INSIDE AANA

Arthroscopy Association of North America Newsletter Volume 25 Number 4

# Hollywood Honing

by Jeffrey S. Abrams, MD

This year's 29th Annual Meeting will be held at the Westin Diplomat Hotel in Hollywood, Florida on May 20-23, 2010. This beautiful resort in South Florida near Fort Lauderdale and Miami has easy access from any destination. An exceptional program has been planned to present the newest developments in arthroscopic surgery.

The Annual Meeting combines state-of-the-art information with innovative new ideas and concepts. There will be 22 instructional course lectures including shoulder, hip, knee, foot and ankle, elbow and wrist. Here, faculty will review surgical techniques, video demonstrations, and discuss patient selection and results.

The meeting has been designed around master lectures and paper presentations. Thought-provoking topics that are controversial will be addressed providing valuable information on patient management. Topics include the failed cuff repair, the athletes' hip, best option for knee ligament grafts, and patellar stabilization. Over 60 selected papers are included in the meeting to provide extensive information on arthroscopic topics. In addition, an equal number of electronic "E" posters have been accepted for those registrants who like to investigate new ideas in this venue.

The clinical case panels have been very popular, and audience participation has made these an excellent tool for interactive learning. Clinical cases on rotator cuff, shoulder instability, knee ligament injuries, and foot and ankle injuries will provide lively discussion between expert panels and the audience.

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*Courtesy of Miami Convention & Visitors Authority*

## In This Issue



FALL 2009

# Results of Knee Position Survey

by Ronald P. Karzel, MD

In our previous newsletter, we discussed a survey from Drs. Cannon and Chamberlain regarding knee position and camera orientation during knee arthroscopy. They are particularly interested in whether different knee positions affect the difficulty of learning how to do knee arthroscopy. Once again, AANA members responded enthusiastically with 283 total responses to our e-mail survey.

Members expressed a strong preference for the Figure-4 position for accessing the lateral compartment. 73% used the Figure-4 position compared with 27% who used the 25-30 degree flexed position. Even more overwhelmingly, 98% maintained the picture on the monitor in a horizontal position while working, even if the actual knee position was vertical. Only 1% maintained the image in a vertical position, and 1% reported using another position other than vertical or horizontal. Apparently, most members believe it is easier to work with the picture horizontal even when the true orientation in the Figure-4 position may be closer to vertical. It will be enlightening to see if these findings are similar in residents attempting to learn these procedures. Thank you to all of you who participated in this survey!

# AANA General Information

## New Members

### Resident

Aronowitz, Jessica MD
Barker, Joseph U. MD
Beckett, Michael P. MD
Bhadra, Arup Kumar MD
Bilotta, Jessica Christine MD
Boselli, Karen June MD
Botker, Jesse MD
Campbell, Donald C. DO
Carlson, Michael MD
Chan, Keith Wei MD
Conner, Chad Stephen MD
Crawford, Scott N. MD
Fagan, Bryan C. MD
Fanter, Nathan Joseph MD
Farmer, Kevin William MD
Frank, Jeremy S. MD
Gardner, Eric J. MD
Grannatt, Kathryn Simpson MD
Greiwe, Raymond Michael MD
Healy, Ethan Matthew MD
Johnson, Eric Matthew MD
Kang, Parminder Singh MD
Kasraeian, Sina MD
Kercher, James Saylor MD
Kimber, Kristofer A. MD
Kowalsky, Marc S. MD
Krych, Aaron John MD
Kuremsky, Marshall MD
Kwak, Steve MD
Lesniak, Bryson Patrick MD
Minnich, John M. MD
Moreyra, Carlos E. MD
Naumann, Paul MD
Nelson, Joshua D. MD
Osier, Charles J. MD
Puskas, Brian MD
Ramsey, Jason A. MD
Rios, Clifford G. MD
Salata, Michael J. MD
Sandoval, Carlos Miguel MD
Serrato, Juan A. MD
Smucker, J. Benjamin MD
Stewart, Bruce MD
Strauss, Eric Jason MD
Tabloie, Farshid MD
Thangamani, Vijay R. MD
Ward, Abner MD
Wilkins, Kip Richard MD
Zunkiewicz, Mark Richard MD

### Associate

Burkhart, Bradd MD
Clinton, Camille MD
Koo, Samuel MD
Labriola, Joanne E. MD
Long, Joy L. MD
Roache, Paul B. MD
Todd, Michael S. MD

### International

Arafiles, Ruben P. MD
Herzberg, Guillaume MD
Schlotterbeck, Ricardo M. MD


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## In MEMORY

Burton Berson, MD
New York, NY

## Attention Military

The AANA Board of Directors has made some new policies concerning our much appreciated members who are in military service. Starting with 2010, military members will pay only $200 in dues. Dues and meeting attendance requirements will be waived while members are deployed. Current members of AANA that are serving in the military will need to contact the AANA office to advise us of this. We do not currently have this information on the database. Also the deferral of meeting attendance and dues will be on a one year basis and will have to be requested each year if deployment is more than one year.

# President's Message

The recent healthcare reform measures continue to top the list of priorities that we are addressing. In addition to our position statement ( available on our website) as well as our four "generic" letters sent to the membership to serve as a template for letters to the editor or Op-Ed pieces, AANA has continued to work with the AAOS and the Board of Specialties to represent your concerns and those of our patients to Congress.

Personally, I have met with my local congressional representative, and have had an Op-Ed piece published in the local newspaper. Although my impact may be small, becoming involved is the first step in the process. I was impressed by the number of patients and colleagues that took notice, and were anxious to engage in meaningful dialogue. It is noteworthy that I have heard both positively and negatively from the membership, and although I favor the kinder comments, the passion of those who find fault with our position statement is a healthy indicator of the differences that also define our organization. Sometimes we must simply agree to disagree. The main message is to get involved since the decisions that are made will affect us and our patients for decades to come.

I am pleased to report that three initiatives generated by Walter R. Shelton, MD and the International Task Force have already been implemented. Dr. Rodrigo Maestu from Argentina has graciously agreed to be our first International Master Surgeon, and will be an integral part of the faculty for the Advanced Shoulder Arthroscopy Course to be held at the OLC February 24-26, 2010. AANA recognizes the enormous talent and accomplishments of our international colleagues, and we want to establish a means by which arthroscopists in North America benefit from an international perspective while cultivating a lasting relationship of a global nature, founded in the common desire to enhance education. Moving forward, other international thought and skill leaders will become part of our faculty. Furthermore, Dr. Christian Gerber, a pioneer in shoulder surgery, has agreed to be the inaugural Presidential International Guest Lecturer for our Annual Meeting in May, 2010 in Hollywood, Florida. Lastly, AANA will be partnering with ISAKOS to sponsor a combined meeting with the Chinese Society for Sports Medicine in May of 2010 in Shanghai, China. We hope to continue with this collaboration on a biannual basis, and appreciate the efforts of ISAKOS in the realm of international education.

The Fall Course, which is nearly upon us, represents the very best in content and scheduling. A dynamic blend of didactic lectures, hands-on cadaver labs and a unique opportunity to interface with industry and its latest advancements through the ever popular focus demonstrations are but a few of the highlights of this compact meeting, designed to limit the impact of time out of the office while maximizing a highly specialized learning experience. I am most grateful to the entire Education Committee for their relentless efforts, and especially to Jeffrey S. Abrams, MD, the Fall Course and Education Committee Chairman.

Our efforts through the Development Committee and the AANA Education Foundation continue to mature. Fundraising efforts from industry to solidify our endowment continue to be successful, and we are anxious for a similar commitment from our membership. With the coming year's dues statement, there will be an additional line item that will conveniently allow you to make a donation to the AANA Education Foundation. We would ask that you be as generous as possible, but more importantly, that you participate in this critical effort. Membership support resonates strongly within those organizations that choose to support AANA and its mission of providing cutting-edge arthroscopic education. The greater the involvement of the membership, the more likely we will continue to find partners who will generously support our mission. As you might anticipate, more will follow on this important initiative.

As I conclude this message, I want to welcome two new members to the AANA home office. Beginning November 2, Jeff Spansail, CPA will become our Director of Finance and Accounting. He has worked for the past 15 years for a non-profit in Illinois, and prior to that was Chief Accountant for U.S. Soccer. Christine DiGiovanni will serve as our Member Services Coordinator, having recently graduated from DePaul University with a marketing degree. This necessary expansion in our home office personnel reflects our continued growth as an organization and our desire to serve our membership in every way possible. Ed Goss, AANA's Executive Director, will continue to lead the home office, and will now have the ability to focus on the needs of the Foundation and in turn, on the best interests of our membership. Please join me in extending a warm welcome to Jeff and Christine.

# Point/Counterpoint

## The ACL Bracing Controversy

by Ronald D. Karzel, MD

Although ACL reconstruction has evolved into a successful operation with low failure rates and a high rate of return to sports activities, the utility of functional bracing after an ACL reconstruction remains controversial. Most patients are familiar with the images of high-profile athletes wearing braces after returning to play after ACL surgery, and many are convinced that these braces are essential to protect the reconstructed knee. However, the science of bracing is not so definitive.

In this newsletter, we present a stimulating point-counterpoint by Drs. Peter Millett and Patrick St. Pierre regarding whether functional bracing is indicated after ACL reconstruction. We will also be sending out an e-mail survey to AANA members this month about your bracing practices. Please respond to the survey so that we can all get an accurate idea of what our colleagues are doing. We hope you enjoy this point-counterpoint and hope you will make your voices heard in the debate.

## Bracing is not indicated following ACL Reconstruction

by Patrick St. Pierre, MD, Eisenhower Desert Orthopaedic Center

Recent surveys have indicated that many surgeons continue to recommend functional braces to their patients following ACL reconstruction, in spite of the fact that there is no clinical evidence to support it. In a survey of the AAOS (Marx RG, et al. Arthroscopy 2003) 63% of surgeons recommended bracing for sports participation following ACL reconstruction. In another survey of the AOSSM (Decoster LC, Vailas JC. Orthopedics 2003) 31% of surgeons recommended postoperative functional bracing to almost all of their patients. Proponents of brace usage suggest that braces lead to improved outcomes, by decreasing strain on the graft while it is healing in the tunnels, as well as providing increased proprioception and neuromuscular control. Although controlled laboratory studies support improved proprioception, similar benefit is obtained with simple knee sleeves and clinical studies have not demonstrated an advantage.

Few topics argued in this point-counter point section of the newsletter have been studied well enough to make a decision based on evidence based research. Most arguments are supported by expert opinion and experience. However, the use of braces following ACL reconstruction is a topic that lends itself to prospective study and we have several studies to look at and make a decision. In a review of 12 randomized controlled trials (Wright RW, Fetzer GB. CORR 2007) the authors did not find any evidence supporting improvement in pain, range of motion, graft stability or protection from subsequent injury with brace usage.

In a collaborative effort between the three major service academies, we randomized 100 patients undergoing ACL reconstruction to use of a postoperative brace or not during their rehabilitation (McDevitt ER, et al. Am J Sports Med 2004). This was a fairly homogenous group of patients with acute tears (< 8 weeks), bone-tendon-bone reconstruction, and minimal chondral or meniscal damage. A significant advantage of this group was the mandatory return to a very high activity level. (West Point cadets much higher than Naval Academy midshipmen – I had to say that!) With almost 100% follow-up at two years, we found no statistically significant difference between groups in knee stability, functional testing, clinical scores, range-of-motion, or strength.

This has also proved true in different populations using different grafts. In Canada, another prospectively randomized study of 150 patients, comparing use of a functional brace versus a knee sleeve following hamstring autograft ACL reconstruction, was performed (Birmingham TB, et al. Am J Sports Med 2008). In a more diverse population, the authors found no statistically significant difference in KT-1000 stability, functional testing, clinical scores or adverse events. They did find that patients in the brace cohort, had higher subjective confidence in their knee at one year. They questioned the importance of that finding and were concerned about a false sense of security for the athlete returning to sport. I think an argument can be made that increased confidence is a desired effect in athletes returning to sport.

I would not argue that the use of a postoperative brace in some populations may be desired. The AAOS position statement on the use of knee braces, states that ACL functional knee braces used postoperatively do not appear to be required, although there may be a role in patients with weakened tissue or suboptimal graft fixation. I would also consider brace use in patients returning to competitive collision sports less than eight months postoperatively, or in patients with excessive recurvatum.

For one of the few controversies in Orthopaedics in which we have level 1 evidence to rely on, there is no supportable justification for the routine use of functional knee braces following ACL reconstruction.

**Continued on page 5**

Point/Counterpoint Continued from page 4

# The Advantages of Bracing after ACL Reconstruction

by Peter J. Millett, MD, MSc; Angela West, ATC, Michael Torry, PhD

Bracing after anterior cruciate ligament reconstruction remains a topic of debate. Knee braces are categorized as prophylactic, rehabilitative or functional. Functional knee braces are commonly used for patients that are unstable or have had ligament repairs or reconstructions. We have been asked to discuss the advantages of functional knee braces after ACL reconstruction.

Ligament injuries to the knee are very common. Lyman et al. have recently reported an increase in the surgical reconstruction of ACL tears by as much as 67.8% between 1997 and 2006. Functional bracing after ligament reconstruction is therefore an important consideration, as more patients and surgeons are choosing to reconstruct the ACL rather than live with ACL deficiency. So why brace the knee after ACL reconstruction? The obvious reason is to protect the new graft and decrease the risk of re-injury. The re-injury rate in reconstructed knees, although improving with surgical and rehabilitative techniques, is still significantly higher than that of normal knees as evidenced by the increasing number of revision surgeries. Also both high level athletes and weekend warriors return to high impact sports after ACL reconstruction; placing greater demands on their knees.

The obvious benefits of bracing are increased protection of the knee as the ACL heals. Many ACL tears do not occur in isolation, and a functional knee brace can facilitate protection of the collateral ligaments or menisci as they heal, either surgically or non-surgically. Furthermore, with an increasing number of allograft ACL reconstructions being performed, protection is required for a longer time period as the process of ligamentization occurs more slowly with allografts, even though the knee may feel better sooner.

Several biomechanical and physiological studies of ACL bracing suggest that knee orthoses increase mechanical stability under low loading conditions. This supports the notion that braces are likely to provide the greatest benefit during the early periods of rehabilitation when athletes are not producing high loads across the knee joint. Several studies have also shown that as functional activity levels increase, such as during running, jumping and cutting, braces can negatively affect performance. A recent article by Stephens et al. reported that functional knee braces did not affect the sprinting ability of collegiate basketball players. Stephens tested 25 basketball players, both male and female, on their ability to sprint short distances (baseline to free throw line) and longer distances (baseline to baseline) with and without a brace. This study did not show any significant difference between the performances of the athletes in the control and brace trials.

Another argument against bracing has been that the functional knee brace can affect muscle firing patterns and decrease time to muscle fatigue. Nemeth et al. performed EMG testing on expert downhill ski racers that had ACL injuries. Each racer wore a custom knee brace on their injured leg for two runs and performed two slalom runs without a functional knee brace. EMG activities of the quadriceps, hamstring and gastrocnemius muscles were evaluated. All six subjects felt more stable in the custom functional knee brace and preferred to race with the brace.

A study by Sterett et al. from our institution found that skiers with prior ACL reconstruction who did not wear a functional knee brace were 2.74 times more likely to have subsequent injuries while skiing. Although patients with previous ACL reconstructions still had a higher reinjury rates than skiers without reconstructed ACLs (approximately 3x's more likely), the functional knee brace group had a significantly reduced re-injury rate to their operative knee than skiers who did not wear a brace on their operative knee.

Continued research in this area is needed. Although at this point detailed scientific evidence is lacking, it certainly seems plausible that in certain patient populations, injury patterns, or environmental settings (icy, winter conditions), it may prove beneficial to use a brace. However, there has been valuable research showing that functional knee braces can reduce re-injury rate after ACL reconstruction in high demand sports like skiing. Another important argument is that studies have shown that performance has not been negatively affected by wearing a knee brace. Other than cost, there does not seem to be any evidence of an increased re-injury risk with bracing, and most clinicians know that some patients just feel more stable and comfortable wearing a functional knee brace for high demand sports after ACL reconstruction.

## Upcoming Meetings

### Annual Meeting

2010, May 20-23
Hollywood, FL

2011, April 14-17
San Francisco, CA

2012, May 17-20
Orlando, FL

### Fall Course

2010, November 18-20
Phoenix, AZ

2011, November 17-19
Palm Desert, CA

### Specialty Day

2010, March 13
New Orleans, LA

# Health Policy Committee

by Louis F. McIntyre, MD

## Global Service Data

The HPP Committee has completed the review of the arthroscopic surgical codes in the Global Service Data Book (GSD) in conjunction with the Coding, Coverage and Reimbursement Committee (CCRC) of the AAOS. This project is part of a complete review of the book to reconcile it with the CCI edits of Medicare. It is hoped that by having both the GSD and CCI reflect the same coding bundling packages that the book will be a powerful tool in adjudicating claims denials by insurance companies. We hope to have the entire project completed for the 2011 publication.

## RUC 5 Year Review

Every 5 years the RUC (RBRVS Update Committee) conducts a review of CPT codes to assess changes in value. The RUC petitions the various specialty societies to bring forward codes they feel are incorrectly valued to have them reassessed before the Committee. The HPP Committee reviewed all the arthroscopic codes and came up with seven codes we believe are undervalued and will not affect the value of other codes if brought before the RUC; an issue that presents risks with all the shoulder and knee codes we reviewed. They are all valued by the older "HARVARD" method, meaning they have not been valued by the RUC methodology. All of the codes have a value under 29881, meniscal resection which is 8.56. We felt these codes are at least as difficult and take as much time as 29881. They are all done as outpatient in the Medicare database, meaning there are no site of service problems with their values. The codes are: 29834 Elbow scope loose body, 29835 Elbow scope partial synovectomy, 29836 Elbow scope complete synovectomy, 29837 Elbow scope limited debridement, 29838 Elbow scope extensive debridement, 29846 Wrist scope TFC repair/debridement, 29847 Wrist scope instability/ fracture repair. The CCRC is currently reviewing these codes to determine the risk/reward of presenting them to the RUC in 2010 for the five year review.

## Hip Arthroscopy Codes

The HPP has lead the effort to obtain three new hip arthroscopy codes for labral repair, femoroplasty (for cam lesions) and acetabuloplasty (for pincer lesions). The effort has been conducted in concert with AAHKS and several surgeons who have high volume hip arthroscopy practices. The Coding Change Proposals (CCP) have been completed and will be presented to the RUC in November for approval. If approved, the codes will be surveyed for physician work time at the end of 2009. The codes will then be presented to the RUC in 2010 for formal valuation and included in the CPT book for 2011.

## Health Care Reform

The Congress and President Obama are aggressively pursuing bold reform of the nation's health care insurance/payment system. There are several bills in both houses of Congress but the final form of the legislation remains in Committee as of this writing. The basics of the plan are to establish national standards for the issuance of health insurance including community rating, guarantee issue and basic coverage mandates all to be set by Washington, D.C. Reform of the Medicare payment system include a one year suspension of the dreaded SGR, mandate penalties for providers that are in the top 10% of patient cost, establishment of clinical efficiency boards and standards and pay for performance provisions. Expansion of Medicaid eligibility is part of the reform also. The most controversial proposal is the establishment of some type of public (read government) option that will be ultimately supported by the federal government that will "compete" with the private health insurance market. This legislation will have significant impact on all our practices. The AAOS has done a fine job in keeping us informed about this process. I urge all to keep abreast of this and to contact your representatives in Congress with your opinion of the final legislation.

# Coding Corner

by William R. Beach, MD

The politics of health care have never been more intense than now. The AAOS continues to act in behalf of all orthopaedists to provide input when and where possible. Unfortunately, there seem to be few open ears and fewer open doors for input from the providers or stakeholders. For further updates please go to advocacy@aaos.org.

The CMS Final Rule for the Physician's Fee Schedule and the ASC/OPPS are out with the following highlights (these excerpts are provided by AAOS staff Matt Twetten and Jacque Roche).

## Physician's Fee Schedule

**1** Elimination of Medicare payment for E/M Consultation services

*What the Rule Says*---CMS will no longer pay for E/M consultation (99241-99245 and 99251-99255) services beginning in 2010 and will instead pay an additional 6% for office/outpatient visits (99201-99215) and an additional 2% for inpatient initial visits (99221-99223). CMS will also increase all 10 and 90 global period codes by 0.3% to bundle the office/outpatient visit increase into procedure codes. The rationale from CMS is that providing consultation services is no longer sufficiently greater work than a standard office/outpatient visit and therefore the payment disparity between the two is no longer warranted.

*Fiscal Impact*---Our estimates are that for the average orthopaedic surgeon, the change would be a very small positive fiscal impact (as a rough guide, a provider billing office/outpatient visits at a rate greater than 6 for every one consult code billed will see a positive impact, and a provider billing at rate less than 6:1 would see a negative impact). The additional .3% increase in the global period will have a significant positive impact for orthopaedics, to the tune of approximately $36 million annually.

**2** PE inputs for diagnostic arthroscopy of the Knee

*What the Rule Says*---CMS accepted the RUC recommendation for non-facility (ie, office) practice expense values for CPT code 29870 which prices diagnostic arthroscopy of the knee in the office setting. Previously, all diagnostic arthroscopy codes were not priced in the office; however, some providers have lobbied CMS for years that they are in fact providing diagnostic arthroscopy services in their offices (even though Medicare data does not support this contention) and CMS determined that for 2010 they needed to price the services in the office setting. Importantly, the RUC recommended inputs do not include a disposable diagnostic arthroscope but rather use pricing for a rigid diagnostic arthroscope kit, which means the PE inputs will be less than they would be with a disposable diagnostic scope.

*Fiscal Impact*---Unknown at this point, but expected to be minimal. Providers of this procedure in the office will now receive a higher RVU than previously.

## ASC/OPPS

CMS finalized a 2.1 percent OPPS market basket update for calendar year (CY) 2010. Beginning January 1, 2010, CMS finalized a full OPPS update conversion factor of $67.406. For CY 2010, CMS finalized an ASC payment system conversion factor of $41.873. In addition, as part of the transition to the new ASC payment policy, the relative payment weights will be paid at 25 percent of the CY 2007 payment rate and 75 percent of the revised ASC payment rate.

***"2 Times Rule."*** CMS finalized the movement of healthcare common procedure coding system 29888 and 29889 (Knee Arthroscopy/Surgery) into APC 0052 (Level IV Musculoskeletal Procedures Except Hand and Foot) for violation of the "2 times rule." The "2 times rule" means that the median of the highest costing item or service cannot be more than two times the median of the lowest costing item or service in any single APC. CMS does make exemptions to the rule, for example low volume procedures. The AAOS requested the following changes to the current APC alignment which were rejected by CMS

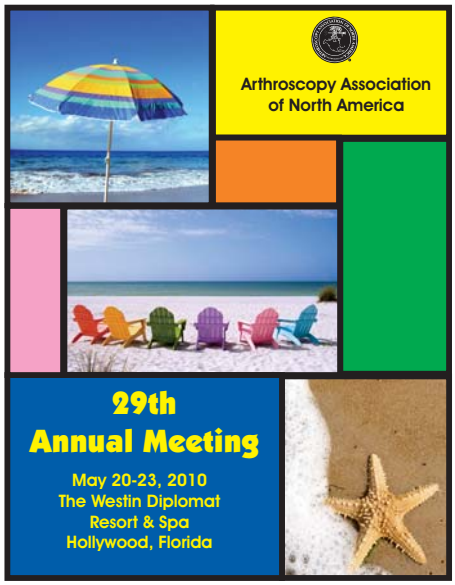
***Shoulder APCs.***

HCPCS 29806 and 29807 (Shoulder arthroscopy/surgery) to APC 052 (Level IV Musculoskeletal Procedures Except Hand and Foot)

***Knee APCs.***

HCPCS 29867 ('Allgrft implnt, knee w/scope) and 29868 ('Meniscal trnspl, knee w/scpe) to APC 052 (Level IV Musculoskeletal Procedures Except Hand and Foot)

HCPCS 29882 and 29883 (Knee arthroscopy/surgery) to APC 042 (Level II Arthroscopy)



# Scientific Papers

## Hip Arthroscopy: The New Frontier

Over the past five years, interest in hip arthroscopy has increased dramatically. This interest has been accompanied by a corresponding increase in our knowledge of hip pathology and in new techniques for treatment. We are pleased to present the following articles about hip arthroscopy to stimulate interest in this exciting topic.

## Treatment Options for Labral Tears

by Marc J. Philippon, MD and Bruno G. S. Souza, MD, Steadman Hawkins Clinic

Tears of the acetabular labrum were first described in association with traumatic dislocations of the hip (Paterson 1957; Dameron 1959). Atraumatic labral tears have been described later (Altenberg 1977) and, at first, there has been no explanation of their causes. See table on page 9 for common causes of labral pathology.

### Surgical treatment

Because labral lesions are often symptomatic and may significantly reduce the hip's capacity to function effectively, surgical techniques have been developed to mend labral pathology. Correct diagnosis is essential for the proper treatment of labral lesions. When indicated, labral repair has shown to provide excellent results (Philippon, 2009). In the great majority of the cases, concomitant pathologies are present and need to be addressed to lower the risk of treatment failure (Beule, 2009, Wenger, 2004). Not recognizing hip impingement or dysplasia has the potential to impede the improvement or worsen the patient's condition. Additional intra-articular lesions such as chondral defects, ligament teres lesions and loose bodies when present should be adequately treated.

While labral debridement is a far less complex treatment option, ablating labral tissue from the hip joint may remove its protective effect on joint cartilage, leading to eventual chondral damage and premature osteoarthritis. The clinical indications for simple labral debridement are restricted to patients with no morphological abnormalities (like FAI or dysplasia) or instability, presenting with simple peripheral tears (small flaps or fraying) in which the resection will allow enough remaining tissue for the labrum to play its important physiological functions. Selective labral debridement can be achieved with aid of arthroscopic shavers and radiofrequency devices.

The clinical success of labral repair has made it the treatment of choice for most labral tears found at time of surgery. Labral repair using suture anchors to reattach the labrum to the acetabular rim has been shown to be an effective treatment option for patients with a detached or torn labrum. The acetabular rim is prepared to provide solid fixation to the anchors and stable base for the labrum. We use preferably one bio-absorbable anchors for every 1cm on average of labral detachment. Several authors have published early clinical results on labral repair that show patients experience significant improvement in function at least six months post-operatively and continue to experience improvement in clinical outcome measurements after that (Espinosa, 2006; Phillipon, 2007; Philippon, 2009; Larson, 2009; Beck, 2009).

There are occasions in which the labrum cannot be repaired primarily. A novel technique of labral reconstruction using iliotibial band autograft was developed to be performed arthoscopically. This method allows for restoration of a labral seal, reinstating overall physiologic function, preserving intra-articular structures (ligament teres) with low morbidity. Between 8/2005 and 11/2009, the senior author performed 155 arthroscopic labral reconstructions using an iliotibial band(ITB) autograft in patients with advanced labral degeneration or deficiency There was significant improvement in the modified Harris Hip score at followup. Patient satisfaction was high. Patients who were treated within a year of injury had higher MHHS compared to patients who waited longer than one year. This study showed that patients who are labral deficient or have advanced labral degeneration had good outcomes and high patient satisfaction after arthroscopic intervention with acetabular labral reconstruction.(Philippon et al. Arthroscopy, In press)

### Conclusion

Several arthroscopic treatment options are available for the injured labrum. However, the type of treatment to use is based on the type of tear and other pathologies seen in the hip. Excellent outcomes have been seen with labral repair, which has become the treatment of choice. The success of the any treatment of the labrum is dependent on treating associated pathologies which may have led to the damage. Specifically, femoroacetabular impingement and hip instability must be addressed for successful labral treatment.

**Continued on page 9**

# Femoroacetabular Impingement

by Carlos A. Guanche, MD, Southern California Orthopedic Institute

Having been in practice for over fifteen years and doing hip arthroscopy for most of that time, I have certainly seen many of cases of hip impingement. Unfortunately, I only started to treat them about six years ago! Currently, the problem seems to be epidemic, so we are all diagnosing the problem much more frequently. A huge factor has been increasing awareness through education, most notably through AANA.

Understanding the etiology of hip osteoarthritis in a younger patient population has been a challenge. Femoroacetabular impingement (FAI) has offered an explanation for a subset of these patients, since the dysfunction and pain secondary to the altered morphology of the femoral neck and acetabulum have now been made known. These congenital or development deviations of the anatomy may alter load-bearing mechanics, leading to joint degeneration. Structural alterations of the femoral neck or acetabulum may cause impingement at terminal degrees of motion, especially flexion and internal rotation. Lack of normal head-neck offset (cam impingement) or increased acetabular retroversion (pincer impingement) may change the load bearing properties of the labrum and bone interface, resulting in labral tears and chondral injuries. This seminal event can lead to chronic groin pain and may serve as a catalyst for hip arthritis.

The concept of impingement predates arthroscopy by several decades. Smith-Petersen (1936) described a femoral neck resection and Stulberg (1965) originally described the "pistol grip" femoral neck deformity as an abnormally shaped femoral neck with a decreased head-neck offset. Our understanding of the problem then grew considerably in the last decade as a result of the pioneering work of Ganz (2003). The deformities have been shown to be risk factors in the development of degenerative arthritis. Degenerative labral tears occur in a large percentage of patients undergoing hip arthroplasty but there is currently not a completely established causal relationship between FAI and arthritis. We can extrapolate from our current understanding, however, that an impinging lesion may begin or contribute to the degenerative cascade of the joint. Whether we can truly impact the natural history of the disease remains to be seen.

FAI is now clearly recognized as a source of hip pain in athletes and we know that treatment offers pain relief and restoration of more normal function. Most notably, the outcomes from arthroscopy have been shown to be at least equivalent to the much more invasive open procedures, with a minimum of complications. The current literature has improved to the point where we are now starting to see data with greater than two years of follow-up and most of these studies are very positive. Whether addressing the impingement, however, abates the degenerative process has yet to be shown. The difficulty in analyzing the literature to date has been that most studies focus on the treatment of the symptomatic labral tear, with no clear separation of the tear from the impingement. With continued research and education on the topic, we will certainly help the next generation of arthroscopists delineate the process further and hopefully develop an ideal treatment algorithm. What is clear is that hip arthroscopy is here to stay and that all orthopaedists should at least be familiar with some of the critical findings in these patients so that we can continue to advance the treatment of the problem.

**Treatment Options for Labral Tears continued from page 8**

**Common causes of labral pathology**

| Type | Base condition | Labral Morphology | Labral Lesion |
|---|---|---|---|
| 1. Morphological alterations | A. Femoroacetabular impingement<br>Cam | Normal | Labral tear (usually base detachment in the watershed zone associated with chondral lesion) |
| | Pincer | Hypotrophic | Labral degeneration (bruising, fraying, with eventual cysts and ossification) |
| | Mixed-type areas | Normal/hypothophic | Labral tear associated with degeneration signs |
| | B. Dysplasia | Hypertrophic (Klaue 1991; Leunig 2004) | Myxoid degeneration and/or detachment from the osseous rim |
| 2. Functional alterations | A. Instability | Normal | Labral tear (usually base detachment in the watershed zone) |
| | B. Iliopsoas impingement | Normal | Inflamation, labral tear or mucoid degeneration. Scarring to the anterior capsule. |
| 3. Trauma | Traumatic | Normal | Variable |
| 4. Degeneration | Hip degenerative disease | Hypothorphic | Labral degeneration (yellow color, bruising, fraying, with eventual cysts and ossification) |

# Getting started in Hip Arthroscopy

by Christopher R. Lehman, MD, Permanente Medical Group

The number of arthroscopic hip surgeries has increase dramatically over the past 5 years across the world. This growth is likely due to increased surgeon and patient interest, improved instrumentation and surgical equipment, and most importantly the awareness of clinical conditions affecting the hip. Therefore it is natural for more and more surgeons to expand their practice to include performing hip arthroscopy. Hip arthroscopy, like all arthroscopy, involves inserting a camera into a joint with water in it. But hip arthroscopy is not just the same surgery on a different joint; it is more complex and requires more equipment. However with some basic additional planning a good arthroscopist, with interest and patience, can safely and effectively perform hip arthroscopy.

Getting started in performing hip arthroscopy can be much different and technically more difficult than other arthroscopic procedures. There is a lot of additional equipment needed, more patient setup and positioning is required, and more pre-op planning is needed. To be successful all of the logistical aspects need to be taken care of prior to any incisions being made. Having a plan to accomplish this is most important. Rather than re-inventing the wheel I found I was most successful and things went smoothest when I learned from others and implemented their strategies. Although I finished orthopaedic residency and fellowship just 7 years ago I took part in only 3 or 4 hip arthroscopies during that time. The biggest benefit from that limited experience was meeting a mentor and wonderful educator about hip arthroscopy, Thomas G. Sampson MD. I reached out to Dr. Sampson as an educational resource when I wanted to perform my first hip arthroscopy in 2006. Having access to his personal experience and learning from his comments was incredibly valuable to me. Both verbal conversations and observational visits were extremely helpful. I then supplemented this with an AANA sponsored Learning Center course in hip arthroscopy. This course provided the right combination of didactic and hands-on surgical training. I also met several other pioneers of hip arthroscopy. Having discussions and asking questions about pitfalls and pearls with these surgeons minimized the struggles of my early hip arthroscopies. Armed with clinical pearls and tips, a new education about specific hip pathology, and a cadaver training course gave me the confidence to proceed with my first hip arthroscopy. The learning curve was steep but smooth. I found my interactions with other hip arthroscopist to have been the single greatest learning tool, and I recommend contacting and learning from other hip arthroscopists.

## My tips for getting started are as follows:

### 1. Understand the Pathology

A wide range of non-arthritic conditions affect the hip. Some of them have parallel condition in other joints and some are specific to the hip, e.g. FAI. Understanding the similarities and differences related to the hip is critical.

### 2. Understand the anatomy

The focal point of your instruments in hip arthroscopy is very deep from the surface, making triangulation and anatomic knowledge critical. It is imperative to understand the anatomic structures to be avoided and how to minimize iatrogenic injury. Also the greater your anatomic understanding the more willing you can be to try different portals and to locate the "best approach" for a specific patient's pathology. Once your confidence with equipment and anatomy progress, the creative use of equipment and portal placement greatly improves access and ease of surgery

### 3. Appreciate/understand the surgical equipment

The specialized equipment available enables a wide variety of procedure to be performed. However, there are both size and curvature/angular limitations that are specific to hip arthroscopy. Also it is important to take the time to explore the different benefits and limitations of rotation, flexion and traction of the hip.

### 4. Patient selection

The more specific the pathology the easier the procedure; start simply and expand the indications and procedures to fit your comfort level.

### 5. Take the pressure off

The set up, OR team coordination and utilization of special equipment takes time. Do not add stress by over scheduling the OR day. However, scheduling more than 1 hip arthroscopy on one day can significantly decrease the learning curve.

### 6. Be ready for limitations

Have both a back up plan and a pre-op conversation with patients regarding limitations. This can include inability to safely examine the entire joint, failure to remove all of the loose bodies, and the potential need for converting to open surgery.

# These Are The Giants

by Douglas R. Kerr, MD

## Brian Day, MD

The foundation of Brian Day's personality and leadership grew out of his youth in Liverpool, England. Even young children needed a sense of toughness and determination, combined with an ability to think clearly on their feet to flourish in a difficult environment. With the guidance of his family and exceptional academic qualifications he chose to pursue a career in medicine.

He received his medical education at the University of Manchester, England where he also served his internship. His orthopedic education was at the University of British Columbia followed by a trauma fellowship in Basel, Switzerland, Oxford, England and Los Angeles, USA. He returned to Vancouver, BC where he served as a specialist in orthopaedic trauma. In an interview during his tenure as president of AANA he spoke of his developing interest in arthroscopy in the late 1970's. He developed his skills from one of the fathers of arthroscopy, Robert Metcalf, MD, and through practicing on cadavers in the morgue. He recalls the resistance to his efforts with some surgeons calling his work unethical and inferior to open surgical procedures. His early presentations were attacked as having exaggerated results. Of course, the naysayers took up the procedure (and later attended his courses).

He was the organizer of the first Canadian university sponsored arthroscopic surgery courses. His early innovations included the first robotic arthroscopic assistant (the world's first surgical robot), which only recently (25 years later) has become a commercially viable concept. Brian has published over 100 articles and investigations concerning arthroscopic surgery and has lectured in many countries.

He was originally a member of the International Arthroscopy Association and was involved with AANA at its origin. He points out that by a quirk he was issued the first membership certificate several months before it was an official organization. As a member he has been active in research, and of course leadership as a chair of multiple committees, a member of the board of directors, and finally as president.

His leadership skills have been evident in many other organizations, including the AAOS, Canadian Orthopaedic Association, and the Canadian Medical Association, of which he was president 2007-2008. He is the only orthopaedic surgeon in the 143 year history of the CMA to serve as its president. He is the founder and president of Cambie Surgery Centre, the first private center of its type in Canada. He has been working to eliminate rationing of care and create a non government option in Canada.

Brian's view of the importance of AANA is its ability to encourage and develop new leaders to refresh and advance the educational leadership role of AANA. He believes the strength of AANA lies in the independent attitude, energy, creativity and, most importantly, the collegiality of its members and its leadership.

# Complications Research

by Julie A. Dodds, MD

Progress is being made on the Complications in Knee and Shoulder Arthroscopy study. AANA is working with Marc Monaco, from the Center for Association Resources to define precisely the data to be collected, and to assist in setting up the secure data base to which surgeons will input their information. Please watch your email in the next several months for further information on this very important undertaking. We hope to begin collecting data in Spring 2010. If you have any questions or comments regarding this project, please contact Julie Dodds at julie.dodds@ht.msu.edu.

# Lively Learning Center

by J. W. Thomas Byrd, MD

Things are lively at the Learning Center. The AANA Masters Experience surgical skills courses continue to enjoy their reputation as the leader in motor skills training for orthopaedic surgeons. Most courses remain oversubscribed, so make sure to register early for the opportunity to enjoy and learn from this experience.

Through the brain trust of the Learning Center Committee as well as many of our seasoned Master Instructors, AANA continues to stay on the leading edge in surgeon education. The courses feature brief lectures focusing on motor skills with emphasis on the lab time to perform the latest procedures on cadaver specimens. Some courses even integrate models that allow repetitive motor training in preparation for optimizing the cadaver experience. In 2010, several courses will introduce specially invited International Master Instructors, featuring global leaders in arthroscopy to share other innovations from around the world.

We know that learning and training is more effective in teams (just ask NASA), thus the AANA Masters Experience courses continue their long-effective structure, creating tandems of surgeons, each with their own specimen, but working together with the instrumentation. However, we also know that some surgeons just prefer to go it alone (ask a cowboy), and thus we also continue the long-standing tradition of allowing some surgeons to bring their own assistant, although naturally with some additional fee.

AANA remains the world's leader in teaching arthroscopic skills with a comprehensive program that is unmatched anywhere else. The diverse group of experienced Master Instructors that steer each course provides the complete spectrum of solutions for challenging problems in arthroscopy. The legion of skilled Associate Master Instructors that staff the stations provides individual guidance for the attendees. This is accomplished in an environment that emphasizes all of the latest technological advances but with a non-biased, even-handed approach and features continuing medical education credits. Don't miss out.

## 2010 Learning Center Courses

### Shoulder

**803 February 26-28**
Richard K.N. Ryu, MD
James C. Esch, MD
William B. Stetson, MD
Anthony A. Romeo, MD
Rodrigo Maestu, MD

**805 June 4-6**
Felix H. Savoie, III, MD
Julie Y. Bishop, MD
Evan L. Flatow, MD
Matthew T. Provencher, MD

**810 September 10-12**
Jeffrey S. Abrams, MD
Robert Harry Bell, MD
F. Alan Barber, MD
Benjamin D. Rubin, MD

**813 October 29-31**
Stephen S. Burkhart, MD
William J. Ciccone, II, MD
John D. Kelly, IV, MD
Scott E. Powell, MD

### Hip

**802 February 19-21** COURSE FULL
J. W. Thomas Byrd, MD
Carlos A. Guanche, MD
Joseph C. McCarthy, MD
Thomas G. Sampson, MD

**807 July 30-August 1**
Victor M. Ilizaliturri, Jr. MD
Christopher M. Larson, MD
Joseph C. McCarthy, MD
Marc R. Safran, MD

**814 November 5-7**
Marc J. Philippon, MD
Srino Bharam, MD
Victor M. Ilizaliturri, Jr. MD
Bryan T. Kelly, MD

### Foot/Ankle

**811 September 25-26**
James W. Stone, MD
J. Chris Coetzee, MD
James Patrick Tasto, MD
Alastair S. Younger, MD

### Knee

**804 "Ligament"**
**April 16-18**
Walter R. Shelton, MD
Darren L. Johnson, MD
Donald H. Johnson, MD
Mark D. Miller, MD
Rene Verdonk, MD

**809 "Cartilage"**
**August 27-29**
Robert E. Hunter, MD
Jack M. Bert, MD
Anthony A. Schepsis, MD

### Wrist/Elbow

**806 June 12-13**
Daniel J. Nagle, MD
James C.Y. Chow, MD
William B. Geissler, MD
Noah D. Weiss, MD

### Junior Resident

**801 January 21-24** COURSE FULL
Mark R. Hutchinson, MD
George C. Bitsimone, III, MD
Daniel D. Feldmann, MD
Robert A. Pedowitz, MD

**808 August 19-22**
Paul D. Fadale, MD
Vipool K. Goradia, MD
S. Joshua Szabo, MD
Daniel Zelazny, MD

### Senior Resident

**812 October 14-16**
Ronald M. Selby, MD
Paul D. Fadale, MD
Mark R. Hutchinson, MD
John F. Orwin, MD

# Excellence in Education

by Nicholas A. Sgaglione, MD

The Arthroscopy Association of North America and the AANA Development Committee are proud to announce the launch of the "EXCELLENCE in EDUCATION" fundraising campaign. The "E2" campaign's mission is to raise funds to support the AANA Education Foundation in its quest to expand ongoing and future arthroscopic education and research projects. AANA has traditionally been the leader in arthroscopic surgical skills education and laboratory based education. The purpose of the Education Foundation is to ensure that AANA can continue to consistently introduce cutting edge education programs, fund new technologies and provide outstanding training and scientific programs for the best and brightest. The "Excellence in Education" initiative will build on the previous successes of the AANA "Building on Excellence" fundraising project to help bolster the financial independence of AANA and effectively endow educational opportunities for all members. This fundraising initiative will have as one of its goals, the establishment of an ongoing sustainable and durable fundraising infrastructure to better serve the AANA Education Foundation's efforts to continue to expand programs going forward.

Specific chartered initiatives include sponsored programs dedicated to simulation and surgical arthroscopy education, increased research funding, development of quality initiatives and outcomes registries, ACCME education assessment tools and metrics and greater funding for resident Learning Center courses and traveling fellows. Plans also include improved communication and technology initiatives including the continued use of the valuable lecture hall audience response systems (ARS) as well as website advances and video library funding. Education task force initiatives will be funded to continue to think "out of the box" in regard to regional courses, international collaborative events, orthopaedic learning center programs, and combined meeting venues with other specialty societies. In addition, AANA's continued leadership in educating its membership on practice management and coding issues as well as advocacy on health care reform remains a central focus that will benefit from these resources.

The "EXCELLENCE in EDUCATION" campaign is reaching out to the entire AANA membership, its leadership, its educational partners in medical industry and private donors as well to provide gifting and endowment opportunities. Members are encouraged to consider tax deductible annual giving as well as directed endowment contributions to sustain future education and research. Recognizing the true value of AANA and what it offers to all will play a key role for those who wish contribute. The AANA Board of Directors and senior AANA leadership has already taken the lead in charitable gifting by funding the AANA – EF with a gifting commitment that continues to expand. A donor recognition reception honoring those who have already committed to the initiative will be held at the 2009 AANA Fall Course in Palm Desert, California on November 19, 2009. Those interested in receiving more information or learning how to provide a tax deductible gift to AANA, please contact AANA's Executive Director, Ed Goss, at 1 800–991–2262.

**Hollywood Honing**
**Continued from page 1**

We are fortunate to have special guest speakers at next year's event. Dr. Richard Carmona, a former United States Surgeon General, will provide valuable insight and experience from a perspective allowing us to appreciate qualities of motivation, persistence, and success. Dr. Christian Gerber is the international invited speaker. He has been titled the most innovative clinical investigator in rotator cuff repairs over the past decades and has had great influence over surgical decisions that impact our patients.

New features to this year's meeting include feature speakers and debates. A well-known AANA speaker, Dr. Steven Arnoczky, will address the merits and shortfalls of biologic augmentation. Advanced shoulder imaging including MRI and ultrasound will be presented by Drs. Hollis Potter and Don Buford.

During the 2010 Annual Meeting in Hollywood, Florida, a new wrinkle will be introduced to the sessions. "Why My Results Are Better Than Yours" will be unveiled. This will consist of didactic lectures provided by expert arthroscopists on timely topics such as the Latarjet procedure, biceps tenodesis, and femoroacetabular impingement. The format will focus on surgical innovations and complex decision-making that can accompany challenging clinical situations.

We are looking forward to a large registration including health professionals from North and South America. The extensive program will include arthroscopic procedures being performed in South America and will provide clinical cases to provide open discussion on the different approaches.

A unique afternoon will be dedicated to the arthroscopic and sports medicine Fellows and Residents. Live broadcasted surgical procedures, business management symposium, and informal faculty interaction will open the door to valuable practice information and are open to all registrants.

The 29th Annual Meeting for AANA is a must see for individuals interested in the latest developments. Mark your calendars and plan to attend this international event.

# Coding 101

## 10 Tips for Getting Paid for What You Do

by Juliet DeCampos, MD, Pensacola, FL

*Fresh from the Learning Center course, you undertake new arthroscopic surgery challenges - your knowledge and skills have improved…will your bottom line?*

It's as basic as learning your ABCs in kindergarten. Whether solo, in a group or employed, to be successful, you need to know your ICD-9s and CPTs to increase your RVUs. Sure, there are coders reviewing your notes from your practice, surgery center or hospital. Do you speak their language? Do they know exactly what you did, what you diagnosed, whether it was typical or hard, how your assistant helped? Like all language, orthopaedic surgery has familiar and formal versions. Here are some simple tips to correct coding for the orthopaedic surgeon.

### 1 Know your ICD language.

ICD = diagnosis code…an imperfect system that doesn't necessary correspond to the orthopaedic vernacular, it is its own language. This is the language in which doctors get paid.

When is a medial meniscus tear not an 836.0? Technically, 836 is for current or acute injury. It's in the "Dislocation" category. What about a chronic or degenerative tear? A degenerative tear is also called a "derangement"--look in your ICD book or CODEX program at the 717 codes:

Use the 717.3 code for a chronic extensive medial degenerative tear, a 717.2 for a posterior horn problem "including fraying" and save 836.0 for those acute injuries that might occur with a recent ACL tear. Coding an "injury code" results in delay of payment while payors send long letters to the patient to determine when, where and how the "injury" occurred…to see if someone else will pay that bill.

*When you dictate, make it clear so that every reader, whether a coder or an insurance company, knows the diagnosis!*

### 2 Know your CPT language.

CPT = procedure code. Know what each code includes and excludes. Here is the rotator cuff example:

You have a big tear, so you do an open approach…23420 "reconstruction of complete rotator cuff avulsion, including acromioplasty"---

But with the arthroscopic repair of the same tear, the acromioplasty is NOT included. With arthroscopic repairs, 29827, add the 29826 if you perform an acromioplasty. Code correctly and get paid correctly.

Then you dictate:

"1. Arthroscopy, shoulder, surgical with rotator cuff repair with suture anchors AND 2. arthroscopic subacromial decompression with acromioplasty and release of CA ligament"

Did you repair a chronic tear via a "mini-open" approach, then do an ASAD? Code 23412, 29826 …that ASAD was not included as it was above for the open procedure. That ASAD added another procedure, with its reimbursement.

### 3 Cross code.

This means that the ICD and CPTs must match. *I use the AAOS Cross Coder, which, usually includes the diagnosis I used.* Although it does not contain ALL possible diagnoses for each procedure codes, it is very helpful. This is a common sense issue. You don't get paid for doing a 29824 Arthroscopy, shoulder with distal clavicle excision… (Mumford Procedure) for a 718.0 (Loose body, shoulder). Simplify your life…learn about Codex, the AAOS Coding Software, which can be downloaded to your PDA, the computer in the surgery center or your office. Look it up until you know your own frequent codes. *Link the appropriate procedure to each diagnosis.*

### 4 Dictate in coding language.

Not dictated = not done for coders and payors. I know you want to dictate like you talk to your patients and other doctors, but remember that a clear dictation means no confusion on what you did. Dictate similar verbiage to the CPT procedure and ICD 9 code.

Dictate "Diagnosis**:** Right shoulder SLAP lesion (Code 840.7) - Procedure Right shoulder arthroscopy, surgical, with repair of type II SLAP lesion (29807)"…It's a match, no question….And, for fractures, there is no code for "Open reduction and internal fixation…" instead it is usually "open treatment with or without internal fixation."

### 5 You do the coding, first. You are in the best position to tell us what you did.

If you know the codes, why not put them on the dictation? (See #4). If not, use Karen Zupko's surgical coding sheet…room for the codes, the words, numbering to match and the dreaded modifiers…then, give the sheet to your coder or your biller for a second opinion. *Who knows better what you did, how you did it? Anyone else has to read through the op note, figure out if something is hidden in the fine print.*

**Continued on page 15**

Coding 101 Continued from page 14

## 6 Don't unbundle.

Good way to get audited. The best way to avoid this is the AAOS Complete Global Service Data 2 volume set. It tells you what is and isn't included for each procedure. For a 29888, arthroscopically aided augmentation, repair or reconstruction ACL: synovectomy, including resection of plica, notchplasty and harvesting a patellar tendon or hamstring autograft ARE INCLUDED. What else is included in the CPT code you chose? If you do a menisectomy and chondroplasty in one compartment, the chondroplasty charge is "included" in that menisectomy charge…unbundling is not allowed. But a medial menisectomy and patellar chondroplasty can be correctly separated.

Dictate: "1. Arthroscopic medial menisectomy and 2. patellofemoral chondroplasty (separate compartment)"…*nice and clear for all. Collect on both codes!*

## 7 How about that unlisted code?

*29999. Avoid if possible. Adds work, delays payment. 29999 is coding roulette, guaranteed to delay payment. Is it worth it? Is there really no code that describes what you did? Do you have an up-to-date CPT manual or CrossCoder/version of Codex?*

As new procedures are developed, your representatives at AANA work to get a code that describes it. Until recently, there was no code for arthroscopic biceps tenodesis, so that unlisted code was used. It was difficult to jump through payor hoops with pre-emptive letters and then appeals. It was tempting to simply code an open procedure, which is NOT allowed. With modifications in the CPTs, now it has its own code - 29828. Simply using 29999 does not guarantee any payment. There is extra work for your staff certain to delay payment. You must determine what existing code this new procedure is most like and indicate that you should be paid more by a percentage, justify that request with a detailed explanation and ask the Medical Director for that amount Ask AANA. Consider a template letter.

## 8 Stay current on coding practices.

William R. Beach, MD is AANA's Coding King. He has donated countless hours working at national sessions to keep arthroscopy in the forefront of new codes and concomitant reimbursement. Take coding classes every year or two at the AANA annual meetings. Karen Zupko seminars are most beneficial for you and your office staff. Codes change annually. New diagnoses and procedures are added while other go away. Experimental codes are listed sometimes. *Like learning new surgical skills, keeping current with coding is part of your orthopaedic education.*

## 9 Get your assistant or PA paid.

Even if it's just 15% of the surgeon's fee, those RVUs add up. You have to do more than than dictate their name to justify that extra reimbursment. Explain what they did in a separate paragraph. If there is an appeal, the information is there. Remember there is NO payment for an assistant on most arthroscopy codes. You can write down and dictate anything; you WON'T get paid for those codes. *You can still have your PA help you for the benefit of the patient and to save you time, but don't expect payment. Have your staff notify you if the assistant can be paid, then add that detailed paragraph to your dictation.*

## 10 Modifiers –"coding subspeciality".

*Many courses later, the 51 and 59 still confuse me. This is where I ask my coder for help.* Remember the CPTs are listed on the bill in order of RVUs. Do you know how many RVUs each procedure is? I don't! The modifiers tell that story.

*Curse of the -22 modifier:* Most often, doctors feel they should be compensated more for a difficult case. This is that "I deserve more for this horrible case" modifier. Use that =22 modifier sparingly for those complex cases truly well off the Bell curve of average (2-3 SD from your average cases). You may have "an easy 1 anchor cuff" or a "double row after margin convergence cuff repair" you code 29827 for both…remember, case severity averages out. Like the unlisted code, use of -22 modifier drops your claim to paper so the payor can review your claim for appropriate reimbursement increase. You must have documentation to support that added reimbursement.

Including the reasons your case was more difficult in the "indications" or "findings" portions of your dictation makes it easier for the coders and payor. Example - "Indications for surgery: this 59 year old morbidly obese patient with co-morbidity of COPD and IDDM was unable to lift her arm, and MRI showed 5 cm retracted acute rotator cuff tear. " Findings: Her weight of 400 lbs and BMI of 65 made every aspect of this case more difficult, from positioning to fluid management. Extra long instruments were used, and the case took approximately twice my average case time for this procedure. This is the reason for the -22 modifier" Document other reasons in "Findings at Surgery" to supports the substantial additional work with documentation including but not limited to increased intensity, time, technical difficult, severity of patient's condition or physical or mental effort required.

*This added a minute to your dictation, but clarified for all why the case was harder. A cover letter should request a percentage of extra reimbursement based on the added percentage of difficulty.*

***Coding can be fun!***
***Done correctly, it gets you paid for what you deserve.***

# Washington Update

*Reprinted from Medpage Today by Emily P. Walker*

## SGR Fix Fails in the Senate

A procedural vote on the bill that would provide a "doctors' payment fix" has failed in the Senate, sending the message that the bill does not have the necessary votes to become law. A cloture vote to end debate on the bill that would eliminate the sustainable growth rate (SGR) formula used to determine Medicare reimbursements to physicians was defeated in the Senate 53 to 47. Had it passed, the cloture vote would have moved the bill itself, sponsored by Debbie Stabenow (D-Mich.), to a vote.

Doctors have long lobbied for a new payment mechanism – one that does not call for huge cuts in reimbursements year after year. Congress has voted at the eleventh hour to stall planned payment cuts seven times. Stabenow's bill would erase the SGR, and rest the debt accumulated from the 1997 law to zero at a cost of about $245 billion. The bill doesn't lay out a new mechanism to pay doctors under Medicare, however. The healthcare reform bills that the House leaders are working to meld into one bill would eliminate the SGR, but neither of the two Senate bills dealt with the SGR.

In a supposed deal made last week with Senate Majority Leader Harry Reid (D-Nev.), doctor groups agreed to support wider healthcare reform legislation if the SGR issue was dealt with in a separate bill. The president of the American Medical Association (AMA) wouldn't confirm that deal, however, when asked about it on Tuesday.

Earlier this week, Republicans and Democrats alike criticized the SGR bill for adding to the federal deficit because it did not propose a way to pay for the $245 billion bill. Republicans were critical of the SGR measure being moved out of healthcare reform and placed in a separate bill. "It's perfectly obvious why Democrats want to resolve this issue outside the larger debate over healthcare," Sen. Mitch McConnell (R-Ky.) said on the Senate floor on Monday. "They're doing it so they can say their healthcare plan doesn't add to the deficit. It's a gimmick, and a transparent one at that."

Fiscally conservative Sen. Kent Conrad (D-ND.), said he wouldn't vote for the SGR bill unless its cost is offset. "We need to pay for this," he said. "We can't just tack it onto the debt." So even before the roll call was read for the cloture vote, Stabenow and Reid knew they lacked the votes.

Reid took the podium on the floor on Wednesday and lamented the politics of Washington and accused Republicans of trying to railroad healthcare reform by not supporting the SGR bill. He singled out Sen. Jon Kyl (R-Ariz.) who had said he'd vote against the payment fix, despite being a co-sponsor of the bill. "It's very interesting here, one of the sponsors of the legislation is not supporting it," Reid said. "This is another effort by the Republicans to slow down what we're trying to do on healthcare and everything else." Reid said the issue would resurface after a healthcare reform bill passes. "If the Republicans don't want to do it this way, we'll come back after reform and deal with a multiyear fix," Reid said in a Senate floor speech before the cloture vote.

President Obama reset the formula to zero in his budget for this year, but the current formula calls for a 21% cut in 2010. The AMA immediately issued a statement saying it is "deeply disappointed" in the vote. "As we work to improve the health system, permanent repeal of the payment formula is essential to ensuring the security and stability of Medicare," said AMA president James Rohack, MD, in the statement.

# New Orleans News

by Jeffrey S. Abrams, MD

Arthroscopy Association of North America Specialty Day at the AAOS Annual Meeting continues to be a marquis event. This year's meeting will be held March 13, 2010 at the Convention Center in New Orleans. Our meeting continues to attract physicians and allied health professionals interested in the state-of-the art arthroscopic treatment of shoulder, elbow, knee, hip, foot and ankle injuries.

A well-recognized international faculty will present technique videos on arthroscopic surgical repairs. New innovations addressing difficult clinical problems that we commonly see will be presented, including bone grafts for chronic recurrent shoulder instability, biceps and rotator cuff revision, patellar malalignment, and femoroacetabular hip impingement in the middle-aged athlete. Clinical case-based panels with experts will provide insight into the decision process of patient selection, apply pearls and technique advice, review rehabilitation programs and likelihood of return to active lifestyles.

We are in the middle of information overload regarding the anticipated health care reform legislation. Dr. Joseph Zuckerman, President of AAOS, will speak at AANA Specialty Day to advise on current and future developments.

A unique opportunity occurs in the afternoon of AANA Specialty Day. The Arthroscopy meeting will be joined by American Shoulder and Elbow Surgeons and American Orthopaedic Society for Sports Medicine for a series of controversies dealing with upper extremity trauma. The faculty will include members from each of these organizations to debate preferential treatment and results. Here, a variety of opinions will debate open, arthroscopic, and nonoperative approaches to individuals with first-time shoulder dislocations, failed rotator cuff surgery, distal biceps avulsions, and partial-thickness rotator cuff tears. This wide spectrum approach is an excellent way to appreciate multiple options for complex, common problems that we encounter at home.

Mark your calendars and plan to attend this year's Saturday Speciality Day with AANA. This is an educational experience that should not be missed.