



AMERICAN ACADEMY OF
ORTHOPAEDIC SURGEONS

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March 1, 2018

Seema Verma, MPH
Administrator
Centers for Medicare & Medicaid Services (CMS)
7500 Security Boulevard
Baltimore, MD 21244

Re: Medicare Advantage coverage denials for inpatient and forced outpatient site of service for total knee replacements

Dear Administrator Verma:

On behalf of over 34,000 orthopaedic surgeons and residents represented by the American Association of Orthopaedic Surgeons (AAOS), we are writing to request your intervention on widespread Medicare Advantage (MA) denials for inpatient total knee arthroplasty (TKA), CPT code 27447.

As you know, in the 2018 Outpatient Prospective Payment System (OPPS) Final Rule, TKA was removed from the Inpatient-Only List (IPO) effective January 1, 2018. CMS was explicit in that the *“removal of the TKA procedure from the IPO list does not require the procedure to be performed only on an outpatient basis. Removal of the TKA procedure from the IPO list allows for payment of the procedure in either the inpatient setting or the outpatient setting.”* Moreover, CMS was again clear in its decision to delay allowing TKA to be performed in an Ambulatory Surgery Center (ASC) by stating *“[w]hile we are finalizing our proposal to remove CPT code 27447 from the OPPS IPO list for CY 2018, we are not adding the procedures to the ASC covered surgical procedures list for CY 2018.”*

AAOS appreciates CMS’ intent in allowing outpatient TKA procedures and the thoughtful way the removal was discussed in the Final Rule. In our comments to the Proposed Rule, AAOS shared concerns regarding the unintended consequence of forced outpatient care and the potential for payers to drive care to specific facilities based on cost alone. As expected, there have been widespread denials for inpatient TKA among MA plans across the country. Based on the new MA policy, commercial payers are denying coverage, citing “CMS Guidelines.”

One of our members was told by Humana North Carolina (in partnership with Alignment Healthcare) that seventy-five percent of TKAs should be done as an outpatient and all TKAs must be booked as an outpatient with the expectation that twenty-five percent would later be converted to inpatient. We have heard several members echo similar experiences. Humana of

Florida denied an inpatient procedure citing that TKA *“is no longer an inpatient procedure according to CMS Guidelines.”* Even more concerning is the denial from a Wisconsin MA plan which states *“this type of procedure can be routinely performed as an Ambulatory or outpatient procedure.”* In some instances, providers are told to keep the patient under observation, if necessary. The decision to hold a patient’s discharge is often made after business hours, forcing hospitals to keep the patient without knowing whether they will be paid.

The AAOS believes that an outpatient TKA procedure would be appropriate only for carefully selected patients who are in excellent health, with no or limited medical comorbidities and sufficient caregiver support. In fact, CMS stated in the Final Rule that *“[w]e believe that there is a subset of less medically complex TKA cases that could be appropriately and safely performed on an outpatient basis. However, we do not expect a significant volume of TKA cases currently being performed in the hospital inpatient setting to shift to the hospital outpatient setting as a result of removing this procedure from the IPO list. At this time, we expect that a significant number of Medicare beneficiaries will continue to receive treatment as an inpatient for TKA procedures. We do not expect a significant shift in TKA cases from the hospital inpatient setting to the hospital outpatient setting.”*

AAOS supported the removal contingent upon provider-driven identification of appropriate patients for an outpatient TKA procedure. Provision of adequate and safe care to a Medicare beneficiary should be determined through shared decision-making within the patient-surgeon relationship. In addition to the capabilities of a specific facility to treat certain orthopaedic conditions, availability of post-operative care, and a safe home environment must be considered. That said, rigid site of service criteria is not appropriate for the Medicare population at this time. Ultimately, the surgeon must be free to define the appropriate site for a surgical procedure on a case-by-case basis. CMS supported our position, stating *“[w]e agree that the physician should take the beneficiaries’ need for post- surgical services into account when selecting the site of care to perform the surgery. We would expect that Medicare beneficiaries who are selected for outpatient TKA would be less medically complex cases with few comorbidities and would not be expected to require SNF care following surgery. Instead, we expect that many of these beneficiaries would be appropriate for discharge to home (with outpatient therapy) or home health care. We believe that comprehensive patient selection protocols should be implemented to properly identify these beneficiaries. However, we do not believe that Medicare should establish such protocols and believe that physicians and providers should select an appropriate patient selection protocol.”*

We appreciate that CMS is prohibiting the Recovery Audit Contractor (RAC) from denying a hospital claim for patient status for TKA procedures performed in the inpatient setting for a period of 2 years. We believe this decision was made to allow time to gain experience in performing TKA in the outpatient setting. The forced move to the outpatient setting does not echo this intent.

Given the discussion above, AAOS requests that CMS provide education and clarifying guidance for Medicare Advantage plans. Moreover, we believe that minimum coverage standards are

necessary in light of flawed MA policies, especially those which blatantly distort CMS Guidelines. We have provided a sample of MA plans denying inpatient TKA at the end of this letter. The list is not exhaustive. There are also examples of denials from Humana and Network Health. Thank you for considering our comments on this issue. If you have any questions or comments, please do not hesitate to contact William Shaffer, MD, AAOS Medical Director by email at shaffer@aaos.org.

Sincerely,

A handwritten signature in black ink that reads "William J. Maloney". The signature is fluid and cursive, with a large, sweeping loop at the end of the name.

William J. Maloney, MD
President, AAOS

Cc: David A. Halsey, MD, First Vice-President, AAOS
Kristy L. Weber, MD, Second Vice-President, AAOS
Thomas E. Arend, Jr., Esq., CAE, CEO, AAOS
William O. Shaffer, MD, Medical Director, AAOS

Sample of MA plans defaulting to outpatient TKA

Florida- Humana

Kentucky

North Carolina- Humana North Carolina /Alignment Healthcare

Pennsylvania

Texas (commercial plans using "CMS guidelines")- Blue Cross & Blue Shield, AETNA

Wisconsin- Network Health, Anthem Mediblu Access PPO, UHC T-19 (Badger care +),

Anthem Mediblu Plus HMO, Network Platinum Choice PPO (Network Health), Medicare- Blue

Cross OOS, Network Health Medicare, Network Health COMMERCIAL,

UHC of WI T-19/Americhoice

Effective 1/1/2018 CPT code 27447 is no longer an inpatient procedure according to CMS Guidelines.
Please resubmit this request as an Outpatient Procedure.

Humana
1/2/18 DOS
Florida

88 year old patient (was approved after a
peer to peer)



Important: This notice explains your right to appeal our decision. Read this notice carefully. If you need help, you can call one of the numbers listed on the last page under "Get help & more information."

Notice of Denial of Medical Coverage

Date: February 9, 2018

Member number

Na

Your request was denied

We've *denied* the medical services/items listed below requested by you or your provider:

Acute inpatient hospital stay under Medicare Part A beginning 1/26/2018 following a right total knee arthroplasty.

Why did we deny your request?

We *denied* the medical services/items listed above because:

Network Health Medicare Advantage plans cover inpatient surgical admission according to Medicare Guidelines (2018 Evidence of Coverage Medicare Benefits Chapter 4, Section 2).

A Network Health nurse did a preliminary review of the clinical information provided using MCG criteria: S-700 (Knee Arthroplasty, Total) for an inpatient surgery for right total knee arthroplasty beginning 1/26/2018 at Orthopaedic Hospital of WI Sports Medicine and Rehab. Information was forwarded to the Medical Director to apply medical knowledge and expertise to render a determination.

After Medical Director review, the right total knee arthroplasty procedure itself is approved, but the request for an inpatient hospital admission following surgery is denied at this time. The type of surgery indicated can be performed in an alternate setting, such as Observation, Ambulatory, or Outpatient. Network Health can review your case upon admission to the hospital after your procedure to determine if there is a change in your medical condition that would require an inpatient level of care.

You have the right to obtain a copy of the benefit provision, guideline, protocol or other similar criterion used in making this determination. Your treating practitioner may call Network Health to discuss this decision. To request a copy of this information or for your practitioner to discuss this decision, please call the care management department at 920-720-1602. You should share a copy of this decision with your doctor so you and your doctor can discuss next steps. If your doctor requested coverage on your behalf, we have sent a copy of this decision to your doctor.

You have the right to appeal our decision

You have the right to ask Network Health Medicare Advantage Plans to review our decision by asking us for an appeal.

Plan Appeal: Ask Network Health Medicare Advantage Plans for an appeal within **60 days** of the date of this notice. We can give you more time if you have a good reason for missing the deadline. See section titled "How to ask for an appeal with Network Health Medicare Advantage Plans" for information on how to ask for a plan level appeal.

If you want someone else to act for you

You can name a relative, friend, attorney, doctor, or someone else to act as your representative. If you want someone else to act for you, call us at 800-378-5234 to learn how to name your representative. TTY users call 800-947-3529. Both you and the person you want to act for you must sign and date a statement confirming this is what you want. You'll need to mail or fax this statement to us. Keep a copy for your records.

Important Information About Your Appeal Rights

There are 2 kinds of appeals with Network Health Medicare Advantage Plans

Standard Appeal – We'll give you a written decision on a standard appeal within **30 days** after we get your appeal. Our decision might take longer if you ask for an extension, or if we need more information about your case. We'll tell you if we're taking extra time and will explain why more time is needed. If your appeal is for payment of a service you've already received, we'll give you a written decision within **60 days**.

Fast Appeal – We'll give you a decision on a fast appeal within **72 hours** after we get your appeal. You can ask for a fast appeal if you or your doctor believe your health could be seriously harmed by waiting up to 30 days for a decision.

We'll automatically give you a fast appeal if a doctor asks for one for you or if your doctor supports your request. If you ask for a fast appeal without support from a doctor, we'll decide if your request requires a fast appeal. If we don't give you a fast appeal, we'll give you a decision within 30 days.

How to ask for an appeal with Network Health Medicare Advantage Plans

Step 1: You, your representative, or your provider must ask us for an appeal. Your *written* request must include:

- Your name
- Address
- Member number
- Reasons for appealing
- Whether you want a Standard or Fast Appeal (for a Fast Appeal, explain why you need one).
- Any evidence you want us to review, such as medical records, doctors' letters (such as a doctor's supporting statement if you request a fast appeal), or other information that explains why you need the item or service. Call your doctor if you need this information.

CMS does not discriminate in its programs and activities. To request this publication in an alternative format, please call 1-800-MEDICARE or email: AltFormat@cms.hhs.gov.

We recommend keeping a copy of everything you send us for your records. You can ask to see the medical records and other documents we used to make our decision before or during the appeal. At no cost to you, you can also ask for a copy of the guidelines we used to make our decision.

Step 2: Mail, fax, or deliver your appeal.

For a Standard Appeal: Address:
Network Health Medicare Advantage Plans
C/O Appeals and Grievances
PO Box 120
1570 Midway Place
Menasha, WI 54952
Fax: 920-720-1832

For a Fast Appeal: Phone: 800-378-5234 TTY users call: 800-947-3529 Fax: 920-720-1832

What happens next?

If you ask for an appeal and we continue to deny your request for a service, we'll send you a written decision and automatically send your case to an independent reviewer. **If the independent reviewer denies your request, the written decision will explain if you have additional appeal rights.**

Get help & more information

- Network Health Medicare Advantage Plans Toll Free: 800-378-5234 TTY users call: 800-947-3529 Monday-Friday, 8 a.m. to 8 p.m.
- 1-800-MEDICARE (1-800-633-4227), 24 hours, 7 days a week. TTY users call: 877-486-2048
- Medicare Rights Center: 888-HMO-9050
- Elder Care Locator: 800-677-1116 or www.edlcare.gov to find help in your community:

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1570 Midway Pl.
Menasha, WI 54952

February 13, 2018



Member: [redacted] *ADS: 3/8/18*

Member ID: [redacted]

Date of Birth: [redacted]

Request ID: [redacted]

Dear

Thank you for choosing Network Health for your health care coverage. Network Health works together with our care providers to make sure our members receive quality health care.

A Network Health nurse did a preliminary review of the clinical information provided using MCG criteria: S-700 Knee Arthroplasty, Total for an inpatient admission following R total knee arthroplasty (replacement) at Orthopaedic Hospital of Wisconsin LLC. Information was forwarded to the Medical Director to apply medical knowledge and expertise to render a determination.

After Medical Director review, the determination is that although the total knee arthroplasty (replacement) – CPT 27447 itself is approved, the request for an inpatient hospital admission following your procedure is denied. This decision is based on the fact that your risk is not considered high (such as decompensated medical conditions which would need more intense monitoring), so the request for inpatient admission beginning 3/8/2018 is denied. This type of procedure can be routinely performed as an Ambulatory or outpatient procedure. Network Health will review your case upon admission to the hospital after your procedure to determine if your medical condition at that time requires an inpatient level of care.

*-OK
SINK
BDC*

Your ET-2107cc (State of Wisconsin Group Health Insurance Program – 2018 Benefit Year) Certificate of Coverage (COC) does not allow coverage of inpatient stays that are not medically necessary or that are considered unproven, experimental, investigational or for research purposes under section IV. Exclusions and Limitations: Covered services do not include (page 50) ... q) Any service, treatment, procedure, equipment, drug, device or supply which is not reasonably and **MEDICALLY NECESSARY** or not required in accordance with accepted standards of medical, surgical or psychiatric practice.

Denial Code #50 service not deemed medical necessity

If you would like information on diagnosis/treatment codes and what they mean, along with our Network Health policies contact Network Health and they will be given at no cost. If you do not agree with or understand the reason for this denial, you have the right to ask Network Health to review its decision. Please read the information included with this letter to learn about the appeal

process. To file an appeal, please send your request (and any additional information you would like us to review) to our customer service department.

Network Health
Attention: Grievance Committee
P.O. Box 120
Menasha, WI 54952

If you have any questions about this letter, filing an appeal, or your insurance benefits, you may call our customer service department at 844-625-2208 or 920-720-1811 (TTY line users call 800-947-3529). Department hours are 8 a.m. – 5 p.m. Monday, Wednesday, Thursday and Friday and 8 a.m. – 4 p.m. on Tuesday.

You have the right to receive a copy of the actual benefit information, exclusion, guideline, medical policy or criteria used in making this decision. To request a copy of this information or speak with the medical director to discuss the determination, please call the care management department at 920-720-1600 or 800-236-0208. Please have the authorization ID available when you call with your request.

Sincerely,

Utilization Management

enclosure