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AMERICAN ASSOCIATION OF
HIP AND KNEE SURGEONS

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VIA REGULATIONS.GOV FILING

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS 1770-P
P.O. Box 8016
Baltimore, MD 21244-8016

RE: 2023 Medicare Physician Fee Schedule Proposed Rule

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 physician fee schedule (PFS) proposed rule for calendar year 2023 (hereinafter referred to as "2023 PFS proposed rule" or "proposed rule").

AAHKS is the foremost national specialty organization of more than 4,600 physicians with expertise in total joint arthroplasty (TJA) procedures. Many of our members conduct research in this area and are experts on the evidence-based medicine issues associated with the risks and benefits of treatments for patients suffering from lower extremity joint conditions. AAHKS is guided by three principles:

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

Our comments on the 2023 PFS Proposed Rule are as follows:

I. Conversion Factor

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.

The proposed 2023 PFS conversion factor is $33.08, a decrease of $1.53 to the 2022 PFS conversion factor of $34.61. This conversion factor accounts for (1) the statutorily required update to the conversion factor for CY 2023 of 0%, (2) 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 (3) the statutorily required budget neutrality adjustment (-1.5%) to account for earlier increases in RVUs for E/M services. The reductions to the conversion factor are primarily responsible for the 9% drop in Medicare reimbursements to physicians for TJA in the last three years. Wild fluctuations of this nature are unsustainable for physicians and CMS should join physician associations in calling on Congress for a reform of the conversion factor to remove the requirement for budget neutrality adjustments.

II. Strategies for Improving Global Surgical Package Valuation (Sec. II.B.6)

In preparation for future rulemaking, CMS seeks public comment on strategies to "improve the accuracy of payment for the global surgical packages (herein referred to as ''global packages") under the PFS. CMS states it 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".

a. Data Collection, Analysis, and Findings

CMS bases its concerns on several 2019 RAND reports that found that, according to claims-based data, the reported number of E/M visits matched the expected number for only four percent of reviewed 10-day global packages and 38 percent of reviewed 90-day global packages. As it seeks other data sources on global surgical package visits, we remind CMS that it obtains data on post-operative visits for each procedure through RUC-managed physician surveys. It is likely more accurate to value individual procedures through procedure-specific surveys.

We have concerns over whether one broad CMS policy on valuing all global surgical packages can accurately capture the nuances in postoperative needs across all specialties and procedures. A comprehensive valuation process for all global surgical post-operative visits calls into question the ongoing role of RUC-managed surveys.

b. CMS Cannot Improve Payment Accuracy by Focusing Only on Post-Operative Visits

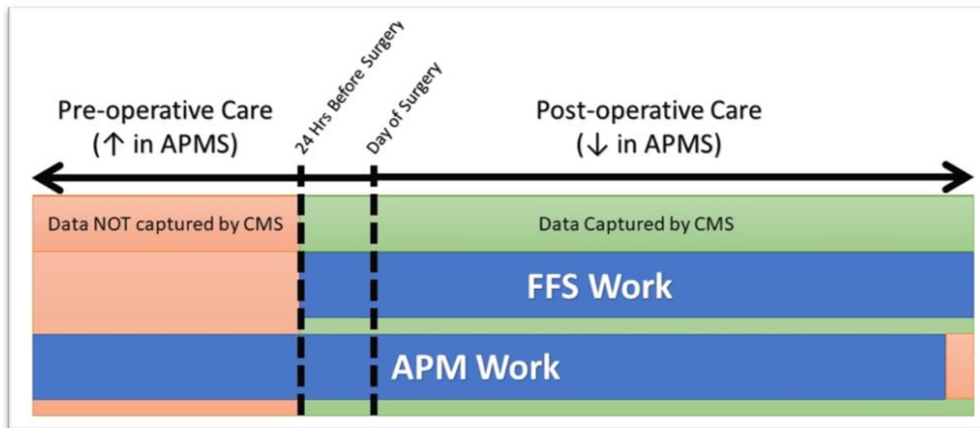
If CMS wishes to "improve the accuracy of payment for the global surgical packages" it can require the RUC to recommend wRVUs based upon a consistent percentile level from physician surveys. As discussed below regarding the valuation for CPT 27447, when the RUC and CMS have actual physician work survey data, they use wildly varying percentiles to set value. The arbitrary nature of the valuation (median amount for some procedures, 25th percentile for some procedures, below 20th percentile for others), suggests that CMS is motivated, not by standards for payment accuracy, but by reducing program expenditures.

Another necessary element to "improve the accuracy of payment for the global surgical packages" is for CMS to look at the entire global surgical package and not post-operative visits alone. The shift to value-based care in the last decade has led to evolutions in how many surgical procedures are managed which requires a new comprehensive consideration on assessing value.

Orthopaedic surgeons, and THA and TKA procedures specifically, have been at the forefront of the transition to value-based care as high-volume, high-value procedures 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. Our members' work within CJR and BPCI-A models has improved outcomes, reduced patient time spent in the hospital, and subsequently saved Medicare hundreds of millions of dollars.

Much of the effectiveness of these programs, however, has come from the shift from reactive, hospital-based postoperative work to proactive, office-based preoperative work. Our members and associated qualified health professionals, 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 fall outside of the global surgical bundle because they are not included in the traditional RUC survey definition of "pre-service activities," nor the time clinical staff spent providing certain pre-service activities for the patient and family.

Increase in Arthroplasty Preservice Optimization Time Due to Value-Based Care



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 performed under the CJR and resulted in a 3.1% reduction in Medicare spending

for Total Knee Replacement and Total Hip Replacement.[1] 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.

Penalizing surgeons for this successful collaboration, by reducing valuation for post-operative visits while not reimbursing preservice optimization time, does not lead to more accurate payments. We encourage CMS to evaluate whether current global surgical bundles are capturing all pre- and post-operative work and consider whether CPT codes exist for work performed outside the bundles.

We wish to echo the comments of our colleagues at the Bone Health and Osteoporosis Foundation and the American Society for Bone and Mineral Research who have argued that Medicare's global payment structures contribute to the osteoporosis care gap as orthopedic surgeons treating an acute conditions like fracture are not compensated for the time and services required to address the underlying chronic condition of osteoporosis.

III. Valuation of Specific Codes - Knee Arthroplasty (CPT 27446 & 27447) (Sec. II.E.3.b.4(6))

a. 27447

CMS proposes to maintain the wRVUs for CPT 27447 consistent with the RUC recommendation of the same valuation implemented for 2021. We agree that the wRVUs should not be reduced in 2023. However, we note that CPT 27447 has been undervalued since its reduction in 2021.

The current wRVU is based upon the AMA RUC's recommendations following a 2019 survey of 206 orthopaedic surgeons. AAHKS and the American Association of Orthopaedic Surgeons (AAOS) conducted the survey with a RUC approved survey instrument. At the time, AAHKS and AAOS recommended maintaining the then current wRVU levels of 20.72 as appropriate and supported by evidence, noting that the median wRVU value from the survey was 24.00. The 25th percentile results were 22.50 for THA and 22.14 for TKA. The value of 20.72 was already below the 20th percentile of the RUC survey results.

wRVU Until 2021	Median wRVU RUC 2019 Survey Results	25th Percentile of wRVU RUC Survey Results	AAHKS Recommended wRVU	Current RUC-recommended wRVU Since 2021
20.72	24.00	22.50 (THA) 22.14 (TKA)	20.72	19.60

CMS accepted the RUC-recommended level of 19.60 wRVUs even though it was even further below the 20th percentile. This punitive, low recommendation is in stark contrast to wRVUs assigned to revised evaluation and management (E/M) codes which were based on the

[1] 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.

median of the RUC's survey results. We maintain that CPT 27447 and 27130 are undervalued due to the RUC and CMS arbitrarily using different percentiles from surveys to assign wRVUs. The integrity of disinterested, transparent rate-setting under the PFS would be improved by a policy of basing wRVUs uniformly on the same percentile of physician survey results.

b. Additional Background on Prior RUC Valuation of CPT 27447

In discussing the RUC recommended valuation of CPT 27447, CMS states the following:

> We previously reviewed CPT code 27447 in the CY 2021 PFS final rule;(see 85 FR 84609 and 84610 for our previous discussion). *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.[2]

We appreciate CMS including language noting support of the RUC for the concept that arthroplasty preservice optimization time is currently not captured. However, we wish to identify some misstatements in this preamble excerpt. For instance:

- "*The RUC proposed a revised survey instrument to ask about additional pre-operative time and resources spent on pre-optimization patient work*."

The RUC *never* proposed a revised survey instrument for preservice time. In fact, at the October 2019 RUC meeting, the RUC specifically rejected a proposal for a revised survey instrument to ask about additional pre-operative time and resources spent on pre-optimization patient work.[3] Also,

- "*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.*"

Per the meeting minutes, the RUC suggested the possible use of current prolonged services, CPT 99358-99359. However, the minutes also make clear that the RUC then acknowledged that prolonged service codes could not be used because the standard of practice is that arthroplasty preservice time occurs over several days, not one single day as described in the prolonged service codes.[4] Nevertheless, AAHKS continues to work with the AMA and the CPT

[2] 87 FR 45912 (July 29, 2022) (emphasis added).
[3] See AMA/Specialty Society RVS Update Committee, Meeting Minutes, pg. 27 (Oct. 2019). Available at https://www.ama-assn.org/system/files/2020-11/oct-2019-ruc-meeting-minutes.pdf.
[4] Id.

Editorial Panel to clarify whether there are existing codes that are appropriate for use by orthopaedic surgeons to bill for arthroplasty preservice optimization service time.

c. *Increases in Other RVUs for CPTs 27447 & 27130*

We support the small, proposed increases in RVUs for practice expense and malpractice insurance for these codes. These increases mostly offset the reduction in the 2023 conversion factor, leading to level TJA reimbursement rates for 2023.

d. *Arthroplasty Illustrating Need for Reform in PFS*

Notwithstanding CMS' proposed level reimbursement to physicians for TJA services in 2023, recent trends in Medicare rates for TJA services for different classes of providers makes clear that coordination and consistency is lacking between Medicare payment systems. Medicare payments for the professional component of arthroplasty have been cut by more than 9% since 2020, while Medicare payments to facilities for the same procedures have skyrocketed.

AAHKS generally supports increased payment rates to facilities for arthroplasty due to the extreme complexity of the procedure, innovations in the standard of care and outcomes, and to recognize increased costs through the COVID-19 public health emergency (PHE). Nevertheless, the ongoing annual increases in Medicare facility payments for arthroplasty present a stark contrast with severely decreasing Medicare physician payments for arthroplasty.

It is unjust that Medicare payment formulas make physicians carry the burden of cost reductions while hospital payments continue to increase. This is especially unjust given that the Medicare physician fee makes up only 6% of the overall episode of care cost. Reduced reimbursement may prevent surgeons from sustaining independent practices, which may lead to mergers and consolidation. Consolidation leads to fewer choices for consumers across the care continuum, higher prices, and decreased access to care—particularly in rural and underserved areas. Reduced reimbursement for THA/TKA can also lead to surgeons shifting their focus to other procedures and conditions for which they have trained, despite the accelerating need for joint replacement in the Medicare age eligible population.

While payments under the IPPS, OPPS and PFS may be calculated according to separate statutory formulas, CMS and Congress should be alarmed at the divergent trends in facility and surgeon reimbursement for arthroplasty. CMS should explicitly state whether it believes that Medicare beneficiaries and the health care system are best served by rapidly increasing reimbursement rates to facilities for arthroplasty paired with severe cuts to the professional services for those procedures, and if so, why. If not, CMS should articulate to Congress any necessary adjustments to statutory reimbursement formulas so that there may be a unified coordinated CMS policy towards the value of arthroplasty. The disturbing and divergent trends are apparent when tracked as follows:

- **2023 Physician Payment for CPT 27447 (TKA) - $1,277.88 (down 10.7% since 2020)**
- **2023 OPPS Payment for CPT 27447 (TKA) - $13,274.06 (up 30% since 2018)**
- **2023 ASC Payment for CPT 2447 (TKA) - $9,351.90 (up 8.6% since 2020)**
- **2023 IPPS Payment for DRG 469 (Knee replacement with MCC - $20,502 (up 15% since 2018)**

IV. Request for Information - Dental Services Integration and Joint Replacement Surgery (Sec. II.L)

Medicare does not cover general dental care, but Medicare Part B currently pays for dental services when they are integral to medically necessary services required to treat a beneficiary's primary medical condition. CMS seeks 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.

We thank CMS for its thoughtful consideration of providing Medicare beneficiaries coverage for medically necessary dental care. Access to covered dental care is unquestionably needed by Medicare beneficiaries who are candidates for, and recipients of, joint replacement procedures. Accordingly, we offer the following guidance for such medically necessary coverage based on generally accepted clinical principles and standards of care:

- Any patient undergoing hip or knee arthroplasty is at risk for infection. These risks are significantly increased in patients with dental disease or poor oral hygiene. Best practices for our surgeons include a dental evaluation in patients at risk prior to arthroplasty. This is particularly important for the poor and disenfranchised. A dental infection is also disastrous in post-operative patients. Prompt, appropriate evaluation of oral infection is critical in patients after surgery.

- Relevant diseases/conditions[5]
    - Arthroplasty (pre- and post-surgery)
    - Fractures / Dislocations
    - Rheumatoid Arthritis
    - Arthrodesis*
    - Bone cancers (primary or metastatis)*
    - Orthopedic Hardware (status post)*
    - Osteomyelitis*

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[5] Those without an asterisk have a significant risk of compromised medical outcomes from unresolved dental infections. A similar medical need for dental evaluation and therapies selectively exists for those listed with an asterisk if the patient is or will be immunosuppressed, or is in a state of chronic inflammation.

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,

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