AAHKS
AMERICAN ASSOCIATION OF HIP AND KNEE SURGEONS

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Glenn M. Hackbarth, J.D.
Chairman
Medicare Payment Advisory Commission (MedPAC)
425 I Street, N.W.
Suite 701
Washington, DC 20001

Dear Chairman Hackbarth:

The American Association of Hip and Knee Surgeons (AAHKS) is a national association of orthopaedic surgeons formed to advance and improve hip and knee patient care through leadership in education, advocacy and research. Given our commitment to serving the needs of Medicare and other patients, care providers and policy makers regarding hip and knee health, we appreciate the opportunity to provide comments on validating relative value units (RVUs) in the Medicare physician fee schedule (MPFS).

AAHKS shares your interest in appropriately valuing physician services under the MPFS. We have long been concerned about the lack of transparency in the current valuation process and the inadequacy of the data utilized by the AMA RUC to determine relative values.

In particular, we have been working with CMS to properly value the work RVUs for CPT codes 27130 (total hip arthroplasty) and CPT code 27447 (total knee arthroplasty), which are currently valued based on interim RVUs established in the final CY 2014 MPFS rule. As you may be aware, during this rulemaking, CMS noted that it shared stakeholder concerns regarding the AMA RUC's recommended valuation of these services, especially with regard to the data available for determining the intraservice time. CMS also observed that there was significant variation between time values estimated through a survey versus those collected through specialty databases. In establishing the interim work values for 2014, CMS noted that it attempted to "take a cautious approach" in light of the "divergent recommendations from the specialty societies and the AMA RUC regarding the accuracy of the estimates of time for these services, including both the source of time estimates for the procedure itself as well as the inpatient and outpatient visits included in the global periods for these codes." While we appreciated CMS's careful review of the specialty society data, the valuation process - including rebuttal of AMA RUC recommendations – has been a long, resource-intensive endeavor for the affected specialty societies.

We therefore agree that there is a need to develop more objective tools for valuing physician services, including the most appropriate reconciliation for the conflicting data regarding time values. While we have recommended that CMS increase payment and ensure a period of stability with regard to the values for hip and knee arthroplasty for several years given the tremendous resources just expended by physicians and CMS alike on valuation of these codes, we are hopeful that more accurate valuation methodologies will benefit CMS as it reviews the relative values of any procedures reimbursed under the MPFS in the future.

In particular, we share policymakers' concerns about the accuracy of survey data, and we believe there are inherent flaws in relying on physician recollection of service times. We believe that the emphasis for policymakers should be on exploring the use of real-time data through hospital and/or registry data collection to promote data accuracy. For instance, with regard to orthopaedic procedures, we have recommended that CMS consider the data from a new registry called FORCE-TJR, or Function and Outcomes Research for Comparative Effectiveness in Total Joint Replacement. This registry draws from more than 30 hospitals, including community and teaching hospitals, in 22 states, and includes data on more than 15,000 total lower extremity joint arthroplasty procedures, including time in/time out data for at least half of these procedures. We will continue to explore this and other options for real-time data collection to better inform CMS valuation of these key orthopaedic procedures.

With regard to MedPAC's specific consideration of a "top down" approach to valuation of physician services, MedPAC has described this as a design in which the physician is the "unit of analysis." Under this approach, practices would submit two types of data:

- Actual hours worked during a specified period of time, and
- The array of services furnished by that professional during the time period and the volume of those services.

We believe the data is too limited at this time to provide a full assessment of its feasibility, although it is our view that for orthopaedic surgical procedures using registry data would be more promising than this approach. If MedPAC pursues development of this option, we believe it would be critical for any such a methodology to take into account variations in patient complexity and comorbidities, as those factors have an important influence on physician work involved with particular patients. The scope of physicians represented in such a data collection will be important as well, as will be compensating physicians for the resources involved with new layers of recordkeeping to ensure the broadest base of physician time data is available.

Going forward, AAHKS appreciates the opportunity to work with MedPAC and other stakeholders to improve the RVU valuation process. We would be pleased to discuss this issue with you in greater depth; you can reach us at aahksstaff@aahks.org.

Sincerely,

Brian S. Parsley, MD
President
American Association of Hip and Knee Surgeons