

Orthopaedic

PRACTICE MANAGEMENT

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When wait times grow, consider long-term fix to improve access

If your waiting room is packed and your surgeons are booking out three weeks or longer, you're not alone. The *2009 Survey of Physician Appointment Wait Times* by physician search and consulting firm Merritt Hawkins & Associates in Irving, TX, found that the average wait time to schedule an orthopaedic surgery appointment across 15 major U.S. markets has reached 16.8 days, with wait times in some markets much longer. With U.S. health care reform likely to swell the ranks of insured patients, demands for access may become an even bigger problem.

Consider Massachusetts, which adopted health care reform in 2006 and mandated coverage for all residents. Even though Massachusetts has more physicians per capita than any other state, Boston reported one of the longest average appointment wait times across the cities examined in the survey. The average wait time in Boston to schedule an appointment with an orthopaedic surgeon for knee pain or injury was 40 days,

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Dedicated hospital fracture room brings hefty returns in dollars, efficiency

As orthopaedic practices collaborate with hospital partners to develop trauma programs and support the services of dedicated orthopaedic traumatologists, a five-year study conducted by the University of Massachusetts Medical School and UMass Memorial Health Care in Worcester, MA, suggests these efforts pay dividends in revenue, efficiency, and physician satisfaction.

David C. Ayers, MD, Arthur C. Pappas chair and professor in the department of orthopedics and physical rehabilitation and director of the Musculoskeletal Center of Excellence at UMass Memorial, and colleagues conducted a cost-benefit analysis on the establishment of a dedicated orthopaedic fracture room and simultaneous reorganization of the call structure in the medical center's Level I trauma center -- one of New

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cautions. On the other hand, if you add a surgeon to an existing subspecialty service line, "promote the subspecialty, not just the new physician," he advises.

As you fix your access problems, leverage your new hire by forming alliances that make sense for your practice. To ramp up a sports medicine specialist or foot and ankle surgeon, for instance, seek strategic partnerships with high school teams or

with youth and adult recreation programs. Early on, give the physician ample opportunities to position himself or herself in your practice and in the minds of referring physicians.

"A new physician has one shot to make a first impression -- and not just a good impression, but the right one," Champion says.

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England's busiest. Their outcome measures included the development of a subspecialty model of care, surgeon satisfaction, and financial return to the hospital and orthopaedic surgery department.

Prior to the orthopaedic fracture room's implementation, "the resources that were utilized to meet the needs of the Level I trauma center were, in effect, choking off the ability of orthopaedic surgeons to develop subspecialty practices," Ayers tells *OPM*. Under the existing system, the orthopaedic surgeon on call often devoted 48 hours of care (including the call shift and next-day surgeries) for trauma patients brought to the center during his or her 24-hour call, at the expense of the surgeon's elective subspecialty practice.

Orthopaedic surgeons, who took call from 7 a.m. to 7 a.m., were required to clear their schedule the entire 24 hours so they were immediately available to care for trauma patients brought to the center who went directly to the OR for surgery. Urgent cases who presented at the trauma center, including those with closed fractures, also were assigned to the on-call surgeon and usually taken to the OR the following day in an add-on room. Thus, on-call surgeons frequently would spend an additional 24 hours in the OR handling the care of unscheduled orthopaedic trauma cases.

New system developed

When Ayers joined UMass in 2003, he initiated an orthopaedic trauma project that includes a dedicated orthopaedic fracture room reserved for trauma patients weekdays from 7 a.m. to 5 p.m. He hired several traumatologists to manage the fracture room during these periods. Under this system, emergent orthopaedic surgery cases still are managed by the on-call orthopaedist and go immediate-

ly to the OR. However, non-emergent cases are assigned to the fracture room, where patients are transferred to the assigned traumatologist for surgery the next day. The team's four traumatologists have the sole responsibility for scheduling and prioritizing cases in the fracture room on weekdays. Meanwhile, non-trauma subspecialists on the call schedule can maintain a mature subspecialty practice and plan for elective cases and/or clinic time on post-call days.

"We needed to have a departmental philosophy of teamwork and a cooperative approach to treating trauma patients," Ayers says of the program's design. "We needed support from the institution to develop all aspects of subspecialty practice in orthopaedic surgery -- not just in trauma. We also had a desire to decrease the number of operative cases that were done in off hours -- particularly after midnight -- but we didn't want to change in any way our commitment to meeting the needs of severely injured patients who were brought to our Level I trauma center."

UMass Memorial Health Care -- the clinical partner of UMass Medical School -- encompasses the UMass Memorial Medical Center in Worcester and five community hospitals. Both UMass Memorial campuses, but not the community hospitals, participated in the orthopaedic trauma project, Ayers explains. The university campus includes the Level I trauma center, where the orthopaedic surgeons are employed by the university and serve as full-time members of the UMass faculty. The Memorial campus, just a mile from the main campus, handles Level II trauma cases and elective surgeries and is staffed by a mixture of private practice and employed surgeons, many of them also full-time faculty members.

"The spirit of cooperation and philosophy of teamwork made it easier for colleagues at the other

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campus to access services at the Level I trauma center and the expertise of our subspecialty-trained traumatologists," Ayers says.

Capture data to demonstrate benefits

To evaluate the effectiveness of the orthopaedic trauma project, the researchers examined operative orthopaedic trauma cases at UMass Memorial from October 2003 to September 2008. They queried the surgical booking database and billing records for the total number of cases per surgeon, start time of cases, case description, number of trauma activators, and reimbursement data. In addition, they reviewed the medical records for a subset of patients with isolated, closed, femoral shaft fractures treated with intramedullary nailing for peri-operative details such as time from admission to surgery, length of surgery, and length of stay. Fiscal year 2004 data, prior to the trauma room's implementation, served as the control. The researchers derived cost data using average reimbursement rates in 2009 dollars for each subspecialty as a standard multiplier.

The traumatology program produced "enormous benefits on multiple levels" for the physicians, hospitals, and patients, Ayers says. Although total orthopaedic cases at UMass campuses increased by 8% between fiscal year 2004 and fiscal year 2005, from 7,046 to 7,640, and orthopaedic cases at the trauma center increased by 14% (1,799 to 2,046), OR starts after 7 p.m. decreased by 16%, and OR starts after midnight dropped by 45%, Ayers reports. Transfers of care increased by 36%, and surgeries completed between 7 a.m. and 5 p.m. increased by 29%. Meanwhile, surgeries completed after 7 p.m. decreased by 18% and those completed after midnight decreased by 11%.

Orthopaedic traumatology cases increased by 48%, from 921 cases to 1,367, while orthopaedic surgeons enjoyed impressive boosts in elective surgeries: an increase of 59% in spine surgeries and 15% in total joint replacements. The additional elective cases resulted in average professional charges of \$19,551 per case, or \$2.4 million per year, and average facility revenue of \$21,443, or \$2.6 million per year. In addition to enhanced productivity, orthopaedic subspecialists and traumatologists both reported increased job satisfaction, fewer after-hours cases, and a greater proportion of preferred cases within their field.

The results mirror a study conducted by **Timothy J. Bray, MD**, and colleagues at the Reno (NV) Orthopaedic Clinic that was presented at the Orthopaedic Trauma Association annual meeting last month in San Diego. In "The Financial Impact of a Dedicated Orthopaedic Traumatologist on a Private Group Practice," the researchers reported that the addition of a dedicated traumatologist benefited the group practice financially, increasing charges for existing elective practices by 13% and increasing collections by 23% even though partners took more vacation days and 14% less call. In terms of productivity, elective arthroplasty cases increased by 13.1% and elective arthroscopy cases by 35.4% over a two-year period while total patient office visits grew by 18.8%. The results were due, in part, to increased non-trauma referrals, full clinics, and uninterrupted elective OR schedules. Although the payer mix for trauma patients was worse than that for the elective group practice, overhead requirements also were lower. The cost of hiring a new trauma partner, though substantial, is recouped after six months, according to Bray and colleagues.

Replicating the UMass model

The UMass model can be reproduced both in academic medical centers and community hospitals with Level I trauma centers that see a sufficient number of cases to ensure high utilization of a dedicated fracture room, according to Ayers. The model requires an orthopaedic community with a collegial approach to patient care and a hospital partner that's committed to the development of subspecialty practice across the spectrum of orthopaedics -- "not just an institution that is purely devoted to trauma," he says. And, since average charges and reimbursement rates vary across the country, the financial impact on a given institution could be greater or less, depending on local rates and payer mix.

For analytical purposes, the UMass study used a constant number of surgeons, so "increasing the number of subspecialty surgeons will obviously add volume and reimbursement and make this model even more successful," Ayers adds.

Samuel G. Agnew, MD, FACS, president of Orthopaedic Trauma Practice Consultants, LLC, in Florence, SC, agrees that the UMass study offers sound methodology and a valid approach to implementing an effective orthopaedic traumatology program. Orthopaedic surgeons "can't function in a bubble," Agnew says. "There needs to be some sort

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of deliverable to the hospital.”

Although orthopaedic surgeons have long promoted the benefits of a dedicated fracture room, community hospitals typically view the required outlay as a “luxury item,” Agnew points out. Most community hospitals don’t have the ability to track the economic value of a particular OR, including metrics such as turnaround time, breakeven revenues, and contribution margin. Because community hospitals also serve many constituents, it’s politically difficult to justify a dedicated orthopaedic fracture room to other specialties, such as neurosurgery and thoracic surgery.

“The surgeons at UMass were able to develop hard, measurable metrics about the benefits of this approach,” Agnew says. “They’ve finally put the viability of a dedicated orthopaedic room in business terms.”

In fact, all acute fractures -- not just trauma cases -- would benefit from this approach, he maintains. Between 20% and 25% of operative orthopaedic injuries that present at a typical hospital ER don’t return to the hospital for surgery after the injury is stabilized, he says. Instead, they go to an ambulatory surgery center or another hospital. Yet 90% of the individuals who don’t return to the original hospital have private insurance, according to Agnew. When a hospital offers a dedicated fracture room and an efficient process to manage the care of insured patients, they’re more likely to complete their treatment in a single setting, which generates additional revenues for physicians and the hospital.

To validate this approach, orthopaedic surgeons should partner with one or more hospitals in their community and conduct one-year pilot studies to measure the fiscal viability of a dedicated fracture room on a “day-to-day, minute-to-minute level” across all dimensions of care and cost. Consider gathering metrics such as time per work RVU for anesthesiology, radiology, nursing, and other services as well

as the ability to improve hospital productivity by scheduling additional cases, Agnew says.

“If you start a trauma room and you’re doing 22 minutes per work RVU, you can look at data from the CDC or a proprietary database and predict within 50 cases the number of cases you’ll handle in the next year or the next two years and how many work RVUs are attached to each case,” he explains. “If you knew where you were before the orthopaedic trauma room and you know where you are every quarter afterwards, it’s reasonable to project your volume. These programs have to be managed on a different level than just a passive OR.”

A dedicated trauma suite doesn’t just improve efficiency and quality of life for orthopaedic surgeons. “Early on, anesthesiologists may be reluctant participants, but they will quickly gravitate to a program that gives them 40 billable hours of surgery every week without cutting into their dinner hour,” Agnew points out.

Orthopaedic trauma and fracture care, combined, are growing at a rate of 16% annually -- on par with the growth of ER utilization, Agnew points out. Dedicated orthopaedic trauma rooms could help physicians and hospitals to shoulder this load, but orthopaedic surgeons need to demonstrate the value of these programs.

“Orthopaedic surgeons have to be leaders and educators of this model,” Agnew insists. “They have to drive the process and track performance metrics and cost of care. The easiest thing to deliver is 750 square feet of space with lights. Unless you measure everything, it’s harder to deliver a program that works well and improves in efficiency every year. If hospitals would study OR utilization, every hospital would see the benefits that UMass has produced in its dedicated orthopaedic trauma room.”

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However, the anti-kickback law does apply to these relationships. “The safe harbors are very narrow, and almost never help,” he says.

The new CMS interpretation of Stark also prohibits unit-of-service lease arrangements for physicians both as direct lessors or lessees and as indirect owners of a lessor or lessee entity, according to Madden. “This specifically relates to a referring

physician who leases space on a unit-of-service or per diem basis from a facility and then submits a claim to Medicare for the global fee,” she explains.

The final IPPS rule does not impose a blanket prohibition on per-click payments but prohibits these payments to the extent that they reflect services provided by the lessee to patients referred to the lessee by the lessor, Madden adds. The rule also adopts a companion provision restricting the use of

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per-click or other unit-of-service pricing formulas in space and equipment leases when the number of “clicks” is affected by referrals between the parties to the lease arrangement. For example, it’s no longer permissible for an orthopaedic surgeon to own a scanner and lease it to a hospital for \$500 per scan, Glaser says. However, per-click leases are still permissible if the owner does not refer to the lessee, and “time-based” leasing remains acceptable under the final rule.

Examine existing financial relationships

In light of these changes, practice administrators must carefully scrutinize the financial relationships between their practice or physicians and other health care entities.

“If you have a financial relationship with another entity, examine how that arrangement might infringe on the new rules,” Madden suggests. For example, the physician referral law prohibits a physician from referring patients to an entity for a DHS if the physician or a member of his or her immediate family has a financial relationship with the entity, unless an exception applies. The law also prohibits an entity from presenting a claim to Medicare or to any person or other entity for DHS provided under a prohibited referral.

Medicare will not pay for DHS rendered as a result of a prohibited referral, and entities must refund any amounts collected for DHS performed under a prohibited referral or face the prospect of civil financial penalties, she adds. “Orthopaedic practices need to be concerned about any arrangements where one party provides a service and another party bills for some or all of that service,” Madden says. For example, if your practice leases space from a hospital for any of the services you provide, review the terms of the lease to ensure they don’t violate the per-click and percentage lease provisions.

Certain arrangements that may still pass muster with CMS include:

- lease, supply, and billing contracts that do not constitute full-service “under arrangement” services;
- referrals to “under arrangement” providers by non-owner employee or contract physicians if a compensation exception is met; and
- rural “under arrangement” contracts where the physician’s ownership of the performing entity

-- such as the physician’s group -- qualifies for the rural entity exception.

“There aren’t many exceptions for referrals from physician-owned entities,” Madden admits. “If in doubt, check with your attorney.”

In-office ancillaries may be next

So far, the in-office ancillary services exception -- where an orthopaedic practice can refer Medicare and Medicaid patients to its own in-house imaging services, for instance -- doesn’t necessarily violate the law, Glaser says. However, that exception may not last long, since the use of advanced diagnostic technology in physician offices is coming under fire from CMS and faces possible Congressional action.

“Ancillaries are under siege right now,” he warns. “Orthopaedic practices need to pay close attention to what’s happening at both the national and state levels because lots of different players want to prohibit them from doing diagnostic work if they’re ultimately going to do therapeutic work.” Glaser likens such a move to prohibiting an auto mechanic who diagnoses a problem in a car from

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Ask these questions to provide due diligence on Stark

Thanks to the stricter interpretation of referral relationships between physician practices and other designated health services by the Centers for Medicare & Medicaid Services, orthopaedic practices face new compliance challenges under the Stark law. **Susanne Madden**, president and CEO of The Verden Group in Nyack, NY, suggests that orthopaedic practices consider three key questions to perform due diligence in meeting the stricter Stark enforcement:

1. Are the services furnished to hospitals deemed “under arrangement”? When a practice furnishes services “under arrangement” to a hospital and the hospital bills Medicare for those services, a financial relationship is created for Stark purposes if the practice refers patients to the hospital for the same or other services. CMS now considers these arrangements to create both a referral to the hospital and a referral to the group itself.

2. Do we have a “per click” lease? Be aware of the provision restricting the use of “per click” or other unit-of-service pricing formulas in space and equipment leases where the number of “clicks” is affected by referrals between the parties to the lease arrangement.

3. Are we referring and have a percentage lease with the hospital? If your practice uses the space or equipment rental exceptions, fair market value exception, or indirect compensation exception to Stark to protect a space or equipment rental arrangement, you can’t use percentage formulas based on revenues that are attributed to services performed in the space or using the equipment.

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fixing it, “yet there seems to be a strong move in that direction,” he says.

That being said, orthopaedic surgery practices with an in-house MRI, for example, should not necessarily shy away from upgrading the equipment. “If the group thinks an upgrade is good for patient care, I wouldn’t forego buying an MRI based on what might happen in the future,” Glaser says. However, existing equipment might not be grandfathered if CMS or Congress lowers the boom on imaging technology in physician offices, so a decision to expand in-house diagnostic imaging “depends on your risk tolerance,” he admits.

Orthopaedic surgery practices also should expect ongoing scrutiny of the relationships between device manufacturers and physicians. “It’s not wrong for physicians to have relationships with device companies,” Glaser maintains. “Just make sure someone is paying attention to the relationships, knows that they’re structured legally, and discloses them to patients. Disclosure can cure a world of hurt. If you’ve got a relationship that you’re reluctant to acknowledge, that should tell you something.”

Reviewing financial arrangements that involve your surgeons or practice with an attorney is the most practical step you can take to continue providing seamless orthopaedic care without violating the new rules, Madden says. “Stark is a strict-liability

statute, meaning that violators will be penalized regardless of whether or not they meant to violate the statute,” she points out. “In other words, ‘I didn’t know’ is not a defense.”

Although the revised rules may limit the ability of orthopaedic surgeons to create traditional joint ventures with hospitals, the changes also may spawn new relationships with hospitals “that can improve the lives of physicians and also improve the bottom line of their practices,” Glaser suggests. For example, properly structured co-management agreements present opportunities for physicians to gain greater influence over hospital operations.

“I think we’ll see an increasing move toward integration,” he says. “If that happens, physicians will be happier and the health care industry will be better served. If physicians can improve patient flow in the OR, for example -- and do it in a way that they can be compensated for that work -- they’ll be happier and more productive.”

But as these relationships unfold, practice managers must continually reexamine them against the increasingly long reach of Stark, together with anti-kickback and relevant state laws. “That relationship you have with the hospital to do joint athletic trainer outreach might be fine, but on the other hand there could be issues with it,” Glaser points out. “Be willing to ask questions, but don’t panic.”

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and legal protections for surgeons and device manufacturers, Callaghan says. The AJRR was incorporated in Illinois, in part, because the scope of privilege under the Illinois Medical Studies Act will help to protect collected information.

Formation of the AJRR also would allow the orthopaedic surgery community to control the registry. In June, Reps. Bill Pascrell, Jr. (D-NJ) and Lloyd Doggett (D-TX) introduced H.R. 2813, “The National Knee and Hip Replacement Registry Act of 2009,” to house a government-run registry within the Agency for Healthcare Research and Quality (AHRQ). Although the stated goals of the government registry would largely mirror those of the AJRR, data collection would be limited to federal reporting requirements and voluntary submission of Medicare and non-Medicare data. In contrast, the AJRR would be an independent organization with

its own governing board. For the time being, the House bill remains in committee.

Other factors on the national scene, such as the U.S. Food and Drug Administration’s efforts to require unique identification numbers for medical devices, lend a sense of urgency to the AJRR initiative, Callaghan adds.

Throughout the fall, project work groups have been tackling data, governance, and oversight issues with the goal of beginning data collection next year. Callaghan, who specializes in adult hip and knee joint reconstruction, advises orthopaedic surgeons and practices to begin promoting the AJRR in their communities.

“The biggest help that an orthopaedic surgeon can offer right now is to encourage individual hospitals and insurers to get on board,” he says.

Editor’s note: Contact Callaghan at 319-331-2479 or john-callaghan@uiowa.edu. To read more on the AJRR, visit www.aaos.org/registry. ♦

Red Flags delayed, but HHS issues new rule on patient privacy breaches

At the behest of the U.S. Congress, the Federal Trade Commission (FTC) has again delayed enforcement of the identity theft Red Flags Rule until June 1, 2010. In the meantime, the House of Representatives unanimously passed a bill to amend the provisions of the Fair Credit Reporting Act to exclude small businesses -- including physician practices -- with 20 or fewer employees from the rule. The Red Flags Rule requires health care providers that are deemed "creditors" to execute an identity theft prevention program. (For details, see Feb. 2009 *OPM*, p. 15.)

Orthopaedic surgery practices should continue to prepare for the rule, as Congress may not offer significant relief, experts say. At press time, the Senate had not yet considered the bill, but the House version would allow practices to avoid the Red Flags Rule only if the business:

- knows all of its customers individually;
- only performs services in or around the residences of its customers; or
- has not experienced incidents of identity theft and identity theft is rare for businesses of that type.

Practices would need to apply for the exclusion and the FTC would determine if they meet the criteria. It's unlikely that even the smallest orthopaedic surgery practice could escape all three exceptions, says **Robin Fisk**, principal of the Fisk Law Office in Ashland, NH.

In addition, practices now face compliance with regulations that address security breaches involving patient information. The Department of Health and Human Services (HHS) issued a final rule (<http://edocket.access.gpo.gov/2009/pdf/E9-20169.pdf>) that requires health care providers, health plans, and other entities covered by the Health Insurance Portability and Accountability Act (HIPAA) to notify patients promptly when their personal health information is affected by a security breach. Breaches that affect more than 500 individuals also must be reported immediately to the HHS secretary and to the media, while those affecting fewer than 500 individuals must be reported to the HHS secretary annually.

The new rule -- part of heightened privacy and security protections under the American Recovery and Reinvestment Act of 2009, better known as the stimulus law -- is a companion to regulations released by the FTC covering breaches that involve vendors of personal health records and other associ-

ated businesses not covered by the privacy and security provisions of HIPAA.

Encrypt data to avoid 'notification hell'

The HHS breach notification and Red Flags rules are "sequentially related," Fisk says. The Red Flags Rule was established by the FTC and five other regulatory agencies to address identify theft, primarily at financial institutions. Physician practices fell into the net because they fit the definition of a "creditor" under the rule. One aspect of medical identity theft under the Red Flags -- the disclosure of protected health information to an individual who presents a stolen ID -- now represents a data spill that also can land practices in the HHS breach notification requirements.

"If your practice discloses unencrypted personal health data to someone who wasn't entitled access under the law, and there's a substantial risk of harm, you have to notify the person who owns the protected health information," Fisk explains. "But encrypted data is exempt, and the regs tell you where to find standards for what's considered adequate encryption for data in use, data in transit, data in storage, and data being destroyed." On top of the onerous notification requirements, a large data spill -- such as the theft of a laptop or flash drive with unencrypted data -- could create a legal and financial nightmare for a practice.

Fisk advises orthopaedic practices to amend their policies and procedures -- beyond the measures they may have taken to comply with the Red Flags Rule -- to institute safeguards against unintentional breaches of protected health information. "The HHS rules say that password protection and user IDs are great but not sufficient," she says. "Encryption and destruction are the only two methods the HHS accepts to render protected health information unusable, unreadable, or indecipherable to unauthorized individuals." The National Institute of Standards and Technologies (NIST) offers guidelines for encryption processes for various types of media that are accepted by HHS. (See the NIST tools at <http://www.csrc.nist.gov/>.)

Although the level of data encryption suggested in the breach notification regulations might seem excessive to orthopaedic practices, the resulting security is worth the investment. "If you follow these encryption procedures and somebody steals a laptop, you don't have to notify," Fisk says. "But if that laptop goes missing and the data are not

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encrypted, you're stuck in notification hell."

On a more basic level, examine all situations when your practice transmits medical records to various parties -- patients, physicians, hospitals, payers, accountants, and attorneys, for instance -- and by what means. Simply e-mailing an unencrypted medical record could now expose your practice to a data breach under the HHS rule.

"Stop and think," Fisk advises. "Remember those four buckets of data you need to protect -- used, transmitted, stored, and destroyed. Get your IT folks involved in setting up a protocol at every one of those points, and get those protocols in the hands of the staff who actually transmit data. You can't just live in your IT department anymore, unless all of your data passes through it."

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Question of the month: How did you slash paperwork costs?

Even in an age of EMR and electronic billing systems, physician practices are spending billions of dollars annually on wasted paperwork, according to recent studies. What are the best candidates for automating billing-related tasks in orthopaedic practices? What strategies did you implement to reduce the paperwork associated with your payer interactions? What savings in time and FTEs did you realize? *OPM* wants your feedback on the topic for a future article. Contact Editor Marie Powers at 770-487-8673 or mpowers@oakstonepub.com. ♦

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