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AAHKS AMERICAN ASSOCIATION OF HIP AND KNEE SURGEONS

MEMORANDUM

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

Date: December 3, 2020

Re: Summary of the Final 2021 Medicare Payment Rules: Physician Fee Schedule; Outpatient Prospective Payment System; and Ambulatory Surgical Center Proposed Rules

This week, the Centers for Medicare & Medicaid Services (CMS) released both the CY 2021 Medicare Physician Fee Schedule (PFS) final rule and the CY 2021 Medicare Hospital Outpatient Prospective Payment System and Ambulatory Surgical Center Payment System (OPPS & ASC) final rule. In October, AAHKS submitted comments in response to these proposed rules. The following is a summary of CMS actions in the final rules related to the comments submitted by AAHKS.

See the last page for a table summarizing proposed changes in Medicare rates in 2021.

PHYSICIAN FEE SCHEDULE

CMS Finalizes RUC Recommended Cut in TKA and THA Reimbursement Codes of 3.4%

- CPT codes 27130 and 27447 were nominated as potentially misvalued and were resurveyed for the October 2019 AMA RUC meeting. CMS proposed to accept the RUC recommendation of a reduced work RVU of 19.60 for both codes. This 5.4% cut in work RVUs leads *to a reduction in physician payment rates for TJA of approximately 3.4%*.

- Throughout the summer and early fall, AAHKS leadership and lobbyists held teleconferences and virtual meetings with numerous officials at CMS, the Department of Health and Human Services, and the White House Office of Management and Budget to summarize the arguments from the AAHKS comment letter in support of maintaining current wRVU levels: (1) the RUC-recommended levels are well below the RUC survey results; (2) the RUC did not account for arthroplasty preservice optimization work which both the RUC and CMS acknowledge is performed; (3) extensive independent data confirms preservice optimization time; and (4) there are no existing CPT codes that are appropriate to capture this preservice time.

- *CMS states that they are finalizing the RUC recommended wRVU levels of 19.60 for CPT code 27130 and 19.60 for CPT code 27447 in spite of "many commenters in overall opposition to the proposal."* One commenter was in support of CMS accepting the RUC recommendation and believes "accepting the RUC recommendation will address the

reimbursement imbalance, increase the primary care workforce, and improve the finances in primary care."

- Regarding AAHKS comments, CMS stated, "We appreciate the commenters' feedback about maintaining the work RVU and potential resource costs that are not reflected in the RUC recommendation. We are also appreciative of the dialog we have had with stakeholders. We continue to assess the accuracy of service valuations, including global services paid under the PFS, and believe it would be prudent before considering further changes to better understand how existing codes that could be billed prior to these procedures do not reflect the pre-optimization activities as described by stakeholders . . .

  "As we continue to consider this issue and how to best reflect pre-optimization in the valuation for the services, we welcome information from stakeholders as to which services may be included or which coding selections would be appropriate for various services that are or would be provided outside of the global period. We continue to be interested in stakeholders' thoughts and would like to discuss and consider the potential for more accurate coding, and what kind of coding framework, if there is currently none, could be used to capture these pre-optimization activities."

Additional Cuts of 10% to Multiple Surgical Procedures, Including TKA and THA

- 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 in Medicare expenditures under improved rates for E/M services, CMS is reducing the PFS conversion factor to maintain "budget neutrality" in the PFS. CMS maintains that it lacks legal authority to waive these adjustments.

- *This reduction in the conversation factor is projected to reduce Medicare reimbursement for CPTs 27130 and 27447 by approximately 10%, in addition to the cuts due to the reduction in work RVUs.*

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OUTPATIENT PROSPECTIVE PAYMENT SYSTEM & AMBULATORY SURGICAL CENTER PAYMENT SYSTEM

Elimination of the Medicare Inpatient Only (IPO) List by 2024

- The IPO list was created by CMS in 2000 using its discretionary authority. CMS no longer believes that the IPO list is necessary to identify services that require inpatient care. CMS was persuaded by commenters who believe physicians should use their own judgement and by "significant developments in the practice of medicine that allow numerous services to be provided safely and effectively in the outpatient setting."

- CMS will begin by removing approximately 300 musculoskeletal-related services from the IPO list in 2021, including procedures identified by the following CPT codes:
    - 27702 (Arthroplasty, ankle; with implant [total ankle]); 27703 (Arthroplasty, ankle; revision, total ankle); 27445 (Arthroplasty, knee, hinge prosthesis [for example, walldius type]); 27487 (Revision of total knee arthroplasty, with or without allograft; femoral and entire tibial component); 27488 (Removal of prosthesis, including total knee prosthesis, methylmethacrylate with or without insertion of spacer, knee); 27125 (Hemiarthroplasty, hip, partial [for example, femoral stem prosthesis, bipolar arthroplasty]); 27132 (Conversion of previous hip surgery to total hip with or without autograft or allograft); 27134 (Revision of total hip arthroplasty; both components, with or without autograft or allograft); 27137 (Revision of total hip arthroplasty; acetabular component only, with or without autograft or allograft); 27138 (Revision of total hip arthroplasty; femoral component only, with or without allograft); and 27140 (Osteotomy and transfer of greater trochanter of femur [separate procedure]).

- CMS will continue to remove procedures until the IPO list is completely phased out in 2024.

Interaction between Inpatient Hospital Admissions and the 2-Midnight Rule

- As procedures are removed from the IPO list, the Medicare 2-Midnight Rule applies. Earlier, CMS proposed that for the first 2 years following a procedure's removal from the IPO list, that procedure would be exempt from:
    - Automatic site-of-service claim denials;
    - Beneficiary and Family-Centered Care Quality Improvement Organizations (BFCC-QIOs) referrals to RACs; and
    - RAC reviews for "patient status" (or site-of-service)

- AAHKS commented that procedures removed from the IPO list should be exempt from review for a period longer than 2 years. AAHKS made the point that additional time would necessary fully to educate physicians, hospital compliance departments, and CMS-contracted auditors and inspectors.

- In response to these comments, CMS announced in the final rule that the period of exemption for site-of-service review would be extended indefinitely until such time as the procedure is widely performed in the outpatient setting. During this exemption, short-stay inpatient claims could still be reviewed for medical necessity of the underlying services and to educate providers and practitioners regarding compliance with the 2-midnight rule, but claims would not be denied based on site of service alone.

Major Expansion of the List of ASC Covered Surgical Procedures

- CMS finalizes its proposal to add THA and 10 other procedures to the ASC covered procedures list (CPL) under its normal process for adding new procedures. Specifically addressing THA, CMS proposed adding THA to the CPL based on their belief that a subset of Medicare beneficiaries may be suitable candidates to receive THA procedures in ASC setting, physicians should continue exercising clinical judgment for site-of-service determinations, and THA meets existing regulatory requirements for covered surgical procedures in the ASC setting.

- CMS also adopts a new, second method to add procedures to the ASC CPL. What had earlier been 5 factors under which CMS would exclude procedures from the CPL are now 5 factors that individual physicians should consider when determining whether a procedure should be performed on a patient in an ASC. 267 surgery or surgery-like codes are therefore added to the 2021 ASC CPL.

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Medicare Payment Trends for Hip and Knee Surgeries in the United States

Code (DRG/CPT)	2017		2018		2019		2020		2021		% Change from 2020
	Weight	Rate	Weight	Rate	Weight	Rate	Weight	Rate	Weight	Rate	
IPPS[1],[2]											
469	3.2906	$19,756.47[3]	3.201	$17,837.66	3.1742	$17,921.78	3.1399	$18,200.84	3.0989	$18,530.61	**+1.8%**
470	2.0671	$11,777.82[4]	2.0543	$11,447.64	1.9898	$11,234.56	1.9684	$11,410.09	1.9104	$11,423.69	**+0.1%**
521[5]	--	--	--	--	--	--	--	--	3.0652	$18,329.99	**--**
522[6]	--	--	--	--	--	--	--	--	2.1943	$13,121.34	**--**
OPPS											
27130	--	--	--	--	--	--	147.2988	$11,899.38	148.7344	$12,314.76	**+3.4%**
27447	--	--	128.7225	$10,122.22	134.7827	$10,713.88	147.2988	$11,899.38	148.7344	$12,314.76	**+3.4%**
27429*	110.4967	$4,974.12	128.7225	$10,122.22	134.7827	$10,713.88	147.2988	$11,899.38	148.7344	$12,314.76	**+3.4%**
ASC											
27130	--	--	--	--	--	--	--	--	180.4429	$8,833.04	**--**
27447	--	--	--	--	--	--	180.3081	$8,609.17	179.2409	$8,774.20	**+2%**
27429*	110.4967	$4,974.12	111.2415	$5,069.83	151.2694	$7,041.74	224.0958	$10,717.80	211.7260	$10,364.41	**-1.7%**
PFS											
27130[7]	35.8887	$1,403.61	35.9996	$1,409.74	36.039	$1,408.77	36.0896	$1,415.07	32.4085	$1,227.63	**-13.3%**
27447[8]	35.8887	$1,402.89	35.9996	$1,408.30	36.039	$1,408.05	36.0896	$1,413.27	32.4085	$1,226.01	**-13.3%**

[1] **National Payment Amount** – Projected by CMS of the baseline amount that will be paid nationally for the MS-DRG. This amount **DOES NOT INCLUDE** facility-specific calculation of teaching, disproportionate share, capital, and outlier payments for all cases. *With the exception of 2017, see footnote 2.*

[2] Assumes hospital reported quality data and is a meaningful EHR user.

[3] **National Average Amount** – Amount calculated in later years that represents that average amounts actually paid to facilities for Medicare's share of the MS-DRG. This calculation **INCLUDES** the MS-DRG amount, teaching, disproportionate share, capital, and outlier payments for all cases. Medicare payments DO NOT include beneficiary co-payments and deductible amounts nor any additional payments from third parties for coordination of benefits. Data is available through 2017.

[4] National Average Amount.

[5] **New DRG code finalized for 2021** "hip replacement with principal diagnosis of hip fracture with MCC"

[6] **New DRG code finalized for 2021** "hip replacement with principal diagnosis of hip fracture without MCC"

[7] **Total RVUs** – 2020 (39.21); 2021 (37.88)

[8] **Total RVUs**: 2020 (39.16); 2021 (37.83)