West Virginia Orthopaedic Society

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No Bones About It

Great News on SGR and Ortho PAC

by David D. Ede, MD
President, WVOS

I have GREAT NEWS for my fellow orthopedic surgeons as well as other practicing physicians and providers. The full House Energy and Commerce Committee in Washington D.C. approved their bill (H.R. 2810) that will replace the sustainable growth rate (SGR) by a vote of 51-0. Committee Chairman Fred Upton (R-MI) stated, "This legislation reforms the current physician fee schedule by repealing the highly flawed SGR and replacing it with a system that promotes the highest quality of care for seniors and provides fair payment to doctors. This was the culmination of an over two-year effort to fix SGR that is the product of a thoughtful, bipartisan, transparent, and fair process."

As you may or may not know, if left unaltered, the SGR would have led to a reduction of around 25% in reimbursements to physicians and other providers for care provided to Medicare patients.

Got that? 25%.

How does a government that is supposed to be "by the people and for the people" make changes that are really for the people? Well, it is an extremely complex process. I don't have the writing space here to go into the details of this, but I was hoping to give you all a highlights tour and take-home message.

The most important thing to understand is that the United States government is really set up as a government by and for the people WHO PARTICIPATE. If you want yourself represented and

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Inside:

By AAOS Councilor Greg Krivchenia, MD

The View From K2

The devil is in the (unfinalized) details.

Updating.....

The summer of 2013 is drawing to a close and ObamaCare is marching forward. What exactly is going to happen is still up in the air and trying to plan for it as an orthopaedist is not as challenging as trying to get access to medical information from his or her hospital IT systems. At our hospital, there is no easy way to get access to the charts, access patient medical information to treat your patients, or to easily view X-rays. What I am seeing is more "patient" time in front of computers, even though the patient is the one who is in need of healthcare, not a computer terminal.

Unfortunately, the bureaucrats have us spending time meeting "quality" reporting requirements instead of the health needs of our patients. Yet, this is how we are being measured. As reported in the "Wall Street Journal" (6-16-13), pay for performance forces doctors to shift their attention from patients to computer screens, documenting trivial details useless for patient care, but essential for compliance. When trying to find how these pay for performance measures are "rigorously tested," there is no "evidence based" medicine available to check the parameters. It appears to me that the non-treating people are making things up as they go along. Evidence based medicine at its best!!! One should be wary when any speaker talks about "risk adjusted data" when they do not explain specifically how the data is risk adjusted. To the best of my knowledge, this is not being done (at least at any of the talks I have heard). Meaningful use now becomes meaningless use.

With all the machinations going on in Washington, now more than ever, giving to our PAC is essential. ObamaCare is law, but the devil is in the details and all the details have not been finalized. Our lobbyists in Washington are working on our behalf to make sure that our patients' needs are protected. West Virginia is fourth among all states on the level of donor participation at 18%. We need to expand on our giving to the OrthoPAC. Let's keep up the great work with our involvement!

"The only nonrenewable resource an orthopaedic surgeon has is his or her time. The government bureaucrats and hospital administrators do not seem to care about our time."
– Unknown frustrated orthopod, 2013

By WVOS Program Chairs Ali Oliashirazi, MD, Steve Lochow, MD, and Jack Steel, MD

2014 "Spring Break" Planning

Plans are underway for the 2014 WV Orthopaedic Society (WVOS)/WV Association of Orthopaedic Eexecutives (WVAOE) Spring Break meeting in conjunction with the WV Physical Therapy Association (WVAPT). The dates are April 4 and 5, 2014, at Stonewall Resort.

Friday will feature a scramble golf tournament for all participants and exhibitors and will include skill competitions as well as some more light-hearted awards.

Friday evening will feature a social event including light refreshments and cash bar from 8:00-10:00 p.m.

The WVAOE will host its practice management conference on Saturday.

Topics for Saturday's WVOS/WVAPT joint programming will include what's new in hip and pelvic fractures, with a short talk on metabolic issues, and what's new in arthroplasty. These talks will include both orthopaedists and PTs. The joint session will conclude at 11:30 a.m., followed by the WVOS/WVAOE lunch with exhibitors.

WVOS will pursue its own meeting in the afternoon, including presentations from both Marshall University and West Virginia University residents.

The exhibit hall will be open throughout Saturday. You will have the opportunity to visit with exhibitors during the continental breakfast, morning and afternoon breaks and lunch.

Final topics and speakers will be selected at the summer meeting of the membership and board of directors on August 23, so please contact wvos@frontier.com by that date if you have a topic for consideration.

Thanks to our program chairs Dr. Ali Oliashirazi and Dr. Steven Lochow, and CME Chair Dr. Jack Steel for their hard work in making this program a great success.

Mark your calendar and make plans to join us in April! This would be a great time to include your family in a weekend outing to a beautiful state destination!

Join us for the Spring Break Meeting on April 4-5, 2014, at Stonewall with the WVPTA.

By Jimelle Rumberg, PhD, CAE, Ohio Foot and Ankle Medical Association

Patient Accommodation Guide

Patient accommodation is not an option.

The American with Disabilities Act (ADA) classifies physicians' offices as places of public accommodation. Office accessibility can be an accommodation problem if you're physically disabled. Regulatory accessibility wasn't a problem when your office was built in 1970, but times have changed. Ramps, elevators, thresholds and even nonpowered doorways really impact patient accessibility in today's world. Would a gurney actually fit through your office or operatory doorways? If you have been fortunate to build or modify office construction, your contractor knows what is required by code for accessibility standards.

Your practice must make "reasonable modifications" as part of your office policies and practice procedures in order to accommodate other forms of disabled patients. One of the most common questioned accommodations occurs regarding hearing, vision or speech impaired patients. The ADA requires "appropriate auxiliary aids and services where necessary to ensure effective communication" with disabled patients. As you may have guessed, "effective communication" methods are not defined in the ADA. Depending on the circumstances surrounding each individual patient, effective communication could range from the use of written materials, audio/visual aids, handwritten exchange, or tablet typing to the use of a qualified interpreter. One site that is of particular reference is http://www.disabilityrightsohio.org/right-to-sign-interpret#right. (Your Right to a Sign Language Interrupter During Appointments with Medical and Other Treatment Providers.) This site is for the patient, but will assuredly address many of your questions. Most of your disabled patients are savvy consumers; they know the rules and will be assertive in exercising their rights under the law.

Another consideration is the nature of the patient communication that will take place. This should be at the forefront of any determinations on auxiliary aids. Patient communication skills or cognitive levels should always be assessed and documented. That is not always easy to ascertain if the patient has had a stroke or suffers dementia. Lengthy conversations that deal with complex issues, such as a discussion of symptoms, a diagnosis, treatment plan

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By Stanley Tao, MD

What's New in Sports Medicine?

In the past 20 years, sports injuries in pediatric and adolescent athletes have dramatically increased. About 38 million young athletes participate in organized sports annually in the United States. Of these, nearly 2 million high school students and almost twice as many athletes <14 years are treated for a sports-related injury each year. This has been thought to be due surge in participants, emphasis on year round competition, single-sport concentration, and more intense training.

Injuries to the anterior cruciate ligament (ACL) were once thought to be rare injuries in pediatric patients. This however is not the case and the incidence of midsubstance tears and bony avulsions has increased considerably in recent years. In a recent study of high school athletes, female soccer players were found to have the highest rate of ACL injury followed by male football players.

Management of ACL injuries in the skeletally immature (not done growing) athlete is challenging. In the past, reconstruction by placing "bony" tunnels was avoided in younger patients because of the risk of damaging the cartilage that causes the bone to grow. Past treatment options have included activity modification and bracing until the onset of skeletal maturity (stopped growing) to do the traditional surgery. Recent studies show this leads to recurrent instability and a high incidence of damage to other structures in the knee. This is however a good option for a partial tear with no clinical evidence of instability on examination in the office.

Recent data suggests complete ACL ruptures should be managed surgically even in the very young patient. One of the most important parameters in determining what surgery is to be done is skeletal bone age as patients mature at different levels and times. Prepubescent patients are a bone age of <12 for boys and <11 for girls. A bone age above this is considered adolescent. Adolescent patients can be treated with a traditional reconstruction with bone tunnels and a soft tissue graft. It is important to use smaller more vertical tunnels than normal with fixation away from the growth plate. If the growth plate is closing, an "anatomic" adult-type reconstruction may be done.

Sports Med

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Pediatric and adolescent sports injuries have increased in the past 20 years.

By Stanford Isrealsen, MD

MU Resident Research Summary

Dr. Shuler received a $293,000 NIH R15 grant, plus a scholarship was formed in his name by a patient.

Marshall Orthopaedics' Dr. Shuler has partnered with Dr. Xie of Marshall's Institute for Interdisciplinary Research to use nanotechnology to improve tendon to bone repair. They were awarded a $293,000 NIH R15 grant from the National Institute of Arthritis and Musculoskeletal and Skin Diseases. Dr. Shuler stated, "We are very proud of this success and are excited to strengthen our collaborative, multidisciplinary approach to Orthopaedic translational research."

The Joan C. Edwards School of Medicine has received a donation to establish a Dr. Franklin D. Shuler expendable scholarship. This scholarship was established by a grateful patient in honor of Dr. Shuler "for his medical abilities in providing life changing care and treatment." This recipient of this award is a 4th year medical student at the JCESOM who has demonstrated an interest in Orthopaedics. We are pleased to announce that the inaugural recipient is Thomas Schlierf, MSIV.

Marshall Orthopaedic Residents are expected to graduate with at least one publication listed on Pub Med. We are very appreciative of all faculty involved in this process and like to thank Vice Chairman for Research Dr. Shuler and Chairman Dr. Oliashirazi for setting the tone for respect, research and evidence based medicine. We have summarized some of our resident research accomplishments over the past year and provided expanded highlights for our graduating chiefs.

So far in 2013, the Marshall Orthopaedic Residents have done a fantastic job presenting at national and regional meetings with our entire resident core involved in active research projects. Our 2013 highlights are below with an expanded discussion focusing on our graduating residents:

- **10 podium presentations:** These included two AAOS podiums and an ISAKOS podium – Congratulations to Dr. Daniel Woods (PGY V), Dr. Justin Jones (PGY IV) for their syndesmosis anatomy project and Dr. Michael Chambers (PGY IV) on his ACL obesity project and congratulations their faculty advisors Drs. Shuler, Tankersley, Giangarra, Jasko, Garabekyan, Cheung and Oliashirazi.

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o First Place Award for the Millennial Education project – congrats to Dr. Thomas Riley (PGY III) and MSI researcher Ilia Iliev and faculty advisors Drs. Shuler, Shah and Oliashirazi.

o Second Place Award at the WVOS resident podiums for the Syndesmosis anatomical project done at the Smithsonian Institution in Washington, DC with congratulations to Drs. Woods (PGY V) and Jones (PGY IV) and faculty advisors Drs. Shuler and Tankersley.

- **35 poster presentations:** These have included national presentations at AAOS, AOA, SRS and have included all 15 of our residents with a First Place Award for the Constraining Function OR Traffic Project with Dr. Jonathon Salava (PGY V) and Dr. Riley (PGY III).
- **16 recent Pub Med papers:** Congrats to Dr. Matthew Wingate (PGY I) on his Sports Health Benefits of Vitamin D paper in Sports Health, Dr. Thomas Gill (PGY I) on his Bone health and Physical Education paper in this month's WV Med J, Dr. Chad Lavender (PGY V) on his two papers including Bilateral Knee OCD in the Int J Athletic Ther & Training and WV ATV injury paper in the Journal of Orthopaedic Trauma, Dr. Salava (PGY V) on his Osteoporosis CME article in Orthopedics, Dr. Dana Lycans (PGY I) on his two papers including the Extraskeletal effects of vitamin D in the WV Med J and the previously mentioned Bone Health and Physical Education paper.

Our graduating chiefs are highlighted below.

Dr. Jonathon Salava will join Marshall Orthopaedics following his Ortho Carolina Joint Fellowship. He has a special interest in revision total hip arthroplasty and has the following research accomplishments:

a. First Place in the 2013 25th Annual Joan C Edwards SOM Research Day competition for "Constraining Function for Reducing OR Traffic". This research was also presented at the WVOS meeting and is being presented at the AOA meeting in Denver this June. Faculty advisors were Drs. Cheung, Oliashirazi and Shuler.
b. Pub Med – Featured CME Article in Orthopedics with Dr. Shuler on "Understanding the

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Residents have completed 10 podium presentations, 35 poster presentations and 16 papers in Pub Med.

Graduating chiefs move on, then come back to WV!

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Burden of Osteoporosis and use of the World Health Organization FRAX Assessment Tool."

Dr. Chad Lavender will practice in the Charleston area after a fellowship at Orthopaedic Research of Virginia. He will participate in the care of the Washington Redskins and Virginia Tech football teams next year. His recent research accomplishments:

a. Posters – Two posters at the 25th Annual JCESOM Research Day with discussion of the published report on OCD highlighted below and a discussion of AVN of the femoral head.
b. Pub Med -- Article in the Int J Athletic Therapy and Training on "Bilateral OCD of the Lateral Trochlea in the Knee" and an article in the Journal of Orthopaedic Trauma on a project that started at WVU entitled "Orthopedic Related ATV Trauma in WV, an 8 year review".

Dr. Daniel Woods will do a Sports Medicine Fellowship at the Rothman Institute. He will participate in the care of the Philadelphia Eagles and Philadelphia Phillies next year. His recent research accomplishments:

a. AAOS Podium on the syndesmosis anatomical study done in conjunction with the Smithsonian Institution with current submission to the Journal of Bone and Joint Surgery.
b. Posters –25th Annual JCESOM Research Day poster on PVNS with non-classical MRI findings with Dr. Cheung and an American Society of Hand Surgery poster on "Ulnar Longitudinal Deficiency".

Consider contributing to Ortho PAC to help make your voice heard on issues of importance to orthopaedic medicine and your patients!

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or surgical explanation may necessitate use of a sign language interpreter. Written notes may suffice when interacting with patients during dressing changes, discharge instructions, orthotic care or when dealing with front office billing and insurance issues. If a patient is hearing impaired and can read lips, he or she may not require a sign language interpreter. Patients' specific requests for interpreters and the availability of qualified interpreters are other factors that should be considered. More often than not, a family member or attendant/aide may accompany the patient; however, it is critical to involve the patient in the decision on auxiliary aids. By law, this decision is not yours alone to make. Patients must be able to understand your instructions and to ask questions regarding their care, so an office visit may well-necessitate the use of an interpreter's services. In these instances, your office will be required to obtain and pay for the interpreter's services unless such payment places an "undue burden" on the office. Proving that an undue burden exists is nearly impossible and the cost of providing the interpreter services cannot be passed along to the patient or payer as a surcharge. It's the law and your obligation to supply and pay in most instances. Truly patient accommodation is not optional. Accordingly, it's the cost of doing business and being mindful of the regulatory requirement.

Patient access is included in the cost of doing business.

The Greenbrier®

Join us at The Greenbrier for the summer board of directors and membership meeting.

Date: August 23, 2013
Time: 9:00-11:30 a.m.
Place: Wilson Room

See you there!

If you want your views heard, you must participate... especially in government!

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represented fairly, you must participate. There is no other more important piece of information that you need to know than that. Participation gets your voice heard.

The people in Washington will make decisions with or without your input and they will only promote your interests if you let them know what those interests are. Hoping that others will stick up for you without your input is not realistic. There are others who will oppose your point of view and if left unopposed, they will prevail.

Each year, your WVOS officers travel to D.C. to promote patient and physician interests. We meet with our elected officials and their staff to promote issues that are important to you. SGR is something I have been discussing with them for the past few years. Our efforts are starting to show results as evidenced above. Yes, it is a lot of effort, but it was worth it and will help all physicians.

The other good news I have for you is that we, as West Virginians, are very good contributors to the Orthopaedic Political Action Committee (PAC). As a state, we are in the top 10 of the highest percentage of orthopedic surgeons who contribute to their PAC. This means that 18% of you are making contributions to help promote policies that are favorable for you and your patients. I think we can do better. Iowa boasts the top spot at 27%. Stuart Weinstein is your Ortho PAC Chairman and he has implemented ways to make contributing to your PAC easier and less painful. If you go to www.aaos.org/pac you can learn more about your PAC and how to get involved. Do it after you read this article. Do it before you get busy and forget how important this really is.

Lastly, apathy is something that really is a silent killer. If you become apathetic, then you are essentially resigning yourself to allow others to make important decisions for you. Orthopedic surgeons are a hard-working, self-motivating, intelligent group of individuals. I know we can do better.

Sincerely,

David E. Ede, M.D.
President, WVOS

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Newer procedures have been developed for the prepubescent patient with a complete ACL rupture. Most agree a growth plate sparing procedure is the best technique. The tunnels that are made do not violate the growth plate at all. Results are superior to non-operative treatment.

Another issue is graft selection. Controversy exists with the use of autograft (patients own tissue) versus allograft (donated tissue). In a recent study, patients between 10 and 19 years of age were found to have the highest percentage of graft failures regardless of type. More importantly, the odds of graft rupture were four times higher with allograft reconstruction than with autograft reconstruction. For this reason, autograft should be the graft of choice in this patient population.

Another frequent topic that comes up is what to do with an athlete with a first time shoulder dislocation. Shoulder dislocation and subluxation are common in young athletes. Controversy exists regarding optimal treatment of these injuries.

The young male athlete is at greatest risk of sustaining a shoulder instability injury. The highest rates are in contact sports such as football, wrestling and hockey. A traumatic dislocation has a high incidence of tearing the labrum which is a ring of tissue that provides stability to the socket of the shoulder. This is called a Bankart lesion. This lesion can predispose the shoulder to re-dislocating and is documented with an MRI. It is also important to rule out any bony injury with a dislocation. Studies show that the risk of re-dislocation depends primarily on the patient's age and activity level. Recently a study showed a recurrence rate of 27% in patients older than 30 and 72% in those younger than 23. Another study showed a recurrence rate of 87% in patients aged 15 to 20 years. One study showed shoulder arthritis occurred in up to 40% of patients with recurrent instability increasing with the number of dislocation events.

Nonsurgical treatment includes brief immobilization (3-10 days) with early rehabilitation and potential bracing. Return to play criteria typically includes symmetric pain free range of motion and strength, ability to perform sport specific drills, and a normal stability examination. It is important to emphasize the relatively high risk of recurrence even if these parameters are met. Recurrent instability appears

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First-time shoulder dislocations bring their own issues.

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to produce more frequent and severe soft-tissue and bone pathology.

The decision to pursue surgical stabilization depends on many factors. Traditionally, failure of non-operative treatment (recurrent injury), bone loss greater than 25%, irreducible dislocation, associated rotator cuff injury or inability to resume normal activity were reasons to pursue surgery. Surgery generally is directed to repairing the torn capsulolabral complex to its anatomic position and addressing co-existing lesions. This can usually be done as an outpatient surgery either arthroscopic (with a camera) or a small open incision with success rates in the ninety's. Return to full activity/sports is a six month recovery. A recent study that compared Bankart repair in a first time dislocator to either sling or arthroscopic lavage (cleaning out joint) showed that Bankart repair was superior. Given high re-injury rates in the younger patient with a traumatic dislocation, surgical intervention is a reasonable option to prevent future damage with a recurrent injury as well as potentially preventing future arthritis.

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David Ede, MD, President
Diane Slaughter CAE, APR, Executive Director

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WVOS
PO Box 13604 • Charleston, WV 25360
(304) 984-0308 • wvos@frontier.com