



December 11, 2019

Gift Tee

Director, Practitioner Services, Center for Medicare

Centers for Medicare & Medicaid Services

Mail Stop: C1-13-077500 Security Blvd.

Baltimore, MD 21244

RE: Total Hip and Total Knee Arthroplasty RVU Recommendations

Dear Mr. Tee,

The American Association of Hip and Knee Surgeons (AAHKS) and the American Association of Orthopaedic Surgeons (AAOS) are writing in regard to the review of the work RVUs for Total Knee Arthroplasty and Total Hip Arthroplasty under the Medicare Physician Fee Schedule. We wish to inform CMS during its development of the 2020 Medicare Physician Fee Schedule Proposed Rule so that you may evaluate the AMA/Multispecialty Relative Value Update Committee's (RUC's) recommendations based on all the relevant data. We request an in-person meeting with you to further expand upon our data, enumerated in this letter, justifying maintaining current work RVUs for these codes to better reflect the time being spent on the procedures.

I. Private, For-Profit Insurance Company Nominates the Codes as Misvalued

The procedures, 27130, Arthroplasty, acetabular and proximal femoral prosthetic replacement (total hip arthroplasty), with or without autograft or allograft and 27447, Arthroplasty, knee, condyle and plateau; medial AND lateral compartments with or without patella resurfacing (total knee arthroplasty) were identified in the 2019 Medicare Physician Fee Schedule Final Rule as part of the potentially misvalued code initiative. The two services were part of a set of seven services that were nominated by a payer-Anthem Inc., who, while a public stakeholder, is also a stakeholder with a clear conflict-of-interest related to the Medicare Physician Fee Schedule.

CMS referred the codes to the RUC for review and the AAOS and AAHKS argued to the RUC and the CMS Practitioner Services department that 27130 and 27447 did not need to be surveyed as the previous, 2013 valuation was still appropriate for work RVU and minutes. AAOS and AAHKS also argued the Anthem Inc. request for review was problematic and not sufficient to justify a review and change in value. In particular, the AAOS and AAHKS believed and continue to believe, that Anthem's statement that the intra-service times from the 2013 RUC survey were not accurate was insufficiently supported by direct evidence and that the 2013 intra-service times represent an accurate assessment of the typical time required to perform the surgeries.

The AAOS and AAHKS believe the data in the Urban Institute report, cited by Anthem, regarding intra-service time had substantive shortcomings compared to the robust data from the RUC survey methodology. Only two institutions, both selected with input from CMS, form the basis of the analysis.

The sample size was small in comparison to the RUC survey data and important characteristics of the institutions and surgeons were not provided. Together, this results in a clear selection bias and, as the authors state, “these sites were very much a sample of convenience and should not necessarily be viewed as representative of other health systems.” In addition, the Urban Institute report was designed as a feasibility study to obtain empirical time data and an author of the report explicitly stated “not to rely on its’ results”. We believe that a random sample of surgeons with a broad range of volume and experience provides a more accurate estimate of intra-service time.

At the April RUC meeting, the AAOS and AAHKS presented to CMS and to the RUC data from additional sources to support this contention and the AAOS and AAHKS continue to believe this to be the case. Nevertheless, because the RUC requested an updated survey at the April 2019 RUC, the AAOS and AAHKS agreed to conduct a survey for review at the October 2019 RUC meeting.

II. Accounting for Time Related to Value-Based Care Through Expanded Survey Questions Was Not Allowed

The AAOS and AAHKS, in preparation for the RUC survey for CPT 27130 and 27447, sought to include two questions asking survey respondents to estimate the time the Physician/Qualified Health Care Provider (QHP) spends in specific pre-service activities that are not included in the standard RUC survey definition of pre-service activities for the patient and family, as well as the time clinical staff spend in providing specific pre-service activities for the patient and family (please see Appendix A for the proposed questions). The AAOS and AAHKS provided the RUC Research Subcommittee with a substantial body of literature and peer-reviewed evidence that Physicians/QHPs and clinical staff providing Total Knee Arthroplasty and Total Hip Arthroplasty services have seen a substantial increase in pre-service work to optimize patients through screening, education, and coordination of care by other health care providers such as a patient’s primary care physicians, physical therapists, and other activities required to ensure the best outcome for a patient’s surgery. The evidence is clear that additional time is spent, and that this additional time spent pre-operatively has resulted in improved clinical quality for patients, and significant savings in spending on the services by reducing patient lengths of stay post-operatively, and reducing readmissions and other complications.

This effort to improve the overall delivery of care in this procedure has been the result of considerable cooperation and collaboration amongst surgeons, hospitals, and payers, including the prominent efforts by the Center for Medicare & Medicaid Innovation (CMMI) through their Bundled Payments for Care Initiative (BPCI) and Comprehensive Care for Joint Replacement (CJR) programs. According to an April 2019 New England Journal of Medicine article, 42% of Medicare Total Knee Arthroplasty and Total Hip Arthroplasty 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.¹

Based on this evidence, the AAOS and AAHKS felt it was important to survey surgeons about the time they and their staff spend on this pre-operative work. However, the RUC Research Subcommittee voted to not allow a question about additional Physician/QHP time as they determined the RUC was obligated to include Physician/QHP time spent only on the day-of-surgery and 24-hours prior to the day-of-surgery. The RUC Research Subcommittee and the RUC maintain that this is CMS policy; however, the RUC did not ask CMS in advance whether the agency would welcome this additional information. Based

¹ Two year Evaluation of Mandatory Bundled Payments for Joint Replacement, Barnett, Michael L. et al., New England Journal of Medicine, Volume 380, Volume 6, 252-262. <https://www.nejm.org/doi/full/10.1056/NEJMsa1809010>

on our collaborative and productive relationship with CMS and CMMI, the AAOS and AAHKS believe that in fact CMS and CMMI would have welcomed this additional information as important to assessing the resources used in provision of the service in 2019 and that it is unfortunate the survey did not provide this information for CMS to consider in your review of the relative value of 27130 and 27447.

The AAOS and AAHKS also believe that, even without the survey results, there is considerable literature to establish that Physicians/QHPs and clinical staff are spending significant time in the pre-operative period for Total Knee Arthroplasty and Total Hip Arthroplasty and we urge CMS to add that time and associated Relative Value Units to the total time and work and Practice Expense RVUs for 27130 and 27447 in order to maintain the current RUC values.

III. Recommendation to Maintain Current Work RVUs Based on Survey Results

Subsequent to the final survey instrument review and approval by the RUC Research Subcommittee, the AAOS and AAHKS surveyed orthopaedic surgeons with the approved survey instrument and presented the results at the October 2019 RUC meeting. The AAOS and AAHKS recommended the RUC maintain the current work RVUs of 20.72, which is below the 25th % survey work RVUs of 22.50 and 22.14 respectively for both 27130 and 27447. The AAOS and AAHKS based this recommendation on the results from the survey indicating median intra-service time of 100 minutes for 27130 (equal to the intra-service time from the 2013 RUC survey) and 27447 of 97 minutes (3 minutes less than the 100 minutes from the 2013 RUC survey) and the pre-service and post-service times from the survey which included two hospital visits, a hospital discharge visit, and three post-discharge office visits in the 90-day global period for a total of 6 visits, with an additional 30 minutes of pre-service time for the time AAOS and AAHKS believe surgeons and/or QHPs spend in pre-operative optimization activities. The total time for 27130, with these recommended times are equal to the 2013 CMS accepted times of 407 minutes for 27130 and a reduction of 3 minutes to 404 minutes for 27447.

AAOS' and AAHKS' recommendations are shown in the table below.

CPT Code	27130	27447
Recommended Work RVU	20.72	20.72
Recommended Pre-Service Evaluation Minutes	70 minutes	70 minutes
Recommended Pre-Service Positioning Minutes	15 minutes	15 minutes
Recommended Pre-Service Scrub, Dress, and Wait Minutes	15 minutes	15 minutes
Recommended Intra-Service Minutes	100 minutes	97 minutes
Recommended Immediate Post-Service Minutes	20 minutes	20 minutes
Recommended Post-Operative Facility Visits Quantity and Level	2-99232 1-99238	2-99232 1-99238
Recommended Post-Operative Office Visits Quantity and Level	3-99213	3-99213
Recommended Total Time	407	404

The AAOS and AAHKS recommended to the RUC Practice Expense Subcommittee an increase of 30 minutes in pre-service clinical staff time for both 27130 and 27447. This recommendation was based

on the literature supplied by AAOS and AAHKS to the RUC, and the median time from a question on the survey instrument (see attachment B for the specific wording of the survey question) on pre-service clinical staff time.

IV. RUC Recommendations Acknowledge that Pre-Service Planning Activities Occur, but Recommend Reduction Regardless

At the October 2019 RUC meeting, the AAOS and AAHKS initial recommendations were not accepted and the RUC instead recommended a work RVU of 19.60 for both 27130 and 27447, with the following time components:

CPT Code	27130	27447
RUC Recommended Work RVU	19.60	19.60
RUC Recommended Pre-Service Evaluation Minutes	40 minutes	40 minutes
RUC Recommended Pre-Service Positioning Minutes	15 minutes	15 minutes
RUC Recommended Pre-Service Scrub, Dress, and Wait Minutes	15 minutes	15 minutes
RUC Recommended Intra-Service Minutes	100 minutes	97 minutes
RUC Recommended Immediate Post-Service Minutes	20 minutes	20 minutes
RUC Recommended Post-Operative Facility Visits Quantity and Level	2-99232 1-99238	2-99232 1-99238
RUC Recommended Post-Operative Office Visits Quantity and Level	3-99213	3-99213
RUC Recommended Total Time	377	374

In addition to the work RVU and time recommendations, the RUC also recommended no change in the practice expense clinical inputs, despite the RUC Practice Expense Subcommittee’s vote to accept compelling evidence that AAOS and AAHKS presented that the clinical staff work for 27130 and 27447 had changed from the previous valuation in 2013.

The RUC noted as part of their rationale for not accepting the 70 minutes of pre-operative evaluation time that they believe surgeons would be able to use CPT code 99358 to capture this time. Their summary submitted to CMS in October 2019 stated:

“The RUC agreed that the pre-service planning activities occur, however the current code and 090-day global period structure is not the way to capture it. 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. The RUC noted that the additional clinical staff activities would not be captured within the prolonged service codes.”

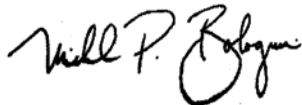
The AAOS and AAHKS appreciate the RUC's recognition of this work; however, we believe that there are more appropriate and expeditious ways to account for the additional pre-service planning work done by Physicians/QHPs and clinical staff as well; namely, assigning the additional time in the pre-operative periods for work and practice expense and maintaining the current work RVUs for 27130 and 27447. This would be consistent and not disrupt bundled payment efforts such as CJR and BPCI initiatives involving 27130 and 27447. In addition, it would align with the mission of the agency to encourage new, more efficient and more equitable payment models that properly incentivize quality efforts. CMS could take these actions in the 2020 Medicare Physician Fee Schedule Proposed Rule to ensure physicians are compensated for this value now, rather than undertaking the process of evaluating or creating alternative codes.

V. Conclusion

Orthopaedic surgeons have been strong partners with CMS and CMMI on efforts to improve the quality of care for Total Hip Arthroplasty and Total Knee Arthroplasty and we would like to continue that progress. Reductions in work RVUs, which do not reflect the time spent with patients, will undermine surgeons' ability to embrace and participate in the transition to value-based care. The potential to improve care for our patients and reduce overall Medicare expenditures through Advanced Alternative Payment Models and other value-based care arrangements should not be threatened by simultaneous reductions in work RVUs.

We would welcome an opportunity to address these recommendations and efforts at in-person meetings with the Practitioner Services Group at CMS at your earliest convenience. Thank you for your cooperation and your efforts in promoting high quality care for Total Joint Arthroplasty patients. We believe we can and will continue to build on all the positive work we have accomplished in the past five years in the future.

Sincerely,



Michael P. Bolognesi, MD
President, AAHKS



Kristy L. Weber, MD, FAAOS
President, AAOS

CC: Joseph A. Bosco, III, MD, FAAOS, First Vice-President, AAOS
Daniel K. Guy, MD, FAAOS, Second Vice-President, AAOS
Thomas E. Arend, Jr., Esq., CAE, CEO, AAOS
William O. Shaffer, MD, FAAOS, Medical Director, AAOS
C. Lowry Barnes, MD, 1st Vice President, AAHKS
Richard Iorio, MD, 2nd Vice President, AAHKS
Bryan D. Springer, MD, 3rd Vice President, AAHKS
James I. Huddleston III, MD, Chair, AAHKS Health Policy Council
Michael J. Zarski, JD, Executive Director, AAHKS