Orthopaedic
PRACTICE MANAGEMENT

In This Issue . . .

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Focus on collections is critical to profits in down economy

When should you send your accounts to a collection agency? That's an increasingly important question as payers shift more of the financial responsibility for health care services onto patients and orthopaedic practices struggle to collect growing out-of-pocket payments.

"In terms of collections, we're going to have some horrible times coming down the road," says **Owen J. Dahl**, FACHE, CHBC, president of Owen Dahl Consulting in The Woodlands, TX, and author of *Think Business! Medical Practice Quality, Efficiency, Profits*. "We're seeing an emphasis on higher deductible plans. We're seeing patients with higher acuity because they're delaying visits to the doctor. These kinds of issues are going to create payment problems, both in the volume and the acuity of activity."

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Case study

Consider the pros and cons before opening a prompt care clinic

If your orthopaedic practice suffers from the perennial problem of long referral lists and appointment backlogs, an orthopaedic prompt care clinic is an expansion worth considering. These specialized urgent care centers are designed to triage patients with orthopaedic injuries while eliminating the redundancy associated with ER visits. At a prompt care clinic, a physician assistant (PA) who's trained and supervised by an orthopaedic surgeon can take patients without an appointment, manage those who need wound closure and debridement or the application of a cast or splint, and refer those who need surgery to the attending physician.

A clinic can alleviate overcrowding in the orthopaedic practice but requires surgeons to relinquish some control, as the physicians at Amarillo (TX) Bone & Joint Clinic, LLP, have learned. **Keith D. Bjork**, MD, and his partners have a private

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Coding Spotlight

Code properly to track reasons for hip replacement failure

A study published in the January 2009 issue of *The Journal of Bone and Joint Surgery* reveals that hip instability and mechanical loosening -- not failure of bearing surfaces -- are the most common reasons for the failure of hip replacement procedures in the United States.[1] Through the proper use of ICD-9-CM diagnosis and procedure codes that were introduced on October 1, 2005, orthopaedic surgery practices can help researchers track outcomes for this procedure nationally and influence future research efforts and implant design, says **Kevin J. Bozic**, MD, MBA, associate professor in residence in the Department of Orthopaedics and Philip R. Lee Institute for Health Policy Studies at the University of California, San Francisco.

"This is the first study in which we were able to look at the entire country and gain a better understanding of why total hip replacement surgeries can fail," says Bozic, who served as lead investigator. The findings have enormous implications, since hip replacements are not only one of the most common orthopaedic procedures, but also one of the most common surgical procedures in the U.S.

Bozic was part of an earlier research group that argued for greater specificity in administrative claims data for revision total hip arthroplasty. Prior to 2005, the most commonly used ICD-9 diagnosis code associated with failed total joint replacement was 996.4 -- mechanical complication of an internal orthopaedic device -- regardless of the type or mechanism of failure. Furthermore, ICD-9 procedure codes categorized all hip revision procedures simply as "revision of hip replacement" (81.53), regardless of the type or complexity of the revision surgery. "The same codes would be used to describe anything from a loose screw to a complete redo of the joint replacement," Bozic explains. In April 2005, CMS agreed to the researchers' recommendations for more specific codes.

In the new paper, Bozic and colleagues analyzed data from 51,345 U.S. patients who underwent revision total hip arthroplasty procedures between October 1, 2005 -- the effective date of the new ICD-9-CM codes -- and December 31, 2006. They found that the most common reasons that patients needed subsequent hip replacement surgery included dislocation of the implant (22.5%), mechanical loosening (19.7%), and infection (14.8%), including staph infections that occurred prior to or following surgery. Revision total hip arthroplasties were most often performed in large, urban, nonteaching hospitals for Medicare patients between the ages of 75 and 84. The average hospital length of stay for all types of revision arthroplasties was 6.2 days, with average total charges of $54,553, but results varied considerably by region, type of hospital, and type of revision procedure.

"This study is important because up until now it has been believed that the most common reason why hip replacements fail is because the bearing surface wears out," Bozic explains. "Although our study confirmed that problems related to bearing surface wear do cause hip replacements to fail, we found that other problems may be even more common causes."

The findings suggest a need for research aimed at developing better implants. However, the study also indicates that factors within the surgeon's control -- not just design factors -- are potential causes for failure. These include surgical technique and installation of the implant. "We need to do more detailed studies to find out the reasons why dislocation and

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infection are common causes of hip replacement failure," Bozic concedes.

Document cause of failure in notes

Orthopaedic practices can play a key role in gathering this information. Encouraging physicians to use the proper ICD-9-CM diagnosis and procedure codes to describe the cause of a hip replacement failure and the type of revision procedure performed will help to improve clinical care for these patients, Bozic says.

"It's really important for practice managers and orthopaedic surgeons to know that these codes exist and to use them properly," he says. "One of our goals is to use the new diagnosis and procedure codes related to hip replacement to help create a national joint replacement registry, which has been done in many other developed countries. Every patient who has a joint replacement gets entered into a national database and is tracked over time."

The newer ICD-9-CM diagnosis codes include 996.41 (mechanical loosening of prosthetic joint), 996.42 (dislocation of prosthetic joint), 996.43 (prosthetic join implant failure / breakage), 996.44 (periprosthetic fracture around prosthetic joint), 996.45 (periprosthetic osteolysis), 996.46 (articular bearing surface wear of a prosthetic joint), and 996.47 (other mechanical complication of prosthetic joint implant). The ICD-9CM procedure codes include 00.70 (revision of both acetabular and femoral components), 00.71 (revision of acetabular component, includes femoral head), 00.72 (revision of femoral component, includes acetabular head), 00.73 (isolated revision of head, liner), 84.56 (insertion of cement spacer), and 84.57 (removal of cement spacer).

Although a registry would track hip replacement revisions by these codes, the researchers found that, in some practices, surgeons are not even aware they exist and continue to use the nonspecific codes. "In order for this data to be useful and to be accepted, surgeons need to document the actual cause in their operative notes," Bozic says. That information should be abstracted and included in the claims submission to the insurer, he adds.

Educating orthopaedic surgeons about the new codes isn't rocket science. In fact, the best way to remind them to use the codes is a simple, low-tech tool: cut the list out of a coding book, place it on a laminated card, and give a copy to each physician to keep in his or her pocket, Bozic suggests.

"When surgeons are seeing patients in the office or dictating in the operating room, they have those J codes available so they can code those causes of failure," he says. "Having a lunchtime seminar or some peer-to-peer acknowledgement of these codes is helpful to make people aware of them, but I still keep the card in my pocket and refer to it periodically, even though I'm the one who created these codes."

In light of the new findings, practices also should examine their clinical guidelines for hip replacement surgery, failure rates within the practice, reasons for failure, and patient screening methods. The study suggests that two of the three most common reasons that hip replacements fail -- dislocation of the prosthesis and infection -- fall more under the control of the surgeon even though failure of the bearing surface is more commonly blamed.

Patient factors such as obesity, immune status, presence of diabetes or inflammatory arthritis, and history of steroid use also heighten the risk of hip replacement failure. When discussing the procedure with patients, surgeons should caution that these factors might influence the risk of failure as much or more than the design of the implant.

Editor's note: Contact Bozic at 415-476-3900 or kevin.bozic@ucsf.edu.

Reference

1. Bozic KJ, Kurtz SM, Lau E, et al. The Epidemiology of Revision Total Hip Arthroplasty in the United States. *JBJS* 2009;91(1): 134-141. ◆

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The best collections strategy is one you manage in-house without paying a portion of your accounts receivable (A / R) to a collection agency, experts agree.

"I'm a huge proponent of fixing a process internally rather than going outside," Dahl says. "Why would you give up a percentage of your collections if you had a way to collect the money internally?"

To improve your internal collections process, **Janet Marcus,** CPC, senior consultant at Sinaiko Healthcare Consulting, Inc., in Los Angeles, advises orthopaedic practices to monitor the volume of four measures of activity: 1) mail; 2) accounts with balances less than $30; 3) self-pay accounts; and 4) accounts with balances greater than $1,000 that are being sent to collections.

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"Less is better, so if your practice has small numbers in these four areas, you're probably doing well in your internal collection efforts," Marcus says.

Watch these metrics

Other metrics that orthopaedic practices should track to assess the effectiveness of internal collections include:

• **Gross collections percentage.** When monitoring this metric, which is calculated by taking the ratio of charges to payments, trend is more important than a one-month snapshot because seasonal variations can skew results. Summarize total charges and receipts over a six- or 12-month period, calculate a monthly average, then examine gross collections for that "average" month, Dahl suggests. As you trend the average forward -- examining the monthly average for the 12-month period from January to January, then February to February, etc. -- you'll gain better insight into your collections performance.

• **Net collections percentage.** This metric adjusts the ratio of charges to payments for contractual and other adjustments, including bad debt and other uncollectables. "If all of the insurance adjustments are correct when you look at long-term trends, the net collection percentage should be 100%," Dahl says. When net collections fall below 100%, the difference represents bad debt. Consider using a collection agency once this percentage hits a predetermined trigger.

• **Average days or months in A/R.** Calculate this metric by totaling your average charges over a six- or 12-month period, dividing by the number of months to determine your average monthly charges, then dividing that figure into your total A/R to calculate the number of months those charges are sitting in A/R, Dahl explains. Multiply that result by 30 to calculate the days in A/R, which is a more transparent metric. Practices that consistently hold their A/R average below 70 days are managing collections efficiently, Marcus says.

• **Percentage of A/R dollars greater than 120 days.** Orthopaedic practices tend to have a higher percentage of worker's compensation patients and those involved in litigation -- from car accidents, for example -- than other specialties, which may inflate accounts older than 90 days. Your goal should be to keep aging accounts below 10-15% of your total A/R. "If this percentage creeps toward 20%, you should examine which charges are lingering in A/R, and why," Marcus says.

Update collections policies, procedures

If you're tracking your collections metrics carefully and see that A/R begins to grow, don't panic, experts say. Instead, examine your collections policies and procedures to ensure they're up to date. For example, the practice should have a well-defined, written policy that specifies the number of collection letters you will generate, the timing and sequence of those letters, and whether or when you will follow up with a phone call to the patient before sending an account to a collection agency.

"If a patient has a $5 outstanding balance, it's hardly worth a phone call, but if it's a $500 balance, it's definitely worth a phone call," Dahl says, noting that a formal collection policy allows you to manage each account consistently.

Orthopaedic practices offer a variety of services, so dollar thresholds should be consistent with each category of services, Marcus says. Because of the high dollar amounts, surgical accounts should be worked diligently within the practice before sending them to an agency. "For balances over $500, you want to be sure that you've done everything you can to collect those accounts in-house," she says. In contrast, physical therapy (PT) accounts might have a much lower threshold -- $100 or even $50 -- to send to an agency once the in-house process has been exhausted.

Internal procedures should support your collections policies. Since the best time to collect is when a patient is standing in front of you, your goal should be to collect co-pays and deductibles at the time of service, experts agree. Notify patients of co-pays and outstanding balances when you call to remind them of appointments. Process claims and payments electronically using tools that are readily available in the marketplace, such as authorization and verification modules, to improve accuracy.

In addition, establish A/R triggers to ensure that you don't neglect accounts until they become delinquent, Marcus adds. Program your software to monitor the number of statements you send each patient and to flag any accounts that receive multiple statements without submitting a payment. Create a monthly management report that lists all accounts exceeding a certain dollar amount that remain unpaid after initial follow-up. "If you have thorough practices in place, you'll decrease the volume of accounts that have to be considered

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for referral to a collection agency," Marcus says.

Don't sit on delinquent accounts

Once you've thoroughly examined your in-house processes, consider which accounts to send to a collection agency. Physician practices typically send debts of a certain size or age to an agency to remove them from A/R. The difference between what the agency collects and the full value of the debt is then written off as a loss.

Time is the most important trigger for sending accounts to a collection agency. Many practices wait too long to contact an agency because the physicians don't want to give up on their internal collectors and pay a fee, admits **Jeffrey N. Hausfeld**, MD, MBA, FACS, managing director of FMS Financial Solutions, a full-service debt recovery firm based in Greenbelt, MD. However, an agency can help the practice to monitor A/R and examine trends so that accounts don't become stale, he says. Having a collection agency involved in the process also frees internal staff to focus on collecting accurate payments from insurers in a timely fashion.

"In every industry, there's a very nice bell curve showing that the greater the time from the date of service to the time that it reaches the collection agency's database, the less likely you are to recover those funds," Hausfeld says.

Orthopaedic practices should process a patient's claim within one business day of the service and should expect an explanation of benefits from the payer within 30 days. Once the EOB is in hand, "the clock starts ticking," Hausfeld says, advising practices to send a letter to the patient during each of the next three months unless payment is received. (See sample letters at right.) At that point, unpaid bills should be sent immediately to an agency, he suggests.

"If a patient hasn't paid within three months following adjudication of the claim, chances are -- and statistics prove this out -- the patient doesn't plan to pay the remaining balance," Hausfeld says. The patient may think the insurer is responsible for the remainder of the bill, have a dispute about the bill, or not have sufficient funds to pay the bill. "In any case, continuing to do the same thing over and over will be fruitless," he adds.

To avoid misunderstandings, your physicians should set the group's collection policy and make the final decision on which accounts go to an agency. When your practice has followed all of the established collections policies and a patient still

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Table 1: Sample collection letters

Use the following salutation for all letters

FORWARDING SERVICE REQUESTED

JOHN DOE
123 ANY STREET
ANYTOWN, US 12345

Date

Patient Name:
Account Number:
Balance Due:

COURTESY NOTICE

Thank you for choosing [practice name] for your orthopaedic surgery needs.
We appreciate the opportunity to serve you.

The balance indicated above was not paid by your insurance and represents your deductible, copay, and/or other non-covered charges remaining after the insurance payment (s) was applied.

If you have any questions or wish to discuss the status of your account, please contact me at XXX-XXX-XXXX between the hours of 8:00 a.m. and 5:00 p.m., Monday through Friday.

Your prompt payment is appreciated.

Sincerely,

[Collection representative's name]
Patient Representative

Letter 1

THIS IS AN ATTEMPT TO COLLECT A DEBT. UNLESS YOU NOTIFY THIS OFFICE WITHIN 30 DAYS OF THE VALIDAITY OF THIS DEBT, OR ANY PORTION THEREOF, [PRACTICE NAME] WILL ASSUME THIS DEBT IS VALID.

DELINQUENT ACCOUNT

ATTENTION -- Our records indicate that you have an unpaid balance in the amount indicated above, and it is now considered XX days past due.

In an effort to settle this account in a most reasonable way, we are asking that you remit full payment immediately. If you are unable to pay the full amount at this time, please contact me at XXX-XXX-XXXX.

If your payment has already been sent, please disregard this notice.

Thank you for your cooperation.

Sincerely,

[Collection representative's name]
Patient Representative

Letter 2

THIS IS AN ATTEMPT TO COLLECT A DEBT. UNLESS YOU NOTIFY THIS OFFICE WITHIN 30 DAYS OF THE VALIDAITY OF THIS DEBT, OR ANY PORTION THEREOF, [PRACTICE NAME] WILL ASSUME THIS DEBT IS VALID.

FINAL DEMAND

IMMEDIATE ATTENTION -- Our records indicate that your account has become seriously delinquent and it is now considered 120 days past due.

In an effort to settle this account in a most reasonable way, we are willing to offer you settlement options. If you wish to discuss your options, please give me a call within 15 days from the date of this notice.

If we don't hear from you by then, we will forward your account for further review.
We would prefer not to go in this direction and would be more than happy to work with you. However, Mrs./Mr. [Patient name], we must hear from you.

Please contact me at XXX-XXX-XXXX.

Thank you for your cooperation.

Sincerely,

[Collection representative's name]
Patient Representative

Letter 3

THIS IS AN ATTEMPT TO COLLECT A DEBT. UNLESS YOU NOTIFY THIS OFFICE WITHIN 30 DAYS OF THE VALIDAITY OF THIS DEBT, OR ANY PORTION THEREOF, [PRACTICE NAME] WILL ASSUME THIS DEBT IS VALID.

Source: Owen J. Dahl, FACHE, CHBC, Owen Dahl Consulting, The Woodlands, TX.
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refuses to pay, in theory the account should always go to collections. But, recognizing that an account sent to collections may damage a patient's credit rating, physicians may want to use some discretion when a patient or even the referring physician is a close friend or colleague.

"The physician is the authorizer because, in the end, the care is rendered between the physician and the patient," Marcus explains. "You don't want a physician to be surprised when an account goes to a collection agency."

Don't give a doctor 30 patients to review for collections without emphasizing the urgency of the matter, however. "Tell the doctor, 'If I don't hear back from you in a week, these are going out,'" Hausfeld suggests.

Structuring your service agreement

In general, hiring an outside collection agency will cost your practice 25-35% of the outstanding debt that's recouped. That's a big chunk of change, but an outside agency will have a skill set that your office staff may lack. For example, collection agencies are well-versed in the Fair Debt Collection Practices Act of 1977 (FDCPA), a federal law that limits the hours during which the agency may call the patient and prohibits communication of the debt to a third party. The FDCPA also prohibits false, deceptive, or misleading representations and prohibits the agency from making threats that it cannot legally pursue.

Interview at least three collection agencies to identify one that feels like a good fit with your practice. (See sample questions in box below.) The relationship between your practice and the agency is governed by a service agreement, which stipulates the amount of the fee and other terms. Once you've selected a candidate, structure your agreement carefully so both parties understand their responsibilities. For example, collection agencies expect accurate information from the practice on debtors and the amount of their debt. In turn, they can offer a smorgasbord of services, from writing letters to pulling credit reports to referring accounts for legal action.

Most medical collection agencies work on a contingency basis, which costs the practice nothing until and unless the agency collects money from a patient. However, an agency may require payment even if it doesn't recover the full amount of the debt or if the practice cancels the collection effort before the debt is collected. Some agencies also acquire portfolios of debt, which may get worked harder while smaller accounts languish. "Every debt that comes to a good collection agency should get attention," Hausfeld says.

You'll want to retain the ability not only to negotiate the threshold dollar amounts and age of the accounts that are sent to the agency, but also the authority to make final decisions before delinquency notices are sent to a credit bureau. Practices need the flexibility to override collection agency procedures in isolated cases, "and that needs to be a frank, open discussion before the contract is signed," Marcus says. The contract also should specify which individ-

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Consider these questions when evaluating collection agencies

To find a collection agency that's a good match with your practice, develop a checklist or questionnaire and use the same rigor in evaluating candidates that you would use to interview other types of vendors. Following is a list of questions that experts recommend:

- When was the collection agency established, and what percentage of its business is represented by orthopaedic practices?
- Does the agency have experience working with a variety of orthopaedic services and, if so, which ones?
- Does the agency have a local office so it can understand the nuances of your geographic market?
- How does the agency manage customer service relationships, both with practices and with patients?
- What is the agency's experience with worker's compensation claims?
- Does the agency belong to the Better Business Bureau?
- What training does the agency provide for its staff?
- What are the agency's policies with respect to hiring and background checks?
- How are accounts handled when they're referred to the agency: sequentially, by size of the debt, or according to other factors?
- How is debt worked by the agency?
- What technology does the agency use, and how much of the work generated for each patient account is available online?
- What is the agency's collection success rate, and how is that defined?
- Are payments from patients sent directly to the practice or to the agency, and how does the agency settle those payments with the practice?
- Does the agency maintain a suspense file to reexamine accounts that can't be recovered immediately?
- What is the fee schedule? To what extent are fees negotiable based on volume and other factors?
- What additional costs may be incurred in the collections process? For example, if an account goes to trial, does the agency's collection percentage increase?

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uals in the practice have the authority to release accounts to the collection agency and which individuals in the agency have the authority to file a lawsuit on behalf of the practice.

"Practices should look for the ability to influence and customize the collection agency's approach, both on a global and on an individual basis," Hausfeld says.

A collection agency has the authority to locate patients, negotiate payment plans, and even extend loans to creditworthy patients. Because each collection agency develops its own strategies to recover payments from patients, "sit down with the collection agency's leadership during the negotiation stage and explain your customer service requirements," Marcus suggests. Some agencies are quick to strong-arm customers while others have a softer touch. Some skilled collectors can establish rapport with patients during an initial phone call and work out a payment plan from the get-go. But the time to talk about what tactics are used and your potential influence as a client is when you're still at the courting stage.

"Doctors need to get paid for the services they render, but they don't need to alienate the patient or incite the patient to go to the medical bureau or to a lawyer," Hausfeld maintains. "Practices need to find [an agency] which understands that delicate balance."

On the other hand, it's counterproductive to hire an agency and then micromanage its efforts. Although practices want to preserve good relationships with patients, "if you tie the hands of your collection agency, they can't do the job you hire them to do," Dahl points out.

During contract negotiations, ask for the collection agency to assign a manager to interface with the practice manager. "This gives you a direct source for quick problem-solving and for more effective communications," Marcus says. She also advises orthopaedic practice managers to interview some of the staff who would be assigned to your account. Are they diplomatic, tactful, and solution-oriented? How do they address patient complaints and correct mistakes that may occur during the collections process?

In addition, ask for a sample report that illustrates how the agency will communicate the status of each account. Learn whether the reports will be sorted by type of surgery and/or PT service and how often they'll be generated. As the last step before selecting an agency, ask for references at other orthopaedic practices and call those practices to learn about their experience with the agency, Marcus suggests.

"We recommend that orthopaedic practices contract with two collection agencies simultaneously," she adds. "Distribute the assignments equally to those two agencies, then evaluate and compare the results." Practices that are heavily involved with worker's compensation should find a collection agency that specializes in those services, which are governed by different rules and regulations, she says.

Other collection methods

A collection agency isn't your only alternative to address delinquent patient accounts. Most states allow physician practices to pursue patient debts through small claims court, which may be cheaper than a collection agency. Although you may not receive your money right away, filing in small claims court "gives you a leg up" in recovering financial judgments for a modest up-front fee, Dahl says. However, this option requires considerably more oversight by the practice staff, "so you have to weigh the cost versus the benefit," he adds.

Having an attorney simply write collection letters on the law firm's letterhead is another option that may save your practice time and money. In fact, some collection agencies also offer letter-writing services where, for a small flat fee, they generate a series of increasingly urgent letters instructing patients to pay the amount owed directly to the creditor or risk a collection action and negative credit report. Hausfeld's firm offers an early recovery program that kicks in three months after the first bill is generated by the practice. Once a practice faxes, e-mails, or exports delinquent account information, FMS Financial mails two letters to the patient within the next month, giving the patient 30 days to dispute the account as required by the FDCPA and warning that the account will be sent to a credit reporting bureau.

"This is one of the major differences between a collection agency and a practice," Hausfeld explains. "Practices can't pull credit on anyone, and they can't report people to credit agencies. That's a tool that we leverage significantly to get people to pay us."

If patients respond to the letters, the practice pays a flat fee -- $30 at Hausfeld's firm -- whether the balance is $100 or $5,000. However, depending on the terms of your agreement with a collection agency, these accounts may automatically go to the agency's collection floor at its regular rate if the patient does not respond within a few weeks.

Whatever solution you choose, tough economic times dictate that you examine every option to optimize your collections.

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"In any orthopaedic surgery practice, physicians need to focus on their core competency, and that core competency is to provide excellent medical care," Hausfeld says. "The administrator is the key person in the practice who monitors the flow of debt and the liquidation of that debt. You have to examine the revenue cycle with an eye to maximizing the amount of money the practice takes in."

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Coming next month: Learn how an orthopaedic practice implemented a revenue recovery department as part of its billing process before sending accounts to an external collection agency.

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practice in Amarillo, a city with only 16 orthopaedic surgeons for a regional draw area of some 750,000 people that extends from the Texas Panhandle east to New Mexico and north to Colorado and Kansas. In addition to the enormous catchment area, I-40 goes directly through Amarillo, so the orthopaedic surgeons often take trauma victims. With demand outpacing supply, physicians found themselves booking out up to eight weeks in advance just to evaluate patients who didn't have an emergency.

"We found ourselves in an incredible crunch," Bjork tells *Orthopaedic Practice Management*.

When the physicians opened a prompt care clinic in the same medical building with their practice, they began to shift most new patients from the practice to a full-time PA with 20 years of experience in orthopaedic surgery who routinely sees 50 patients per day.

"Having a prompt clinic is like having a big catcher's mitt," Bjork explains. "We're able to see more patients and take care of people in a timely fashion. It's great for the patients and for the physicians."

Don't establish clinic 'on the cheap'

Bjork and his partners conducted a pro forma before they opened the prompt clinic to assess the operation's bottom line impact. They examined patient demographics and determined that replicating services for patients with urgent needs would pay for itself while freeing the surgeons to see more complex cases in the office.

"When we looked at our outpatient population and our wait times for patients to be seen for hand or knee surgery, it was a no-brainer," Bjork says.

However, "to do a prompt clinic and do it right, you need to reproduce everything you have in your office," he adds, including imaging equipment, supplies, and durable medical equipment. The practice minimized capital expenses by purchasing equipment from an orthopaedic surgeon who left Amarillo to join an academic medical center, but the new clinic also required outlays to expand its EMR and billing programs as well as its software licenses -- some at $1,500 per user.

"A prompt clinic functions as a completely independent operating orthopaedic clinic," says **Dave Clark**, the practice's administrator. "Whatever it costs you to set up an office, that's about what it costs you to set up a prompt clinic."

The clinic also required the replication of the practice staff, including a receptionist, X-ray technician, several medical assistants, and billing staff. In short, a prompt clinic isn't an inexpensive proposition.

"We looked at the model pretty closely," Clark says. "We knew we had the right orthopaedic physician assistant and we had the right physicians. We had the location, which is directly across from the physicians' practice, with MRI and X-ray just across the hall. But we still underestimated some of the start-up costs."

Bjork and Clark advise practices to prepare for a $500,000 outlay during the first 18 months for start-up costs. In addition, a prompt clinic demands the skills of a PA who can work as efficiently and independently as his or her licensure allows, and that kind of experience can command a salary of $150,000 annually, Bjork says.

"I know of some people who have tried to do this on the cheap, and it was a disaster," he says.

Initially, the practice hired two PAs, but one left and wasn't replaced. "With a racehorse, you can make this concept work with one PA," Clark says, noting that the practice added support staff to enhance the PA's efficiency. The PA is equipped with the same EMR and PACS as the main practice and is always directly supervised by one of the surgeons, who also is available for consultation. When

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the PA examines a patient with a broken arm or leg who needs surgery, he can make a single phone call to the surgeons, who often can place the patient on that day's surgical schedule and simply move the patient down the hall to their office. The surgeons continue to see all surgical patients and review their records prior to surgery.

Initially, offering new patients immediate appointments in the clinic rather than having them wait three to four weeks to see a physician in the practice created a false sense of profitability because the practice was simply working down its patient backlog. Although the clinic is run as a separate operation with its own budget, "we underestimated how much business we would initially pull out of the practice," Clark admits. The physicians expected the clinic to see 20 to 25 patients a day for the first few months before growing to 30 to 35 patients "once the word got out," Clark says. Instead, the clinic attracted upwards of 40 patients per day from the get-go, including a surprising high percentage from outlying rural communities.

The PA also began to see repeat patients -- for example, individuals with knee or ankle sprains who returned for follow-up care.

"We counted on first-time patients, but how many more times would some of those patients return, with recurrent charges?" Clark asks. Initially, those patients pulled business from the practice, "and we flat missed that part of the summary."

Marketing the prompt care clinic

Despite some early missteps, the clinic has generated profits since its second month of operation. In part, Clark attributes that success to an extensive marketing program that keyed on the clinic's name.

"The word 'prompt' doesn't indicate urgent or immediate or emergency," he points out, "and we've never encountered a bad leg or knee or arm or foot come flying in and think we're an emergency room." The only glitch occurred when a new physician in the practice was taking emergency room call and the clinic began to see a spike in uninsured and other self-pay patients from the ER. "These would make our numbers look good, but at the end of the day they were a loss financially, and we didn't build that into our model," Clark says.

Nevertheless, the group generated an overwhelmingly positive response from patients -- without raising too many hackles among other orthopaedic surgeons in the community -- by running 12-second spots on a popular local television station during morning, evening, and late-night newscasts. The spots ran daily on the half-hour, for a cost of $2,800 a month.

Newspaper advertising was prohibitively expensive, so the practice spent another $1,000 per month for ads in several community magazines. In addition, the practice produced two glossy direct mail pieces for its target population -- the community's $50,000-plus households -- for $0.12 each plus mailing costs. Clark also sent a direct mail piece to major employers in Amarillo advising them of the clinic's services as an alternative to the ER for employees and family members.

The marketing effort didn't overlook family practice and other referring physicians, both in Amarillo and outlying rural areas.

"The number one problem they have is that they can't get people in for quick referrals," Clark says, "so we directly marketed to those practices -- direct mail pieces, physician hotline numbers -- and that worked well for us."

"It's been a home run with our referring doctors," Bjork agrees.

Clinic doesn't cannibalize practice

The clinic, which is open weekdays, encourages appointments but welcomes walk-ins. Its biggest advantage to the practice is an efficient, cost-effective alternative for screening new orthopaedic patients, who can receive an X-ray or MRI and begin appropriate treatment until and unless they need to see a surgeon. Those referred for surgery also receive pre-op education, which is reinforced when they see their surgeon.

If anything, the prompt clinic has succeeded too well. Managing a steadily growing volume is now its biggest challenge. Surgery schedules for existing patients in the practice are booked three to four weeks in advance, yet a handful of the dozens of patients seen each day at the prompt clinic also need surgery -- and they usually slip into the schedule more quickly.

"This was a real paradigm shift, at first," Bjork admits, noting that the practice's staff were adept at screening out patients without clear orthopaedic needs and referring patients who needed back or neck surgery, which is not performed in the practice. But since most new patients now choose to be seen in hours or days by the PA at the prompt care

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clinic rather than waiting weeks to see a doctor at the practice, the physicians had to relinquish the responsibility of seeing every new patient.

"It's really more efficient for the PA to see everybody initially," Bjork explains. "Otherwise, I've got to wade through 60 people in a day to find the five who may need an operation, and that's not the best use of my time. We've changed our operating mode to try to get as many new patients as possible into the clinic, and that's an efficient way to get those who need surgery to the front of the line." For the process to work, however, "you've got to have a PA who's on the same page as the physicians and is someone you trust," he adds.

Despite the success of its prompt clinic, Clark advises practices to study the local market carefully, be "patient in the profits," and continue their marketing efforts until clinic volume builds to a sustainable level without cannibalizing the practice. During the past six months, he's suspended the clinic's comprehensive marketing program in favor of a targeted approach aimed at self-pay patients.

"We've not been hurt by a lot of walk-in self-pays," he explains, noting that the clinic also has "packaged" certain types of visits, such as ankle sprains, for these patients, for a flat fee that includes the visit, X-ray, crutches, and boot.

"Self-pay patients love the idea," Clark says.

When insured patients wanted to use the same flat-rate service, Clark approached several insurers, who theoretically liked the package concept. The hitch was that they couldn't decide how to reimburse the service since their systems were set up to bill by factors such as clinic visit, patient acuity, and supplies, Clark says. Nevertheless, it's essential for a prompt clinic to accept every available insurance plan as well as self-pay patients and to see all types of injuries -- even if some are referred to orthopaedic surgeons outside the practice.

"This is a great model, but you need a busy practice where you've seen over a period of years that you cannot get your patients down to be seen within a week," he adds. "You can't do this as a flash in the pan to get people in. You need to validate that it's a sustainable model."

"After a time, a prompt clinic is a good cash cow, but if you go into it from the standpoint of making money, you're going into it for the wrong reason," Bjork agrees. "If you look at how to more effectively and efficiently see patients, you'll be very happy. You'll see more surgical patients and fewer patients with contusions on their big toe. Those patients can be managed by primary care physicians, unless they break their big toe and need to come to you for surgery."

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Expect decline in arthroscopies

New guideline addresses medical management for OA of the knee

As expected, the American Academy of Orthopaedic Surgeons (AAOS) in Rosemont, IL, last month released an evidence-based clinical practice guideline on treatment of osteoarthritis (OA) of the knee. The guideline, developed specifically to address medical management for patients with moderate to severe OA but no additional damage to their knee, will likely reduce the number of knee arthroscopies but may increase opportunities to provide physical therapy (PT) to these patients.

The new guideline recommends that orthopaedic surgeons not perform arthroscopic lavage if a patient displays only OA symptoms without other problems, such as loose bodies or meniscus tears. Several clinical studies and an exhaustive scientific review by researchers at the Rockville, MD-based Agency for Healthcare Research and Quality (AHRQ) concur that medical management is more effective than arthroscopic surgery for these patients. (See *OPM*, Oct. 2008, p. 97.)

Excluding the presence of mechanical problems with the knee, "the current science shows us that just washing out the joint does not decrease the patient's osteoarthritis symptoms and can expose the patient to additional risk," says **John C. Richmond**, MD, chair of the Department of Orthopaedics at New England Baptist Hospital in Boston and professor of orthopedic surgery at Tufts University School of Medicine, who chaired the AAOS physician volunteer work group. However, arthroscopy may potentially benefit patients if mechanical problems such as loose bodies and meniscal tears are present, he adds.

Orthopaedic practices may need to tweak the schedules of physicians who see many patients

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with OA of the knee. Without the need to perform arthroscopic surgery for uncomplicated OA, physicians generally will have room in their schedules to perform other types of surgery for additional patients in a timelier manner, Richmond points out.

"For my own personal practice, I've found it helpful to have the information from the studies that point out the lack of efficacy for arthroscopy," Richmond says, noting that it's easy to talk patients out of surgery when they come in with uncomplicated OA of the knee.

"Will this reduce the number of visits to an orthopaedic practice?" he asks. "It's hard to tell. If the orthopaedic surgeon leaves the medical management to the primary care physician or physical therapist, it will reduce the number of people coming to their office and free them up to treat other problems."

Seek revenue opportunities for PT

The guideline advises patients with a body mass index (BMI) greater than 25 to lose a minimum of 5% of their body weight as part of their clinical care. Orthopaedic surgeons also should advise all patients with OA of the knee to begin or increase their participation in low-impact aerobic fitness and to participate in self-management education programs such as those conducted by the Arthritis Foundation.

"These two recommendations are very important because patients can self-manage the progression of their OA and take more control of their issues," Richmond says. In particular, weight loss "has the highest potential to actually slow the progression of the disease," he adds.

OA of the knee is a leading cause of physical disability, especially in those 65 and older, accounting for up to one-third of the patient population in general orthopaedics, Richmond estimates. Total knee arthroplasty (TKA) -- recommended for end-stage OA -- is not even addressed in the guideline but is the most rapidly growing procedure in orthopaedic surgery, he points out.

The goal of orthopaedic treatment for moderate to severe OA of the knee is to enable patients who are not yet candidates for TKA to continue with daily activities such as walking and climbing stairs by minimizing symptoms such as pain, stiffness, and swelling in the knee joint. The work group suggests that orthopaedic surgeons select an appropriate analgesic for patients with symptomatic OA of the knee. Unless contraindicated, recommended treatment includes acetaminophen (not to exceed 4 grams per day), non-steroidal anti inflammatory drugs (NSAIDs), or intra-articular corticosteroids for short-term pain relief.

"One of the goals of the work group was to create a guideline that was supported by family practitioners, rheumatologists, and physical therapists," all of whom can medically manage OA of the knee, Richmond says. When primary care physicians manage these patients optimally, the patients would be referred to an orthopaedic surgeon only if additional damage occurred or a worsening condition warranted a TKA.

Orthopaedic practices should examine the size and composition of their PT program for opportunities to capture additional revenue from managing patients with OA of the knee through exercise modification, weight training, and rehabilitation, Richmond suggests. In terms of rehabilitation, the work group suggests range of motion exercises and quadriceps strengthening for patients with symptomatic OA of the knee. Orthopaedic surgeons also should consider patellar taping for short-term pain relief and functional improvement for these patients, though the guideline advises against prescribing lateral heel wedges for patients with symptomatic medial compartmental OA of the knee.

Clinical judgment still needed

After analyzing current scientific literature, the work group also recommends against three treatments that are commonly sought by patients or prescribed by physicians for OA of the knee. In addition to needle lavage, these include use of customized foot orthotics and of the over-the-counter supplements glucosamine, chondroitin sulfate, and hydrochloride.

"Everything you do in medicine is a balance of risk and benefit," Richmond points out. "There's no risk in taking glucosamine -- only an expense -- so it ends up being an expensive placebo. If a patient comes in and asks about it, as an orthopaedic surgeon you're best saying there's no evidence to support its use, but it doesn't have any downside risk.

"Additionally, there's no evidence to support the use of customized foot orthotics," he says. "There are a few poorly done studies that suggest it might be of value, but if you look at them critically there's nothing there."

Based on a lack of current scientific evidence,

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the work group does not recommend for or against the use of bracing, acupuncture, and intra-articular hyaluronic acid, so orthopaedic surgeons will need to use discretion when considering these treatments for individual patients.

In general, physicians should keep in mind that the guideline for OA of the knee is a recommendation, not a rule, serving "as a point of reference and educational tool for both primary care physicians and orthopaedic surgeons to streamline possible treatment processes for this ever-so-common ailment," Richmond explains.

Although a wide range of treatment options is available, medical management should always be tailored to individual patients, Richmond emphasizes, noting that orthopaedic surgeons may sometimes choose to work outside the guidelines. For example, a physician may advise patients whose health is otherwise excellent to continue with their regular exercise program while advising others to modify their activities by walking or swimming instead of running or jogging.

The 265-page guideline, a five-page summary, and supporting documentation are available on the AAOS website at http://www.aaos.org/Research/guidelines/GuidelineOAKnee.asp. Patient education materials on causes, diagnosis, and treatment options for OA of the knee also are available from AAOS at http://www.orthoinfo.org.

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Coming in future issues...

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