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Wayne Burge, Vice President  
Provider Contracting and Reimbursement  
BlueCross BlueShield of Kansas City  
One Pershing Square  
2501 Main  
P.O. Box 419169  
Kansas City, MO 64141-6169

Dear Mr. Burge:

The Missouri State Orthopaedic Association recently became aware of BlueCross BlueShield of Kansas City's (BCBSKS) new privileging guidelines for providers of imaging services and would like to meet with you regarding the content of these guidelines and their implementation.

MSOA was formed in 1969 and serves more than 450 orthopaedic physicians and surgeons in Missouri. Medical imaging provided by our member-physicians provide BCBSKC-covered lives with prompt, efficient, high-quality test results that allow for more timely diagnosis and the initiation of treatment. At the same time, in-office medical imaging provides cost-savings in other areas covered by BCBSKC by supplanting invasive diagnostic and therapeutic techniques performed in hospital settings.

Simply put, orthopaedic physicians and surgeons have recognized that providing in-office imaging offers:

- Immediate results and faster diagnoses
- Improved patient compliance
- Better health outcomes
- Reductions in invasive diagnostic techniques
- Fewer duplicative office visits

While MSOA shares BCBSKC interest in providing their beneficiaries with high-quality imaging services that lead to effective diagnosis and treatment, we have some concerns that BCBSKC's proposed privileging guidelines could create unintended consequences that may not achieve the goal of improving a patient's overall quality of care and would create a barrier to prompt, convenient, high-quality test results for BCBSKC's members allowing for timely diagnosis and treatment.

Specifically, our concerns include:

*Serving its members through promotion of the science and art of orthopaedic medicine, protection of the health of the public, and betterment of orthopaedics in Missouri since 1969.*

**Proposed staffing requirements.** The proposed privileging guidelines require physicians to employ a certified technologist on-site or must arrange for an off-site credentialed radiologist to over-read all films. MSOA strongly believes that specialists who have the appropriate training in an imaging modality should be allowed to provide the imaging services. Requiring a radiologist or certified technologist does not ensure quality. Moreover, this requirement limits the ability of orthopaedic physicians from offering patient-centered diagnosis in a timely manner by potentially causing BCBSKC patients to wait longer and drive further to receive care.

It is critical that BCBSKC understand that an orthopaedic surgeon never makes a surgical decision, such as whether surgery is necessary or what type of procedure is appropriate, strictly from a radiologist's report. An orthopaedic surgeon never makes a diagnosis strictly on an x-ray, a MRI, or a piece of lab work. It must be correlated with history and physical findings.

An orthopaedic surgeon's read of a patient's images is a crucial part of the evaluation and treatment process. The orthopaedic surgeon is able to add functional, anatomical and clinical assessments—resulting in patient-specific information—to the interpretation of an image.

For example, with a fracture of a distal radius, which is the most common fracture in adults, it cannot be ascertained from a radiologist report whether the fracture needs an operative approach versus a closed approach, and what type of operation must be done. It must depend on the orthopaedic surgeon's interpretation of the actual image.

In addition, unlike radiologists, orthopaedic surgeons have the advantage of examining patients and being intimately familiar with the specifics of a patient's case, outside of just what is seen in a diagnostic image. For example, the orthopaedic surgeon who has performed knee replacement surgery on a patient is the most qualified to interpret the results of a follow-up imaging study.

MSOA encourages BCBSKC to reconsider this staffing requirement which may impede orthopaedic surgeons from providing the full range of medically appropriate diagnostic and interventional imaging services for their patients. MSOA is committed to the principle that a patient's physician is best qualified to decide when a test is necessary, and may be the best qualified to administer and interpret the results. Only a patient's physician can integrate imaging results into the medical treatment plan. Qualifications for imaging service provisions should be based on training and experience, as opposed to specialty alone.

**Staffing requirements discount extensive imaging qualifications of orthopaedic physicians.** MSOA takes exception to the notion that the imaging services provided by nonradiologist physicians are of inferior quality compared to radiologists. In addition, MSOA strongly disagrees with the impression that orthopaedic surgeons are not as qualified as radiologists to provide imaging services to patients with orthopaedic conditions.

Because imaging is so integrated into the provision of quality orthopaedic care, orthopaedic surgeons receive extensive training in the reading and interpretation of radiological images.

- During residency, orthopaedic residents are required to interpret images, including x-rays, computed tomography (CT) scans and magnetic resonance images (MRI), on almost every patient seen.
- In addition, a majority of residency programs require orthopaedic residents to perform a full radiology rotation. The nature of orthopaedics, with the treatment of bones, joints and surrounding structures, requires some type of imaging in nearly every case.

**NIA is predisposed to underutilization of imaging services.** BCBSKC has retained National Imaging Associates to manage the privileging program. According to NIA's website, NIA believes there is an "***Imaging Problem***" and that "*about one third of advanced imaging tests are either inappropriate or do not contribute to the physician's diagnosis or ultimate health outcomes.*"

MSOA objects to the contention that the increased use of imaging services is wholly inappropriate and, therefore, action needs to be taken to restrict the provision of such services. Advances in technology, the shift in site-of-service from hospitals to the in-office setting, and higher standards of patient care have all contributed to the increased use of imaging. Few, if any, would argue that these are negative changes in the direction of health care.

NIA refers to inappropriate utilization of imaging services, but no evidence is cited to support this allegation. While there is likely some degree of inappropriate usage—just as there is with all health services—it is important to note that the vast majority of imaging services, including MRIs and CT scans, are performed and read by radiologists, even on patients that present with orthopaedic conditions.

- For example, in 2003, there were a total of 34,557 CT scans of upper extremities billed under Medicare – 32,228 (93.3%) were performed by radiologists; nonradiologists billed for only 2,329 (6.7%) scans.
- During the same year, there were 553,352 MRIs on lower extremities billed under Medicare—radiologists performed 464,150 (83.9%) of these MRIs. Since radiologists clearly control most of the imaging done in the United States, if there is indeed concern about inappropriate utilization, it makes sense to also examine the utilization practices of radiologists.

MSOA believes that credentialing does nothing to address volume control and could be used to severely restrict who is able to provide imaging services instead of ensuring quality.

**Diagnostic imaging services are an integral component of quality orthopaedic care.** When a patient is able to receive imaging services in an orthopaedic surgeon's office, important judgments about the course of care can be made without delay. Forcing patients to leave an orthopaedic surgeon's office in order to receive a diagnostic imaging service can cause additional harm and injury to a patient, especially with elderly patients. It is untenable for an orthopaedic surgeon to remove a cast and then send a patient across town to obtain an x-ray in order to decide if the cast needs to be replaced. In addition to being inconvenient to a patient, it is dangerous. The patient must make two appointments at the orthopaedic surgeon's office—the initial appointment and then the follow-up after the imaging service is performed. In addition, since the extremity

would be unsupported during transfer, or at least during x-ray, it is dangerous if the fracture is not completely healed.

Orthopaedic surgeons rely on medical imaging every day as they strive to provide the highest level of orthopaedic care to their patients. **I would encourage BlueCross BlueShield of Kansas City to exempt orthopaedic physicians and surgeons from the proposed privileging guidelines.** Orthopaedic surgeons receive extensive training and testing in imaging services and are well-qualified to provide such services. Orthopaedic physicians are familiar with the patient's clinical condition, medical history and previous test results. They have the expertise, educational background and experience to perform and interpret images that could impact clinical decision-making.

We urge BCBSKC to move cautiously and deliberately through this privileging program, examining all of the facts and weighing all decisions against how patients will be affected if undue restrictions are put on the provision of imaging services.

If you do not carve-out orthopaedic physicians, I would encourage you to delay implementation of the privileging program with a three-year transition period for providers and imaging facilities to achieve certification and accreditation. This transition period is necessary for physicians to have adequate time to properly implement the requirements of their specialty's programs and not compromise patient care and access.

In addition, orthopaedic physicians should be involved in the development and use of any privileging guidelines. There is little to no consensus among the physician community as to what standards for training and experience are appropriate for each modality. It is absolutely imperative that orthopaedic surgeons be involved in the creation of any standards which orthopaedic surgeons will have to meet.

On behalf of the Missouri State Orthopaedic Association, I look forward to the opportunity to discuss this matter with you. The courtesy of a reply is sincerely appreciated.

Sincerely,

Brian Treece  
Executive Director