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AAHKS
American Association of Hip and Knee Surgeons

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News for you

American Association of Hip and Knee Surgeons

from the President

I hope all of you are enjoying your summer and everyone had a chance to relax. We need you all well-rested for the Annual Meeting in Dallas this coming November.

Each committee chair and member deserves a thank you for participating in the spring conference calls, as we encouraged all committees to meet and discuss existing and future projects. As a society we challenged committees to change with the times and think outside of the box. It can be a thankless chore, but everyone did what was asked and the Board of Directors appreciates the effort and the vital role each committee plays in the success of this society.

I would also like to thank those members who took time to complete the Total Knee Survey. We had a nice response and the Research Committee should have a report for us at the Annual Meeting. Dozens of surveys cross your desk—this survey was important to our society and we appreciate the time it took to participate.

Some of you may have noticed a change to the web site. James Stiehl, MD and his committee are still working on this project. Dr. Stiehl has some excellent ideas and innovative uses for this wonderful technology including the participation of the AAHKS with the AAOS's "Your Orthopaedic Connection." Keep on the watch for information about this huge AAOS project as well as changes in look, feel, design, and content of the AAHKS website.

Douglas Dennis, MD and the Education Committee have put together an excellent, well-rounded program which is included in this newsletter with highlights and session topics. We already have secured 27 exhibitors (10 more than last year) with room to expand our exhibits in the Texas Grand Hall. We are still looking for sponsorship contributions, so if you have any industry contacts, please let them know.

I look forward to seeing all of you in Dallas, November 3-5.

Richard M. Welch, MD, President

Dallas Events, November 3-5, 2000

Friday, November 3

2:00 - 5:00 pm *Co ı E ıo ı ı M M , RN, B N*
Margie Maley of KarenZupko & Associates joins us to discuss CPT coding.

1:00 - 4:00 pm *AAHK G ıı o o ı Rı B , MD, Rı Co , MD, ı o ı , MD, o ı , MD*
This grant writing course is for the researcher wishing to enhance his/her grant writing skills. Space is limited to 25.

6:00 - 7:00 pm *o R ıo*
Reacquaint yourself with old friends, meet new members, & visit exhibit booths

7:00 - 9:00 pm *P ob Hı K C P ıo*
Bring your x-rays and difficult cases to this forum

Saturday, November 4

7:30 - 8:00 am *B ı M ı*
It is essential for all members to attend this meeting, important society business will be discussed. Additionally, we will hear progress reports from the Executive Board and Committee Chairs.

I ı R

North American Summit on Computer Assisted Orthopaedic Surgery Draws Record Global Attendance!

Pı b , PA: J 2000 The 4th annual North American Conference on Computer Assisted Orthopaedic Surgery (CAOS) was held June 15 with more than 150 orthopaedic surgeons, researchers, and commercial representatives from 11 countries participating in the successful two and a half day event.

CAOS/USA 2000 was sponsored by the Centers for Medical Robotics and Computer Assisted Surgery (MRCAS) at Carnegie Mellon University, UPMC Shadyside Hospital, and The Western Pennsylvania Institute for Computer Assisted Surgery (ICAS). The course co-chairmen were Anthony M. DiGioia, III, MD from Pittsburgh, and Lutz Nolte, Ph.D. from Davos, Switzerland.

"Each year, we are amazed at the growing interest and attendance at this event. As a result, participants learn how innovative computer based technologies are being used clinically and in many cases, routine surgical practice. The focus of CAOS is to detail the 'surgical toolbox of the future' which includes such areas as the integration of medical imaging and computer vision directly into surgery, robotic assisted devices, intra-operative navigational systems, and surgical simulations and planners."

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North American Summit continued

The CASO goals include:

• Educating practicing orthopaedic surgeons on the new and enabling technologies that have the potential to improve clinical practice and patient outcomes;

• Identify new tools and technologies that will enhance patient care by making procedures more accurate as well as less and minimally invasive; and, most importantly, foster interdisciplinary clinical research through the use of technologies not traditionally used by orthopaedists.

The CASO model is being replicated in Spain, Italy, Germany, Japan, and other countries. In addition, plans are underway for CAOS/Davos (Switzerland) in February 2001 and CAOS/USA 2001 in June 2001. For more information about CAOS/USA, visit **www.caosusa.org.**

As a follow up to CAOS/USA 2000, clinicians from all sub-specialties, researchers, and medical device developers will gather at MICCAI 2000 which is the third international conference on medical robots, imaging, and computer assisted surgery. MICCAI 2000 theme is "Tools and Technology for Clinical Practice." MICCAI 2000 includes representation from multiple clinical and research sub-specialties, including neurosurgery, orthopaedics, and cardiovascular surgery on the clinical side, and robotics, computer science, and engineering on the technical element.

This event, slated for October 11 through October 14, 2000 at the Pittsburgh Hilton and Towers, is also sponsored by The Centers for Medical Robotics and Computer Assisted Surgery at Carnegie Mellon University, UPMC Shadyside Hospital, and the Western Pennsylvania Institute for Computer Assisted Surgery (ICAS). It will be co-chaired by Anthony M. DiGioia, MD (Pittsburgh) and Scott Delp, PhD (Stanford University).

DiGioia adds, "The upcoming MICCAI conference will be an excellent opportunity to bring together physicians from all sub-specialties, scientists, and commercial representatives from all over the world." For more information about the event, visit **www.miccai.org.**

North American Knee Arthroplasty Revision

(N.A.K.A.R.) Study Group:

where we were, where we are, and where we hope to be.

***Khaled J Saleh** MD, MSc, FRCSC Principal Investigator*

Numerous long-term studies attest to the remarkable improvement in the quality of life, following joint replacement surgery. The effectiveness of joint replacement and demographic aging account for the dramatic rise in the number of joint replacement procedures globally. In 1995, 243,919 total knee arthroplasty (TKA) procedures were performed in the U.S. By the year 2030, the total number of procedures is expected to reach an unprecedented 454,000. Concomitantly, there has also been an increase in the number of total knee arthroplasty revision (TKAR) procedures performed. In 1995, 19,138 TKAR procedures were performed in the United States. Over the next decade, present patterns are anticipated to shift toward an increased contribution of revisions and re-revisions as a result of higher rates of primary TKA procedures and increased rates of TKAR implant failures, respectively. Revision surgery, generally, is technically more difficult to perform and consumes greater health care resources at all stages of the process. Therefore, increased healthcare costs are anticipated as the demand for TKAR procedures continue to increase.

Toward this end, the Knee Society undertook the initiative of identifying, and measuring variables that effect TKAR outcome. The evaluation of these variables will help to facilitate the identification of more effective procedures and cost-effective protocols. Therefore, in 1998 the Knee Society undertook to improve the ability to quantify the severity of a failed TKA. With the help of the members of the Knee Society potential risk factors that could be used to determine how a failed TKA might do after a revision were identified. A consensus group developed the final version of the Knee Society Index of Severity (KSIS). As a result the ability to study patient outcome after TKAR using the KSIS to stratify failed TKA became available.

Members of the Knee Society were subsequently, invited to join a multicenter, four-year outcome project. As a first step to this process, efforts had to be invested in a pilot study (Phase 1) for two reasons: A) Optimize the study protocol by rectifying methodological issues that may arise and B) Assess the feasibility and sample size necessary for subsequent, clinical studies (Phase 2). We therefore organized a multi-center pilot Study entitled *E w o KAR: M ı Co o ó -P 1* to meet these objectives. The project has been funded by the Orthopaedic Research and Education foundation.

Enrollment in the pilot project has begun on a rolling basis since June 1st, 2000. Each site has been asked to enroll patients for three to four months. Each patient will be asked to complete one follow-up at the six-month post-operative point. The pilot will be completed by June 2001.Based on the results from the pilot it is anticipated that a re-submission will be made to NIH for funding to allow for a four-year follow-up on the patients enrolled in the two-year OREF project.

Anderson Orthopedic Institute Alexandria, VA *G. Engh MD, J. McAuley MD;*
Booth Bartolozzi Balderston Philadelphia, PA *R. Booth MD, D. Nazarian MD;*
Buffalo General Hospital Kaleida Health Buffalo, NY *K. Krackow MD*
Columbia University New York, NY *W. Macaulay MD*;
The Hospital for Special Surgery New York, NY *S. Haas MD, R. Laskin MD, T. Sculco MD, & R. Windsor MD*;
Insall, Scott, Kelly Institute New York, NY *G. Scuderi MD*;
Johns Hopkins Medicine Baltimore, MD *M. Mont MD*
Lahey Clinic Burlington, MA *W. Healy MD, and R. Iorio MD*;
Massachusetts General Hospital Boston, MA *H. Rubash MD*;
Mayo Clinic Scottsdale, AZ, *J. Rand MD*;
Rothman Institute, Jefferson Philadelphia, PA *W. Hozak MD, P. Sharkey MD*
Tulane University New Orleans, LA *R. Barrack, MD*;
University of Iowa Hospitals Iowa City, IA *C. Clark MD*;
University of Minnesota Minneapolis, MN *T. Gioe MD, J. Holtzman MD, R. Kane MD, K. Saleh MD, M. Swiontkowski MD*;
University of Pennsylvania Philadelphia, PA *P. Lotke MD, P Garino MD.*

When Is Staged Joint Reconstruction Reported As A Complication? Never

by Margaret M. Maley RN, MS

Every day in the operating room, reconstructive orthopaedic surgeons face the difficult challenge posed by modern revision surgery. Coding these cases does not need to be complicated or mysterious. It does require extensive knowledge of the modifier –58.

The modifier –58 is attached to a related procedure performed in the postoperative or global period. The modifier is appended to the CPT code for the subsequent procedure to indicate that it was:

1. Planned prospectively at the time of the original procedure (staged) or
2. Subsequent surgery that is more extensive that the original procedure or
3. For therapy following a diagnostic surgical procedure.

Medicare assigned a 90-day global period to joint reconstruction and revision surgery. This means that any surgery done during the global period would require the use of a modifier:

-58 if the subsequent procedure is "staged" (see 1, 2, and 3 above)

-78 if the subsequent procedure is the treatment of a complication requiring a return to the operating room

-79 if the procedure has nothing to do with the original procedure (Open treatment of a wrist fracture 3 weeks after THR)

…The list goes on.

Modifiers –58 and -78 cause the most confusion among surgeons and their billing staff. Modifier –58 is never used to indicate the treatment of a surgical complication. This is done using the modifier –78 notifying the payor of a return to the operating room for a related procedure during the postoperative period. The difference between these two modifiers cannot be overemphasized.

Margaret M. Maley is a consultant with KarenZupko & Associates, 625 North Michigan Avenue, Suite 702 Chicago, Illinois 60611 (312) 642-5616 http://www.karenzupko.com Sign up for our bi-monthly KZAlert and stay up-to-date with orthopaedic practice management tips and e-healthcare news. Visit our website and select the orthopaedic community and see the "Orthopaedic Coding Coach" for further advice on CPT and diagnosis coding.

Comparing Modifier -58 to -78

MODIFIER –58 Staged or Related Procedures	**MODIFIER –58** Return to the OR for treatment of Complication
Appended to subsequent procedure when done in the global period	Same
Unnecessary to use the modifier if the 2nd stage is done after the global of the 1st surgery	Same
Resets the global period starting with the date of the subsequent surgery and going for 90 days (if 2nd procedure is a major procedure)	Global period stays with the original case
100% of the allowable reimbursement for the subsequent procedure	30-50% reduction of the allowable reimbursement for treatment of the complication

Two-stage knee reconstruction illustrates the classic use of the modifier –58

Procedure: Removal of infected total knee prosthesis
Insertion of cement spacer

History & Indications: This is stage 1 of a 2-stage procedure.
We, will remove the knee prosthesis today, consult ID, and give IV antibiotics. If cultures are negative following antibiotic therapy, we plan to go ahead with joint reconstruction.

23 DIAGNOSIS OR NATURE OF ILLNESS OR INJURY RELATE DIAGNOSIS TO PROCEDURE IN COLUMN D BY REFERENCE NUMBERS 1,2,3, ETC OR DX CODE
1. **996.66** **Infection due to Joint Prosthesis**
2.
3.
4.

Dr. Knee
Stage 1

24 A DATE OF SERVICE FROM	TO	B PLACE OF SERVICE	C FULLY DESCRIBE PROCEDURES, MEDICAL SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN: PROCEDURE CODE (IDENTIFY)	(EXPLAIN UNUSUAL SERVICES OR CIRCUMSTANCES)	D DIAGNOSIS CODE	E CHARGES *RVU's		F DAYS OR UNITS
6-17-00			27488	Removal knee prosthesis	1	30	47	

Procedure: Total Knee Replacement (six weeks later)

History & Indications: This is the second stage of a 2-stage procedure initiated on 6/17/00

23 DIAGNOSIS OR NATURE OF ILLNESS OR INJURY RELATE DIAGNOSIS TO PROCEDURE IN COLUMN D BY REFERENCE NUMBERS 1,2,3, ETC OR DX CODE
1. **996.66** **Infection due to Joint Prosthesis**
2.
3.
4.

Dr. Knee
Stage 2

24 A DATE OF SERVICE FROM	TO	B PLACE OF SERVICE	C FULLY DESCRIBE PROCEDURES, MEDICAL SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN: PROCEDURE CODE (IDENTIFY)	(EXPLAIN UNUSUAL SERVICES OR CIRCUMSTANCES)	D DIAGNOSIS CODE	E CHARGES *RVU's		F DAYS OR UNITS
7-30-00			274447-58	Total knee replacement	1	44	55	

Remember the following five things about the modifier -58:

1. No reduction in reimbursement for the subsequent procedure is expected when using the modifier –58.
2. The –58 is only required if the second stage is done in the global period of the original case.
3. No modifier is necessary if the second stage is done after the global period of the first case (i.e. 27123- Conversion of previous hip surgery to THR done 6 months following 27091- Removal of THR)
4. Each operative report should have a "history and indications" paragraph explaining the staging of the 2 procedures (see chart 1)
5. The modifier –58 should not be used to indicate the treatment of a complication.

Follow these rules to keep the coding from becoming the most complicated part of these reconstructive surgeries.

AMA meeting a brief report

b No L. D ı , MD

As a representative for the AAHKS at the American Medical Associations House of Delegates and Specialty Services Society meeting held in June of 2000, Dr. Dunitz reports of no contentious problems brought to the AMA at this time that would have any great affect specifically on our society.

Solid support for a resolution by the Orthopedic Foot and Ankle Society, which established policy in the AMA for insurance providers to provide therapeutic shoes for patients with diabetic and Charcot-like syndromes involving their feet, was formed and passed without difficulty. This is now policy and moving forward will be used by the AMA in their lobby activities with various insurance providers.

The problem of moratoriums on legal executions was discussed and handled intelligently by recommending that the American Medical Association support the availability and use of all appropriate medical forensic techniques in the criminal justice system, but did not ask for any moratorium.

An extended focus of the meeting was held on comprehensive reproductive health care systems. In spite of stimulus from the press and outside sources, the AMA stuck to its reaffirmation that neither physicians nor hospitals, etc. should be required to perform any act that violates personally held moral principles. Hospitals may prohibit the act if they wish, however, physicians who want to do these procedures have the right in other institutions that do allow the procedures.

Legislative efforts were directed to the Patients Rights Bill, which is in Congress in a joint conference between the Senate and the House. The AMA continues to push the House version and has been lobbying and attempting to influence the Senators who have obstructed this so far. The Campbell Bill, which allows negotiations of physicians with providers, is being pushed forcibly by our AMA and we now have well over the desired number of House member supporters; therefore passage of this Bill should be without difficulty. Some of the House leadership attempted to derail its passage but aided by a quick response from the AMA leadership, this problem was overcome and it should be voted upon and undoubtedly passed within the next few weeks. The AMA plans to continue to push this problem as forcibly as possible in light of the fact that it may run into problems in the Senate.

Of interest is the adoption of directions to the Board of Trustees to have the AMA central office assist any physician or medical society in filing class action suits against managed care organizations. Other moves include the addition of a non-physician member to the AMA Board of Trustees. It is felt this will add certain business expertise to the Board's deliberations. The new president, a very articulate and capable representative of the AMA, will be Richard Korlan, MD from California.

Hopefully, we now have the required number of AMA members in the AAHKS society as we will be voted upon at the interim meeting for membership in the House of Delegatess. We will join a handful of other orthopedic organizations that have a voting seat in the House helping to influence and aid the ability of the specialty of Orthopedic surgery to help set policy for American physicians in the future.

AAHKS
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