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AAHKS AMERICAN ASSOCIATION OF HIP AND KNEE SURGEONS

MEMORANDUM

To: AAHKS **From:** Epstein Becker & Green, P.C.

Date: July 12, 2022

Re: Summary of the Proposed 2023 Medicare Physician Fee Schedule

On July 7, 2022, the Centers for Medicare & Medicaid Services (CMS) released the CY 2023 Medicare Physician Fee Schedule (PFS) proposed rule. Comments on the proposed rule are due September 6, 2022. This memorandum summarizes key provisions that are relevant to AAHKS.

A. Proposed Conversion Factor

- The proposed 2023 PFS conversion factor is $33.08, a decrease of $1.53 to the CY 2022 PFS conversion factor of $34.61. This conversion factor accounts for the statutorily required update to the conversion factor for CY 2023 of 0%, the expiration of the 3% increase in PFS payments for 2022 as required by the *Protecting Medicare and American Farmers from Sequester Cuts Act*, and the statutorily required budget neutrality adjustment (-1.5%) to account for earlier increases in RVUs for E/M services.

B. Potentially Misvalued Services

- CMS is required by the *Social Security Act* to identify potentially misvalued codes at least once every five years. CMS considers "nominations" from the public on potentially misvalued codes and reviews each flagged code on an induvial basis. No orthopedic CPT codes were nominated as potentially misvalued

C. Proposed Valuation of "Potentially Misvalued" CPT Codes

- ***CPT 27447***
  - CMS proposes to maintain a work RVU of 19.60 for CPT code 27447: "[T]he RUC reaffirmed the same valuation that it recommended for the CY 2021 PFS rulemaking cycle. Since we did not receive any new information regarding this code, we are not proposing to change our previously finalized values."
  - Note that in the proposed rule, CMS incorrectly states that the RUC proposed a survey instrument to account for arthroplasty preservice time.

- "We previously reviewed CPT code 27447 in the CY 2021 PFS final rule . . . The RUC proposed a revised survey instrument to ask about additional pre-operative time and resources spent on pre-optimization patient work. The RUC agreed that the pre-service planning activities are being performed routinely for the typical patient but the inclusion of this work is not reflected in the 090-day global period structure. The RUC indicated that separate planning codes may be developed, or current codes such as the prolonged service codes may be reported for these activities."

- ***CPT 27446***
  - CMS proposes to adopt the RUC-recommended work RVU of 17.13, a reduction from the current RVU of 17.48.

  - "The survey 25th percentile actually showed an increase in work RVU even though there was a decrease in total time. One post facility visit, CPT code 99232 (Subsequent hospital care/day 25 minutes), was removed and replaced with CPT code 99214 (Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using time for code selection, 30-39 minutes of total time is spent on the date of the encounter) a post-operative visit in the office. Given a decrease in the total time spent and a lower level postoperative visit, it is reasonable that the work RVU went down. There was no change in the global period… We are proposing the RUC-recommended direct PE inputs for CPT code 27446."

D. <u>Impact on Arthroplasty Rates</u>

- Small, proposed increases in RVUs for practice expense and malpractice insurance offset the reduction in the 2023 conversion factor, leading to level reimbursement rates for 2023.

CPT	2021	2022	2023 (proposed)
27130	$1,322.45	$1,277.40	**$1,279.86**
27447	$1,320.70	$1,276.06	**$1,277.88**

E. <u>Improving Global Surgical Package Valuation</u>

- CMS has "ongoing concerns about whether E/M visits presumed to be furnished in connection with global packages were actually being performed by the physician receiving the global package payment" and seeks public comment on strategies to improve the accuracy of payment for the global surgical packages.

- Recall, in 2014, CMS finalized a policy to transition all services with global periods to a 0-day global periods because CMS believed it would be more accurate to value surgical procedure-day services separately from pos-top E/M visits. Congress ultimately blocked CMS from implementing this transition.

- Nevertheless, CMS notes several RAND studies, including one that found that, according to claims-based data, the reported number of E/M visits matched the expected number for only 38% of reviewed 90-day global packages. CMS notes it has not received any data suggesting that postoperative E/M visits are occurring more frequently than indicated by RAND.

F. <u>Dental Services Integration and Joint Replacement Surgery</u>

- Medicare does not cover general dental care, but Medicare Part B currently pays for dental services when that service is integral to medically necessary services required to treat a beneficiary's primary medical condition. Perhaps because efforts in Congress to add a dental benefit to Medicare have stalled, CMS is now seeking comment on additional medical conditions where dental services are inextricability linked to the clinical success of clinically related services, such as for joint replacement surgeries, which would justify Medicare payment.

- CMS says "in joint replacement surgery (such as total hip and knee arthroplasty surgery) we believe there may be risks to the outcome of the procedure if an oral infection is not treated. There is evidence that some joint replacement patients have significant dental pathology found before their surgery. Given the incidence of dental pathology in joint replacement patients, there may be some joint replacement patients who would experience a clinically significant benefit from a pre-operative dental exam and medically necessary treatment of oral pathology(ies) . . . The presence of an overlooked oral infection may increase the risk for acute and chronic surgical site infection."

- CMS acknowledges the existence of clinical evidence <u>*that does not support*</u> the need for a dental exam and treatment prior to total joint replacement surgery. CMS therefore asks for "<u>*public comment providing systematic clinical evidence as to whether there is an inextricable link between dental service(s) and joint replacement surgery such that the dental services are substantially related and integral to the clinical success of the surgical procedures*</u> . . . Specifically, we are looking for medical evidence that the provision of certain dental services leads to improved healing, improved quality of surgery, and the reduced likelihood of readmission and/or surgical revisions, because an infection has interfered with the integration of the implant and interfered with the implant to the skeletal structure. Evidence needs to be clinically meaningful and represent a material difference that results in some level of persistence in the clinical success of the procedure

to support that pre-operative dental services are similarly inextricably linked to, and substantially related and integral to the clinical success of, certain other covered medical services, and therefore in connection with, and substantially related and integral to that primary covered medical service.

- "If commenters are able to provide us with compelling evidence to support that a dental exam and necessary treatment prior to joint replacement procedures such as total hip and knee arthroplasty surgery would result in clinically significant improvements in quality and safety outcomes, for example, fewer revisions, fewer readmissions, more rapid healing, quicker discharge, quicker rehabilitation for the patient, then we would consider whether such dental services may be inextricably linked to, and substantially related and integral to the clinical success of, the joint replacement surgery."

- CMS is also seeking comment on the potential establishment of a process to collect public input when additional dental services may be integral to the clinical success of other medical services.

G. <u>Updates to the Quality Payment Program (QPP)</u>

- Proposed Changes in Quality Measures for the CY 2023 Performance Period/2025 MIPS Payment Year and Future Years

  - (**NEW**) <u>Q480</u>: *Risk-standardized Complication Rate (RSCR) following elective primary THA and/or TKA*
    - "We propose to include this measure in the Orthopedic Surgery specialty set as it is clinically relevant to this clinician type. We agree with interested parties' feedback that the management and avoidance of surgical and post-surgical complications is a critical component of high-quality, patient-centered care. Postoperative complications after THA/TKA can delay a patient's recovery time, prolong hospitalizations, increase readmission rates, and increase disability or rates of mortality. Effective supportive care management can reduce the risk for complications, improve patient outcomes, and reduce overall healthcare costs."

  - (**REMOVAL**) <u>Q375</u>: *Functional Status Assessment for TKA - percentage of patients 18 years of age and older who received an elective primary TKA and completed a functional status assessment within 90 days prior to the surgery and in the 270- 365 days after the surgery.*
    - "We propose the removal of this measure as a quality measure from MIPS because this measure is duplicative to measure *Q470: Functional Status After Primary Total Knee Replacement*. The process measure Q375 is only assessing whether pre- and post-assessments were completed; however, outcome

measure Q470 requires a certain post-surgical PRO-PM score to meet performance."

- (**REVISION**): Q376: *Functional Status for Total Hip Replacement*
  - This measure currently captures patients 18 years and older. CMS proposes to revise the measure to read "[p]ercentage of patients 19 years of age and older who received an elective [THA] and completed a functional status assessment within 90 days prior to the surgery and in the 270 – 365 days after the surgery."
  - In addition, CMS proposes to revise the measure to exclude (1) patients with two or more fractures indicating trauma in the 24 hours before or at the start of the total hip arthroplasty or patients with severe cognitive impairment that starts before or in any part of the measurement period; and (2) patients who are in hospice care for any part of the measurement period.

- MIPS MVP: Improving Care for Lower Extremity Joint Repair
  - Proposed Quality Codes
    - Q024: *Communication with the Physician or Other Clinician Managing On-Going Care Post-Fracture for Men and Women Aged 50 Years and Older*
    - Q128: *Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan*
    - Q350: *Total Knee or Hip Replacement: Shared Decision-Making: Trial of Conservative (Non-surgical) Therapy (Collection Type: MIPS CQMs Specifications)*
    - Q351: *Total Knee or Hip Replacement: Venous Thromboembolic and Cardiovascular Risk Evaluation*
    - Q376: *Functional Status Assessment for Total Hip Replacement*
    - Q470: *Functional Status After Primary Total Knee Replacement*
    - Q480: *RSCR following elective primary THA and/or TKA for MIPS*

  - Proposed Improvement Codes
    - IA_AHE_3: *Promote use of Patient-Reported Outcome Tools*
    - IA_BE_6: *Regularly Assess Patient Experience of Care and Follow Up on Findings*
    - IA_BE_12 *Use evidence-based decision aids to support shared decision-making*
    - IA_CC_7: *Regular training in care coordination*
    - IA_CC_9: *Implementation of practices/processes for developing regular individual care plans*
    - IA_CC_13: *Practice improvements for bilateral exchange of patient information*
    - IA_CC_15: *PSH Care Coordination*
    - IA_PCMH: *Electronic submission of Patient Centered Medical Home accreditation*

- IA_PSPA_7: *Use of QCDR data for ongoing practice assessment and improvements*
- IA_PSPA_18: *Measurement and improvement at the practice and panel level*
- IA_PSPA_27: *Invasive Procedure or Surgery Anticoagulation Medication Management*

- CMS is proposing to modify the MVP development process by posting a draft version of new MVP candidates on the QPP website (https://qpp.cms.gov/) and open comment for a 30-day period.

H. <u>Proposed Benchmarks for MIPS Administrative Claims Measure Calculation</u>

- Beginning with the 2023 performance period/2025 MIPS payment year, CMS is proposing to score administrative claims measures using benchmarks calculated using performance period benchmarks. "We believe that using a performance period benchmark to score these measures would allow for scores that are more reflective of current performance, while adding no additional burden to clinicians."

- In addition, CMS believes the use of performance period benchmarks would help improve quality measurement. "For example, the *Risk-standardized Complication Rate (RSCR) Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA)* has a 3- year performance period (consecutive 36-month timeframe) that would start on October 1 of the calendar year 3 years prior to the applicable performance year and conclude on September 30 of the calendar year of the applicable performance year, proceeding with a 3-month numerator assessment period (capturing complication outcomes) followed by a 2-month claims run-out period. For the CY 2023 performance period/2025 MIPS payment year, the 3-year (36 consecutive months) performance period for this measure would span from October 1, 2020 to September 30, 2023 with a 90-day numerator assessment period followed by a 60-day claims run-out period. This means that according to standard scoring policy, the corresponding baseline would include data from October 1, 2018 to September 30 2021. We believe that comparison to data that precedes that standard 2-year baseline period may limit the usefulness of this measure . . . By comparing performance to data that was collected 5 years prior, this measure does not account for changes to the healthcare landscape and improvements in care that might have been made in the timeframe."

- CMS seeks public comment on proposals to score administrative claims measures in the quality performance category using performance period benchmarks.

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