AAHKS
AMERICAN ASSOCIATION OF HIP AND KNEE SURGEONS

OFFICE: 847.698.1200 • FAX: 847.698.0704 • WEB: aahks.org
9400 W Higgins Road, Suite 230 • Rosemont, IL 60018-4976

October 5, 2020

VIA E-MAIL FILING

Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS-1734-P
P.O. Box 8016
Baltimore, MD 21244-8016

RE: Medicare Program; CY 2021 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment Policies; Medicare Shared Savings Program Requirements; Medicaid Promoting Interoperability Program Requirements for Eligible Professionals; Quality Payment Program; etc.

The American Association of Hip and Knee Surgeons (AAHKS) appreciates the opportunity to submit comments to the Centers for Medicare & Medicaid Services (CMS) on its Medicare physician fee schedule (PFS) proposed rule for fiscal year 2021 (hereinafter referred to as "FY 2021 PFS proposed rule" or "proposed rule").

AAHKS is the foremost national specialty organization of more than 4,000 physicians with expertise in total joint arthroplasty (TJA) procedures. Many of our members conduct research in this area and are experts in using evidence based medicine to better define the risks and benefits of treatments for patients suffering from lower extremity joint conditions. In all of our comments, AAHKS is guided by its three principles:

- Payment reform is most effective when physician-led;
- The burden of excessive physician reporting on metrics detracts from care; and
- Patient access, especially for high-risk patients, and physician incentives must remain a focus.

Our comments focus on the FY 2021 PFS proposed rule are summarized as follows:

I. Executive Summary

- CMS Should Maintain the Current Work RVUs for CPT Codes 27130 and 27477 as the RUC-recommended Levels Do Not Represent Work Actually Performed
- Rather, the RUC-recommended Work RVUs are Below RUC Survey Results

DRAFT

- The RUC Survey Results Do Not Account for Preservice Optimization Work Which the RUC and CMS Acknowledge is Performed
- CMS Should Recognize Preservice Optimization Work by Including Pre-service Time in the Work RVUs for CPT 27130 & 27447
- Preservice Time Exists and is Increasing Through the Growth in Arthroplasty Bundled and Value-Based Care
- Extensive Peer-Reviewed Data Support the AAHKS & AAOS Recommendations for Preservice Optimization Work Time
- Medicare Law Clearly Gives CMS Authority to Reimburse Preservice Surgical Time
- CMS Has the Authority and Rationale to Decline the RUC Recommendations
- Existing CPT Codes are Imperfect to Capture Arthroplasty Preservice Optimization Work
- None of the Existing CPT Codes Can Appropriately Capture All Preservice Optimization Time
- CMS Should Create New G-Codes Specifically for Arthroplasty Preservice Optimization If It Accepts Current RUC Recommendations
- Accepting the RUC Recommended wRVU Reductions Has Multiple Adverse Consequences
- Medicare-imposed Reimbursement Reductions Based on Efficiencies in Physician Post-operative Time Will Undermine the Transition to Value-Based Care
- A Combined Pandemic and Economic Crisis is the Wrong Time to Reduce Reimbursement to Medicare Providers
- Implementing this Reduction Incentivizes Commercial Payers to Manipulate the Misvalued Code Nomination Process
- Any Reduction in Work RVUs Must Occur Concurrent with CMS Confirmation of Appropriate CPT Codes to Capture Preservice Optimization Work
- When Evaluating Public Nominations for Potentially Misvalued Codes, CMS Should Formally Consider Whether Other Factors are Changing the Practice Patterns Associated with the Codes in Question, Such as Overall Status of the Procedure Transitioning to Value-based Care, and What CMS-directed Policies are Driving the Changes
- CMS Should Provide All Technical Assistance Necessary to Aid Congress in Preventing the 10% Reduction in Reimbursement to Specialists Due to the Conversion Factor

DRAFT

II. Hip-Knee Arthroplasty (CPT codes 27130 and 27447) – Valuation of Specific Codes (Sec. II.H.4.(8))

a. CMS Should Maintain the Current Work RVUs as the RUC-recommended Levels Do Not Represent Outcome-Maximizing Work Actually Performed

i. RUC-recommended Work RVUs are Far Below RUC Survey Results. Therefore, the RUC's Own Survey Data Justifies Maintaining Current Levels Even Without Adding Preservice Time

For reasons discussed later in this comment letter, in the 2019 PFS Final Rule, CMS added CPT codes 27130 and 27447 for total hip arthroplasty (THA) and total knee arthroplasty (TKA) to the list of potentially misvalued codes. As a result, the codes were surveyed at the October 2019 meeting of the American Medical Association's Relative Value Scale Update Committee (RUC). CMS now proposes the RUC-recommended levels of 19.60 work relative value units (wRVUs) for each code.

Subsequent to the final survey instrument review and approval by the RUC Research Subcommittee, the American Association of Orthopaedic Surgery (AAOS) and AAHKS surveyed orthopaedic surgeons with the approved survey instrument and presented the results at the October 2019 RUC meeting. The survey data was generated by 206 orthopaedic surgeons, a robust response by RUC standards. The AAOS put forth a compelling, data-driven assessment that supported maintaining the current wRVU levels of 20.72, despite the fact that the median wRVU value from the survey was 24.00. The 25th percentiles were 22.50 for THA and 22.14 for TKA. The basis for our reaffirmation of 20.72 accounted for one less visit in the hospital post-operatively. A copy of the AAOS presentation to the RUC is attached below as **APPENDIX A**.

Table 1. Comparison of wRVU Survey Results and Recommendations for CPT Codes 27130 & 27447

Current wRVU	Median wRVU RUC Survey Results	25th Percentile of wRVU RUC Survey Results	AAHKS & AAOS Recommended wRVU	RUC-recommended wRVU
20.72	24.00	22.50 (THA) 22.14 (TKA)	20.72	19.60

We note that our recommended value of 20.72 is already below the 20th percentile of the RUC survey results. The RUC-recommended level of 19.60 wRVUs is even further below the 20th percentile. This anomalous, punitive, low recommendation should be contrasted against the new wRVUs assigned to the revised evaluation and management (E/M) codes which become effective in 2021. For those E/M codes, the values are based on the median of the RUC's survey results.

DRAFT

Further, AAHKS does not concede that one less post-operative patient visit in the hospital suggests that there is less work occurring for joint arthroplasty patients. One less post-operative visit is generally occurring because overall patients are being discharged from inpatient status sooner following arthroplasty surgery. However, earlier discharge times are the result of more, not less, work by surgeons and clinical staff. As discussed further in this comment letter, it is additional surgeon and staff time spent on managing comorbidities, patient and family education, intra-facility coordination, and discharge planning that leads to a patient being ready for safe discharge in a shorter time-frame.

ii. RUC Survey Results Do Not Account for Pre-service Work Which the RUC Acknowledges is Performed

At the April 2019 meeting of the RUC, in preparation of surveying the codes, AAHKS and AAOS requested a modified survey instrument that would have the ability to capture the additional preoperative work outside the global period that is being done by physician practices to optimize patient outcomes (fewer adverse events, shorter lengths of stay, fewer discharges to skilled nursing facilities, fewer readmissions, etc.) and increase the overall value of the care being delivered. The RUC declined this proposal, claiming there was a lack of compelling data and asserting that it would have to grant preservice time for everybody.

This rejection was reaffirmed by the RUC Research Subcommittee during their June 4, 2019, call, partly on the grounds that if the RUC allowed preoperative time to be surveyed and included for orthopaedic surgery then the RUC would have to "allow it for everyone." While the RUC did permit an additional question in the survey to help capture clinical staff time on the practice expense side, the response was troubling as the RUC had indeed recently allowed this type of request for additional physician/qualified health professional preservice time for both kidney transplants as well as endovascular reconstruction of abdominal aortic aneurysm.[1]

Secondly, during that call, the RUC expressed their opinion that there was a lack of compelling data on preservice time to justify such a request. Below, we discuss the extensive data on preservice time performed for THA and TKA. AAHKS and AAOS were gratified that, as stated in the RUC's summary submitted to CMS in October 2019, the RUC agreed that the pre-service planning activities occur.

iii. CMS Should Recognize Preservice Optimization Work by Including Pre-service Time in the Work RVUs for These Joint Arthroplasty Codes

While we recommend that CMS recognize preservice optimization work within joint arthroplasty RVUs, we understand that CMS will establish a standard by which it can transparently and fairly evaluate any requests to add preservice time to various CPT codes. We

[1] *See* recognition and reimbursement of preoperative work for Endovascular Aortic Repair (CPTs 34701, 34703, 34705, 34707) and Liver Transplant (CPTs 47140, 47141, 47142).

DRAFT

propose below a series of requirements for CMS to evaluate to determine whether preservice time should be added. For each, we explain how joint arthroplasty satisfies these requirements.

Briefly, these requirements are as follows: (1) CMS can confirm that the preservice work is occurring; (2) extensive, independent data supports the values that would be assigned to preservice work; (3) preservice time in question is not otherwise precluded by Medicare program regulations or guidance; (4) the preservice time cannot be captured by currently available CPT codes; and (5) data supports the determination that the preservice work is at least as prevalent as other work included in current wRVUs.

A. Preservice Time Exists and is Growing Through the Growth in Arthroplasty Bundled and Value-Based Care

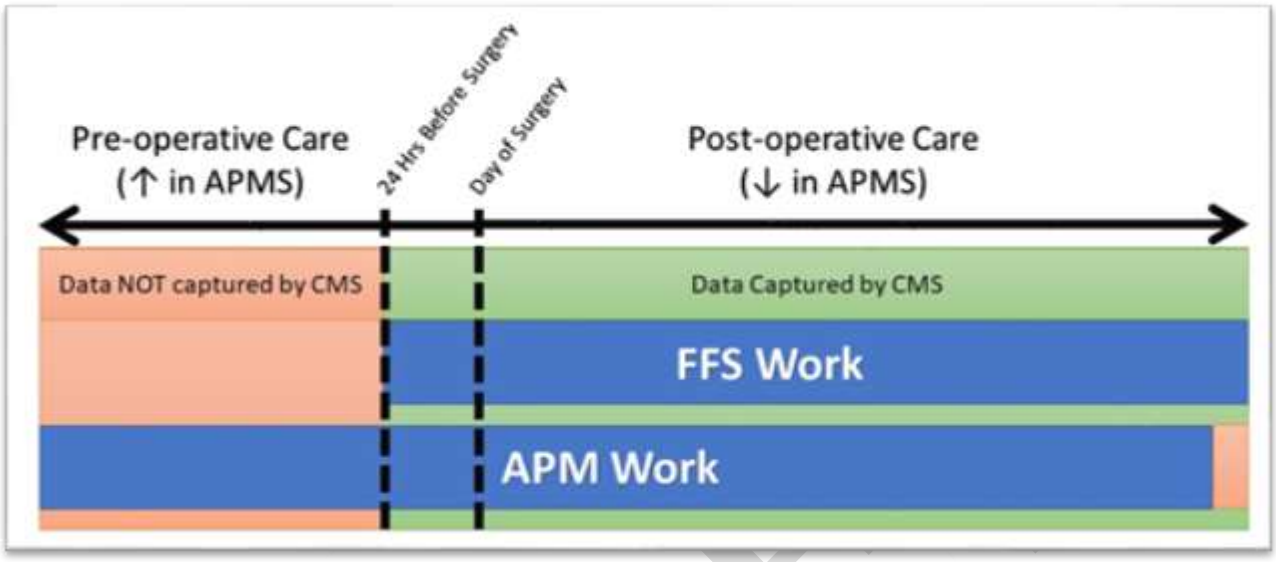
We believe CMS has rightly been persuaded that arthroplasty preservice time is frequently occurring, as reflected by CMS's statement, "we are seeking comment from the medical community on how to consider and/or include pre-optimization time […] going forward."[2] This conclusion is supported and confirmed by the RUC's own acknowledgement that arthroplasty preservice time exists: "The RUC discussed options on how to capture these pre-service activities performed by the physician or QHP."[3] Consistent with other elements of the Medicare program, the RUC's findings are informative but not determinative for CMS. In this case, the RUC statement offers confirmation of arthroplasty preservice optimization time.

Orthopaedic surgeons, and THA and TKA specifically, have been at the forefront of the transition to value-based care and as high-volume, high-value procedures that present significant opportunities for improvements in quality and efficiency. Hip and knee surgeon participation in alternative payment models (APMs) is approaching 50%, the highest rate of any subspecialty.AAHKS has worked with CMS and its Center for Medicare and Medicaid Innovation (CMMI) to improve the quality of care for THA and TKA, particularly through our members' adoption of the Medicare Bundled Payments for Care Improvement (BPCI) and Comprehensive Joint Replacement (CJR) models.[4] Our members' work through these models has improved outcomes, reduced patient time spent in the hospital, and subsequently saved the trust funds hundreds of millions of dollars.

DRAFT

[2] 85 Fed. Reg. 50155 (Aug. 17, 2020).
[3] AMA RUC Oct 2019 Report to CMS.
[4] In 2015, AAHKS convened with CMS and others the *Patient Reported Outcomes (PROs) Summit for Total Joint Arthroplasty* that led to coordination on PROs that could be used in public and private bundled payment models.

Table 2. Increase in Arthroplasty Preservice Time Due to Value-Based Care



Much of the effectiveness of these programs, however, appears to have come from the shift from reactive, hospital-based postoperative work to proactive, office-based preoperative work. Our members and associated qualified health professionals (QHPs), and clinical staff have experienced significant increases in preservice work to optimize patients through screening, education, and coordination of care with other health care providers (patients' primary care physicians, medical specialist consultants, physical therapists, post-acute care, and others), and from other activities required to ensure the best outcome for a patient's surgery. However, these activities on behalf of the patient and family are not included in the traditional RUC survey definition of "pre-service activities," as well as the time clinical staff spent providing certain pre-service activities for the patient and family.

Evidence has made clear that the additional time spent on these preoperative activities has resulted in improved clinical quality for patients and significant savings by reducing patients' post-operative lengths of stay, readmissions, and other complications. An April 2019 New England Journal of Medicine article estimated that 42% of TKA and THA procedures over a two-year period were done through CJR and resulted in a 3.1% reduction in Medicare spending for Total Knee Replacement and Total Hip Replacement.[5]

In support of adding this preservice time, it is important to note that it is the increased work by surgeons, managing the patient experience and optimization, that leads to arthroplasty savings realized in reduced spending by the facility and post-acute care. Over the last seven years, arthroplasty surgeons have led the efforts which have reduced the average cost of an episode of care from approximately $35,000 to approximately $20,000. The current Medicare reimbursement to arthroplasty surgeons of approximately $1200 (20.72 wRVU) accounts for

[5] Michael L Barnett, et al., Two year Evaluation of Mandatory Bundled Payments for Joint Replacement, 380 NEW ENGLAND J. OF MED., 252-262, (Jan. 17, 2019), https://www.nejm.org/doi/full/10.1056/NEJMsa1809010.

about six percent of this reduced episode cost. The proposed reduction in wRVUs (5% or $60) is diminutive when compared to the hundreds of millions of dollars that arthroplasty surgeons have saved the trust through our commitments to value-based care. Penalizing surgeons for this successful collaboration is disheartening, especially given the current RUC survey data which yielded a median of 24.00 wRVUs.

B. Extensive Data Supports the AAHKS & AAOS Recommendations for Preservice Work Time

We proposed to the RUC that the current wRVU levels be increased by adding 30 minutes of physician time to the standard preservice time of 40 minutes. We also proposed to the RUC a total of 90 minutes of clinical staff preservice time, which is an addition of 30 minutes to the standard package of 60 minutes. These recommendations are supported by ample "extant" peer-reviewed data discussed below. The clinical staff time request was supported by data that the RUC allowed to be captured through an additional survey question.

Although the current RUC values includes 40 minutes of preservice time starting from the day before surgery, a published, peer-review survey of our membership finds that surgeons spent an average of an additional 43.2 minutes while physician assistants and nurse practitioners spent an additional 97.9 minutes per patient on preoperative care prior to that time.[6] Ancillary medical staff spent a mean of 110.2 minutes per patient. The most common tasks include preoperative phone calls for care coordination, templating and surgical planning, and preoperative patient education classes.[7] The conclusion is that surgeons and advanced practice providers spend nearly two hours per arthroplasty patient on preoperative care not accounted for by current RUC methodology. This study, *Substantial Preoperative Work Is Unaccounted for in Total Hip and Knee Arthroplasty* from the Journal of Arthroplasty, is attached as **APPENDIX B.**

The following is a list of the most common preservice work activities that were surveyed for this study.

Table 3. Most Common Preservice Work by Physicians, QHPs, and Clinical Staff as Surveyed by AAHKS

- Screening and risk assessment of comorbidities
- Shared decision-making, goal setting
- Patient education and optimization discussion
- Medical interventions, referrals, consults
- Follow-up visits, reassessments
- Discharge planning
- Enter data into prospective longitudinal outcome databases or registries
- Pre-operative planning, templating, packet presentation
- Select data with patient and family; schedule surgery in OR scheduling system
- Obtain prior authorization
- Schedule and/or confirm appointments for evaluations by appropriate consultants (PCP, cardiology,

[6] Matthew J. Grosso et al., Surgeons' Preoperative Work Burden Has Increased Before Total Joint Arthroplasty: A Survey of AAHKS Members, 35 J. OF ARTHROPLASTY 2318-2322 (2020).
[7] *Id.*

neurology, dentist, vascular surgery, endocrinology, etc.)
- Schedule pre-operative assessment with anesthesia
- Schedule pre-operative appointment with physical therapy
- Schedule pre-operative appointment with case manage and/or social worker
- Schedule pre-operative education class
- Coordinate and schedule final clearance assessment
- Staff 1-2 hour education class attended by multiple patients
- Phone calls, e-mails, other communication with patient, family and other providers
to coordinate post-operative visits and optimization
- Pre-operative patient and family member form completion
- Phone call to patient or family to review preparation instructions (NPO, medications, antibiotic shower)

Additionally, we have performed a review of published peer-reviewed surveys of preservice arthroplasty time. Compiled data, raw data, and excluded studies are presented in detail in **APPENDIX C**. We summarize the average times found below in **Table 3**.

Table 4. Preservice Time (from decision to operate until the day before operation) Prior to Primary TJA (Minutes)

			Physician or QHP			Office Staff		
Author	Title	Patients/ respondents	Mean	Standard dev.	Median	Mean	Standard dev.	Median
Grosso, MJ et al	Surgeons' Preoperative Work Burden Has Increased Before Total Joint Arthroplasty: A Survey of AAHKS Members	Approx. 256	153	179	110	176	176	125
Krueger, CA et al	Substantial Preoperative Work Is Unaccounted for in Total Hip and Knee Arthroplasty	438	134	87.04	n/a	110	72.04	n/a
Halawi, MJ et al	Quantifying Surgeon Work in Total Hip and Knee Arthroplasty: Where Do We Stand Today?	666	22	10	n/a	n/a	n/a	n/a
Husted, H et al	Time-driven activity-based cost of outpatient total hip and knee arthroplasty in different set-ups	1110	50	n/a	n/a	n/a	n/a/	n/a
Wasterlain, AS et al	Quantifying the Perioperative Work Associated With Total Hip and Knee Arthroplasty: The Burden Has Increased With Contemporary Care Pathways	1000	42	12	n/a	n/a	n/a	n/a
Totals			76.83	70.46	110	143	124.02	125

C. Inclusion of the Preservice Time in the Arthroplasty Codes is Not Otherwise Precluded by Medicare Program Regulations and Guidance

A thorough review of program regulations and guidance finds no current policies or procedures that preclude the arthroplasty CPT codes from including in the wRVUs time for non-face-to-face preservice optimization time. This time is distinguishable from E/M visits, which are face-to-face visits between physician and patient. Program guidance is clear that such visits that

DRAFT

occur after the decision to schedule surgery, and before the day before admission, are already considered a part of the global surgical package.[8]

D. The Proposed Arthroplasty Preservice Time is Not Otherwise Captured in Existing CPT Codes

Another necessary requirement is that the proposed preservice time is unique and could not be double billed through the use of other existing CPT codes. A thorough review has found that no current CPT codes accurately describe the time, personnel, sequence, or work involved in arthroplasty preservice work. This analysis is discussed at length below in **Section II.b.i**.

iv. Medicare Law Clearly Gives CMS Authority to Reimburse Preservice Surgical Time

Recognizing and including preservice optimization time as a component of the TJA CPT codes is permitted under the broad authority Congress has given the Secretary to set a value for the work of physicians associated with a surgical procedure. Work RVUs must be based on the time and intensity required for furnishing a service and may include pre-operative and post-operative physicians' services related to a procedure. Under Medicare program law, the Secretary's determination of work RVUs for a service must be "based on the relative resources incorporating physician time and intensity required in furnishing the service."[9]

Notably, the Social Security Act also specifies "activities that occur *before* and after direct patient contact," and, with respect to surgical procedures, that "the valuation of the work component for the code would reflect a 'global' concept in which *pre-operative* and post-operative physicians' services related to the procedure would also be included."[10] Further, when validating relative value units, the Act specifies that the Secretary's review process may include validation of work elements involved with furnishing a service, including time, mental effort and professional judgment, technical skill and physical effort, and stress due to risk, and "validation of the pre-, post-, and intra-service components of work."[11] As mentioned above, precedent already exists under which CMS includes physician preservice time in surgical CPT codes.[12]

Adding this preservice time to CPTs 27130 and 27447 is the simplest, most direct means to capture this work without disrupting the definitions of episodes under existing Medicare bundled payment programs. Otherwise, capturing this time though other codes has the effect of unbundling surgical services, which is the opposite of the trend of value-based care.

[8] *See* Medicare Claims Processing Manual Ch. 12 § 40.1.B.
[9] SSA § 1848(c)(2)(C)(i)
[10] *Id.* at (c)(1)(A); *see also* 75 Fed. Reg. 73169, 73215 (Nov. 29, 2020).
[11] *Id.* at (c)(2)(L).
[12] *See* recognition and reimbursement of preoperative work for Endovascular Aortic Repair (CPTs 34701, 34703, 34705, 34707) and Liver Transplant (CPTs 47140, 47141, 47142).

v. CMS Has the Authority and Rationale to Decline the RUC Recommendations

The Social Security Act and CMS rulemaking unambiguously confirm that AMA RUC recommendations are advisory and non-binding when CMS evaluates RVUs for potentially misvalued codes. As such, CMS may accept, modify, or reject the RUC's recommendations. The breadth of published literature provided by AAHKS to the RUC and CMS as well as the survey conducted by AAHKS and AAOS confirming the additional preservice optimization time more than justify CMS declining to adopt the RUC's recommendation of reduced wRVUs for CPT 27130 and 27447.

Section 1848(c) of the Act specifies that when the Secretary identifies potentially misvalued codes, the Secretary must make "appropriate adjustments to the relative values established"[13] and requires the Secretary to develop a process to validate the RVUs of certain potentially misvalued codes under the PFS.[14] The process for validating RVUs may include validation of work elements involved with furnishing a service, including time, mental effort and professional judgment, technical skill and physical effort, and stress due to risk, and may include validation of the pre-, post-, and intra-service components of work.[15]

In addition to using other methods, for both the adjustment and validation, the Secretary may use existing processes to receive recommendations on the review and appropriate adjustment of the potentially misvalued code.[16] The existing processes to receive recommendations on the review are enumerated in the Act for both determining relative value units and in the scope of periodic review and adjustments of relative values. The Act states that when determining the RVU using extrapolation, the Secretary "shall *take into account* recommendations of the Physician Payment Review Commission and the results of consultations with organizations representing physicians who provide such services," [17] and when considering periodic adjustments, states the Secretary "shall *consult with* […] organizations representing physicians."[18] In neither case does the Social Security Act mandate the Secretary follow the RUC recommendation or take into account such recommendations beyond mere consultation.

CMS expressly confirmed the role of the RUC's recommendations in the 2011 PFS Final Rule, stating that CMS "determine[s] appropriate adjustments to the RVUs, *taking into account* the recommendations provided by the AMA RUC and MedPAC,"[19] and that upon the RUC's recommendation, CMS "then assesses the recommended revised work RVUs and/or direct PE inputs and, in accordance with section 1848(c) of the Act, […] determine[s] *if the recommendations constitute appropriate adjustments* to the RVUs under the PFS."[20] Moreover,

[13] *Id.* at (c)(2)(K)(i)(II).
[14] *Id.* at (c)(2)(L).
[15] *Id.* at (c)(2)(L)(ii).
[16] *Id.* at (c)(2)(K)(iii).
[17] *Id.* at (c)(2)(A)(ii) (emphasis added).
[18] *Id.* at (c)(2)(C)(iii) (emphasis added).
[19] 75 Fed. Reg. 73169, 73214 (Nov. 29, 2010) (emphasis added).
[20] *Id.* at 73215.

in response to commenters that "urged CMS to rely solely on the AMA RUC to provide valuations for services under the PFS" and "expressed the belief that since CMS has reviewed the AMA RUC recommendations for codes and generally accepted these valuations in the past, these actions constitute a 'CMS validation process,'" CMS expressly rejected commenters' assertions that the RUC's "actions constitute[d] a formal CMS validation process as envisioned by" the Act. [21]

CMS also stated that its "formal validation process *will further complement* the ongoing work of the AMA RUC to provide recommendations to us regarding the valuation of PFS services," again emphasizing that the CMS valuation is not dependent on the RUC.[22] CMS re-affirmed this methodology in a CY 2012 final rule,[23] a CY 2015 final rule,[24] and again in a CY 2020 final rule, stating:

> We establish work RVUs for new, revised and potentially misvalued codes based on *our review* of information that *generally includes*, but is not limited to, recommendations received from the American Medical Association/Specialty Society Relative Value Scale Update Committee (RUC), the Health Care Professionals Advisory Committee (HCPAC), the Medicare Payment Advisory Commission (MedPAC), and other public commenters; medical literature and comparative databases; as well as a comparison of the work for other codes within the Medicare PFS, and consultation with other physicians and health care professionals within CMS and the federal government.[25]

Further, when describing the role of RUC in the valuation process for work RVUs, CMS specifically stated "we conduct a review that included the current work RVU (if any), RUC-recommended work RVU, intensity, time to furnish the preservice, intraservice, and postservice activities, as well as other components of the service that contribute to the value," and notably discussed CMS's approach in instances when CMS chose not follow the RUC recommendation, stating "rather than ignoring the RUC-recommended value, we have used the recommended values as a starting reference and then applied one of these several methodologies."[26]

[21] *Id.* at 73217.
[22] *Id.* at 73218.
[23] 76 Fed. Reg. 73025, 73052 (Nov. 28, 2011).
[24] 79 Fed. Reg. 67547, 67603 (Nov. 13, 2014).
[25] 84 Fed. Reg. 40482, 40484 (Sept. 27, 2019) (emphasis added).
[26] 84 Fed. Reg. 40482, 40565 (Aug. 14, 2019).

b. Existing CPT Codes are Imperfect to Capture Arthroplasty Pre-optimization Work

i. None of the Existing CPT Codes Can Appropriately Capture All Preoptimization Time

We appreciate the acknowledgement that AAHKS members are performing important preservice pre-optimization work that is presently uncaptured. CMS stated as follows:

> We are also interested in stakeholders' thoughts on what codes could be used to capture these pre-optimization activities that could be billed in conjunction with the services discussed previously. Overall, we are interested in continuing our ongoing dialog with stakeholders about how CMS might pay more accurately for improved clinical outcomes that may result from increased efficiency in furnishing care through activities, such as pre-optimization and are appreciative of information provided by the medical community.[27]

On a related note, the RUC stated:

> The RUC discussed options on how to capture these pre-service activities performed by the physician or QHP. The RUC indicated that separate planning codes may be developed or the current prolonged services, CPT codes 99358 Prolonged evaluation and management service before and/or after direct patient care; first hour or 99359 Prolonged evaluation and management service before and/or after direct patient care; each additional 30 minutes (List separately in addition to code for prolonged service) may be reported for these activities.[28]

We appreciate the advice and request for input, and we provide our survey of potential candidate codes to capture surgeon and clinical staff preservice time for arthroplasty. *See* **APPENDIX C. Evaluation of CPT Codes for Applicability to TJA Pre-optimization Time (Which existing CPT codes may be billable now; which would require some adjustment).** As shown in that table, many of these codes are close and related to preservice arthroplasty work, but no one code or combination of codes allows appropriate capture of the full work being performed.

"Prolonged service w/o contact codes" are close to describing physician work, but do not include clinical staff time. Further, these codes (99358 & 99359) are billed per day, and, in practice, arthroplasty preservice work is spread over multiple days and may not equal sufficient cumulative time on any one day. Transitional care management codes describe preservice

[27] 85 Fed. Reg. 50155, 50074 (Aug. 17, 2020).
[28] AMA RUC Oct 2019 Report to CMS.

optimization work, but this kind of discharge planning usually occurs before the operation, and not at the required time of immediately before discharge. G2064 (Principal Care Management) also seems close, but we would need confirmation from CMS that the osteoarthritis treatment, of which TJA is a part, would quality as the principal chronic condition that supports billing this code by physician and clinical staff.

CMS should also clarify whether the kind of non-face-to-face work by physicians and staff discussed here is excluded from included in the surgical bundle. For example, Medicare program guidance says that "Medicare includes the following services in the global surgery payment when provided in addition to the surgery: Pre-operative *visits* after the decision is made to operate. For major procedures, this includes pre-operative visits the day before the day of surgery."[29] We would need conformation from CMS that this manner of preservice preoperative work is or is not included in the global surgical payment. For instance, can we presume that non-face-to-face work does not comprise a pre-operative ***visit*** under this policy? What about staffing education classes attended by multiple patients?

ii. If CMS Does Not Add Preservice Time to the Existing Joint Arthroplasty Codes, CMS Should Instead Create New G-Codes Specifically for Arthroplasty Preservice Optimization

If no existing code in its current reimbursement standard can adequately capture the preservice optimization time, AAHKS urges CMS to set alternative reimbursement language/standards through the creation of a new G-code for arthroplasty preservice optimization. This code could reimburse up to 30 minutes of physician time and up to 90 minutes performed by clinical staff cumulatively per patient for the activities described in Table 2. We believe that if preservice time will not be included in the underlying TJA CPT codes, CMS should implement this option now without losing one or two years going through the process with the RUC to create a new code.

c. Accepting the RUC Recommendations Has Multiple Adverse Consequences

Accepting the RUC recommendations amounts to a 5.4% cut in work RVUs for CPTs 27130 and 27447 and an overall reduction in physician payment rates for TJA of approximately 3.4%. Such a reduction, imposed in this manner, hurts the Medicare program in multiple ways.

i. Reimbursement Reductions Based on Efficiencies in Physician Time Will Undermine the Transition to Value-Based Care

CMS should preserve incentives for participation in Medicare innovation models by not reducing fee-for-service rates based on new value-based care driven efficiencies. Such a reduction broadcasts a strong, chilling message to all physicians participating in—or considering participating in—APMs: when providers in the vanguard of value-based care and bundled

[29] MLN Matters, Global Surgery Booklet, 5 (Sept. 2018) (emphasis added).

payments begin to achieve some efficiencies in the delivery of care, CMS will use those positive developments as a justification to cut fee-for-service reimbursement. Providers, patients, and policy makers should be clear on the process that led to this development, particularly given that a for-profit commercial insurance company initiated this valuation process with the intention of ultimately driving down reimbursement to contracted physicians who are paid a percentage of Medicare rates.

The potential to improve care for our patients and reduce overall Medicare expenditures through Advanced APMs and other value-based care arrangements should not be threatened by simultaneous reductions in work RVUs. Maintaining the current level would align with the agency's mission of encouraging new, more efficient and more equitable payment models that properly incentivize quality efforts. The combination of the Medicare program putting TJA procedures at the forefront of value-based and site-neutral care and simultaneously threatening a potential PFS reimbursement reduction for these procedures cannot help but create an impression among orthopaedic surgeons that their profession is under assault. In effect, the Medicare program is encouraging orthopaedic surgeons to take on more risk under alternative payment models, but simultaneously threatening to reduce overall reimbursement, leaving our members with more at risk for lower reimbursement. Rate reduction is risky in light of extensive CMS-driven transition in regulation and reimbursement of joint replacement surgery now, including the transition to outpatient and Ambulatory Surgery Centers (ASCs); learning the 2-midnight rule; CJR extension and interaction with BPCI-A; upcoming MIPS MVP episodes; and partnering with CMS to develop new models and new measures.

ii. A Combined Pandemic and Economic Crisis is the Wrong Time to Reduce Reimbursements to Medicare Providers

In addition to the challenges of the multiple Medicare-imposed transformations of TJA reimbursement and regulation discussed above, the external factors of the COVID-19 pandemic make this a curious time for CMS to propose reducing Medicare reimbursements. Orthopaedic surgeons and their practices have been significantly impacted by the pandemic. Consistent with CMS guidelines on elective procedures, many AAHKS practices closed for several months earlier this year. That suspension has created a backlog in joint replacement surgeries to be scheduled, but also equates to lost volume for surgeons as they had already been operating at full capacity before the pandemic. Additionally, the ability for these surgical practices to work at full capacity is now diminished due to the extra precautions of reducing COVID-19 transmission risks in the surgical setting. Closed practices and delayed surgeries impact not only surgeons but also the staff they employ.

Moreover, of AAHKS members surveyed:

- 12% report that their hospitals are still unable to recommence elective inpatient surgery
- 60% report that their clinic volume is reduced
- 27% report that restrictions on elective procedures have remained in place with no change

- 49% report that they remain unable to rehire furloughed staff
- 52% report they are concerned that their work poses a risk to their families.

It is ironic that during a time when Congress has directed HHS to distribute $175 billion in Provider Relief Funds in a matter of months as economic relief, CMS believes that Medicare provider reimbursement can and should be reduced without adverse impact. It is further ironic that during the COVID-19 public health emergency, CMS has issued three regulations exercising the maximum extent of its regulatory discretion to ensure payments flow to Medicare providers and plans, but CMS is choosing to use its discretion in this case to reduce reimbursements to Medicare providers.

Orthopaedic surgeons and others are already facing a 10.61% PFS reduction in 2021 due to the statutorily imposed conversion factor, which must maintain PFS budget neutrality in light of improved rates to primary care providers for E/M services. Proposing a wRVU reduction with a simultaneous conversion factor reduction during a time in which CMS is otherwise exercising maximum regulatory flexibility and distributing billions in Provider Relief payments reinforces the impression that orthopaedic surgery is under assault by Medicare.

iii. Implementing this Reduction Incentivizes Commercial Payers to Manipulate the Misvalued Code Nomination Process

Thecode review process for CPT codes 27130 and 27447 was initiated by a for-profit commercial insurance company that manipulated CMS's public nomination process for potentially misvalued codes with the intention of ultimately driving down reimbursement to contracted physicians who are paid a percentage of Medicare rates. CMS's approval of the proposed reduction will create a growth industry among commercial payers to use the slimmest of data to nominate their high paying services codes as misvalued to similarly manipulate the misvalued code nomination process. If CMS fails to protect the code nomination process from this kind of abuse, the integrity of CMS's RVU valuation system will be undermined. Congress gave the Secretary a mandate to appropriately reimburse providers who serve Medicare beneficiaries, and this mission should not be conflated or confused with payers' commercial objectives to improve their negotiating leverage with physicians and increase profits.

d. <u>CMS Must Distinguish Between Value-Based Care Incentives and Its Statutory Responsibility to Set a FFS Rate Based on the Time and Intensity of Physician Work</u>

We wish to respond to CMS's last remark from the preamble on the arthroplasty codes. CMS says it is "interested in continuing our ongoing dialog with stakeholders about how CMS might *pay more accurately for improved clinical outcomes* that may result from increased efficiency in furnishing care through activities, such as pre-optimization and are appreciative of information provided by the medical community."[30] AAHKS is always appreciative of dialogue

[30] 85 Fed. Reg. 50155 (Aug. 17, 2020) (emphasis added).

with CMS over incentivizing quality and efficiency through reimbursing for improved clinical outcomes. That is the root of value-based care. AAHKS appreciates that CMS staff has always been available to hear our suggestions, concerns, and feedback over the Medicare Quality Payment Program (QPP) as well as various innovation models sponsored by CMMI. In fact, in 2015, AAHKS convened with CMS and others in Baltimore the *Patient Reported Outcomes (PROs) Summit for Total Joint Arthroplasty* that led to coordination on PROs that could be used in public and private bundled payment models.

Nevertheless, it is important to distinguish between CMS's statutory programs that reimburse Medicare providers for quality (CMMI and QPP) and CMS's statutory obligation to reimburse Medicare FFS providers based on time and intensity of work.[31] AAHKS supports Medicare paying for quality through CMMI and QPP, but those programs adjust for quality or set target episode prices based on the FFS rate. That is why the FFS rate is still so important to providers. The FFS rate is the starting point that will be positively or negatively adjusted through MIPS. It is the starting point that leads to a target episode price for which providers are at risk under CMMI bundled payment programs. Further, it is the starting point for many contract negotiations with commercial payers. AAHKS members, and we suspect many other physicians, will be less interested undertaking risk based on quality or outcomes if the underlying base rate for the procedure is shrinking.

e. <u>Addressing Preservice Time in the 2021 Final Rule as Proposed by AAHKS is a Logical Outgrowth of the Issues Presented by CMS in the Proposed Rule</u>

We believe that it would be a logical outgrowth from the proposed rule for CMS to decline to accept the RUC-recommended wRVU reductions based on input from specialty societies. We also believe that CMS may maintain level arthroplasty wRVU values by including arthroplasty preservice optimization time. This, too, would be a logical outgrowth from the proposed rule since CMS specifically asked for "comment from the medical community on how to consider and/or include pre-optimization time (pre-service work and/or activities to improve surgical outcomes) going forward."[32] Similarly, it is this same invitation for comment that we believe justifies CMS acting in the 2021 Final Rule to add a new G-code to capture arthroplasty preservice optimization time if CMS cannot add preservice time to the existing CPT codes. Per the section immediately above, if CMS is not persuaded that our recommendations are a logical outgrowth from the proposed rule, then CMS should delay implementing the RUC-recommended reductions until arthroplasty preservice time is resolved.

f. <u>Any Reduction in Work RVUs Must Occur Concurrent with CMS Confirmation of Appropriate CPT Codes to Capture Preoptimization Work</u>

In conclusion, if CMS proceeds with its proposal to reduce wRVUs for TJA under the PFS, any reduction should be delayed until CMS formally confirms—after consultation with AAHKS

[31] *See* SSA § 1848(c)(1)(A).
[32] 85 Fed. Reg. 50155, 50074 (Aug. 17, 2020).

and AAOS—what codes orthopaedic surgeons and their staff may appropriately use to capture pre-optimization time going forward. Now that CMS has conceded that pre-optimization time is being performed but not captured by current reimbursement, there is no reason that CMS should reduce overall reimbursement before the underlying problem is resolved.

III. Potentially Misvalued Services Under the PFS (Sec. II.C.2)

We again suggest new criteria regarding transition to value-based care that should be routinely included in CMS's evaluation of public nomination of potentially misvalued codes and subsequent evaluation of recommendations from the RUC. Our suggestions are informed by CMS's decision in 2018 to refer CPT codes 27447 and 27130 for review as potentially misvalued codes following a public nomination. Under the *established* process, CMS evaluates public nominations of potentially misvalued codes that include documentation of any of the following:

- Peer-reviewed medical literature or other reliable data that demonstrate changes in physician work due to one or more of the following: Technique, knowledge and technology, patient population, site-of-service, length of hospital stay, and work time
- An anomalous relationship between the code being proposed for review and other codes
- Evidence that technology has changed physician work
- Analysis of other data on time and effort measures, such as operating room logs or national and other representative databases
- Evidence that incorrect assumptions were made in the previous valuation of the service, such as a misleading vignette, survey, or flawed crosswalk assumptions in a previous evaluation
- Prices for certain high cost supplies or other direct PE inputs that are used to determine PE RVUs are inaccurate and do not reflect current information. Analyses of work time, work RVU, or direct PE inputs using other data sources
- National surveys of work time and intensity from professional and management societies and organizations, such as hospital associations[33]

The nomination and referral in 2018 of CPTs 27447 and 27130[34] illustrates a central and relevant characteristic of nominated codes currently not included in CMS's list of factors for evaluation: namely, *the degree to which performance of the procedure may be in transition due to it being thrust into value-based care*.

Misvalued code evaluations may be of limited accuracy or appropriateness for procedures in the midst of rapid and wide-ranging transition. Data reviewed by CMS and the RUC capture only a cross-section moment in time and cannot predict the nature of how TJAs may be performed in five or even two years during this current transition. The following are some of the

[33] *See* 84 Fed. Reg. 40516, 40482 (Aug. 14, 2019).
[34] *See* 83 Fed. Reg. 59502, 59452 (Nov. 13, 2018).

most high-profile policies that significantly alter the landscape in which TJA procedures are performed:

- TJA procedures were the first to be subjected to a mandatory bundled payment model, the CJR
- The CJR is about to undergo alteration through the proposed rule, *Comprehensive Care for Joint Replacement Model Three Year Extension and Modifications to Episode Definition and Pricing* (CMS-5529-P)
- TKA was made available for Medicare reimbursement in outpatient facilities beginning in 2018
- CMS seems poised to make THA available for Medicare reimbursement in outpatient facilities beginning in 2020
- CMS seems poised to make TKA available for Medicare reimbursement in ASCs beginning in 2020
- CMS proposes not accepting RUC-recommended valuation updates of global surgery periods
- CMS is proposing a new MIPS Value Pathways system for 2021

The national variation in site of care, admission status, services bundled, and gain-sharing incentives calls into question to what degree current limited procedural data can be representative of the procedures in all settings. It would be more appropriate to defer misvalued code evaluation for TJA procedures until practice of the procedure can stabilize after several more years of experience with outpatient Medicare delivery and stable bundled payment models.

Going forward, when reviewing public nominations for misvalued codes and when evaluating AMA RUC recommendations regarding those nominations, CMS should take into account other factors impacting providers in question, such as overall status of the procedure transitioning to value-based care and what other CMS-directed initiatives are changing practice patterns and demanding greater surgeon attention, focus, and time.

IV. Calculation of the CY 2021 PFS Conversion Factor (Sec. VIII.C.Table 88)

The Medicare statute requires that any increases or decreases in RVUs may not cause the amount of Medicare PFS expenditures for the year to differ by more than $20 million from what expenditures would have been in the absence of these changes. When this threshold is exceeded, CMS makes other increases or cuts in the PFS to maintain "budget neutrality." In general, this means that increases in RVUs, if not offset by other decreases in RVUs, will be offset by a reduction in all procedures rates through an adjustment to the PFS conversion factor.

In this case, largely due to increases in 2021 Medicare expenditures under improved rates for E/M services, CMS is reducing the PFS conversion factor by 10.61% to maintain "budget neutrality" in the PFS. *This 10% reduction applies to CPTs 27130 and 27447 in addition to the cuts*

due to the reduction in work RVUs. As this cut is broadly applicable across surgical specialties, a coalition of such specialty societies is lobbying Congress to waive Medicare's budget neutrality requirements. We urge CMS to provide all technical assistance necessary to aid Congress in preventing this reduction and to concurrently exercise the maximum extent of CMS's regulatory discretion to coordinate with Congress in this effort.

***

AAHKS appreciates your consideration of our comments. If you have any questions, you can reach Mike Zarski at mzarski@aahks.org or Joshua Kerr at jkerr@aahks.org.

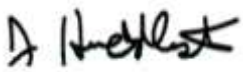
Sincerely,



C. Lowry Barnes, MD
President



Michael P. Bolognesi, MD
Immediate Past President



James I. Huddleston III, MD
Chair, Health Policy Council



Michael J. Zarski, JD
Executive Director

cc: **Demetrios Kouzoukas**, Principal Deputy Administrator
Brad Smith, Director, CMMI
Amy Bassano, Deputy Director, CMMI
Elizabeth Richter, Deputy Director, CM
Carol Blackford, Director, Hospital and Ambulatory Policy Group, CM
Gift Tee, Director, Division of Practitioner Services, HAPG, CM

APPENDIX A

APPENDIX B

APPENDIX C

HCPCS/ CPT Code	Short Description	Long Description	Reactions/Feedback
99358 99359	Prolonged Service w/o contact Prolonged Service w/o contact add	Prolonged evaluation and management service before and/or after direct patient care; first hour each additional 30 minutes (List separately in addition to code for prolonged service)	Allows physician to capture 30-74 minutes of cumulative non-face-to-face time on a day other than a visit. However, arthroplasty preservice time is usually spread over several days and may not equal 30 cumulative minutes on one day. Also, does not capture clinical staff time. Also, not clear how close or far from face-to-face visit, code may be billed
99415 99416	Prolonged clinical staff services with physician supervision	Prolonged *clinical staff service* (the service beyond the highest total E/M service time) during an evaluation and management service in the office or outpatient setting, direct patient contact with physician supervision; first hour	Not applicable to arthroplasty preservice time as it is for prolonged clinical staff face-to-face time during which a physician is present to supervise.
99495 99496	Transitional care management	Transitional care management services with the following required elements: • communication with patient and/or caregiver within 2 business days of discharge; medical decision making of at least moderate complexity during the service period; face-to-face visit within 14 days of discharge	Services described are similar to AAHKS member work but are not applicable because the code is tied to being provided immediately before discharge and tied to a face-to-face visit post-discharge. Much arthroplasty preservice work performs transition care management before operation.
99367 99368	Medical team conference without direct contact with patient and/or family	Medical team conference with interdisciplinary team of health care professionals, patient and/or family not present, 30 minutes or more; participation by physicians	Medical team conferences do not include clinical staff and require the face-to-face participation by a minimum of 3 qualified health professionals from different specialties or disciplines (each of whom provide direct care to the patient). This is not widely applicable to arthroplasty preservice time
99441 99442 99443	Phone E/M Phys/QHP 5-10 MIN Phone E/M Phys/QHP 11-20 MIN	Telephone evaluation and management service by a physician or other qualified health care professional who may report evaluation and management services provided to an established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment	Not applicable to arthroplasty preservice time as this is for a discrete health matter when the patient initiates the call

HCPCS/ CPT Code	Short Description	Long Description	Reactions/Feedback
	Phone E/M Phys/QHP 21-30 MIN		
99490	Chronic care management	Chronic care management services, at least 20 minutes of clinical staff time directed by a physician or other QHP, per calendar month, with following required elements . . . 2 or more chronic conditions expected to last at least 12 months; conditions place patient at significant risk of death, exacerbation or functional decline; comprehensive care plan established, revised or monitored	Covers only 20 minutes per month. Would apply only to limited number of arthroplasty patients who have multiple chronic conditions managed by the orthopaedic surgeon
99215	Office/ outpatient visit, established patient	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of 3 key components:	Not applicable to arthroplasty preservice time as these services must be performed on the day of a face-to-face visit.
99XXX (beginning 2021)	TBD Prolonged Service With or Without Direct Patient Contact on the Date of an Office or Other Outpatient Service	Prolonged office or other outpatient E/M service(s) (beyond the total time of the primary procedure which has been selected using total time), requiring total time with or without direct patient contact beyond the usual service, on the date of the primary service, each 15 minutes	Not applicable to arthroplasty preservice time as these services must be performed on the day of a face-to-face visit. Intended for walk-in disaster/trauma care.
G2064	Principal Care Management (physician)	Comprehensive care management services for a single high-risk disease, e.g., principal care management, *at least 30 minutes of physician or other qualified health care professional time* per calendar month with the following elements: • one complex chronic condition lasting at least 3 months, which is the focus of the care plan; the condition is of sufficient severity to place patient at risk of hospitalization or have been the cause of a recent hospitalization; the condition requires development or revision of disease specific care plan; the condition requires frequent adjustments in the medication regimen, and/or; the management of the condition is unusually complex due to comorbidities	Seems very similar to preoptimization work performed by orthopaedic surgeons for many arthroplasty patients but limited to those with complex chronic condition, which is common but not universal.
G2065	Principal Care Management (clinical staff)	Comprehensive care management for a single high-risk disease services, e.g. principal care management, at least 30 minutes of *clinical staff time directed by a physician or other qualified health care professional*, per calendar month with the following elements: • one complex chronic condition lasting at least 3 months, which is the focus of the care plan; the condition is of sufficient severity to place patient at	Seems very similar to preoptimization work performed by orthopaedic surgeons for many arthroplasty patients but limited to those with complex chronic condition, which is common but not universal.

HCPCS/ CPT Code	Short Description	Long Description	Reactions/Feedback
		risk of hospitalization or have been the cause of a recent hospitalization; the condition requires development or revision of disease specific care plan; the condition requires frequent adjustments in the medication regimen, and/or; the management of the condition is unusually complex due to comorbidities	
GXXX1 **GXXX2**	Preoperative personalized optimization plan for surgery (includes all classes and phone calls)		