or insurer about a pro-rated premium. One of Davis's clients actually snared a \$10,000 refund when he demonstrated to the insurer that the group had overpaid premiums for its part-time physician over several years.

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Case study: Make your merger a win-win for doctors, patients

In May 2007, Tri-Rivers Surgical Associates, Inc., an eight-physician orthopaedic practice based in Pittsburgh, PA, merged with a three-physician physical medicine and rehabilitation (PM&R) group, consummating a long relationship between the two practices that, so far, has been a marriage made in heaven. Not only do the two groups of physicians offer complementary services, but their personalities and work ethics are closely in sync as well. Examining both the clinical implications and relationship issues was key to making the decision to buy rather than build, says **D. Kelly Agnew, MD**, the practice's managing partner.

"We knew from years of dealing with this group the hours they like to work and the patient volumes they like to see," he explains. "Knowing them as well as we did made the transition easier than I would have expected."

"We had known this practice for years and referred back and forth," agrees **Judith H. Esman, MD**, one of the PM&R physicians. "We certainly had a comfort level with the doctors in the group and the way their practice functions, and our work was interrelated."

Tri-Rivers already offered a full array of orthopaedic surgery services across four offices. The practice could have sought to hire physical medicine physicians coming out of fellowships. However, a merger with colleagues to whom the group had referred patients -- even family members -- for nearly a dozen years seemed like a natural fit.

Nevertheless, the practice conducted due diligence prior to the merger, running the numbers almost weekly from the time discussions began the fall of 2006. Serious negotiations began after a month of data gathering and number crunching.

"The mathematical work came internally from our CEO and our internal finance office," Agnew recalls. "Externally, we used our corporate attorney and an external corporate accountant to nail down the differences and make projections."

To avoid overloading its staff, systems, and physical plant, Tri Rivers needed to ensure that its existing practice structure could support the additional physician and patient load. Fortunately, the practice had recently added an office and possessed substantial space to accommodate additional physicians and staff as well as higher patient volume. Its information management and billing and collection systems also had more than sufficient capacity to handle the additional workload.

"All of those building blocks were in place," Agnew says.

"We realized we needed to be smart about how we expand, given the forces in the marketplace, adds **Robyn L. Beckwith, MBA**, Tri Rivers Surgical Associates' CEO. "We had built our space a little bigger with the intent of growing into it, but we looked at what kind of growth would allow us to position ourselves intelligently in the market."

Like any merger, the most critical piece was the honest exchange of information, Agnew adds.

"Our physical medicine friends were open and forthcoming about information involving their practice, their patient mix, the codes they saw, and their financial data for the preceding four or five

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years," he says. "That allowed us to look deeply at synergies -- opportunities to capitalize on economies of scale."

Keeping more revenue in the system

Tri Rivers examined the smaller practice's clinical service line, which includes electrodiagnostic testing, spinal injections, and nonoperative treatment of many conditions commonly seen at the orthopaedic surgeons' office, such as chronic pain management. "Having the opportunity to briskly refer nonoperative patients instead of having them out in 'waiting land' for a nonoperative care provider" was a key element of the merger, Agnew says.

"We don't have a spinal surgeon in our practice and we didn't have a doctor who focuses on back pain, yet we have a substantial patient base who would want to see our physicians for back pain issues," Beckwith adds. "Bringing the physical medicine physicians onboard allowed us to address that need, to retain a patient population that previously we would have referred, and to keep that revenue in the system."

By the end of 2006, the two groups had reached a decision to merge and began developing a plan to close the old practice and assimilate the three physicians and their patients into Tri Rivers. The merger also needed to address dozens of practical issues: adding the PM&R physicians into Tri Rivers' marketing program, forwarding phone calls, informing payers, ordering additional supplies, and managing the rollover of PM&R group's retirement funds while assimilating them into the practice's 401(k) retirement plan.

"We put our management team in a room and they developed a checklist of items that needed to be addressed," Beckwith says, noting that implementation took place over six months.

By all accounts, the integration was remarkably smooth. The practice plugged the PM&R physicians directly into its information management system, which had extra scheduling and billing capacity. Since these physicians were dissolving their old practice, they finished billing under their old practice and were simply added to the billing system at Tri Rivers on the day they began practicing there, Beckwith explains. Some of Tri Rivers' billing staff had experience handling physical medicine, which eased the transition. The practice also hired a transcriptionist to handle increases in volume and used

independent contractors to assist with work in the medical-legal arena.

"We did a master staffing plan, because we had a hand specialist coming on at the same time," Beckwith says. "We added to our clinical staff, but that was not solely to support the PM&R physicians."

Two of the PM&R group's four staff had been offered positions at Tri Rivers but decided to seek other opportunities, Beckwith says. The existing Tri Rivers staff quickly embraced the new physicians, and new hires brought into the practice to support the physical medicine specialists adapted easily to the corporate culture.

Tri Rivers also developed a marketing campaign to introduce the PM&R physicians to the community and referring PCPs. In addition, the practice integrated the new doctors into existing marketing pieces, including a newsletter to referral offices, community advertising programs, and its web site. Beckwith combined Yellow Pages listings for the two practices, enabling Tri Rivers to take more ad space for the same money.

Collections expected to grow 30%

The results have met or exceeded the expectations of physicians from both practices. For instance, prior to the merger the physical medicine docs ran their own information management system, used their own administrative support team, and did their own injections at an ambulatory surgical center.

"We were able to take them in under our umbrella so that our information management system run by our internal IT director can manage all of their needs," Agnew says. "Our scheduling, billing, and collections staff were able to absorb their work, with some small additions on our side. And we were able to construct a fluoroscopy suite in one of our newest offices to allow our invasive physical medicine partner to do his injections on-site, capturing the fluoroscopic revenue. All of that gives them an opportunity to improve their financial outlook while doing the same volume of work and enjoying the economies offered by a much larger practice."

Typically, a physiatrist's office work is more time-consuming than that of an orthopaedic surgeon's, Esman says. Still, she's seen a noticeable improvement in efficiency. In her old practice, patients were scheduled about every 30 minutes except for independent medical exams and electromyography, which required longer appointments.

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On an average day, she might see 12 patients. Now, she often sees 20.

With the opening of the fluoroscopy suite in January 2008, gross collections for the PM&R physicians are expected to grow 30% this year. Much of that increase is tied to Tri Rivers' ability to provide clinical staff who improve the practice efficiencies of the physical medicine specialists. Projections suggest that injection collections alone will exceed a 150% increase, thanks to the addition of facility fees and the in-house fluoroscopy suite.

The physical medicine specialists also are on track to increase Tri Rivers' overall practice revenues by 14% -- slightly ahead of expectations. In addition to significant revenues from the fluoroscopic injections, the practice is now able to capture additional X-ray revenue. With the addition of hand and upper extremity specialists, Beckwith expects the practice's electromyography business to grow, since all that work will go directly to the physical medicine physicians. And the practice recently hired a CRNT to work exclusively with the physical medicine physicians.

"Staff involvement in our previous day-to-day operations was pretty minimal," Esman says. "Our office staff would put people in exam rooms, and we took care of everything else -- writing prescriptions, taking care of telephone messages, filling out forms for worker's comp and other requests. One of the appealing things about a large practice that employed more than 100 people was the opportunity to have more support for our clinical work. We now have orthopaedic technicians practicing alongside us -- helping to write prescriptions and making arrangements for tests and therapies -- so we can focus on the clinical services that only physicians can do."

And even though the surgeons had always referred patients with physical medicine problems to the three-physician group, "we suspected that many of the patients weren't getting there," Beckwith says. "For whatever reason, they would choose not to make the appointment or go somewhere else. Once we brought the physicians on board, we didn't lose those patients anymore. They were able to go to the front desk right after their appointment with one of our orthopaedic surgeons and make an appointment with the physical medicine doctors."

'Stick with people you know'

As expected, a few hitches occurred along the way. For the first few months, the paper charting

system used by the PM&R physicians wasn't integrated into the computerized medical record used by Tri Rivers. New patients were automatically entered into the computer, but information about existing patients couldn't be retrieved electronically. Until the paper records could be entered into the computer, there were delays in pulling those charts.

Tri Rivers also underestimated the volume of patients the PM&R physicians would generate, both from its existing caseload and new referrals.

"We sent staff to spend time with the PM&R physicians before they came here," Beckwith recalls. "We had their financial records, so we knew what to expect in billing. But the volume of phone calls overwhelmed us initially.

"Some of their patients have chronic pain issues, and they require more intensive support than what we were used to in orthopaedics," she adds. "You can plan and plan and plan, but until you turn on the phones you can't fully anticipate every need."

"Our old patients were accustomed to a much smaller practice that was more personal," Esman adds. "Some of them didn't quite know how to negotiate our new practice. There are a lot more people who answer the phones, for instance, and the patients didn't know them." Nevertheless, most of the PM&R group's established patients made the transition, and the doctors are seeing many new patients as well.

Agnew advises other orthopaedic practices that might be considering a merger or acquisition to "stick with people you know if you're going outside the specialty you know."

"If I'm hiring a young orthopaedic surgeon, I know the answers I want to hear during an interview and the behaviors I'd want to see in practice and reflected in the letters of reference," he explains. "Quite frankly, when you go outside your own specialty, you get into no-man's land. As a surgeon, I might not be able to find nonsurgical partners who behave just like I do or like I want my young surgical partners to behave."

Due to the nature of their practice, for example, nonsurgical orthopaedic specialists often work slightly fewer hours and see fewer patients during the average work week, Agnew says. "But if you start with people you know and trust, whose work is of the highest quality, you can get beyond any hurdles of specialty difference."

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\$1.15 million. Growth in operating costs over the same period actually slowed from previous years, to 2.5%. Nevertheless, operating costs for orthopedic groups have risen a startling 14.6%, or about 4.6% annually, since 2003, while medical revenue has merely kept pace.

“Practices have to work harder to seek opportunities for change and improvement,” says **Cynthia L. Dunn, RN, FACMPE**, Cocoa Beach, FL-based senior consultant for the MGMA Health Care Consulting Group. “Benchmarking is the key.”

Dunn cites total days in A/R, percentage of A/R over 90 days, and net collection percentage rate as key indicators for orthopaedic practices. **Figure 1** illustrates these measures from MGMA’s survey by practice size. Percentiles are calculated by ranking values from smallest to largest, so the 10th percentile illustrates the 90% of values above that particular value. Thus, when looking at costs and A/R, the 10th percentile exhibits better performers. MGMA also provides breakouts by geographic region and ambulatory surgery center (ASC) ownership.

Robin L. Kretchmar, FACMPE, practice administrator for Northern Rockies Orthopaedics in Missoula, MT, and 2007 president of MGMA’s Orthopaedic Practice Assembly, benchmarks against best practices in these measures every year. Due to the vagaries of individual practices, it makes sense

to use external benchmarks that are “qualified and quantified,” Kretchmar explains. “I don’t think benchmarking yourself against some of your colleagues is a fair standard for your own practice. You need to look at data from an organization that has quantified the results and removed the outliers.”

Identify key indicators to benchmark

Kretchmar compares her five-physician practice on regional cost benchmarks since Missoula has a higher-than-average cost of living. “Holding the line on costs has been a struggle, especially with declining reimbursement,” Kretchmar admits.

She advises practices just getting started in benchmarking to identify a few key indicators, such as billed charges, days in A/R, and patient mix -- new, established, and surgical. “These give you great insight on potential gaps in your practice,” Kretchmar says.

Dale A. Reigle, CEO of Rocky Mountain Orthopaedic Associates in Grand Junction, CO, also emphasizes the need to assess performance against local benchmarks. “There are huge differences in what payers will do in different areas,” he says.

Reigle tracks the practice’s A/R and collection rates -- “the areas where you can see the biggest return for your effort, especially early on,” he says -- but he eliminates write-offs from the data to prevent skewing comparisons.

“We do the primary trauma call for our local hospital, so we get auto accidents that are in litigation for up to two years,” he explains. “I’ll keep that in my A/R, whereas other groups may have rules to write off anything over 150 days. For practices like ours that have a lot of trauma or litigation-related services and a huge amount in that final A/R category, this approach makes more sense when comparing external benchmarks to see whether or not we’re doing a good job collecting from insurance companies.”

Reigle then develops dashboard indicators that he shares monthly with physicians so they’re abreast of the practice’s financial performance. (See **Figure 2** on page 7.) He takes the dashboards a step beyond the MGMA benchmarks, breaking out the source of A/R by category, such as self-pay, commercial carriers, worker’s comp, and other third-party liability.

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Figure 1: Key Performance Indicators for Orthopaedic Practices

	Six FTE Physicians or Fewer (n=47)				
	10th %tile	25th %tile	Median	75th %tile	90th %tile
90+ days in A/R*	9.94%	15.81%	22.09%	30.62%	53.90%
Total days in A/R	30.91	39.61	47.68	61.66	80.27
Gross FFS collection %	34.79%	37.69%	43.48%	51.37%	59.90%
	7-12 FTE Physicians (n=24)				
	10th %tile	25th %tile	Median	75th %tile	90th %tile
90+ days in A/R*	6.32%	13.30%	22.50%	31.37%	46.75%
Total days in A/R	33.64	37.72	46.10	51.21	64.68
Gross FFS collection %	33.55%	36.35%	41.66%	48.60%	55.99%
	13 FTE Physicians or More (n=24)				
	10th %tile	25th %tile	Median	75th %tile	90th %tile
90+ days in A/R*	12.76%	16.51%	24.08%	29.84%	35.71%
Total days in A/R	27.90	38.89	50.24	55.21	64.35
Gross FFS collection %	26.90%	34.06%	40.64%	45.40%	63.83%

*Note: Data for 90+ days in A/R calculated by adding MGMA values for 91-120 days and 120+ days in A/R.

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“In Colorado, we now have a prompt pay law, so insurance companies are required to pay within 30 days if we file electronically,” he says. “As a result, our insurance carrier A/R has dropped dramatically, but we’ve found that a lot of the self-pay and third-party liability have gone up.”

Use internal benchmarks to spot trends

In addition to examining external benchmarks, practices should benchmark against themselves, Dunn advises.

“More than ever, it’s time to focus on right-sizing your orthopaedics practice,” she explains. “That doesn’t necessarily mean letting people go, but you need to look carefully at opportunities to improve. How can you generate additional income? Are you capturing all of your charges and revenue opportunities? If you have an electronic medical record or a document management solution, is your staff using

them? Look at the processes and work flow in your practice -- how you intake a patient, load the information, and receive payment for those charges.”

Kretchmar benchmarks her A/R internally and reviews the results with her physicians each month. She examines the percentage of A/R, by physician, that is current and at 30, 60, 90, 120, and 150 days. (See **Figure 3** on page 8.) Next, she compares individual physician A/R against the entire clinic, using a simple pie chart that each physician can understand at a glance. (See example in **Figure 4** on page 8.)

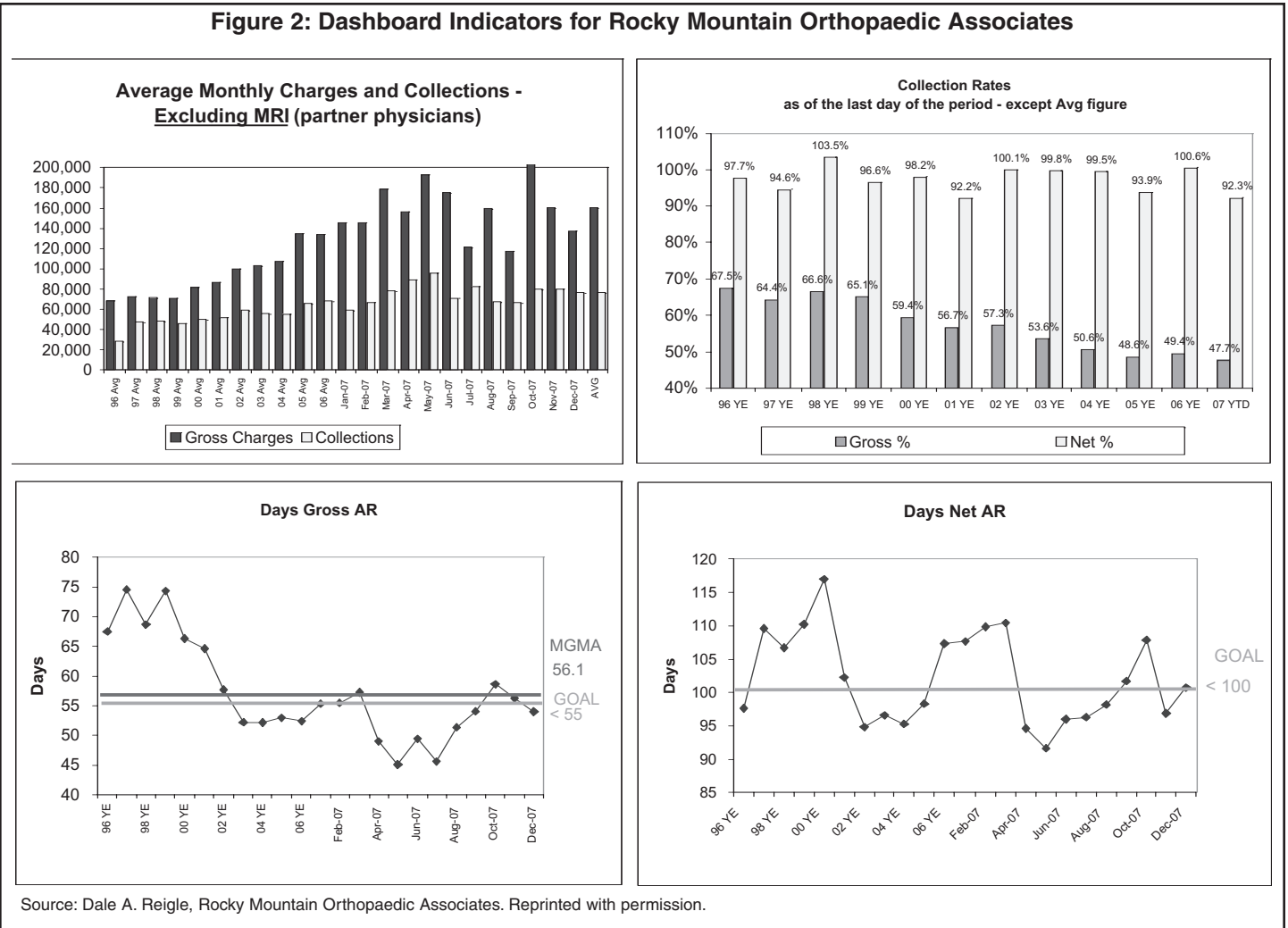
“I also watch write-offs carefully,” Kretchmar says. “I divide these into categories, and if something doesn’t look right, I research to make sure someone isn’t just trying to clear an account from their A/R -- that they’re actually working it and it’s a legitimate write-off.”

Practices also can use internal benchmarks to identify and examine trends they spot in their practice.

“If you have a practice management system

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Figure 2: Dashboard Indicators for Rocky Mountain Orthopaedic Associates



Source: Dale A. Reigle, Rocky Mountain Orthopaedic Associates. Reprinted with permission.

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that can break down your reimbursement rate per insurance contract, you can look at the patients sitting in your A/R who always go out over 90 days," Kretchmar suggests. "Maybe you can connect the dots and find a problem insurer there. A/R is a great place to start your benchmarking."

Select indicators unique to orthopaedics

On a quarterly basis, Reigle tracks staffing levels, patient visit and procedure rates, and physician compensation data. He augments some of the MGMA benchmarks in his dashboards. Although he reports the average number of staff per physician, he also monitors total staff per million dollars of revenue and per 1,000 patient visits, medical assistants (MA) per 1,000 patient visits, X-ray staff per 1,000 films processed, front-office staff per 1,000 patient visits, and back-office staff per 1,000 billable visits.

"To me, these indicators are more helpful to benchmark internal staffing," Reigle says. "We've been doing this since 2003, and I can catch trends more quickly. Let's say the number of MAs per patient visit has risen dramatically. Maybe you've hired some MAs, or maybe the number of visits has dropped. It's a good indicator to alert you that something is different."

Reigle also tracks several measures that he finds unique to orthopaedics: number of visits to generate a surgery and number of radiology procedures per visit. On a monthly basis, he also calculates the ratio of new patient visits to total visits and the number of surgeries to total visits.

"We want a general idea of the kind of patients we're seeing," he says. "Are we generating the number of surgeries that we should? Our goal is to be around seven to 7.5 visits to generate a surgery, but that varies by specialty. My pediatric orthopaedic surgeon takes many more visits to generate a surgery because many of his patients need fracture care and more conservative treatment. Sports medicine tends to take slightly fewer visits.

"I find it more important to benchmark against ourselves over the years

that I do externally," Reigle adds. "Every orthopaedic practice has so many individual quirks that they're not always directly comparable. I like to use external benchmarks, but they don't alert me to trends nearly as quickly as benchmarking against our internal trends over the years."

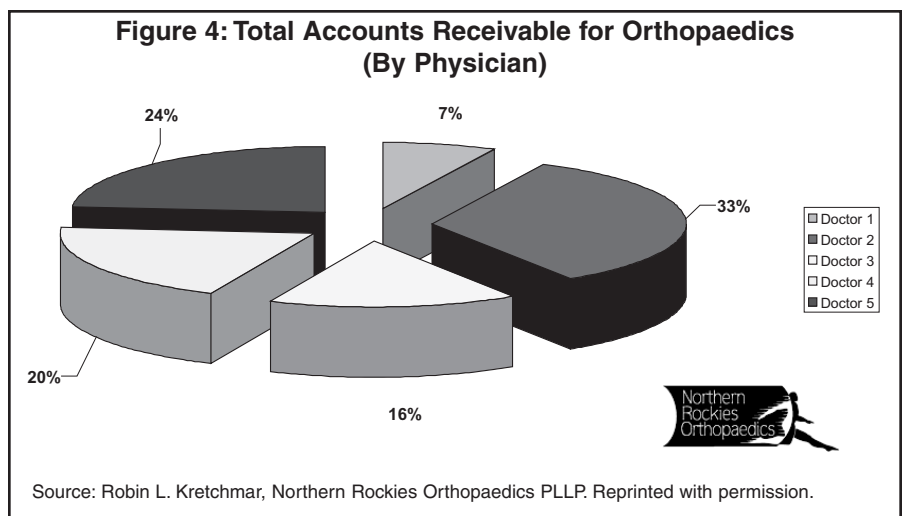
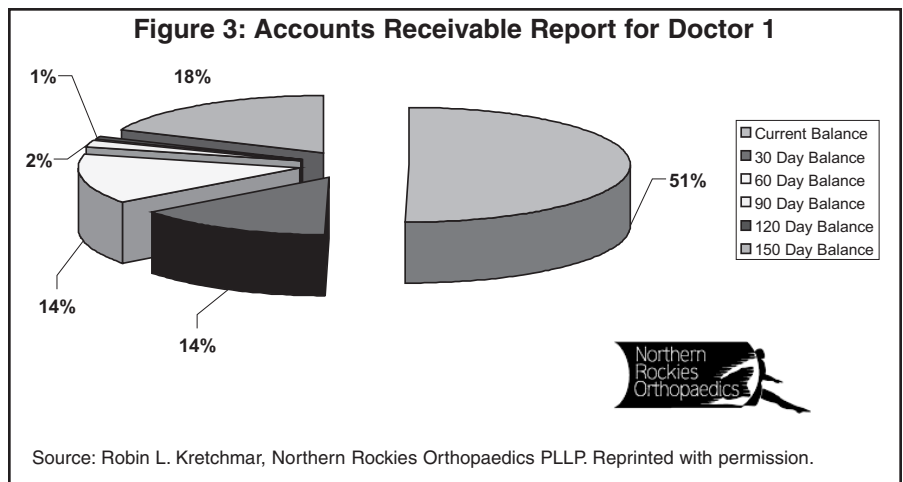
Internal benchmarking also enables orthopaedic practices to maximize opportunities both to reduce costs and improve revenues. That balance is important, Reigle says.

"If you focus too much on costs, you become focused on the short term," he says. "You have to invest and spend money in order to make money later."

Kretchmar agrees, noting that last year she took the counterintuitive step of spending money in order to reduce overall costs by installing a new practice management system. She's already noticed an improvement in her bottom line.

"The new system allows us to track claims in a more timely manner," Kretchmar says. "It refiles,

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understands where our problems occur, and has a great collection module that doesn't allow patients to book appointments if they have a past due balance. All of these have contributed to our cost reduction."

The practice also uses an electronic filing cabinet to store scanned charts over three years old. As part of the IT upgrade, Kretchmar added an automated fax system that reduces the time needed by medical records to fax requests for the older charts.

"We automated multiple departments at one time," she says. "Even with outsourcing some of our functions, we saved money."

Monitor your payer mix vigilantly

On the revenue side, Kretchmar watches her payer mix vigilantly. The practice's caseload tends to involve a high proportion of expensive procedures and rapid turnover in lower-cost procedures. And the payer mix doesn't include as much Medicare or Medicaid as many other specialties.

"My hand specialists are high worker's comp,

and worker's comp in the state of Montana pays well for us," she says. "It's a little more paper-intensive, but these physicians can see 50 to 60 patients in a day, so it's worth it. For sports medicine, even with a physician assistant, the best you can do is 40.

"That's why we look at each physician individually when we're benchmarking, to compare apples to apples," she adds. "You cannot benchmark subspecialties against a general orthopaedic surgeon."

Ultimately, benchmarking requires practices to identify unique attributes and core competencies and to adopt sound business practices around these.

"There's no secret that I can whisper in your ear," Dunn confesses. "Look at what the best practices are doing and decide what changes to make to become one of them. Orthopaedists don't get up in the morning and say, 'I want to be average. I want to be at the median.' They want their practice to be one of the better performers. That's what benchmarking allows you to do."

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Champion recalls an orthopaedic practice that enjoyed a long-standing relationship with a large primary care practice in the community that was a significant source of referrals.

During a two-week period, the PCPs encountered a busy fax line over and over again when trying to fax referrals, so they stopped sending patients to the practice. Fortunately, the orthopaedic group's practice manager was watching referral patterns and noticed when the referral pipeline from one of their main practices shut down. When she called the PCPs and learned the reason, she immediately purchased an additional fax machine and installed a dedicated fax line to handle referrals from the primary care practice.

"This solution didn't involve buying an ad and didn't even take an enormous amount of creativity, but it provided some of the best marketing that an orthopaedic practice could have done in that situation," Champion says. "The problem is that most practices determine their market strategy by having six or seven docs sit around a table in their boardroom."

Tailor your approach to your audience

Orthopaedic marketing should be segmented carefully, with different approaches tailored to each audience, he stresses. The needs of primary care providers are different from those of workers' compensation providers, which are different from those of athletic teams. By subspecialty, trauma also is vastly different from total joints, which is again different from spine or hand.

"Orthopaedic practices should start their marketing just by asking people what they're looking for," Champion says.

Taking such an approach with referring PCPs is relatively easy, he adds. Doing the same with patients is more difficult but still possible.

"Your patients either are or should be your largest referral source," Champion insists, noting that, on average, patients comprise 40% of new referrals for an orthopaedic practice and, in some cases, more than half. "Patient referrals represent an asset that no other practice owns. It's not a scenario like primary care where referrals can switch if there's a political flip in the market or you can lose them altogether if you upset one primary care

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physician in a practice. Patient referrals are something an orthopaedic practice can control.”

Champion advises marketing your services proactively to patients rather than reacting to competitors’ programs. The key is to convey the message that patients want to hear -- not necessarily what the physicians want to say.

He cites the example of a large orthopaedic practice that enjoyed significant name recognition locally. Its physicians were leading researchers and teachers who wanted to promote their published

papers and market their research findings to boost their clinical practice. When this strategy was tested, however, patients overwhelmingly rejected the idea of seeing physicians who conduct research, fearing the physicians might view them as guinea pigs. But the patients were impressed that the physicians taught other local orthopaedists, so the marketing was steered in that direction.

“The physicians wanted to pound out the message that they do research,” Champion says. “Instead, the market wanted to hear that they are the teachers -- more the ‘Sensei’ than the young

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Designing a marketing program: Should you build or buy?

Even large orthopaedic practices with dozens of docs need focused marketing efforts. But whether a marketing program is handled by an internal department or an outside consultant depends largely on the organization’s needs and budget.

Until a year ago, the marketing budget for the Southern California Orthopedic Institute (SCOI) in Los Angeles was less than 0.5% of total budgeted expense, but the organization’s marketing effort also was a disorganized jumble of unrelated activities. SCOI revised its business plan, making marketing a two-year strategic initiative. The organization retained an outside marketing consultant to provide services such as market research, branding, resource allocation, and strategic advertising placement. SCOI also hired a marketing coordinator to interface with the marketing firm by relaying information and materials back and forth in a timely manner and keeping internal decision makers on task.

“We didn’t need somebody [in-house] going out to market us, to develop ads, or to develop spots,” says **Darrell L. Schryver**, DPA, SCOI’s CEO. “We just needed someone to coordinate these services internally. Administratively, we’re pretty thin so we didn’t think we could just tell one of our vice presidents that the marketing effort was now on his or her plate. Whether this approach will meet our needs two or three years from now remains to be seen, but it was a good first step for us.”

In contrast, **Mike West**, CEO of the Rothman Institute in Philadelphia, has built his marketing effort over a nine-year period, using a combination of traditional advertising across a variety of print and broadcast media, a heavy schedule of educational and promotional events, and two full-time marketing representatives who spend four days a week on the road meeting with referring physicians.

“We maintain an extensive database of all of the primary care and referring physicians,” West explains. “All of them are rated A, B, or C based on consistent,

sporadic, or no referrals. Our marketing reps sit down regularly and decide which markets to target and which physicians to visit within those markets, based on our database.”

A skilled referral development rep who knows your orthopaedic practice and local referring physicians is worth his or her weight in gold, West says. Providing the rep with good data helps that person to compare historical referral patterns and track trends so he or she can quickly identify and remedy any falloff in referrals.

“Although we don’t like hearing bad news, we don’t want people to stop referring to us and not know why,” West says. In addition to troubleshooting problems at the outset, the marketing reps help to facilitate relationships between the referring physicians and the office managers at each practice site, who can take steps to prevent any issues from recurring.

On top of his three-person marketing staff, West retains Omaha, NE-based Orthopaedic Marketing Group, which specializes in orthopaedics, “for resources and creativity,” he says. “You could build everything inside, but you’d have to build a pretty extensive marketing department to get the same level of creativity and knowledge. For instance, they have better knowledge of media buying and placement so they can achieve more value-added than we could on our own.”

The Rothman Institute typically allocates 2% to 2.5% of annual revenues -- 6% to 7% of practice overhead -- to marketing costs. The direct return on investment is almost impossible to calculate, West says, “but we’ve grown 30% per year for nine years. I attribute much of that to our marketing.

“We take our marketing efforts seriously,” he adds. “Many practices take marketing for granted and think that if they can’t measure it, they shouldn’t budget for it. But we think marketing is a strategic component of our success.” ♦

'grasshopper.' Those nuances make a huge difference, especially when you're moving toward a consumer-driven strategy."

Start with good research

Champion incorporates research into all of his orthopaedic marketing programs. Patient surveys conducted in-house and competitive information compiled by market research firms can be useful tools in the hands of good decision makers.

"Good research is smart business," Champion says. "You identify areas of opportunity and find the holes you probably would have stepped in. It's when seven docs are sitting around the table and sharing what they know -- or think they know -- about the market that things get a little dicey."

He advises orthopaedic practices to survey new patients to learn how those patients chose them and why: Where did you hear about us? What's the primary reason for your visit today? Who referred you? Ideally, the surveys should be simple one-page forms that patients can complete in the waiting room after they update their personal information. To achieve statistical significance, an orthopaedics practice should obtain at least 200 completed surveys, according to Champion.

Last year, his firm surveyed 8,000 patients at two practices to learn the answers to those two questions. Roughly 15% of the patients chose their orthopaedic surgeon based on reputation and expertise. Most of the remainder selected their physician because a friend, family member, or coworker had visited the practice. In some markets, patients actually choose physicians based on their location rather than reputation and expertise because they don't have access to objective information about clinical outcomes, Champion says.

The importance of market research came home to roost when Southern California Orthopedic Institute (SCOI) conducted its first consumer survey, recalls **Darrell L. Schryver**, DPA, the organization's CEO. Previously, SCOI's physicians had disdained any wholesale marketing effort, counting on the institution's clinical prominence -- more than 40 physicians, seven locations, three ambulatory surgical centers, three fellowship training programs, and 400 employees throughout metropolitan Los Angeles -- to sell itself. When OMG surveyed 4,000 Los Angeles area residents about orthopaedic serv-

ices, however, it was clear that consumers didn't even recognize Southern California Orthopedic Institute and SCOI as one and the same.

"When people came here -- whether for their ankle or knee or whatever -- they thought that was all we did," Schryver explains. "They didn't realize we provide the full spectrum of orthopaedic services. We needed to put together an educational process to address that."

Building image awareness

The changing health care environment also convinced SCOI's doctors that they needed to reestablish and promote the organization's image -- "not necessarily advertising but an awareness of what we did and how we did it," Schryver says. SCOI subsequently retained an outside consultant to develop a marketing plan, which is currently underway.

Orthopaedists also should survey their referring PCPs, workers' compensation contacts such as adjusters and case managers, and individuals in the sports community such as coaches, athletic directors, trainers, and therapists.

"Ask who they are referring to and why," Champion suggests. "What are they looking for from an orthopaedic practice? What are their needs? You'll be significantly more successful in finding the right approach to work with these organizations if you ask than if you guess, but most practices just guess."

SCOI receives nearly 25% of total revenues from workers' compensation, so it promotes aggressively to employers, adjusters, and others involved in selecting workers' comp providers. "We know that we need to create a clear image of how we are different in the workers' comp arena," Schryver says.

SCOI's marketing campaign for workers' comp also integrates more direct selling than advertising. The organization hosts several workers' compensation conferences every year, each attracting 70 to 100 adjusters to hear presentations by a half-dozen of SCOI's physicians. The organization also is taking a more visible stance at the state level by exhibiting for the first time at the state Division of Workers Compensation educational conference in February, where it is distributing a new brochure about its services and meeting one-on-one with conference participants.

As part of its proactive marketing effort, SCOI also has launched a new tagline for its promotional

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materials, redesigned exam rooms, and initiated a tracking mechanism for referrals.

A community focus

The Rothman Institute in Philadelphia established its marketing program nearly a decade ago. The organization, which encompasses more than 50 physicians and 13 surgery sites across Philadelphia and South Jersey, seeks to promote its message in creative ways, explains **Mike West**, CEO. For example, the Institute's three-person marketing staff manages a community, education, and lecture (CEL) program that sponsors at least 200 events, or an average of four per week, ranging from sponsorship of athletic events and tournaments to community talks by physicians and exhibits at Arthritis Foundation meetings and other events.

"We're out in the community all the time in some capacity, whether exhibiting at a local conference, having a physician give a talk at a nursing home or an athletic club, or having a dietitian talk at local schools," West says.

The Rothman Institute also uses an innovative, three-pronged advertising approach across television, print, billboards, and radio. With the first prong, the organization simply seeks to ally the Rothman Institute name with its theme, which is "trust." The impact of the name branding program, which was developed based on consumer research, isn't even measured.

"We just want to have our name and our theme out in the market on a consistent basis throughout the year," West says.

In addition, each of the Institute's orthopaedic subspecialties is allocated a budget for its own marketing campaign -- typically in small newspapers in each of the Institute's local communities.

"If you want your ad placed on the second or third page of a major city newspaper, you're going to spend a boatload of money," West says. "But the cost of print ads in local papers is not that significant."

Finally, the Institute partners some marketing dollars with specific hospitals across five local health systems -- again, using a three-tiered approach that includes Rothman's name branding in specific markets, co-marketing with certain hospitals to promote orthopaedics services, and co-branding with the hospitals. Rothman foots the bill for its own name branding and asks hospitals to match dollar-for-dollar on the co-marketing and co-branding efforts.

"The combination of our name branding, co-marketing of orthopaedics, and co-branding with the hospitals gives us more bang for our bucks," West says. "If we spend \$200,000, we feel that we get \$400,000 in value from these campaigns."

Beware high-cost ads

Ad campaigns can be useful under certain circumstances, but Champion cautions that practices sometimes get the least benefit from the highest cost strategies. Most orthopaedic groups either don't have an advertising message that's compelling in their market or don't use enough frequency in a given media to have an impact.

"Advertising can be very powerful, but it has to be in the right market for the right practice with the right objectives," he says. "Most practices have a difficult time getting these to line up."

Web sites, however, are cost-effective marketing vehicles for practices of every size, from solo practitioners to large single- and multispecialty groups.

"Health care is the number one searched item on the Internet," Champion says. "In some markets, 30% of patients look at a web site prior to a visit. One of the simplest and lowest cost ways to differentiate yourself from competitors in a market is to have your web site look better. Ironically, I've seen physicians spend more on a dinner jacket for an event than on the design of their web site."

Web sites also are terrific tools for capturing marketing data, such as queries from potential patients, as are other electronic media, such as e-newsletters.

"We send our e-newsletter to 30,000 people every quarter," West says. "A tracking mechanism tells us how many were opened and how many were forwarded. We don't know the direct return on investment for the newsletter, but we know that a significant number of people open them."

The Rothman Institute also asks every new patient who calls for an appointment where they learned of the organization and tracks that data. Though referring physicians account for some, more than half of new referrals are generated from recommendations by existing patients, and others come from print and television ads, West says.

Orthopaedic practices don't need to be the best in the country to find a marketing approach that will help them drive volume, according to Champion. They just need to be a little better than their closest competitor.

"What are the market needs, what are the com-

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petitive influences, and how do you draw a solid strategy based on having good information about those two areas?" he asks. "Conducting patient surveys, talking with primary care physicians, and looking at market data take time, but they produce

results. An orthopaedic surgeon who personally reaches out to primary care physicians, in general, sees a 20% to 30% increase in referrals."

Editor's note: Contact Bill Champion at 800-967-1860 or bchampion@orthopaedicmarketing.com, Darrell L. Schryver at 818-901-6600 ex. 3368, and Mike West at 267-339-3622. ♦

Coding Spotlight

Use the right codes for these confusing cases

Various CPT coding rules, complex anatomy, and frequent changes to codes and definitions often confuse coders in orthopaedics, says **Cynthia L. Dunn**, RN, FACMPE, Cocoa Beach, FL-based senior consultant for the MGMA Health Care Consulting Group. She gives these examples that can stymie coding staff, and offers the correct codes for each:

- **Using code pairs.** In 1996, Medicare implemented the Correct Coding Initiative (CCI), a collection of rules or "edits" that specify the conditions under which multiple CPT codes may be used. Code pairs are assigned either a 1 indicator or a 0 indicator. A 1 indicator indicates that two CPT codes may be used together if certain conditions are met; a 0 indicator means that two CPT codes will not be reimbursed together under any circumstance. If a physician bills for both CPT codes despite a 0 indicator, the payer could disallow the code with the higher reimbursement.

CCI rules are updated quarterly, so a code set that worked for a particular case one quarter may not work the next, Dunn points out.

"An example of this CCI edit is found in the CPT code for arthroscopic knee chondroplasty (CPT 29877)," she explains. "Before 2002, this code could be used with a meniscectomy code if the arthroscopic chondroplasty was performed in a different compartment than the meniscectomy. In January 2002, a 0 indicator was applied so that the two codes could not be used together under any circumstances. The following quarter, in

April 2002, Medicare reversed its decision and made the change retroactive to the beginning of the year. In October 2002, the edit again was changed to a 0 indicator. Finally, on December 31, 2002, a new code (G0289) was introduced for use when the two procedures were performed together."

- **Use proper terminology for the distinct regions of the shoulder.** The American Association of Orthopaedic Surgeons (AAOS) recognizes three "areas" or "regions" of the shoulder: the glenohumeral joint, the acromioclavicular joint, and the subacromial bursal space. These "areas" are clearly distinct, so procedures done in one area should not influence coding in a different area, Dunn says.

- **Sorting out shoulder surgery codes.** "Generally, code 29820 is used for a partial synovectomy, similar to the separate procedure code," she explains. "If only a diagnostic arthroscopy is performed, and some synovium is resected for visualization, only a diagnostic arthroscopy can be reported. If a partial synovectomy is medically necessary for a redundant synovial plica or limited synovitis, code 20980 should be reported. Code 29821 should be used for a complete synovectomy for a synovitic disease, such as rheumatoid arthritis or pigmented villonodular synovitis, with removal of the entire intra-articular synovium.

"Code 29822 covers limited debridement of soft or hard tissue and should be used for limited labral debridement, cuff debridement or the removal of degenerative cartilage and osteophytes," Dunn adds. "Code 29823 should be used only for extensive debridement of soft or hard tissue. It includes a chondroplasty of the humeral head or glenoid and associated osteophytes or multiple soft tissue structures that are debrided such as labrum, subscapularis and supraspinatus."

Editor's note: Contact Cynthia L. Dunn at 859-421-2219 or cdunn@mgma.com. ♦

NCQA recognition program designed to standardize back pain care

Orthopaedists are among the specialty physicians who have felt the heat from payers, including the Centers for Medicare & Medicaid Services, about potential overuse of studies and procedures -- especially MRIs, CT scans, and X-rays -- to treat back pain. Now, the National Committee for Quality Assurance (NCQA) in Washington, DC, thinks it has built a better mousetrap to promote a standardized level of care for patients with low back pain. Through its Back Pain Recognition Program (BPRP), NCQA already has recognized 32 physicians across the U.S. for delivering what it considers top-quality care to patients with low back pain. Another 200 physicians are completing applications to be evaluated through the program.

NCQA is perhaps most familiar to most physicians as the private, non-profit organization that oversees health plan accreditation and the use of HEDIS measures. The BPRP, which was launched last year, seeks to provide an independent assessment of back pain care, explains **Mina Harkins**, the NCQA's assistant vice president of physician recognition programs. Other physician recognition programs focus on diabetes, heart disease and stroke, and information technology.

"All of the recognition programs provide physicians with a set of standards that have been agreed upon by experts and stakeholders in the field -- not only physicians and surgeons, but also health plans, employers, and patients," Harkins explains. "This way, we get a balanced view of the assessment of quality back pain care. Physicians have the opportunity to assess their treatment protocols against that set of standards."

During the first six weeks of a back pain episode, for example, clinical evidence shows that physicians should advise most patients to resume normal activity within a few days. Absent other clinical indications, patients also should not be exposed to unnecessary X-rays and other imaging services during the initial period of care. Clinical studies have found that as many as four in 10 imaging studies associated with low back pain are unnecessary, and up to two in three epidural steroid injections are avoidable, according to NCQA.

An actuarial analysis performed by Towers Perrin found that strict adherence to NCQA's evidence-based guidelines on these two dimensions of back pain care alone could result in savings of at least \$205 per patient per year.

"Solid, evidence-based guidelines are the cornerstone of quality improvement efforts," says **William C. Watters III**, MD, a private practitioner at the Bone & Joint Clinic of Houston who chairs the Guidelines Oversight Committee of the American Academy of Orthopaedic Surgeons (AAOS). "The treatment guidelines set forth in the BPRP are a promising platform upon which health care providers of every stripe can build their efforts to improve the care they deliver to their patients with back pain."

Measures 'robust' for orthopaedists

Physicians -- both surgeons and non-surgeons -- as well as osteopaths and chiropractors may apply for recognition by submitting data that documents their delivery of care to a specific sample of eligible patients with low back pain.

"This program is particularly well suited to the orthopaedic practice," Harkins says. "The measures for the entire program are applicable to orthopaedic surgeons, so the program is more robust for their practices. A number of the measures are not applicable to physiatrists, who don't perform surgery, and other physicians."

The program consists of 13 clinical measures and three structural standards that address patients in all stages of low back pain -- acute, chronic, and sub-acute -- as well as the underuse, misuse, and overuse of treatment modalities. Some clinical measures assess the care of patients with low back pain of less than six weeks duration, while others look at back pain greater than 12 weeks in duration. These distinctions are especially critical in evaluating the care of orthopaedic surgeons, who often see patients who have experienced disappointment with other treatment. The clinical measures also address the amount, frequency, and timing of surgery.

Clinical data are abstracted from individual patient records, and scoring is based on the percentage of the sample that meets the performance criteria for each measure. Structural standards are based on processes that apply across patients and are not documented in individual patient records.

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The 13 clinical measures include:

- $\geq 50\%$ of patients in the sample received appropriate care during their initial visit, as documented in their medical record (8 points);
- $\geq 50\%$ of patients in the sample received an appropriate physical exam; physicians must pass this measure to receive recognition (9.5 points);
- $\geq 72\%$ of patients in the sample received an appropriate mental health assessment and counseling or referral, as indicated (5.0 points);
- $\leq 50\%$ of patients in the sample received an imaging study that did not meet appropriate clinical criteria (7.5 points);
- based on data collection only, the chart sample indicates that the physician acquired information about patients' previous imaging and treatment and no duplicative imaging was performed (no score);
- $\geq 76\%$ of patients in the sample were assessed for tobacco use and counseled, as indicated, for smoking cessation (3.5 points);
- $\geq 48\%$ of patients in the sample were appropriately advised to continue or resume normal activities (8.5 points);
- $\geq 48\%$ of patients in the sample were appropriately advised against bed rest (7.5 points);
- $\geq 71\%$ of patients in the sample were advised on an appropriate exercise routine (5.5 points);
- $\leq 10\%$ of patients in the sample received an epidural steroid injection that did not meet appropriate clinical criteria (6.5 points);
- $\leq 5\%$ of the patients in the sample received surgery that did not meet appropriate criteria for timing or frequency (8.5 points);
- $\geq 25\%$ of patients in the sample were reassessed for low back pain at appropriate intervals (5.0 points);
- $\geq 50\%$ of patients in the sample participated in shared decision-making about any procedure or surgery that included a discussion of risks and benefits and of alternative treatment options (6.5 points).

The three structural standards, which are new to the back pain recognition program, include:

- the physician or practice provides patient education materials in lay language that address the natural history of low back pain, treatment

options, risks and benefits, and medical evidence for different treatments (6.5 points);

- the physician or practice monitors and compares post-surgical outcomes for patients and implements process improvement programs, as needed (8.5 points);

- the physician or practice tabulates and compares each patient's experience and implements process improvement programs, as needed (3.5 points).

"These measures can help a physician see what a coordinated approach to the patient's care should look like," Harkins explains. "They are tools for physicians to see how they're doing and to implement improvements either in care or documentation.

"Many physicians say, 'I always talk with patients about their smoking status,'" she adds. "But do they document these recommendations, and do they give the patients direction or counseling about smoking cessation and health status?"

Sample sizes used in the evaluation are 35 patients for one physician, 25 patients per physician for two to eight doctors, and 25 patients per physician or an alternative sampling methodology totaling 200 patients for nine or more doctors. The structural standards may be submitted once for an entire practice. Physicians must score at least 40 points and they must pass the requirements for the physician exam and post-surgical outcomes to achieve BPRP recognition.

"Physicians can score themselves, using our software, to see how they measure against the standards," Harkins points out. "If physicians find that they don't have documentation of those elements, they can set their data collection aside, put that documentation into place, and come back to the application once they've had a chance to operationalize these measures in their practice."

Applying to the BPRP isn't free. The data collection tool costs \$80 per data submission, although this may include multiple physicians and sites. The software also includes multiple user IDs so that physicians may be assisted in completing the application by nursing, medical records, and other staff. Application fees range from \$450 for a single physician to a cap of \$2,700 for six to 200 physicians.

Based on an average of 35 minutes for manual chart review, NCQA estimates that the data

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collection portion of the BPRP application requires several days of staff time.

Benefits of recognition

Why should physicians apply? In addition to demonstrating to patients and peers that they meet objective standards of back pain care, a number of health plans use NCQA recognition to reward physicians in pay-for-performance bonuses or differential reimbursement rates, Harkins says. Physicians also can use NCQA recognition to leverage rates when contracting with purchasers and payers. And NCQA offers additional perks, such as recognition on its web site, five press releases mailed to various media outlets, and a press kit physicians can use to promote their recognition.

Physicians who meet the back pain criteria are recognized for two years, in contrast to the diabetes and heart/stroke programs, which recognize physicians for three years.

"This is a new program, and we want to assess whether we've set the thresholds for these measures at the appropriate level," Harkins says. "Our approach is to recognize physicians [above] the 50th percentile, so we would expect about half of the physicians who apply to currently meet the measures. If we find that we've set these thresholds too high or two low, we may make adjustments."

Editor's note: Contact Mina Harkins at 202-955-3500. For more information about the program and a copy of the materials, visit the NCQA web site at www.ncqa.org/bprp. ♦

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