BACKBONE

Volume 13 ***a publication of the Connecticut Orthopedic Society*** *Winter 2009*

President's Corner *Robert Biondino M.D. - President*

As 2008 closed, I look back on the year or so and felt the Connecticut Orthopedic Society had done much more than the SEC.

The Connecticut Orthopedic Society had met podiatry issues with patient's safety in mind and a common ground. Our negotiators met knowledgeable podiatry specialists and established that common ground. The area not negotiated was patient safety and valid credentials. When it came to chiropractic issues, your Society bore the brunt of legal fees and opined that hospital admission and general anesthesia manipulations were not based on scientific evidence or patient safety. Again, we were successful in protecting the well being of all patients. When the American Academy of Orthopedic Surgeons sought to develop policy on Emergency Room coverage programs and mandate a direction, our Society balked and along with Society Presidents of Arizona, Colorado, California, Connecticut, Florida, Illinois, Nebraska and New York State as well as Tennessee and Texas presented a more reasonable on-call discussion. Our Academy has rescinded its original position. The Orthopedic Trauma Association now continues to explore further initiatives. Our Society continues to garner information on a regional hospital policy basis as well.

We also raised the issue of dwindling number of physicians in the State to Governor Rell and a decision to forego specialty loans was the offshoot. Response to a Waterbury Attorney's letter in the Republican concerning tort reform was also on the agenda. The unbalanced health care system with age and specialty were underscored. Orthopedists in Connecticut average nearly 56.7 years of age. The present medical education trains males and females about equally. However, current AMA statistics suggest that less than 40% of the trained females are in an active full-time practice after five years. Furthermore, education is structured more towards specialty than general medical care. Our present medical residency programs are filled predominantly with non-American trained students. We now become more dependent on mid-level providers. Our system is flailing with no direction. Consider that mid-level providers are recognized by the government and Medicare with an 85% payment schedule for medical care. That is 85% of the specialist charge. Since they are less expensive, they are more available and we become our own worst enemies by necessity.

What has the SEC done for you lately? In 2006, a potential investor took his suspicion to the SEC about the Madoff Fund. A fund that averaged a 10% return in good times and bad. The manager calmly stated that he simultaneously sold stock and purchased option contracts. Yet there were too few documented sales or purchases over the past few years. Some of the world's most sophisticated investors were taken in by the fraud. A French hedge fund actually was responsible for the final investigation. Yet, the SEC investigated and said Bernard Madoff's fund was not a problem and needed only the polishing of a few minor issues. So the Watch Dog Agency under President Bush made a mistake. A FEMA like mistake. (In 1999, they were also investigated).

A few red flag lessons to all.

1.Reliance – What do you trust? Everyone is not a thief. Hedge funds are impossible to understand. As investors, sometimes we abdicate responsibility. Corporate plans cannot afford to do that. There is often a fiduciary responsibility. As foolish as it sounds, orthopedists need to actually understand their investments. We all have lost upwards to 35% with the market downturn. Who understands why? If no attempt was made to listen, why wouldn't it be repeated? Who amongst us really believes that

(cont. on p. 4)

Legislative 2009

The 2009 Legislative Session in Connecticut is well underway and while much discussion and debate is centered around the economic crises and state budget deficit, there is still plenty of health care debate.

The CT Orthopedic Society continues to work with the CT State Medical Society and other specialty societies to support and augment important health care and practice legislation of concern including:

Transparency within Health Care System
Health Care Reform
Standards & Fairness in Contracting
Rental network Contract Agreements
Cost- benefit analysis of health care mandates
Medical Loss Ratio
Medical Liability

Medical Liability continues to be at the forefront of debate and details about the two House Bills that are currently in the process are available on the links that follow. They are H.B. No. 6253 AAC PRETRIAL SCREENING ON MEDICAL MALPRACTICE CLAIMS http://cga.ct.gov/2009/TOB/H/2009HB-06253-R00-HB.htm H.B. No. 6383 AAC MEDICAL MALPRACTICE (Governor's Bill) http://cga.ct.gov/2009/TOB/H/2009HB-06383-R00-HB.htm

We are pleased to support the initiative of the Connecticut Eye Physicians and add our Society's name as a sponsor of its' Legislative Priorities for Healthcare brochure which focuses on transparency issues and contracting process. This is being distributed to members of the legislature.

Our lobbyist, Bill Malitsky of Halloran & Sage works on your behalf to bring our messages to legislators however, it is imperative that orthopedic surgeons stay active and visible at the legislature and to this end encourage you to respond to future "Call to Action" you may receive via email from the Society. Your voice in these matters strengthens all of medicine's stances on critical issues facing physicians and their practice.

If you would like to stay up-to-date on legislative issues, the Society offers a membership benefit of instant web access to a bill tracking website to obtain details of the bill, legislative sponsors and where it is in the process (***see box at right for login information***).

President's Corner

(cont. from front page)

the market bottom has been found. I for one would expect 7000 to be in our not-too-distant future. That is another 12 to 15% correction in 2009 after the enthusiasm wanes. With the bailouts and moneymaking, when will inflation revisit us?

2.Diversify – This is so obvious. Just because one investment is doing well, do not tie up large amounts of assets in one fund. Foreign stocks did very well in 1999, 2005 and 2007. Reits did poorly in two of those years yet were top performers in 2000, 2001, 2004 and 2006. T-Bills were mediocre throughout. Large stocks or the stocks which always paid a dividend did well in 2000 but were terrible from 2001 through 2006. I guess the word "risk" is important. You want an appropriate return for the given level of risk you assume. A sound asset allocation requires time, education and trust.

To measure risk for next year, think – if losing money in my retirement plan is like a "kick to the gut", why risk it all over again? Get to the central question! If I lose another 25 to 35%, what will I do? Sell? Do nothing? Buy? How much more can one risk losing?

3.Opinion – Dr. Chit Ranawat in a Louisiana duck blind years ago said to me about a medical question he had posed – "Bob, that is your opinion, what is your scientific data?". All truths may not be scientifically based. Certainly, a fund has an auditor. Madoff had an auditor who no one could find. Of all the stocks, of all the mutual funds, there are really only three our four large commercial auditors. These accounting firms usually have a strong reputation, many clients and many references. Why did the SEC not see this? Why when Google was a fingertip away? The SEC allowed Madoff to be Made-off?!

Thankfully, it ended on January 20th. FEMA, SEC, Environment Abuse, Judicial Miscarriage and intentionally buffoonery will be behind us. Madoff simply got caught in the wrong year. Bush might have freed him with a year-end amnesty.

CT Orthopedic Society Members
CT Legislative Bill Tracking Site

Log Onto
www.ctbilltracking.com/HS/
username: **hs-ortho**
password: ortho6871
(use all lowercase for Username and Password)

Orthopedic Foundation

The Connecticut Orthopedic Foundation, Inc., is committed to the training and education of orthopedic surgeons and to this end have donated $60,000.00 over the past few years to both the Yale and University of Connecticut Orthopedic residency programs. Please join your colleagues in making a contribution to the Foundation.

Enclosed is my contribution, payable to the "Connecticut Orthopedic Foundation, Inc." *(Please Print)*

Name_____

Home Address_____

City_____**Zip** _____

Phone_____

Email_____

I am pleased to support the Connecticut Orthopedic Foundation with a gift of *(check one)*

___$500.00 __$250.00 __$125.00 __$ ____(other)

Send to the Connecticut Orthopedic Foundation, 26 Riggs Avenue, West Hartford, CT 06107. Your cancelled check is your receipt. **Thank you!**

Connecticut ORTHOPEDIC Society

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Evidence Based Medicine *by BackBone Contributing Editor - Ron Ripps, M.D., Danbury, CT*

The term "evidence based medicine" was first used by Gordon Guyatt of the McMaster University research group and published in JAMA (268) in 1992 : "Evidence based medicine: a new approach to teaching the practice of medicine." The idea was that decisions we make regarding the care of our patients should be based on the current best evidence. While it is generally conceded that an important part of medical care depends on individual factors and quality of life judgments, evidence based medicine addresses that part of medical practice that is based in scientific principle in the hopes of enabling us to predictably get better outcomes.

In an effort to weigh and validate the medical literature, articles are judged on the basis of statistical analyses that rank randomized, prospective, controlled, double blind studies (RCS's) on the top and anecdotal experience on the bottom. The strength or power of a study depends on the sample size, such that a well constructed RCS may lack credence if the sample size is too small.

We apply evidence based medicine through the decisions we have to make, and we learn this through various CME seminars, hospital rounds, and journal clubs. At the institutional level, evidence based medicine is applied through guidelines, treatment algorithms, and practice policies. Every managed care insurer has laundry lists of acceptable and unacceptable therapies which are supposedly based on the applicable and current medical literature. It is by this ploy that managed care insurers have purloined the noble purpose of evidence based medicine for their own commercial interests. They abuse best practice guidelines to deny coverage for treatments which physicians know to be effective, but for which there is little or no support in the medical literature. One of the strongest criticisms of evidence based medicine is that lack of evidence and lack of benefit are not the same thing.

Despite the fact that evidence based medicine discounts a physician's clinical observations and experience, health planners foresee the day when medicine will be practiced by mid-level practitioners according to a list of approved best practice guidelines. Managed care insurers are striving for this model and anticipate a time when medical care will be efficiently administered on the basis of computerized algorithms (much easier to manage than physicians).

Before we surrender, bear in mind 1) that we are smarter than computers and probably always will be, 2) we need to be prepared to defend what we do when we don't adhere to best practice guidelines, and 3) we need to avoid the trap where in order protect ourselves from sham medicine, we regulate away meaningful, albeit anecdotal observation (we need to acknowledge the benefit of "thinking outside the box").

The act of catching a baseball requires a mathematical formula that covers three black boards. We don't go through that lengthy computation to catch a ball- so how do we do it? We have found that when we chase a fly ball, all we need to do is to keep a constant angle between us and the ball. This is not intuition, but rather a rule of thumb. Our ability to condense complicated problems into simple solutions is a talent computers have not mastered, and is one of the three critical obstacles to artificial intelligence. If we are asked, "Is a tiger like a lion?" we can immediately reply, "Yes," because we know what is relevant and what is irrelevant. A computer has to categorically run the whole list of physical properties- do they both have two eyes? two ears? a tail? etc., etc.- before it can draw that same conclusion (Dreyfus, What Computers Can't Do).

In his bestselling book Gut Feelings, Gerd Gigerenzer, a psychologist and proponent of evidence based medicine, examines the three ways doctors can make treatment decisions: by a complex statistical system, by clinical intuition, and by a simple rule of thumb. He cites a Michigan hospital where patients presenting to the ER with chest pain were evaluated using the usual criteria to include a family history of heart disease, diabetes, smoking, hypertension, and high cholesterol. 90% of patients with severe chest pain were admitted, which not only created overcrowding but was very costly. Researchers were appalled to find that doctors were just as likely to admit someone who had a legitimate cardiac problem as one who did not.

Speculating that the doctors needed to pay more attention to the clinical evidence and tests at hand rather than a predictive history, the researchers created a complex systems algorithm that was so comprehensive they had to install it on a small handheld computer called the heart disease predictive instrument. Although initially the doctors were

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The Backbone is a publication of the **Connecticut Orthopedic Society.** *Comments and suggestions should be directed to:*

Susan Schaffman, *Executive Director*
26 Riggs Avenue, West Hartford, CT 06107
(860) 561-5205 phone
email: sasshops@aol.com

Membership Dues 2009

The 2009 Dues Membership information has been mailed to your office. Membership dues for 2009 remain at $250.00 which includes admission to the Annual Meeting with CME credits, reduced rates for coding workshops, legislative representation and members' directory listing for patient referrals on www.ctortho.org. Please complete the form at right and mail with dues payment (for your convenience, we accept MasterCard or VISA – earn miles). This year, with your support, your Society will:

Lobbying – Continue working with the Society's lobbyist, Halloran & Sage, to guarantee that the Society has a seat at the legislative table with upcoming debates and decisions in Legislative 2009. In addition, we continue to safeguard the practice of medicine and assist the Society's members with presentations at public hearing, bill tracking and meetings with key legislators. ***Please consider an additional contribution to the Society for political activities (*see invoice).***

Scope of Practice and Practice Preservation - Work to protect the standards of care of emergency room patients and ensure adequate physician coverage and reimbursement, continue our representation on **Worker's Compensation** to the Chairman of the Commission and open dialogue with key legislators to discuss health care coverage for the citizens of Connecticut.

Coding & Other Programs for Your Practice - Offer educational seminars at reduced rates with CEU accreditation. Don't miss the Karen Zupko & Associates 2009 **Coding Workshop** scheduled for March 12, 2009, at St. Francis Hospital and Medical Center. This workshop will cost members and their staff only $250.00 per attendee - SEE REGISTRATION FORM IN THIS ISSUE. This year we will also continue to offer the **Communications Workshop** for members to help you enhance effective communications with your patients staff and colleagues. This program offers 4 CME credits and premium reduction to CMIC policy holders.

Annual Meeting & CMEs - Provide educational opportunities and CME credits at the Society's Annual Meeting. This year's event will be held on May 29, 2009, at the Farmington Marriott Hotel and will offer informative clinical sessions from renowned speakers and more. **YOU WON'T WANT TO MISS IT!**

Communicate and update members using the Society's website (www.ctortho.org), "Backbone", the Society's newsletter and email.

Save The Date
2009 Annual Meeting
May 29, 2009
Farmington, CT

2009 Membership Dues Invoice

2009 CT Orthopedic Society Membership	$250.00
Political Activities Contribution (*optional)*	*$ 50.00**
Total Due	**$300.00**

Please complete the information below and mail with payment payable to the Connecticut Orthopedic Society. *(not tax deductible)* (Please print/type)

Name_____

Address_____

City_____Zip_____

Telephone_____Fax_____

Physician Email Address_____

Practice Manager's Name _____

Email Address_____

I will____ will not____ be attending the Society's Annual Meeting on May 29, 2009 at the Farmington Marriott.

CREDIT CARD PAYMENT Type of Card(circle one)
MasterCard VISA

Name_____
Account Number:_____
Expiration Date: _____(month) _____(year)
Signature_____

___**Yes,** charge my credit card each year (January) for the membership dues to the Connecticut Orthopedic Society until I notify otherwise.
___**No,** do not charge my credit card each year for membership dues in the Connecticut Orthopedic Society. I will issue a new credit card authorization each year.

Remit payment to:
Connecticut Orthopedic Society
c/o Susan Schaffman
26 Riggs Avenue, West Hartford, CT 06107
Payment by credit card - fax completed form to (860)561-5514.

For questions or comments, please contact Susan Schaffman, Executive Director at (860)561-5205, email sasshops@aol.com.

2009 Coding & Reimbursement for Orthopedic Practices

Sponsored by the Connecticut Orthopedic Society

Revised for 2009, this workshop will provide updates and new information for orthopedic surgeons and their practice.

Topics of Discussion will include:

- **Coding and Reimbursement Rules**
- **Orthopedic Reimbursement Tool**
- **Medicare Updates**
- **CPT & Diagnosis Coding Update**
- **E & M Categories and Levels of Service**
- **Definition of Global Surgical Package**
- **Office & Surgical Coding with Modifiers**

The workshop is conducted by **Karen Zupko & Associates, Inc.**, a nationally-recognized practice management consulting firm, that teaches national coding and reimbursement workshops for the American Academy of Orthopaedic Surgeons. **Back by popular demand is speaker, Ms. Mary LeGrand, R.N., M.A.** Mary LeGrand has twenty-five years of professional nursing and administrative experience. Previously, she held various clinical and administrative positions at the Washington University School of Medicine affiliated Barnes-Jewish Hospital in St. Louis, Missouri. Mary has a Bachelor's of Science Degree in Nursing and a Master of Arts in Health Services Management from Webster University in St. Louis.

This program has been submitted for approval CEU credits to the American Academy of Professional Coders.

Don't Delay, Register Today!

Thursday, March 12, 2009

9:00 a.m. Registration and Coffee
9:30 a.m. - 3:30 p.m. Program and Lunch

St. Francis Hospital and Medical Center
Gengras Center
114 Woodland Street
Hartford, CT 06105

Special thanks to Robert Green, M.D., Connecticut Orthopedic Society Past-President, for his planning assistance and to St. Francis Hospital & Medical Center for providing the workshop location.

The Connecticut Orthopedic Society is pleased to offer this workshop at a **reduced rate of $250.00** per attendee to its 2009 dues paying members and their office staff. For your convenience, on page 3 is a dues invoice form if you have not yet submitted dues for 2009. Complete the form below and return with fee to :

COS Administrative Office c/o Susan Schaffman
26 Riggs Avenue, West Hartford, CT 06107

Please register me(us) for the coding workshop, payment is enclosed. *(checks payable to Connecticut Orthopedic Society or use your credit card.)*

__YES, I am a 2009 Dues Paying Member of the Society
Enclosed is payment of $250.00 per participant, to cover the cost of the workbook and lunch.

__I am NOT a Society Member. Enclosed is payment of $375.00 per participant, to cover the cost of the workbook and lunch.

Name_____

Name_____

Practice_____

Address_____

City_____ Zip_____

Telephone_____ Fax_____

Payment by Credit Card - fax (860) 561-5514

Cardholder Name_____

Type of Card (circle) MasterCard Visa

Account No._____

Expiration Date_____

Signature_____

(cont. from page 2)

more efficient when they used their small calculators, after a while they remained efficient whether they used the devices or not. The hand held computers had taught the doctors how to weigh significant tests and observations. The doctors still used their clinical intuition, and, armed with a few new simple algorithms they had learned (e.g. ST changes were given the greatest weight), they no longer needed the computers. Unknowingly the doctors had "trained" their intuition.

In November Dr. Biondino and I attended the AAOS course in Las Vegas on Occupational Orthopaedics and Workers' Compensation: a Multidisciplinary Perspective. From the authors of Occupational Disability Guidelines (ODG) and of the American College of Occupational and Environmental Medicine (ACOEM) Guidelines, the two most common references for most workers comp carriers, it was noted that minor trauma does not cause significant low back injury. Major trauma is high energy trauma that results in visceral injury, proximal long bone, pelvic or spinal fracture or dislocation. Everything else is minor trauma. Caragee et al (Spine 2006; 31 (25):2942-2949) noted "Minor trauma was only associated with serious low back pain in a compensation setting." ODG is based on the work loss data from over 10 million cases, whereas ACOEM is based on the literature. Their conclusions:

1)Low back pain following minor trauma should be treated with one day of bed rest, no Xrays before 3 weeks, and an MRI only if there is no improvement by 4 weeks.

2) Only aerobic exercise is beneficial. Stretching and strengthening are not. There is a positive predictive value for manipulation within the first 3 weeks, but the most important function of PT is to allay the worker's fears. Acupuncture is effective after the acute phase of inflammation.

3) Epidural steroids are only beneficial for HNP with radiculitis and spinal stenosis- not for chronic back pain. Facet injections and radio frequency rhizotomies are of no benefit. Trigger point xylocaine injections work, but steroids add no benefit. Amytriptiline is good for chronic low back pain, but gabapentin is not.

4) A moderately firm mattress is more beneficial than a firm mattress.

5) Predictors of a bad outcome: depression, somatization, pre-existing chronic pain, smoking, workers compensation. (Patients with any of these were much more likely to get multiple MRIs).

6) Spinal structural abnormalities (on MRI and discogram) were only weakly associated with serious back pain and had no association with disability or medical utilization.

If you were to serve as an expert witness in a workers' comp or personal injury case in support of a plaintiff with chronic low back pain from minor trauma, you would have to be prepared to rebut this evidence with the appropriate references. Your experience as a spine specialist, your personal expertise with the problem, and your familiarity with the patient are not as important as they used to be.

At the recent Annual Meeting of the New England Hand Society a surgeon presented a small series of patients who had medial elbow pain he attributed to median nerve compression under the lacertus fibrosis. He made the diagnosis with manual muscle testing and claimed that within 30 minutes after release of the lacertus fibrosis his patients experienced immediate relief and restored strength. A critic raised the point that this was a subjective condition diagnosed by subjective tests and judged by a subjective end point- the perfect setup for sham surgery. I asked Dr. Kirk Watson, founder of the New England Hand Society and noted authority on hand surgery, what he thought- whether or not the lack of evidence based science here discredited the surgeon's findings and served as an opportunity for sham surgery. He replied that such observations should be encouraged and often create an interest for more formal studies. As for those who do sham surgery, says Dr. Watson, everything is an opportunity.

By establishing standards and best practice guidelines, evidence based medicine serves as a basis for the evaluation and accreditation of us as well as of hospitals and healthcare organizations. The guidelines will never absolve us of the irrevocable responsibility we bear to choose the right therapy for a specific patient at a specific time. To be fair, it is a shared responsibility- a disposition made with the participation of the patient and the approval of the insurance carrier.

Remember, the best evidence is always being updated and changed. You may have to use complex algorithms, simple rules of thumb, or gut intuition, but beyond the changing likelihood ratios, mutating probability factors, variables and placebo effects, the final decision will always be yours- and yours alone.

Save The Date

Connecticut Orthopedic Society Annual Meeting

Friday, May 29, 2009

Registration 8:00 a.m. Program 8:15 a.m. - 3:30 p.m.

Farmington Marriott Hotel, 15 Farm Springs Road, Farmington, Connecticut

Michael Kaplan, M.D., Program Director, has assembled an impressive educational program for the Society's 2009 Annual Meeting. **You won't want to miss this event which will provide you with important clinical information, updates and an opportunity to earn CME Credits.**

All Society physician members and physician assistant affiliate members (2009 dues paid), medical interns and residents are invited to attend this event free of charge. Emeritus Members can attend for $45.00. Physician assistants(non-members), physical and occupational therapists will be charged $150.00 for the meeting and luncheon.

LOOK FOR REGISTRATION MATERIALS AND COMPLETE DETAILS IN THE MAIL OR USE THIS FORM. Please contact the Connecticut Orthopedic Society's Executive Director, Susan Schaffman at (860)561-5205 or log onto www.ctortho.org to register. The Society looks forward to your participation.

Speakers

Instability Following THA – What are My Options?
Periproshetic Infection – Problems on the Horizon
Javad Parvizi, MD - Rothman Institute, New York

New Polys for Old in Joint Arthroplasty: Hopes vs. Realities
Performance Characteristics of Mobile Bearing Knee Designs
Seth Greenwald, MD
Orthopedic Research Laboratories, Cleveland, OH

Pilon Fracture
Ankle Instability
Judith Baumhauer, MD - University of Rochester

Sports Medicine 2009
Topic to be Determined
Keith Lawhorn, MD - Sports Medicine, Fairfax, VA

2009 Orthopedist of the Year Award

Connecticut ORTHOPEDIC Society

2009 Annual Meeting Registration Form

___**Yes**, please register me (us) for the Annual Meeting on May 29, 2009, at the Farmington Marriott Hotel from 8:00 a.m. - 3:30 p.m.

Name_____

Name_____

Practice_____

Address_____

City_____**Zip**_____

Telephone_____ **Fax**_____

E-mail_____

Registration Status (check one)

___Connecticut Orthopedic Society Member (2009 Dues Paid - NO FEE)

___Connecticut Orthopedic Society Physician Assistant Affiliate Member (2009 Dues Paid - NO FEE)

___Connecticut Orthopedic Society Emeritus Member ($45.00 FEE)

___Medical Student, Resident or Intern (NO FEE)

___Physician Assistant, Physical or Occupational Therapist ($150.00 per registrant)

Return form and payment (if applicable) to:
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26 Riggs Avenue, West Hartford, CT 06107
(860)561-5205 phone - (860)561- 5514 fax
email - sasshops@aol.com