ORTHOPAEDICS IN MOTION
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SOMOS in Haiti

B. Hudson Berrey, MD COL, MC, USA (RET)

When the earthquake hit Port-au-Prince, Haiti, a struggling nation was dealt a severe blow. A call for help went out for all types of medical responders, with a specific need for orthopaedic surgeons to answer the challenge for what was to become a mass-casualty (MASCAL) event on a cosmic scale. The following is an account from B. Hudson Berrey, MD COL, MC, USA (RET), member of the Society of Military Orthopaedic Surgeons (SOMOS).

When I first moved to Jacksonville, FL, I met George Fipp, MD, who had been going to assist in Haiti for 20 plus years. We talked and decided to create a week-long volunteer program with an attending faculty in Haiti, at the Hospital Sacre' Coeur in Milot, as a goal for each resident in our program. As such, the orthopaedic community in Jacksonville, the University of Florida Department of Orthopaedics and Nemours, and our town faculty had experience with the country, the people, and the culture.

The hospital where we worked in Milot was unaffected by the earthquake and Jacksonville had a team on the ground three days after the event. I was asked to put a team together to relieve the team there. The goal was to overlap each team by a day, to provide continuity of care and a hot-wash of what the previous team had learned, so it could be built on. To put a team together on short notice was a challenge, yet the response from the military orthopaedic community was incredible.

I heard from so many friends and colleagues and it was inspiring to hear that so many would be willing to do whatever it took to help. The "can-do" spirit still lives! Our team included Dr. Bill Buckingham (USN), Dr. Bob Stanton (Army), Dr. Hank Chambers (Army), Dr. Tim McHenry (Army), and Mike Seese, PA-C (Army), as well as many non-orthopaedic types.

> *An average of 16 earthquakes with a magnitude of 7 or greater occur each year around the world.*
>
> — www.earthquake.usgs.gov

There were no egos and everyone pitched in to do whatever needed to be done, from organizing supplies and making wound rounds, to doing yet another I&D, skin graft, or amputation. It was hard work. It seemed like every patient had at least one extremity wound; many had several. The most difficult patients to treat were those with spinal cord injuries who developed early decubiti and needed debriding.

There were no Roto-rest beds or SCI units. We did our best. Patients with pelvis injuries had closed reductions and

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INSIDE

Hoffmann External Fixation System

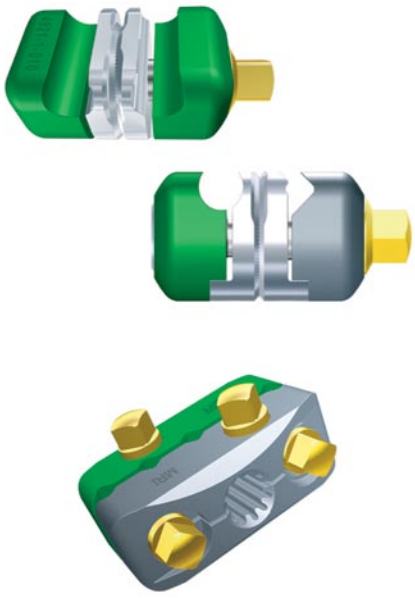
In 1938, Raoul Hoffmann, a surgeon from Geneva, Switzerland, devised a revolutionary External Fixation System. The basic features of this system were its modular design and the ability to reduce fractures or make post-operative corrections to the alignment of fragments in three planes with the frame in situ.

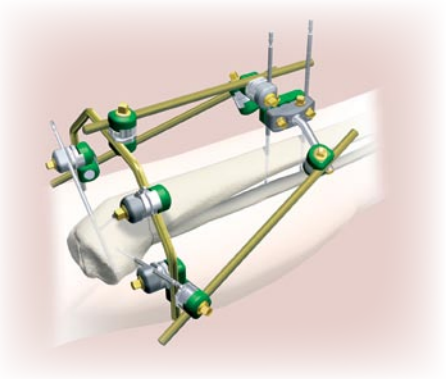
Today's completely modular Hoffmann family of Systems remains faithful to the ingenuity of its inventor. Versatility and ease-of-use are the keys to an effective external fixator. Comprising just five key elements that work in agreement, each Hoffmann device enables surgeons to create a wide variety of frames that allows unhindered access to damaged tissue.

This flexibility enables fast and precise aid to both high velocity and conventional injuries, giving the surgeon the right tools to resolve even the most difficult cases.

Easy to Use and Modular

With just five core components you can build nearly any frame.





Designed to Adapt to Anatomy

Fully articulating pin and rod couplings give you freedom in frame building and pin placement, while the wide range of available pin trajectories lets you fix in multiple planes.

Designed to Enable Fast and Precise Aid to Patients

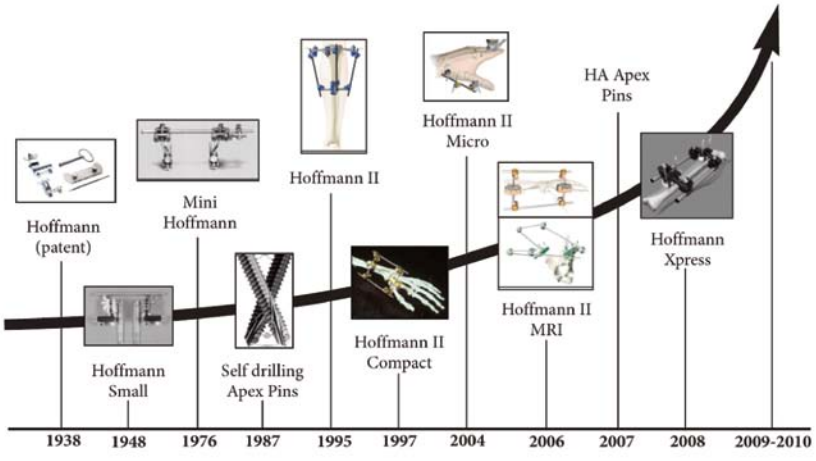
Hoffmann is a modular, multi-planar External Fixation System with independent pin/wire placement capabilities, patented*, rapid assembly Snap-Fit couplings and MR Conditional frame options. MRI features will assist you with Damage Control Orthopaedic situations and post-operative diagnostics.

Fits Patients of Many Sizes

Hoffmann covers a wide variety of patient sizes and conditions and you can cover extremity, pelvic, distal radius and hand indications. ❖

**U.S. Patent Number 5,752,954*

"...each Hoffmann device enables surgeons to create a wide variety of frames that allow unhindered access to damaged tissue."



The Disaster Preparedness and Trauma Care Toolbox Initiative

DT MedSurg, LLC (a Data Trace company), with educational support provided by Stryker, presents a new initiative—*The Disaster Preparedness and Trauma Care Toolbox*. The Toolbox draws upon the vast experience and knowledge of the Society of Military Orthopaedic Surgeons (SOMOS) to provide basic educational tools and resources to help educate non-military orthopaedic surgeons worldwide in the areas of disaster preparedness and trauma care.

As a civilian orthopaedic surgeon, you may never need to manage more than one level-one trauma situation at a time and never have to face a natural or man-made disaster, but if these situations occur, it is important to be prepared.

SOMOS members take the lead in many fields of orthopaedic surgery, positively impacting lives and improving patient care in wartime situations in Iraq and Afghanistan, in disaster areas such as Haiti, and in austere environments around the globe. Their training and first-hand disaster experience will help guide the development of the tools and resources provided as part of *The Disaster Preparedness and Trauma Care Toolbox* initiative.

Toolbox offerings:

- Journal — Special themed issues of the *Journal of Surgical Orthopaedic Advances* exclusively devoted to disaster preparedness and trauma care.

- Online Textbook — Wheeless' Textbook of Orthopaedic Surgery contains the *Disaster Preparedness Toolbox* tab. Information is presented in a textbook-like format to review and refresh your trauma skills. Includes the *SOMOS Combat* and *Disaster-Related Trauma Course*. *[Wheelesonline.com]*
- Newsletter — This quarterly newsletter containing brief overviews of the latest aspects of clinic care, continuing education and research and innovation pertinent to the practicing orthopaedic surgeon. Includes sections on practice management, coding, implants, biomaterials, technology, medical recordkeeping, and international outreach and missionary programs.
- Blog — An interactive forum covering current medical case studies posted by orthopaedists in austere environments. *[Disaster-Rx.com]* ❖

Ortho-Preferred: The Next Step in Medical Malpractice Insurance

Being insured under a traditional insurance program, orthopaedic surgeons may find themselves pooled with general practitioners and physicians of various specialties. This situation can result in orthopaedic surgeons paying premiums that reflect a broad base of covered physician specialties.

In the spring of 2010, DT Preferred Group, LLC, a Data Trace company, established a nationwide professional liability risk purchasing group (RPG) designed exclusively for orthopaedic surgeons. A 1991 Congressional statute permits homogenous groups with similar exposures to loss to achieve the economies of scale that result from purchasing insurance on a group basis.

DT Insurance Agency, LLC and DT Preferred Group, LLC offer the Ortho-Preferred program (Ortho-preferred.com) which is built on the premise that insurance programs should be unique to each medical specialty. The Ortho-Preferred program offers professional liability coverage that is tailored to the specific needs and experiences of orthopaedic surgeons. Members of this RPG will join other orthopaedic surgeons in the common goal of leveraging the power of a group to favorably influence their professional liability insurance pricing and terms, now and into the future. ❖

Did You Know?

In 2010, more than 295,000 people world-wide died as a result of natural disasters.

http://en.wikipedia.org/wiki/Natural_disaster

SOMOS in Haiti

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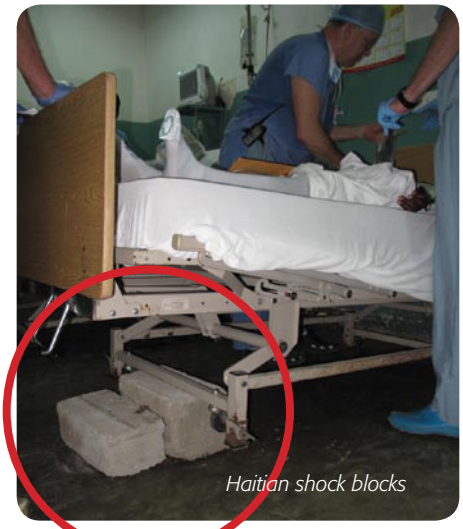
skeletal traction or sometimes an external fixator. We had three OR's and three minor procedure rooms that were converted exam rooms.

Wound care was critical. Nurses in Haiti did little patient care and primarily passed meds. Feeding, cleaning, and wound care fell to volunteers and family. Many patients had either lost their family or didn't know where they were. These patients were "adopted" by adjacent families, which was really heartwarming.

Austere but adequate was the setting. During our week, the team did about 170 cases, mostly debridements, amputations, skin grafts, and the like. A good maxim was: *Closed injuries stay closed and open injuries stay open*. Patients with injuries fixed internally elsewhere arrived infected and needed revision. How many were fixed and did fine we never knew. It was hard to keep things clean and, early on, antibiotics were hard to come by, as were cultures.

In normal times, a volunteer team to the hospital has about 12 members who spend a week in Milot. During our week, there were over 90 volunteers, orthopaedists, anesthesiologists, and CRNAs, nurses, therapists, and non-medical personnel as well. There were about 300 inpatients in the hospital when we arrived (normal census limit is 73).



Haitian shock blocks

The census swelled to over 400 by the time our week was over. With associated family, there were close to 1,000 individuals on site. The operation had taken over two schools and a children's nutrition center to accommodate those medically evacuated to our site.

A week was about as long as one could stay and remain effective. The emotional and physical intensity of the experience takes a toll, but by and large, everyone had a gratifying experience and was glad to have participated. I was proud of our orthopaedic team and everyone who went. SOMOS can be proud of its members. I also think many experienced rejuvenation of the spirit, through just being able to help their fellow man without worrying about billing, authorizations, budgets, or the rest of the "red tape." I encourage everyone to take advantage of the opportunity to look beyond themselves and volunteer in an underserved area. ❖

Scientists with The U.S. Geological Survey believe the Haitian earthquake of January 2010 did not release nearly enough strain on the Enriquillo-Plantain Garden Fault, leaving the region open to risk of another significant, and possibly more damaging, earthquake.

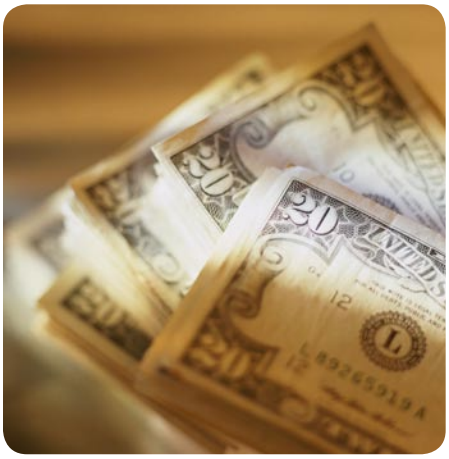
— www.earthquake.usgs.gov

A medical team in Haiti prepares a patient for an airlift to one of the few available medical facilities.

The Haiti SOMOS Team: *Tim McHenry (A), Bob Stanton (A), Hud Berrey (A), Hank Chambers (A), Mike Seese Ortho PA (A) and Bill Buckingham (N)*

Financial Incentives and EHRs

To increase the use of electronic health records (EHRs), the federal government is offering significant financial incentives to physicians whose practices show "meaningful use" of EHRs. Widespread adoption of EHRs, it is argued, would reduce costs, streamline reporting, and reduce medical errors. These incentives are designed to blunt the effect of the costs involved for medical practices that implement EHR technology.



Physicians are entitled to receive incentive payments—beginning in January 2011—once they demonstrate the requisite meaningful use of EHRs. The incentive payment is equal to 75% of Medicare-allowable charges for covered services furnished in a given year. The maximum incentive payments are:

- Year One: $15,000
- Year Two: $12,000
- Year Three: $8,000
- Year Four: $4,000
- Year Five: $2,000

Physicians who start early and hit the threshold for meaningful use in 2011 or 2012 can receive an $18,000 first-year incentive payment. This applies only to Medicare, since there are other incentives for practitioners who practice in rural areas and/or who have a certain threshold of Medicaid patients.

However, there are also penalties for those who are not meaningful users of EHRs.

- The Medicare fee schedule amount for professional services would be reduced by 1% in 2015, 2% in 2016, 3% in 2017, and by between 3% and 5% in subsequent years.

Physicians who start early and hit the threshold for meaningful use in 2011 or 2012 can receive an $18,000 first-year incentive payment.

- For 2018 and thereafter, if it is determined that less than 75% of physicians are meaningful EHR users, then the reductions will be increased by one percentage point each year, but by no more than 5% overall.

What Is "Meaningful Use?"

The Centers for Medicare and Medicaid Services (CMS) issued a proposed outline for EHR meaningful use criteria at the end of 2009. The proposed outline is only the first stage of a planned three-part series of criteria.

The Stage One criteria cover 25 meaningful use objectives and are listed under modules referred to as Health Outcomes Policy Priorities. The priorities are:

- **Improving quality and patient safety**—This includes the maintenance of an active medication list and the use of ePrescribing.
- **Engaging patients and their families in their health care**—This includes providing patients with copies of their health information.
- **Improving care coordination**—This includes the exchange of key clinical information among authorized entities.
- **Improving population and public health**—This includes having the ability to provide data to immunization registries.
- **Ensuring adequate privacy and security protections for personal health information.** ❖

This article is provided by Somerset's Health Care Team. Since technical information is presented in generalized fashion, no final conclusion on these topics should be made without further review. For additional information on the issues discussed, please contact Somerset CPAs on the web at www.somersetcpas.com.

Did You Know?

The Galveston, Texas cyclone remains the deadliest natural disaster in the history of North America, killing an estimated 6,000–12,000 in 1900.

http://en.wikipedia.org/wiki/Natural_disaster

Coding Coach

Brought to you by Karen Zupko & Associates, coding coaches Mary LeGrand and Margi Maley are nationally recognized experts and in-demand speakers, known for their practical advice and positive presentation style. Visit them on the web at www.karenzupko.com.

➢ QUESTION

A surgeon saw a patient in the office last Tuesday and made a decision to go to surgery on Wednesday for a closed reduction of the fracture. During the visit on Tuesday, the surgeon applied a splint. The surgeon was told this is not reportable because the first splint is included in the surgical package thus the splint is not reportable. Was this correct?

➢ ANSWER

Great question and the answer is you are correct and incorrect. You are correct that the first splint or cast is included. However, the temporary splint/cast to stabilize the fracture before the reduction is separately reportable.

➢ QUESTION

How do I bill for a knee injection using Synvisc to ensure I am properly paid for the services and cost of the Synvisc?

➢ ANSWER

The reporting of the drug is pretty straightforward, but the devil is in the detail! 2010 did bring a new challenge with the introduction of the new code, J7325, which is reported for both Synvisc and Synvisc One.

The injection code is easy, so we will start there—20610.

The reporting of Synvisc is dependent on what drug you are using.

Synvisc One is a concentrated dose, is only administered one time, and is reported with 48 units: J7325 x 48 units.

Synvisc is the same drug, but is less concentrated and administered over three different visits. So at each visit, you will report 20610, J7325 x 16 units. Report this for the first, second, and third injections.

If you forget the units, Medicare will only reimburse you for one unit!

➢ QUESTION

Our orthopaedic surgeon recently employed a physician assistant in the office. The physician assistant is seeing patients on rounds in the hospital and he recently submitted a charge for a 99232 on a Medicare patient who was post-op for a total hip arthroplasty. The documentation for the visit all pertained to the hip arthroplasty. Can he report this E&M service when the patient is in a global period? He says yes, because he did not assist and is not in a global period.

➢ ANSWER

Great question and one of increasing concern as it relates to one of many issues related to Non-Physician Provider billing. While the physician assistant (PA) was not involved in the surgery, he is employed by the surgeon who performed the surgery; thus all visits related to the surgical procedure are included in the global period and not reportable, whether performed by the surgeon or the PA.

If the visit was for an unrelated problem that was evaluated and managed, the service would be reportable by the surgeon or the PA, a modifier 24 would be appended to the E&M and the appropriate unrelated diagnosis linked to the E&M. ❖

Sites and Apps to See Before You Travel

Planning a trip? Make sure to check out these travel websites and apps before you go.

Prioritize your itinerary. Chances are someone you know, or a friend of a friend, knows something about the city you're heading to. If not, visit Yelp.com, which has essential insider information on different cities.

Find food. The last thing to do in a new city is to miss out on a good meal or pass up regional cuisine. Head to Urbanspoon.com — it's designed to locate dining options, menus and reviews, all based on where you are and what you're in the mood for.

Find Wi-Fi. Planning on working while you're away? You'll want to know where to find wireless access. For a directory of Wi-Fi hotspots across the U.S., make sure to check out wififreespot.com.

Prep your phone. If you don't have travel apps on your phone by now, you should definitely get them before your trip. An app called AroundMe utilizes your phone's or iPad's built-in GPS to scan what's around you, helping you locate nearby gas stations, hospitals, and other services.

Track flights. All the info you need for an uneventful airport visit can be found on FlightTrack, an app for finding gate numbers, delays, cancellations, and alternate flights at over 5,000 international airports. If you prefer a free version that will also build your itinerary by importing info via email, check out TripIt. ❖

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SECRETS TO

Predicting the Stock Market

Jeffrey Hirsch, president of The Hirsch Organization, an investment research firm, 184 Central Ave., Old Tappan, New Jersey 07675. He and his father, Yale Hirsch, edit Stock Trader's Almanac *(John Wiley & Sons). They also publish* Almanac Investor Newsletter. *Their Web site is www.stocktradersalmanac.com.*

Stock market gyrations aren't entirely random. For nearly 44 years, Stock Trader's Almanac has offered amazingly reliable indicators of market performance.

Consult a financial adviser if you have questions or if trends seem contradictory to you. You still need to analyze individual stocks before you start investing in them.

The January Barometer

The stock market usually sets its direction for the whole year in January.

The S&P 500 Index has reflected this tendency 92.3% of the time since 1950. Eleven bear markets out of 17 began with a poor January.

Best Six Months for Investing

Since 1950, the stock market has performed best from November through April and worst from May through October.

Only three times since 1950 has the Dow posted a double-digit loss during the November through April period—in 1970, during the invasion of Cambodia, in 1973, during the OPEC oil embargo, and in 2008 during the global credit crisis.

December's Free Lunch and The Santa Claus Rally

Investors typically dump losing stocks in December in order to realize tax losses. By late December, many stocks have been hammered down to bargain levels.

The New York Stock Exchange stocks selling at their 52-week lows near the end of December usually outperform the market by February. Over 29 years, these stocks have averaged a 13.9% increase in that short span, compared with the NYSE Composite, which gained 4.2% over the same period.

A short but robust rally during the last five days of December and the first two days of January — the Santa Claus rally — comes to Wall Street most years.

Since 1969, the gain from this rally has averaged 1.7% over just those few days. There have been 25 Santa Claus rallies in the last 33 years.

Beware of Santa's claws: When there's no Santa Claus rally, trouble often is ahead. Hence the couplet—if Santa Claus should fail to call, bears may come to Broad and Wall (where the New York Stock Exchange is located).

There was no Santa Claus rally in 1999. The bear market began on January 14, 2000.

Pre-St. Patrick's Day Rally

Experienced traders know that the market often rallies before major legal holidays. People are about to get time off, so they feel upbeat. Most traders don't realize how strong the market is the day before St. Patrick's Day — which isn't a legal holiday but is celebrated by many.

Going back to 1953, the S&P 500 has gained an average of 0.33% on that day — equal to a 30-point advance for the Dow at today's levels. I view this indicator just for fun, but some people do make money by following it.

Down Friday and Monday

Trouble often looms when stock prices are down sharply on both a Friday and the following Monday — six times out of seven, the market will go lower within five days.

In 1987, the Dow lost 108 points on Friday, October 16, and 508 points the following Monday. ❖

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Links to the Internet

www.disaster-rx.com has a special "LINKS" section that gives you one-click access to the information that is important to you.

Also, while you are on the Disaster Rx site, check out the BLOG and feel free to add your comments.

OTHER LINKS OF INTEREST:
www.datatrace.com
www.wheelessonline.com
www.somos.org

Did You Know?

In the US, at least 41 states are considered to have a moderate to very high earthquake risk.

www.fema.gov

dtp data trace
PUBLISHING COMPANY
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Editorial

Orthopaedics in Motion is a newsletter produced with educational support provided by Stryker Orthopaedics. It is designed to provide a brief overview of the latest aspects of clinic care, continuing education, and research and innovation pertinent to the practicing orthopaedic surgeon. It will include sections on new practice management paradigms, practice management, coding, implants, biomaterials, technology, subspecialty educational societies and associations, how to deal with medical recordkeeping, and international outreach and missionary programs. This innovative newsletter will be delivered quarterly to select orthopaedic surgeons and will be available online.

Links to the Internet will highlight existing and new areas within the Internet that will provide both peer-reviewed, non-peer-reviewed, and industry sites with the newest and latest information. All of these sites will have been reviewed by the editorial board for appropriateness and lack of inappropriate bias. I believe that you'll find the research innovation area to be of great interest since it will highlight new technologies, implants, biomaterials, and drugs crucial for orthopaedic management.

I'm delighted to be a part of this new and exciting newsletter. Please feel free to share any insights or suggestions for future issues.

Sincerely,

L. Andrew Koman, M.D.

Editor-in-Chief

About the Editor: L. Andrew Koman, M.D. *is Professor and Chair of the Department of Orthopaedic Surgery at Wake Forest University School of Medicine in Winston-Salem, North Carolina. Dr. Koman is board certified in Orthopaedic Surgery and has a Certificate of Added Qualification in Hand Surgery. His clinical practice is devoted to Hand, Microsurgery, and Pediatric Orthopaedics.*

Dr. Koman is a member of 20 professional societies and is Editor-in-Chief of the Journal of Surgical Orthopaedic Advances, *a peer-reviewed scientific journal and* Orthopaedic Care, *an online textbook. He reviews manuscripts for more than 10 national and international journals.* ❖

Coming in the Next Issue

- HSAs?? — One Physician's Solution to the Health Care Crisis
- Malpractice Premiums and the Future of Malpractice Insurance