2019 Update
Animas Orthopedic Associates

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Healthcare continues to evolve at a rapid pace and trying to keep up with all of the changes is a daunting task. The information provided in this handout is intended to assist you in navigating the complexities of your care through Animas Orthopedic Associates (AOA) and to educate you on important aspects on that care delivery. You should always engage with your insurance company for clarification on their specific policies and what your specific coverage entails. Please understand that while we make every effort to assist you, it is impossible for we at AOA to understand all of the unique nuances of each plan that exists.

Insurance Coverage:

We accept most plans as does our Hospital and our Anesthesiologists. Our surgery scheduler will be able to confirm that we at AOA accept your coverage plan so long as you provide us with the correct updated information. It is not uncommon for patients to provide outdated insurance information. I have done it myself when my wife changed plans and forgot to give me the updated card. Should outdated or incorrect coverage information be provided we will do our best to reach an amicable solution. You should confirm with the Anesthesia team and Hospital that they accept your plan.

Insurance companies are increasing their use of treatment algorithms. Specific criteria must be met for them to authorize a procedure, surgery, or study. If they feel that the criteria has not been sufficiently met they will deny the request. A “Peer to Peer” review may be requested to attempt to obtain authorization if there are unique circumstances or if we can truly demonstrate that the appropriate criteria have been met. In cases in which their criteria are clearly defined and the criteria have not been met, you will either need to proceed with their established conservative measures or you would need to pay for the intervention or study outside of your insurance plan. For example, if you begin experiencing knee pain and plain radiographs (X-rays) do not reveal the source of the pain and you would like to proceed with an MRI, most of the insurance plans require that you try activity modification and possibly formal therapy prior to proceeding with the MRI. With respects to joint replacement for arthritis, the insurance companies almost universally require specific documentation that the patient has tried appropriate conservative measures (including but not limited to: activity modification, weight reduction efforts, over the counter anti-inflammatories and strengthening efforts) for anywhere between 3-6 months. In addition, we must demonstrate that your condition is sufficiently problematic enough to warrant joint replacement. Our intake paperwork, onerous as it may seem, is instrumental in gleaning that information to assist us in ensuring the appropriate criteria has been met so please be thorough in your answers. Prior authorization from your insurance company does not guarantee payment on your behalf. Ensure with your provider that you are appropriately covered for your procedure or study. Any exclusionary riders would affect their payment and you must understand your co-pay obligations and your deductible situation.

Many insurance companies limit access to physical therapy. Communicate with your therapist and your insurance provider regarding your allowable access. I can prescribe therapy indefinitely but that does not mean it will be reimbursed. Most plans limit the number of visits to which you are entitled for reimbursement and as that is the case if you engage in PT visits prior to surgery, your allowable after surgery may be negatively impacted.

Pain Control and the Opioid Induced Crisis:

Pain control after surgery is critically important not only to how you perceive the experience but also impacts your final functional outcome. In the early 2000's pain became the fifth vital sign. That meant when you were in the Hospital, they would take your normal vital signs (Temperature, respiratory rate, pulse and blood pressure) but also ask you to provide your pain score on a scale of 0 to 10. The healthcare environment pushed this agenda upon us physicians and we were considered bad Doctors if we didn't have your pain adequately controlled. Adequately controlled was as well defined as reasonable doubt in the legal realm and ultimately came to be considered completely controlled. The pendulum has now swung and swung hard at combating the Opioid Induced Crisis. Clearly an issue exists as the US represents less than 5% of the world's population yet we consume nearly 80% of the world's prescription opioids. I do not believe in prescribing narcotics (opioids) for arthritic pain prior to surgery. Studies have demonstrated that their use prior to surgery can lead to higher detrimental effects after surgery. While we are making great progress at minimizing their use after surgery, I do feel that we have not yet reached a point where we can eliminate their use post-operatively in all patients. If you are taking narcotics prior to surgery, you should speak to your prescribing physician about weaning them as much as possible prior to surgery and establish an appropriate plan for post-operative pain management. We at AOA shall not be engaged in chronic pain management. We shall be involved in assisting with the immediate post-operative management of your surgical pain but expect that should diminish within at least 6-8 weeks. Much sooner for most.

There exists Federal, State and insurance driven restrictions regarding how much narcotic may be dispensed and for how long. Colorado SB18-022 restricts a practitioner from dispensing more than one weeks supply of narcotic allowing at practitioners discretion a second fill for a seven day supply. It does state that if post-surgical pain, because of the nature of the procedure, is expected to last more than 14 days that is a case for exemption. Our experience is that pharmacies have not honored any exemption. Cigna is stating, "all opioid prescriptions who exceed a total daily dosage of 90 morphine milligram equivalents (MME) AND who have equal or greater than 2 opioid prescribers will receive a 'soft' rejection at point-of-sale". Walmart is restricting dispensing 60 MME per day. Dosages at or above 50MME/day increase risk of overdose two-fold. You should take the lowest effective dose for the shortest duration. Supplementing your narcotic with Acetaminophen/Tylenol up to a maximum of 3000mg/day and an NSAID (Ibuprofen (Motrin), Naproxen (Aleve), Diclofenac, Sulindac, Celebrex, or Meloxicam (Mobic)) is recommended. People with liver issues should consult their physician before using Tylenol and persons with uncontrolled hypertension, renal/ kidney disease or on coumadin should discuss risks of using NSAIDs.

50MME/day:

-50mg of hydrocodone (10 pills of hydrocodone/acetaminophen 5/300)

-33mg of oxycodone (6 pills of 5mg oxycodone)

Knee Arthroscopy:

Meniscal tears are one of the most common injuries seen by an Orthopedist and arthroscopic partial meniscectomies (APM's) are one of the most common procedures. Meniscal tears do NOT always cause pain. One study performed MRI knee studies on patients with no knee issues and identified 61% of the persons as having a meniscal tear. In patients whom have osteoarthritis and a meniscal tear, recent studies have questioned the benefit of APM over physical therapy. The concern is that APM may not be addressing the true cause of the symptoms and may in fact advance arthritic changes. APM can result in decreased extensor (Quadriceps) strength, proprioception (results in less protective sensation and thus increased risk of injury), and normal knee kinematics/function for at least 3 months following surgery. The risks of APM is quite low but must be weighed against the potential benefit. Trying non-operative treatment of meniscal tears in the face of having underlying arthritis should be attempted prior to proceeding with surgical intervention. If proceeding with knee arthroscopy, consider taking 81mg of Aspirin daily or every 12 hours to prevent post-operative blood clots. If deemed at high risk, more formal anti-coagulant might be considered.

Hip and Knee Replacements (Joint Reconstruction):

Joint replacement surgery is a very successful surgery. The procedures are being performed with such frequency that insurance companies are desperately in search of ways to curtail the costs of the rising demands. The insurance companies want to ensure that non-operative (conservative) management has been attempted. Many require that conservative efforts have been engaged in from 3-6 months. The healthcare industry recognizes that experiencing complications during or after surgery is not only problematic for the outcome for the patient but also increases the financial burden. High volume centers and physicians, which ASH and I are, have clearly demonstrated lower complication rates which leads to better and more reliable outcomes with higher patient satisfaction scores. Currently, we boast an infection rate for hip and knee replacement less than 0.02% where the national average is between 2-3%.

In an effort to reduce complications, most facilities evaluate a patient's modifiable risk factors and seek to maximize the patient's health status prior to proceeding with surgery. Non-modifiable risk factors are variables like your age, your gender, and health conditions which cannot be treated any further than they are currently. Our facility has established some criteria which preclude having your surgery at Animas Surgical Hospital if not corrected prior to surgery.

1) Body Mass Index (BMI) >40. Risks of complications with BMI at this level exceed 30%.
2) BMI 35-39. May proceed after nutritional work-up/consultation and some defined weight loss established on a case by case basis.
3) Diabetics HbA1C level must be below 8. Finger stick blood glucose level elevation day of surgery may post-pone surgery.
4) Nicotine use: those engaged in nicotine use must discuss with their clearing physician their usage of nicotine a plan established to decrease if not eliminate usage prior to surgery.
5) Narcotic usage: those using narcotics prior to surgery must establish an appropriate reduction if not elimination plan prior to surgery and define a pain management plan for after surgery.
6) Anxiety/depression: those whom have poorly controlled anxiety or depression issues must have those addressed with an appropriate professional prior to surgery.

7) I recommend all persons undergoing joint replacement engage in our educational class prior to surgery. To my understanding, an on-line program is available.

Our facility has an Emergency Medicine Physician on-site 24/7 to care for urgent or emergent issues while in the Hospital or upon discharge to home. In addition, we have Internal Medicine coverage to assist with your healthcare needs during your hospitalization. Animas Surgical Hospital has developed a program in which they prefer all patients be introduced to our Internal Medicine team prior to hospitalization. I certainly appreciate the concept but as yet am unconvinced of its necessity. If you do not have a primary care physician, then I feel it is imperative that you engage with our physicians. If you have a primary care physician and they prefer to perform your pre-operative medical optimization assessment or clearance, then I am fine with that so long as your medical issues are not deemed significant by a chart review by either our Internal Medicine team or our Anesthesiologists.

Other:

1) For most patients, we find that taking Aspirin 81mg every 12 hours is sufficient for preventing blood clots. If we feel you are at increased risk, more aggressive anticoagulant strategy will be employed. If you are prescribed Xarelto or some other form of an anti-coagulant, do **NOT** start this medication prior to surgery. The prescription is provided prior to surgery for insurance reasons such that if it were denied we might be able to explain why it is necessary. Do **NOT** take a blood thinner prior to surgery. If you do we will be forced to post-pone your case.
2) If you will be taking Aspirin for post-operative blood clot prevention, recognize that when you are in the hospital, you will likely be given Xarelto or some other blood thinner the day after surgery and be converted to Aspirin upon discharge home.
3) Most patients whom are deemed healthy and are cleared by therapy will be discharged to home the day after surgery. Medicare has removed total knee replacement from the inpatient only category and many private insurers will not authorize over 24 hours of hospitalization unless the patient has significant co-morbid conditions (heart disease, pulmonary disease, neuromuscular disorders or cancer).
4) You have the opportunity to begin outpatient therapy upon discharge. We do feel the sooner you initiate outpatient therapy, the faster your recovery will be. Home therapy while it is convenient from a perspective of travel, is not able to be as comprehensive as presenting to an outpatient therapy location. It is advisable to contact your desired therapy location well in advance so that you may secure time slots.

On my website, be sure to click on the News and Articles section for access to additional up-to-date information. www.durangojointreplacements.com or www.brincetonphippsmd.com.

Hopefully this information was helpful. If you have questions, do not hesitate to ask,