ACGME

News from the ACGME: Case Minimum Changes
Part 4: Case Minimum Changes – Frequently Asked Questions
December 2024

As stated in preceding parts of this series, the goal with the new case minimum requirements is to establish a framework of required case volumes/types for orthopaedic surgery residencies to provide **depth** of surgical training for the core, common procedures that every graduating resident should be able to perform independently, as well as the **breadth** of exposure to all orthopaedic subspecialties/anatomic areas within the field.

The ACGME has notified all programs of the new requirements.

The ACGME will now be tracking **procedures** rather than **cases**. When a resident logs a procedure, all CPT codes will be given credit in the following ways:

1. If the CPT code is listed for one of the common, core, competence (3C) procedures, credit will be given toward these procedure case minimums.
2. If the CPT code is listed in the Anatomic Area section, credit will be given toward these anatomic area procedure minimums. Note that 3C procedures also count toward anatomic area minimums.
3. Five specific procedure minimums are tracked but do not count toward anatomic area totals. These include operative care of the pediatric patient (indicated by checking the “pediatric patient” box when logging); closed reductions with manipulation; irrigation and debridement; removal of deep implants; and application of external fixator.

As with any change in requirements, questions will arise. Frequently asked questions and examples of procedure minimum tracking are given below.

Q: Why are case minimums being updated?
A: The ACGME Review Committee for Orthopaedic Surgery is charged with setting standards for residency programs to ensure that residents who graduate can responsibly care for the public once in independent practice. Current case minimums, set by the Review Committee over a decade ago, are limited in scope and fail to adequately reflect the operative experiences necessary to provide safe and effective orthopaedic surgery care in today’s learning environment.

Q: Is this the same as the Knowledge, Skills, and Behavior (KSB) program?
A: No, it is not. The KSB program is an initiative from the American Board of Orthopaedic Surgery (ABOS) to implement competency-based medical education (CBME) in orthopaedic surgery education and training. The KSB framework allows for ongoing assessment of learners throughout multiple domains over the course of residency but does not establish a curriculum or case minimums. The ABOS announced that participation in the KSB program will be mandatory for all programs as of July 1, 2025.

Q: How will these minimums interact with the KSB platform?
A: Logging of cases for the ACGME and requests for KSB assessments will be on the same platform to avoid the burden of residents logging separately for each organization. The KSB platform will be used by residents both to log procedures and to request assessments from

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attending physicians. The logged procedures and associated CPT codes will be automatically transferred from the KSB platform to the existing ACGME Case Log System, preventing the need for duplicate logging. Additional details on procedure logging can be found below.

Q: What is the general structure of the new minimums?
A: The new minimums were conceived to address both the breadth and depth of experience residents should have exposure to during education and training. There are two general categories of minimums: procedure-specific requirements and anatomic area requirements. The procedure-specific requirements are procedures the committee has deemed **common**, **core** to general orthopaedic surgery practice, and expected that graduating residents should be **competent** to perform independently (3C procedures). The anatomic area requirements are meant to ensure that residents have appropriate exposure to operative care throughout different subspecialties.

Q: Will logged procedures be counted the same way as they were before, with residents only getting "credit" for the primary code added to a case?
A: No, they will not be counted the same way. Part of the impetus for redesigning the minimums was to make logging more straightforward. As such, **all** CPT codes assigned to a patient's case, both primary and secondary, will count toward any associated minimum categories. For example, if a resident logs CPT codes for anterior cruciate ligament (ACL) reconstruction as well as meniscectomy on the same case, both procedures will be counted. Therefore, while minimums have increased, the way in which they are counted should more realistically reflect the resident's operative exposure.

Q: Can a single code count for multiple minimums?
A: Yes, a single logged code counts for all minimums that contain that CPT code. For example, a total knee arthroplasty counts toward the total knee arthroplasty 3C minimum as well as toward the femur/knee anatomic area minimum. However, not all codes will count in multiple areas. See Table 1 for additional examples of how single codes can count toward different numbers of minimums.

Table 1: *Isolated CPT codes and contribution to minimum requirements*

Procedure	**Counts Toward 3C Minimums**	**Counts Toward Anatomic Area Minimums**
Isolated procedures		
Total knee arthroplasty	yes, total knee arthroplasty	yes, femur/knee
Femoral intramedullary nail for shaft fracture	yes, femoral intramedullary nail	yes, femur/knee
Prophylactic intramedullary nail for pathologic femur fracture	yes, prophylactic fixation path femur fracture	**yes, oncology AND femur/knee**
Single-level anterior cervical discectomy and fusion	no	yes, spine
Open reduction and internal fixation of clavicle fracture	no	yes, shoulder
Pediatric femur fracture open reduction and internal fixation with	no	**yes, pediatric AND femur/knee**

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plate		
Leg amputation through tibia/fibula (below-knee amputation)	yes, lower extremity amputation	yes, leg/foot/ankle
External fixator placement	yes, external fixator	No (not anatomically coded)

Q: If multiple codes are added to a single case, how will they be counted?
A: These are counted in the same way as isolated codes. Any codes logged will count toward all minimums to which they have been assigned. See Table 2 for additional examples of common clinical scenarios for multiple codes to be logged for a single case. Note that most, but not all, codes that count toward 3C minimums will also count toward anatomic area minimums. Common exceptions include debridement codes and external fixator placement. Codes may also count toward anatomic minimums even if they do not count toward 3C minimums.

Table 2: *Multiple CPT codes for a single case and contribution to minimum requirements*

Procedure	**Counts Toward 3C Minimums**	**Counts Toward Anatomic Area Minimums**
Combined procedures (multiple codes in single episode of anesthesia)		
1st code: intramedullary nail for femoral shaft fracture 2nd code: irrigation and debridement for open fracture	**yes, femoral** intramedullary nail **AND** irrigation and debridement	yes, femur/knee (1 CPT code)
1st code: calcaneal osteotomy 2nd codes: percutaneous Achilles tendon lengthening, first metatarsal osteotomy	no	yes, leg/foot/ankle (3 CPT codes)
1st code: arthroscopic rotator cuff repair 2nd codes: arthroscopic biceps tenotomy, arthroscopic subacromial decompression	yes, shoulder arthroscopy (3 CPT codes)	yes, shoulder (3 CPT codes)
Three-level anterior cervical discectomy and fusion	no	yes, spine (3 CPT codes)
1st code: trigger release (index) 2nd codes: trigger release (long)	no	yes, hand (2 CPT codes)
Polytrauma: 1) 1st code: intramedullary nail for left femoral shaft fracture 2) 1st code: knee spanning external fixation right lower extremity 2nd code: irrigation and debridement open right tibial plateau fracture	**yes, femoral intramedullary nail AND irrigation and debridement AND external fixation**	yes, femur/knee (1 CPT code) [no anatomic area for irrigation and debridement or external fixation]

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Q: What do programs need to do in order to prepare for the new requirements going into effect?
A: Programs should review the new minimums and assess whether any curriculum or rotation changes may be needed in order to facilitate all graduates meeting requirements. The residents should continue to log all cases through the assigned platform and should be ready to transition to the KSB platform in July 2025 (if not already using the KSB platform). By July 1, 2025, all programs will log cases through the KSB platform. No other changes should be needed.

The ACGME will update reports in the Accreditation Data System (ADS) to reflect new minimums in order for programs to track progress.

Q: When will these new minimums be in effect? Will citations be given by the Review Committee if a program fails to meet minimums?
A: New minimums are scheduled to be phased in over the next few years. Program reports will be given in the next cycle of annual reviews to update programs on their status in meeting these new procedure minimums. No citations will be given by the Review Committee for failure to meet minimums for the initial two years. However, the minimums will be used in committee decision-making regarding complement increases and new program applications to ensure that new resident positions will have adequate procedure volume to meet the new requirements moving forward.

Q: Will the new minimum requirements change after implementation?
A: The goal of the new procedural minimums is to ensure that programs provide adequate surgical breadth and depth to residents. However, the Review Committee also understands that the practice of medicine is constantly evolving and that changes in the minimums may be needed over time. Additionally, the bigger question still looms – how many repetitions are needed to achieve competence in performing specific surgical procedures? Tracking the new procedure minimums, along with ABOS surgical skills assessments, will help the profession to accumulate the data needed to evaluate the question over time. Thank you for your cooperation in making this change.

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