

From the President



Dave Demchuk

July 1, 2007

On June 22-23, 37 of your leaders came to Chicago to discuss the future of this organization. This is the third year we have brought our leaders together and can again count this as a very successful event. I want to take a moment to thank those members who were able to attend. I know giving up a full weekend with family and friends is difficult, and I appreciate their efforts and their participation.

During our strategic review we tackled the core purpose, vision and values of our organization. We actually took some time to restate them more simply:

- As part of our Core Ideology, the BONES Society's Core Purpose is to prepare for the future.
- Our Core Vision is to lead as a resource and advocate for knowledge. We aim to set the standard for excellence for orthopaedic practice management.
- Our Core Values include credibility, responsiveness, and relevance.

Our mission is to be the PREMIER orthopaedic management association. To fulfill that mission statement our goal is to be an association focused exclusively on orthopaedic practice management. BONES will deliver excellence, must-have best practices, and provide unmatched peer-to-peer networking. This organization will be recognized and respected for its professional education and targeted resources, that we believe are fundamental to the success of the orthopaedic practice administrator.

Our programs, products, and services will focus on content, competence, connections, and credibility.

One of the tasks we had as a group was to review and critique the current programs, products, and services. We also looked at new options and needs of our members. Currently the Board of Directors is reviewing this information to set priorities and create new options for increased member involvement. We hope that you will find a program, product or service that you find interesting and become involved with the development and successful completion of it. We need our members to get their hands into these opportunities to help shape the organization as a whole.

I am thrilled at the success of this meeting. I look forward to sharing some new opportunities for volunteer participation. And I hope that each of you will consider actively participating in your organization.

Making PQRI Work

By Marilyn J Orr, MBA, CMPE

Administrator of Dover Orthopaedic Center, Inc., Dover, OH

July 1, 2007 is the initial date for the reporting of CMS quality measures under the PQRI program. Dr Susan Nedza, CMS Chicago and I presented on this topic at the National BONES Conference and our handouts are available at the BONES website. But this is a program that continues to evolve, and as recently as June 18, 2007, CMS has made new materials available on their website, specifically a toolkit section that includes a *Coding Quality Handbook* and Data Collection Worksheets for each measure. You can use the following URL to locate the newest materials: http://www.cms.hhs.gov/PQRI/31_PQRIToolkit.asp. It is key to the success of your participation that you check weekly for updates and new materials until the program is officially launched. CMS has recently published several Technical Corrections. Foot and ankle CPT codes have been added to measures 20-22.

Personally, I have found the AAOS website to be of more help because it has narrowed the materials to only those 10 measures most pertinent to orthopaedics. Most of the materials can be accessed without a password at <http://www.AAOS.org>.

Our group felt that it was important to submit data on surgical measures as well as clinical measures. This offers the opportunity to develop processes that support safety and data collection outside as well as inside the practice. We feel that all future pay for performance initiatives will most likely involve all aspects of the practice, but not likely all staff.

External measures (those involving antibiotic selection, initial orders and discontinuation orders and VTE preventative measures) will be handled by the surgery scheduling staff and the surgery charge posting staff. The worksheets indicate that documentation must be maintained in the medical record. We have added language to our initial surgery scheduling form that addresses the measures and we will use that document as our source documentation. Some patients, who are not scheduled through our office, will present more of a challenge. For those admitted directly from the Emergency Department, copies of the standing order protocols must be obtained from the admitting hospital. Other groups are adding

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PQRI continued from page 1

language to their operative notes to meet documentation requirements, but we have chosen not to do that.

Clinical measurements in our group will focus on fall assessments and medication reconciliation. We have utilized a superbill and a flowsheet chart in our EMR to track the status of fall assessments for approximately 18 months. We have a form that we developed internally with the assistance of our local home health agency and information found on the web. Each eligible patient is given the form to complete annually by the check-in staff. Results are reviewed by the physician and the form is scanned into the EMR. However, the measure is reportable only if done in conjunction with an E&M code. Our existing processes did not recognize that linkage. Currently, a patient seeing us for an initial evaluation following a fracture would be offered the form. Under the billing guidelines, it would not be appropriate to bill the fall assessment with a fracture care code. We are not planning to change our procedure. The assessment code would be billed only when the global period is expired and an E&M is billed. That might mean that it never is reported.

The flowsheet concept is valid for a paper chart as well as an EMR. Just as most paper charts have a master list of prescriptions written by the practice, a master listing of quality measures could be created and utilized in the same fashion. Staff responsible for clinical measures in our group are medical records (selection of which patients receive the form), check-in (introduction of the form) and audit/billing (review of dictation, completion of flowsheet and scanning of completed form and billing of quality measure).

A similar circumstance is found with the Medication Reconciliation Measure. Although we are checking medications at every encounter, the definition is limited to reconciliation between a discharge within the last 60 days (hospital, nursing home, home health) and the physician's office and it is tied to an E&M code for reporting. Almost all patients who present to our office within 60 days of discharge are covered by global periods for surgery or fractures. The key for us will be to report once the global is expired and an E&M is billed. We also will be responsible for securing the list of medications at discharge. Whether it will be feasible for us to secure the list in a timely and efficient manner is unknown right now. We have faxes coming into the group from the nursing facilities now with current medication lists. It is the easiest way for the facility to provide that information, but it is not routinely done at discharge, but rather at the initial appointment for a new problem when we are updating the EMR.

The next few weeks will be a time of evaluating and changing processes as we try to master our reporting and maximize any bonus opportunity. We're just trying to avoid leaving any money on the table.

ANNUAL CONFERENCE COMMITTEE

Marcia Ide Schultz, CMPE

Administrator, Phoenix Orthopedic Group

It does not seem possible that only two months ago I, along with a lot of you, was in Chicago. As I sit in my office in July in Phoenix with the temperatures soaring I reflect on the cool breezes of Chicago. BONES in Chicago offered a fabulous array of educational courses as well as an exhibit hall that was filled to the brim with interesting state of the art material, a one stop shop so to speak.

For those of you who bought raffle tickets from me, thank you, our donation to OREF was significant and we had lots of fun... In fact it was so successful we are going to do it again in Charlotte, so make sure you buy your tickets from me!!!!

Back to the meeting... We listened to your comments and increased our networking time. The new member lunch was a success and was a great time to meet and get to know one another. Something else that was added was a mentoring social. We had a great response from new and existing members looking for an avenue to get help and not reinvent the wheel. Marsha Pinat has done a great job getting this program off the ground, so if you need a mentor or want to be a mentor, contact the BONES Society office at 800-247-9699.

The Blues Brothers rocked Tuesday for our final social. A taste of Chicago was the food fare. The winners of the raffle were announced and great prizes were won by members listed below:

Apple iPod Donated by *Stryker Imaging*; winner Doug Bowen
MotoQ - Donated by *Orthopaedic Marketing Group*; winner Jan Hill
20" LCD Flat Screen TV Donated by *Pyron Medical IT Services*; winner-Jan Hill
1998 Dom Perignon Champagne Donated by *Hyatt Regency Chicago*; winner-Peggy Block
iPod Nano Donated by *Decision Health*; winner-Paul Kayne
\$500.00 Visa Gift Card Donated by *Arizona Orthopaedic Society*; winner-Dawn Benton
\$300.00 Visa Gift Card *Doctor Solution*; winner-Kelly Shellenarger
\$300.00 Macy's Gift Card - *Enterprise Healthcare Systems*; winner-Jan Hill
\$50.00 iTunes Credit *Styker Endoscopy*; winner-Dale Reigle
\$50.00 iTunes Credit *Styker Endoscopy*; winner-Shannon Monroe
\$500.00 Airline Gift *Smith & Nephew*; winner-Rebecca Humphrey
\$400.00 Airline Gift *Arizona Hand & Wrist*; winner-

Congratulations to all, and remember you can win next year. Speaking of next year we are planning a great meeting in Charlotte. I have not been to Charlotte so am looking forward to getting to that area and hopefully spend a couple of vacation days seeing the surrounding area. We have looked at suggestions for the upcoming year and have listened to our membership and are planning an excellent educational program filled with lots of GOOD OLD FASHIONED BONES FUN!!!!!!

Look forward to seeing all of you in Charlotte, remember—buy your raffle tickets from me.

Sizzling in Phoenix!!!!!!

Marcia

ANCILLARIES: A DME SUCCESS STORY

One of our major responsibilities as leaders and managers of our clinics is to explore new ideas on income growth. Granted, this entrepreneurial hat is best worn by our physicians, the true owners of our clinics, but we all know how often they bring such new and refreshing ideas to our attention... right.

Our efforts to change our society's newsletter, the *BONEFIDE*, to a more user-friendly, readable format gave us, your humble volunteers, the idea to compose success stories; testimonials of successes among member practices. It will be my great honor to focus on these successful stories.

Sharing them with you is much like telling a human interest story. I will do my best to describe the successes and failures without editorializing. In the end, I will inquire and seek to learn, just as we do in our networking sessions, what works and what doesn't and how others can create a similarly successful income growth program.

My journey started at a recent BONES strategic planning meeting in Chicago. I asked of those in attendance if anyone had a highly successful DME program similar to those discussed in our educational sessions. Sure enough, a colleague in attendance came through. Don Schreiner, of Rockford Orthopedic Associates in Rockford, Illinois, has created such a successful DME program.

Upon inquiring specifics of his DME program's success, I learned that the performance reflected highly acclaimed results similar to those presented at the educational sessions in Chicago. Impressed, I posed further questions, again learning of this highly successful program's impact on their practice and their overall success story. I would like to share my findings:

Setting the Stage:

- The group is comprised of 14 physicians. Nine (9) are orthopaedic surgeons, specializing in hand, sports medicine and joint replacement, trauma; two (2) podiatrists, two (2) rheumatologists and one (1) PM&R.
- The group has one location, a stand alone, two floor building of 43,000 sq ft, in a health care campus area. The hospital is about a quarter of a mile away. It takes most patients around to 10-15 minutes to get to their office.
- Don has been with the group since 1999 or 7.5 years. Prior to Rockford Orthopaedics, Don was in the HMO business for 18 years. Rich with experience from the "other" side, he lacked orthopaedic knowledge. So, he immediately became a member of BONES.
- In the beginning, he received substantial direction and assistance from his involvement in BONES. The networking sessions gave him considerable data, creating ideas that became initiatives and now success stories. Don stressed that he makes it a point to come out with at least one (1) idea from every BONES conference that

he can implement in his group! Don, you are embarrassing me!

- In addition to DME, Don's group offers additional ancillary services:
 - A surgery center, housed in 7300 sq ft, with two (2) ORs and a procedure room.
 - Physical Therapy and Occupational Therapy.
 - Two MRI units, one (1) closed and one (1) extremity.
 - They have nine PAs who are treated as a profit center even though they are assigned to individual physicians.
 - Prescription drugs as of two years ago.
 - They just started clinical research.
 - A bi-product of our last meeting in Chicago, Don is pursuing the development of an orthopaedic urgent care program, similar to the one in Rochester, NY.

Don's group is quite busy. Their daily patient volume averages about 400, or approximately 100,000 annually. Certainly, they have a core size of patients to implement ancillaries and related programs.

The community of Rockford has turned around since the 1980s. The county's population is about 250,000 and the city is about 185,000. The future looks bright as Chicago residents are moving to live there since cost of living is so much lower.

So, here we go with our key questions on the DME success story:

Q. Don, how long ago did you commence your DME program?

A. We started in 2003 and have grown from approximately \$87,000 in profit margins the first year to an expected \$650,000 in 2007. We started out with four (4) physicians in 2000 and no ancillaries. Joining the group in late 1999, we designed a strategic plan, which included hiring physicians in a variety of specialties and pursuing development of any service, which made financial sense. I was fortunate that I had young physicians who were entrepreneurial.

Our first endeavor was with Physical Therapy. Joining BONES gave me a major jolt of energy to begin implementing ancillaries. I owe everything to BONES. I knew business, but nothing about orthopaedics.

Also, managed care is not as overwhelming as in some other cities. The first thing I did was to cancel all twenty four (24) managed contracts. In the end, we signed up with only six (6). We did not do that in a rude way. We worked with the insurance companies that desired to work with us. (Gee, Don, this sounds like another article for our BONEFide "Managing your Managed Care Contracts")

Q. Was there a single champion of the initiative?

A. Jeff Jones an employee with our group became our leading force. His energy, foresight, creativity and practical approach, created a smoother process to our success. Jeff was a Cast Tech and so he

DME continued

knows the field, and has pushed to move the process into its success. He is very patient oriented and promotes this mindset in all he does. Furthermore, with Jeff's participation we decided not to go with one supplier but to use many. There are many valuable products out there so why limit our line. So, we embraced numerous products and vendors and struck very cost effective deals with each of them, surpassing some larger group purchasing programs.

Q. Compared to other ancillary services, how would you compare the profitability of your DME program?

A. From a total net revenue level, DME ranks below our PT and MRI, but, it is a significant contributor to the bottom line. Gross margins on these products vary but can average at around 100% of cost. Taking overhead out, we end up with a significant contributor to our net margins.

Q. Is this a program you developed or did you hire outside help?

A. No. We started out thinking we would hire an outside partner since we had hired an outside firm to run our PT Dept. However, at the 2003 BONES conference and networking with other practices who had a DME already, we talked to a variety of sources and learned how the experts ran their programs and learned how they were able to generate a profit. Subsequently, we selected the best models and got 3 or 4 quotes to determine if it is more profitable to do it ourselves or hire an outside firm. This was all part of the learning process. We gathered information from as many sources possible. In the end, we did this on our own.

Q. Can you recall the things you did right from the beginning?

A. Focus on the Customer

- Price your products fairly to the patient and insurance company.
- Educate the patient on their benefits coverage and out-of-pocket cost and how to use the product
- Improve product access to patients including retail products that are not covered by insurance.

Purchasing

- Do not limit yourself to one purchasing group, but utilize several purchasing groups and negotiate directly with the suppliers when appropriate.
- Purchase an automated inventory management system to minimize inventory on shelves (just-in-time) and to improve inventory tracking for accounting, and usage reporting by product and physician.
- Minimize staff access to inventory to improve accountability and reduce shrinkage.
- Scrutinize what products you want to offer based on payor reimbursement, patient cost, and quality of product.

Align the payors and physicians practice with a win-win proposition

- Establish protocols with insurance companies for dispensing products by procedure code.
- Educate physicians on benefit coverage and options for value added patient care.

Q. Who is managing- controlling all of these activities?

A. We have a 1,000 sq. ft. area that houses our entire inventory and we have a 500 sq. ft. retail area off the main lobby for display and fitting. It is tightly controlled using an inventory system to monitor and manage our varied items. We are also adding display cases, telling patients that they can “buy the item here or go buy it at Walgreens”. Developing a mini retail concept will add more credibility to the program in that patients will sense that this is running like a business.

We also have an ATC on site who participates in fitting and training the patient and who may also bring the patient into the retail area thus taking the patient out of the exam room. Also, another member of our staff visits with the patient and goes through their benefits. This way, our patients are informed of their obligations up front.

Q. Can you recall what you believed would work, but in the end it didn't?

A. We thought we could do more. We considered hiring an Orthotist but it was too expensive and costly overall.

Q. Can you identify your top five (5) payors?

- A. W/C
Medicare
Local Commercial Carriers
BC/BS
United Health Care

Q. Succeeding in an initiative is great! How do you plan to stay successful?

- A. 1. Continue to improve our inventory system.
– Bar scan product into the patient chart via interface with our EMR system. This will improve billing, documentation, and inventory control.
2. Continue to stay current with new product development and purchasing contracts as our volume increases and new products become available.
– Expand DME store-front (currently 500 sq. ft.)
3. Are currently reviewing the need for certifications and possible addition of an orthotist. We are currently utilizing a certified athletic trainer (ATC).

Q. Any last words of wisdom?

- A. 1. Focus on Customer Satisfaction
– Provide convenient product availability
– Professional fitting and patient education on product use
– Through research and explanation of patient's financial responsibility

Wow. Don rocks! (No pun intended). He has developed a highly successful program and is now reaping the benefits. Don is a testament of our society's mission and we, all of us, who participate in activities within our society; be it administration, task forces, networking, all of us who share our thought and ideas, should be proud.

Using “common business sense” and engaging good people gave Don the support to become aggressive in pursuing his vision. He pushed ahead in uncharted waters, never giving up. Look at him today: he is proud, successful and ready to tackle his next big project.

Thanks Don!

High Deductible Health Plans: *How Will Your Practice Respond to This Trend?*

Barbara Sack, MHSA, CMPE

Executive Director, Midwest Orthopaedics, PA, Shawnee Mission, Kansas

High-deductible health insurance plans are on the rise in America. This comes as no surprise to most; the consistent double-digit percentage premium increases have made many businesses choose between this option or not offering health coverage at all. In an effort to encourage patient participation in healthcare decisions and to enable employers to have lower-cost options, HSAs (Health Savings Accounts) were created in Medicare legislation signed into law by President Bush on December 8, 2003. Some groups also have HRAs, which are Healthcare Reimbursement Accounts (or Arrangements). All of these are associated with “Qualified High Deductible Health Plans”, or HDHPs.

The HSA is actually the savings account that the patient has (hopefully funded) to meet the deductible in the associated HDHP. Although HDHPs have always been around (we used to call them “catastrophic coverage” plans), the implementation of the legislation encouraging the use of them has led to most people identifying most HDHPs as HSAs. In this article I’ll use HDHP and HSA almost interchangeably.

MGMA did a survey in 2005 on “Medical Practice Status and Attitudes” on Health Savings Accounts and HDHPs. At that time, 62% of the 796 respondents had patients covered by HDHPs, with 68% anticipating an increase in the next 12 months. They also asked about the manager’s understanding of HSA rules and regulations, and, also, questions about whether HSAs would be good for the economy, would create more problems than they solve, or were a fad that would fade away. The majority tended to have neutral opinions, but the tone of the questions seemed to reflect the mood and opinions often stated by frustrated practice managers.

Another smaller survey (170 respondents) conducted by MGMA just this past May showed that almost all respondent practices now have patients with HSAs or other high-deductible plans, although almost 95% say that it is less than 10% of their practice. The focus now seems to have shifted from what they are and whether they will last to how we will react to them and how they are going to affect practice revenues. 57% of respondent practices have taken steps to train their staff in regard to collecting payments for HDHP patients, ranging from pre-verifying benefits to estimating the cost of the entire visit and attempting to collect that up front. There are potential pitfalls with that scenario, as some policies prohibit groups from attempting to collect until the claim has been adjudicated.

So what will your practice do? Clearly the status quo will not be acceptable. As managers see their Days in A/R and total A/R start to rise, they are scrambling to figure out the best way to train staff to address the high deductible patients.

At a minimum, practices should be investigating pre-verification of benefits. This is true for all patients, but especially for the HDHP patient. Some companies can even tell you how much of the deductible has been satisfied. This can be harder and more labor-intensive than it sounds, and it will likely push the practice towards increasing the manpower in the billing/insurance verification area.

But there is plenty of evidence suggesting that orthopedic practices with less than 1.0 FTE billing personnel per FTE physician would more than make up the cost of additional staff with increased collections. The BONES 2006 Practice Management Survey shows a median of 1.0 business office FTEs per FTE physician, with a high of 3 per FTE physician. The average number of total staff per FTE physician is up from 5.7 in 2004 and 2005 (“2005 BONES Practice Profile”) to 6.3 in 2006, which reflects the general acknowledgement that better performing groups tend to have more FTEs chasing their money for them.

Other options, such as collecting the entire visit amount (or a large portion) up front generally rely on knowing that the patient has an HDHP, which may not be possible without pre-verification. I expect that we will also see an increase in the instances of groups using companies that finance patients with large patient-responsibility balances.

HSAs and other HDHPs are not going away, so the smart practice administrator either has already implemented some policies to address their impact or they will soon. As BONES becomes aware of successful strategies we will pass them on to members. If you have ideas – let us know!



BUNION SURGERY EPONYMS—*What's in a Name?*

By Heidi Stout, CPC, CCS-P, Director of Orthopaedic Coding Services, The Coding Network, LLC.
Reviewed by Harry Goldsmith, DPM, CEO, Codingline/CodinglineORTHO

A wide variety of surgical techniques are used for bunions and hallux valgus correction. Many bunion surgery techniques are referenced using an eponym or proper name, such as Austin, Akin, McBride, and Lapidus. Unfortunately, not all of these eponyms are listed in the CPT manual and because these eponyms give no information on what technique the surgeon used, code selection is difficult. Confusing eponym procedures coupled with the vast array of bunion repair techniques makes bunion surgery coding difficult even for seasoned orthopaedic coders.

The CPT manual arranges bunion correction codes (28290-28299) in a family. Only the parent code 28290 is printed in its entirety. To determine the complete descriptions for the family codes, the coder must refer back to the parent code; the portion of the description to the left of the semi-colon is common to all procedures in the code family while the information to the right of the semi-colon is specific to the individual code.

The parent code:

28290 Correction, hallux valgus (bunion), with or without sesamoidectomy; simple exostectomy (e.g., Silver type procedure)

The indented family codes:

- 28292** Keller, McBride, or Mayo type procedure
- 28293** resection of joint with implant
- 28294** with tendon transplants (e.g., Joplin type procedure)
- 28296** with metatarsal osteotomy (e.g., Mitchell, Chevron, or concentric type procedures)
- 28297** Lapidus type procedure
- 28298** by phalanx osteotomy
- 28299** by double osteotomy

The language to the left of the semi-colon in code 28290, “Correction, hallux valgus (bunion), with or without sesamoidectomy”, is common to all codes in the family. Coders also must be aware that the procedures listed above all include a set of surgical maneuvers that are considered inclusive. The AMA has defined a set of procedures that when performed at the MTP joint are inclusive to the bunion correction codes listed above: arthrotomy, capsulotomy, synovial biopsy, synovectomy, tendon release, tenotomy, tenolysis, excision of the medial eminence, excision of associated osteophytes, placement of internal fixation, scar revision, articular shaving, sesamoidectomy, and removal of bursal tissue. These adjunct services should not be reported separately when performed at the MTP joint of the great toe in conjunction with bunion correction surgery.

Each bunion correction technique and some of its common eponyms are as follows:

- 28290** Removal of the bump (bunion) on the medial side of the toe.
Common eponyms are: Silver
- 28292** Tightening or loosening ligaments and/or tendons to correct imbalance w/resection of the base of the proximal phalanx or head of the distal metatarsal.
Common eponyms are: Keller, McBride, Mayo.

- 28293** Removal of the damaged joint surfaces with prosthetic replacement.
This is the only bunion procedure with no associated eponym.
- 28294** Tendon transplant to correct imbalance.
Common eponyms include: Joplin
- 28296** Osteotomy of the distal metatarsal.
Common eponyms include: Mitchell, Chevron, Austin, Kalish, Youngswick, Reverdin, Reverdin-Green, Hohmann.
- 28297** Fusion of the first tarsometatarsal joint plus distal soft tissue bunion repair.
Common eponyms include: Lapidus
- 28298** Osteotomy of the proximal phalanx.
Common eponyms include: Akin.
- 28299** A double osteotomy, either of the proximal phalanx and distal metatarsal or double osteotomy of the metatarsal.
Common eponyms: Logroscino, Austin-Akin.

Some eponym procedures include a combination of techniques that cannot be captured in a single code. One of the most common is a distal soft tissue realignment (28292) combined with proximal first metatarsal osteotomy (28306). Common eponyms: Ludloff, Scarf, Juvara.

While this article does not present a complete review of all bunion surgery techniques, the information provided should assist coders in navigating the path of linking eponyms to their corresponding CPT codes. Coders should keep a cheat sheet of eponym procedures and their associated codes, updating it as needed.

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BONES “Blind Dating Service” is up and running!

Marsha Pinat, CMPE
Mentoring Task Force Chair

The BONES Mentoring Program kicked off at the annual conference and is a great success. Are you part of it? If not, take advantage of this excellent new program.

We currently have 35 mentors and 40 protégé’s signed up so we have some excellent teams paired up and we’re off and running.

If you have not heard about the program, here’s the mission statement:

The successful pairing of an experienced administrator with a new administrator to provide guidance, insight and assistance in their personal growth, development and education. The goal is to enhance their abilities and skills to conduct the day-to-day management of their practice as well as provide a rewarding experience for the mentor.

Take advantage of this exciting opportunity by completing the application form found on the BONES website at www.bonessociety.org. The commitment is from annual conference to annual conference. We’ve designed it so that you can meet your partner at the annual conference, set some goals for the upcoming year and get in some quality time getting to know each other.

If you do not attend the annual conference, you can still participate and make contact on your own either in person, through phone calls, by e-mail or whatever way you choose to do so.

At the annual conference in Charlotte, we will once again have a session to meet each other, hear more about the program, and current participants can provide some feedback from the first year of the program.

Charlotte Education Task Force

First I would like to thank all of you who attended the Chicago conference and helped make it such a success.

The Education Task Force has been hard at work putting together ideas for our gathering next April in Charlotte. We appreciate the feedback you have given to both the task force and the Board members. I want to assure you we have heard you loud and clear and I believe you will see some changes as a direct result of your input.

Some of the improvements you will see in Charlotte include the following:

We are planning three general sessions; an opening keynote on Monday, a legislative topic before the business lunch on Tuesday and a third general session to wrap up the conference on Wednesday.

Another change we are planning is to more clearly define the appropriate audience for each of the courses. On one hand we will work with the presenters to assure that the title of the course more clearly defines the content. Additionally we will endeavor to assure that courses are designed and clearly identified as being appropriate for Beginner, Intermediate, Advanced or, on occasion, All Levels.

We have also heard your suggestions with regard to controlling the size of the network breakouts. Look for the next issue of *BONEfide* for some of our proposed solutions.

If there are topics or speakers you feel should be included in our Charlotte presentations, please feel free to drop me an email. I can be reached at lwoods@nycsportsdoctor.com.

BONESNet Staff Benefits Survey

So far, 148 BONES members have participated in the latest BONESNet survey on staff benefits. The table below summarizes part of the responses to one survey question. As you can see, 88% of the responding practices pay the majority of the health insurance premium for the employee, while only 12% pay for the majority of the health insurance premium for the spouse or family.

Benefits Offered to Full Time Employees:

Category	Responses	Not Available		1% to 49% Paid by Employer		50% to 99% Paid by Employer		100% Paid by Employer		100% Paid by Employee	
		#	%	#	%	#	%	#	%	#	%
Health Insurance - Employee	139	4	3%	12	9%	61	44%	61	44%	1	1%
Health Insurance - Spouse/Family	134	12	9%	16	12%	14	10%	3	2%	89	66%

This survey will continue to be “live” at www.bonesnet.org until June 15. Our goal is to have at least 250 participants. You must participate in order to access the full survey results. Results are updated after each response, so remember to revisit BONESNet periodically to see the latest figures.

Your user name is the email address that you have on file at the BONES office and your password is your membership number excluding any leading zeros. If you have any problems or questions, please contact Diane at the BONES office (waligurski@bonessociety.org). You are also encouraged to send ideas for future surveys to the BONESNet Task Force via Diane or Dale (dreigle@rmodocs.com). Please remember that topics should lend themselves to a format that takes 10 minutes or less to complete.



New Members

Zoe Adams – Fremont, CA
Anicete Aguayo – Daytona Beach, FL
Marge Akers – Raleigh, NC
Craig Alpard – Sun City West, AZ
Jay Andrews – Richmond, VA
Jeannine Anthony – Walla Walla, WA
Paul Athey – Columbia, SC
Therese Babcock – Omaha, NE
Mark Baker – Columbus, GA
Barbara Barnard – Plantation, FL
Dana Bass – Tupelo, MS
Wendy Bathke – Fayetteville, NC
Robyn Beckwith – Pittsburgh, PA
Jill Berger-Fifty – Melrose, MA
Valerie Berry – Cincinnati, OH
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Juliet Breeze – Richmond, TX
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Jan Brown – Bradford, PA
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Petula Kelly – Cleveland, OH
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