

September 6, 2016

Andrew M. Slavitt
Acting Administrator,
Centers for Medicare & Medicaid Services
Department of Health and Human Services,
Attention: CMS-5517-P, P.O. Box 8016,
Baltimore, MD 21244-8016.

Submitted electronically via <http://www.regulations.gov>.

**Subject: (CMS-1654-P)
Medicare Program; Revisions to Payment Policies under the Physician
Fee Schedule and Other Revisions to Part B for CY 2017; Medicare
Advantage Pricing Data Release; Medicare Advantage and Part D
Medical Low Ratio Data Release; Medicare Advantage Provider
Network Requirements; Expansion of Medicare Diabetes Prevention
Program Model**

Dear Acting Administrator Slavitt:

On behalf of the 18,000 board-certified orthopaedic surgeons who comprise the membership of the American Association of Orthopaedic Surgeons (AAOS) and that of the orthopaedic subspecialty groups who agreed to sign-on, we are pleased to provide comments on the Centers for Medicare and Medicaid Services' (CMS) Medicare Program's *Proposed Rule on Revisions to Payment Policies under the Physician Fee Schedule to Part B for CY 2017* published in the Federal Register on July 15, 2016.

The AAOS looks forward to working with CMS and other stakeholders to refine and improve the Medicare Physician Fee Schedule (MPFS) policies and regulations for CY 2017 and future years. Our specific comments on the proposed rule address the following provisions:

- **Proposed Revised or New Work Relative Value Units (RVUs) for Musculoskeletal Procedures:** The AAOS is concerned that the work values proposed by CMS for several musculoskeletal procedures do not reflect the full resources identified by the specialty societies. The AAOS is also very concerned that the values recommended by CMS have been arrived at using methodologies that are not consistent with the society and Relative Value Scale Update Committee (RUC) recommended values and therefore are not appropriately relative to other similar services. The AAOS recommends that CMS adopt

the RUC approved values and global period settings for the following procedures: Open Bone Biopsy Deep code (CPT code 20245), the Interlaminar/Interspinous process stabilization distraction device insertion codes (CPT codes 228X1, 228X3), the application of spine fixation device codes (CPT codes 22X81-22X83), closed pelvic ring fracture codes (CPT 271X1-271X2) and the Bunionectomy codes (CPT 282X1-282X2).

- **Mis-valued Code Initiative:** The AAOS supports CMS's efforts to review and update values for procedures under the MPFS. However, the AAOS notes that dozens of the codes listed for review in the 2017 MPFS proposed rule, do not, in fact, meet the screens described in the proposed rule.
- **Collection of Data Related to the Resources Used in Furnishing of Global Services:** The AAOS is very concerned with the methodology proposed by CMS to review and measure resources used in the provision of global services under the MPFS. In particular, the AAOS is concerned that the steps proposed by CMS, particularly the requirement that all providers use G-codes for all post-operative patient encounters are unnecessarily burdensome for physician and physician practices, will result in inaccurate data, and represent an overreach by the agency according to the language in the Medicare and CHIP Reauthorization Act (MACRA) of 2015 calling for CMS to collect data on resources used in the post-operative global period. AAOS strongly urges CMS to significantly revise their proposed methodology to not use the G-codes as proposed, to not make the claims reporting universal to all Medicare providers using global period codes, and to utilize representative samples of services and other approaches that are likely to yield more reliable and accurate data without imposing major burdens on hundreds of thousands of providers.
- **Implementation of Appropriate Use Criteria (AUC) for Advanced Imaging Services:** The AAOS supports the development of evidence-based appropriate use criteria and their use by payers and within the Medicare program. We recommend CMS engage directly with physician and provider stakeholders who will be charged with the implementation of the AUC for advanced imaging services in the conditions announced by the agency in the proposed rule.
- **Phase-In of Significant RVU Reductions:** The AAOS agrees with the CMS proposal to extend the phasing in of significant RVU reductions (20% or greater reduction in RVUs) over a period greater than a single year.
- **Future Changes to the Open Payments Data Program:** While the AAOS would support improvements to the Open Payments data program, we are concerned about suggestions that CMS may expand the already significant reporting burden on physician

practices. We therefore encourage CMS to not pursue additional reporting requirements at this time, particularly in light of the volume of data already available.

Our detailed comments are presented below.

Proposed Work RVUs for Musculoskeletal Codes

For 2017, CMS proposed new or revised work RVUs for dozens of musculoskeletal codes. The AAOS appreciates the opportunity to provide comments on new or revised values and screens related to the misvalued code initiative *before* the new values or screens are implemented. We encourage CMS to make available a full summary of the RUC recommendations and rationale. This would help stakeholders assess the merits of RUC recommended RVUs as compared to the RVUs proposed by CMS, especially when the recommendations diverge.

In many instances from the 2017 proposed rule, CMS proposed values lower than the RVUs recommended by the RUC. The AAOS recommends that CMS implement the RUC proposed values based on feedback from the relevant specialty societies, as noted below. We also strongly recommend that CMS rely on magnitude estimation for determining appropriate RVUs for new or revised HCPCS/CPT codes rather than a “building block” or “reverse building block” methodology where CMS adds or subtracts RVUs based on changes in the time or resource inputs. The use of these methodologies is highly inappropriate and results in inaccurate values which contaminate and undermine the relativity of the RBRVS. In many of the instances where CMS recommends a value different from the RUC, they use some form of building block or reverse building block methodology, and the AAOS strongly believes this is incorrect and recommend CMS change these recommended wRVUs to reflect the magnitude estimation derived values.

Open Bone Biopsy, Deep (CPT code 20245)

CPT code	Descriptor	RUC Rec RVU	CMS Proposed RVU	CMS Work RVU Decision
20245	Biopsy, bone, open; deep (e.g., humerus, ischium, femur)	6.50	6.00	Disagree

CPT code 20245, Open Bone Biopsy, Deep, was reviewed by the RUC and CMS as part of their potentially misvalued code initiative.

For 2017, CMS recommended 6.00 work RVUs for CPT code 20245 based on a crosswalk to the work RVU for CPT code 19298, Placement of radiotherapy after loading brachytherapy catheters into the breast. The RUC recommended work RVU of 6.50 based on a physician survey led by the AAOS which reflects current practice. The previous value was based on a survey of 35 general orthopaedic surgeons over 15 years ago. In addition, the previous value was derived from a survey for a 090 global but then later changed to a 010 global, but with all the post-operative office visits from the 090 survey maintained. This combination indicates the previous value is not a reliable measure of the resources involved in the procedure and it is an error to measure the RUC recommended wRVU against that previous value.

We believe that the RUC recommendations are based on a reliable survey of physicians and more accurately reflects the work involved in the procedure. The crosswalk proposed by CMS not only bears little relationship to an open bone biopsy, but also has 10 fewer minutes total time than the times for 20245. In contrast, the RUC recommended value fits well relative to other similar procedures such as CPT code 20902. The AAOS therefore recommends that CMS adopt and finalize the RUC recommended work RVU of 6.50 for CPT 20245 in the final rule.

Interlaminar/Interspinous Process Stabilization Distraction Devices (CPT codes 228X1-228X5)

CPT Code	Descriptor	RUC Rec RVU	CMS Proposed RVU	CMS Work RVU Decision
228X1	Insertion of interlaminar/interspinous process stabilization/distraction device, without fusion, including image guidance when performed, with open decompression, lumbar; single level	15.00	13.50	Disagree
228X2	Insertion of interlaminar/interspinous process stabilization/distraction device, without fusion, including image guidance when performed, with open decompression, lumbar; second level (List separately in addition to code for primary procedure)	4.00	4.00	Agree
228X4	Insertion of interlaminar/interspinous process stabilization/distraction device, without open decompression or fusion, including image guidance when performed, lumbar; single level	7.39	7.03	Disagree
228X5	Insertion of interlaminar/interspinous process stabilization/distraction device, without open decompression or fusion, including image guidance when performed, lumbar; second level (List separately in addition to code for primary procedure)	2.34	2.34	Agree

For 2017, CMS reviewed the values for four new codes (228X1-228X5) related to the insertion of interlaminar/interspinous process stabilization distraction devices. Specifically, CMS accepted the RUC recommendations for CPT codes 228X2 and 228X5, both of which are add-on codes. CMS recommended lower work values for the two primary codes, 228X1 and 228X4, recommending work RVUs of 13.50 and 7.03 compared to the RUC recommended values of 15.00 and 7.39.

For 228X1, the RUC recommended a direct work RVU crosswalk to CPT code 29915 *Arthroscopy, hip, surgical; with acetabuloplasty (i.e., treatment of pincer lesion)*. CPT code 29915 has identical intra-service time, very similar total time (270 vs 271 minutes), very similar intensity (IWPUT of 0.1083 vs. 0.1065) and a similar amount of time for post-op visits (97 vs. 88 minutes). The RUC's crosswalk code is either an as good or better match than the CMS crosswalk under virtually every point of comparison. CMS did not indicate why CPT code 29915 is not an appropriate crosswalk.

For 228X4, the RUC recommended a direct work RVU crosswalk to CPT code 29880 *Arthroscopy, knee, surgical; with meniscectomy (medial AND lateral, including any meniscal shaving) including debridement/shaving of articular cartilage (chondroplasty), same or separate compartment(s), when performed*. CMS simply just picked a different crosswalk code that is in the same code family as the RUC crosswalk. The RUC's crosswalk is closer to the survey code in both intra-service time and physician intensity. Other than those differences, all other time components of 29880 and 29881 are identical. As both proposed crosswalk codes are in the same code family, their clinical comparison to the survey code is indistinguishable. The RUC's crosswalk code is either identical or a better match than the CMS crosswalk under every point of comparison.

The AAOS urges CMS to finalize the work values recommended by the RUC for all six codes in the family, as noted above.

Biomechanical Device Insertion (CPT codes 22X81, 22X82, 22X83)

CPT Code	Descriptor	RUC Rec RVU	CMS Proposed RVU	CMS Work RVU Decision
22X81	Insertion of interbody biomechanical device(s) (e.g., synthetic cage, mesh) with integral anterior instrumentation for device anchoring (e.g., screws, flanges) when performed to intervertebral disc space in conjunction with interbody arthrodesis, each interspace (List separately in addition to code for primary procedure)	4.88	4.25	Disagree
22X82	Insertion of intervertebral biomechanical device(s) (e.g., synthetic cage, mesh) with integral anterior instrumentation for device anchoring (e.g., screws, flanges) when performed to vertebral corpectomy(ies) (vertebral body resection, partial or complete) defect, in conjunction with interbody arthrodesis, each contiguous defect	5.50	5.50	Agree
22X83	Insertion of intervertebral biomechanical device(s) (e.g., synthetic cage, mesh, methylmethacrylate) to intervertebral disc space or vertebral body defect without interbody arthrodesis, each contiguous defect (List separately in addition to code for primary procedure)	6.00	5.50	Disagree

The AAOS believes the RUC recommended work RVUs accurately reflect the true physician work and that the CMS recommended values underestimate the total physician work involved with this highly intensive procedures. The three new codes for insertion of biomechanical spine devices are written to be incremental in terms of physician work and resources required for the typical patient. CMS’s proposed change to the work RVUs for 22X83 would eliminate the differential between 22X82 and 22X83 and contradict the work incorporated into the codes.

We therefore recommend that CMS adopt the RUC recommended values of 4.88 for code 22X81, 5.50 for code 22X82, and 6.00 for 22X83 to maintain proper rank ordering between these three distinct services for 2017.

For 22X81, the RUC recommended a direct work RVU crosswalk to CPT code 57267 *Insertion of mesh or other prosthesis for repair of pelvic floor defect, each site (anterior, posterior compartment), vaginal approach (List separately in addition to code for primary procedure)* (work RVU = 4.88). CPT code 57267 has an identical amount of intra-service and total physician time relative to the survey code, whereas CMS' chosen crosswalk has physician times which are not identical. Following extensive deliberation, the RUC agreed that the survey code and 57267 involve an identical amount of physician work. The RUC's crosswalk code is either an as good or better match than the CMS crosswalk under virtually every point of comparison. CMS did not indicate why CPT code 57267 is not an appropriate crosswalk.

For 22X83, this service involves more physician work and intensity relative to 22X82 for the following reasons. Proposing to value both procedures demonstrates a misunderstanding of the work being performed. Specifically, the intent is to allow and account for distinctions between 22X82 and 22X83. When trauma, tumor, or infection destroys a vertebral segment, this segment must be reconstructed and durable bony fusion (arthrodesis) achieved from the segment above to the segment below the reconstructed segment. The work of 22X82 describes reconstruction of a vertebral body with a biomechanical spacer, to achieve an arthrodesis that will stabilize the unstable spinal segment and ultimately achieve bony healing and permanent durable spine stability with little risk to subsequent shifts in the construct. Immediate short-term stability is provided by the hardware, but it may weaken or fail over time; arthrodesis achieves the goal of one bone fusing to another through the 22X82 device and provides the long-term stability. The work described by 22X83 is for placement of a biomechanical device with no intention of eventual bony arthrodesis. When tumor or infection causes neural compression, and the underlying pathology or its treatment creates spinal instability, the structural defect must be corrected but bony fusion may not be possible or expected. In this setting, the biomechanical device must be fashioned and placed to provide durable spinal stability without the added security of arthrodesis. The additional precision required for creating a stand-alone construct that will be stable over time results in a quantifiable difference in the overall intensity of the work, even though there are similarities in the code descriptors and the description of work. By way of example, 22X83 would be used in the circumstance where a patient with a thoracic metastatic lesion causing spinal cord compression undergoes a decompression. The patient will need immediate postoperative radiation, and arthrodesis is therefore exceedingly unlikely. In this case, the surgeon completes a transpedicular decompression and then reconstructs the anterior column with either the Steinman pin and methyl methacrylate or other biomechanical spacer. The increased intensity of work in that circumstance warrants a higher valuation.

We recommend that CMS adopt the RUC recommended values of 4.88 for code 22X81, 5.50 for code 22X82, and 6.00 for 22X83 to maintain proper rank ordering between these three distinct services for 2017. We also recommend that CMS provide additional guidance with respect to how these codes should be reported and are happy to work with CMS to provide the examples above in a CMS guidance document as it is critical for users to also understand these differences and scenarios.

Closed Treatment of Pelvic Ring Fracture (CPT codes 271X1 and 271X2)

CPT Code	CPT Descriptor	RUC Rec RVU	CMS Proposed RVU	CMS Work RVU Decision
271X1	Closed treatment of posterior pelvic ring fracture(s), dislocation(s), diastasis or subluxation of the ilium, sacroiliac joint, and/or sacrum, with or without anterior pelvic ring fracture(s) and/or dislocation(s) of the pubic symphysis and/or superior/inferior rami, unilateral or bilateral; without manipulation	5.50	1.53	Disagree
271X2	Closed treatment of posterior pelvic ring fracture(s), dislocation(s), diastasis or subluxation of the ilium, sacroiliac joint, and/or sacrum, with or without anterior pelvic ring fracture(s) and/or dislocation(s) of the pubic symphysis and/or superior/inferior rami, unilateral or bilateral; with manipulation, requiring more than local anesthesia (i.e., general anesthesia, moderate sedation, spinal/epidural)	9.00	4.75	Disagree

For 2017, CMS recommended significant reductions to the work RVUs and changed the global periods to “0” days for codes 271X1, Closed Treatment Pelvic Ring Fracture without

manipulation, and 271X2, Closed Treatment Pelvic Ring Fracture with manipulation. CMS recommended work RVUs of 1.53 and 4.75 for CPT 271X1 and 271X2 respectively.

The AAOS strongly recommends that CMS maintain the 90 global period for these procedures and adopt RUC recommended work RVUs of 5.50 and 9.00 respectively. If CMS finalizes its proposal to adopt a 0-day global period for these two codes, it would deviate from the global assignment for virtually all other closed fracture codes and would create significant rank order anomalies with similar fracture services. It would also create considerable confusion for physicians in terms of when it is correct coding to use the global period and when to use Evaluation and Management codes.

The AAOS recognizes that the 90-day global period setting was not appropriate for the codes as previously written because anterior pelvic ring fractures can and should be billed with discrete E/M codes. This was the reason the AAOS made changes to the CPT codes to reflect this distinction between closed anterior and posterior pelvic ring fractures. Yet, CMS blithely ignores this clinical distinction by assigning a 0-day global period to the closed treatment of posterior pelvic ring fractures.

Most importantly, the entire intent of the 90-day global period for closed fracture care is to provide a comprehensive care experience for Medicare patients to account for the long-term and appropriate healing of closed pelvic ring fractures. CMS stated in the proposed rule that many of the post-operative patient visits included in a 90-day global period would not be performed by the treating physician. AAOS strongly disagrees with this assertion and believes the typical scenario for patients with posterior pelvic ring fractures is that the treating surgeon also does all the follow up care. A 90-day global period obligates the treating physician to follow the patient across the entire global period with regular patient encounters rather than a single 0-day encounter with no follow up requirements or obligations. Furthermore, the use of the global period reduces the potential out of pocket costs faced by patients for discrete office visit E/M codes, and the additional practice costs for coding and billing each office encounter.

CMS has initiated bundled payment programs for other musculoskeletal procedures such as Total Knee Arthroplasty, Total Hip Arthroplasty and Hip Fracture surgery in order to better align payment and patient care. This approach is directly at odds with the recommendations for 271X1 and 271X2.

Therefore, the AAOS strongly recommends restoring the 90-day global setting and the RUC recommended work RVUs for 271X1 and 271X2 in the CY 2017 final rule.

Bunionectomy (CPT codes 28289, 28292, 28296, 28297, 28298, 28299, 282X1, 282X2)

CPT code	Descriptor	RUC Rec RVU	CMS Proposed RVU	CMS Work RVU Decision
28289	Hallux rigidus correction with cheilectomy, debridement and capsular release of the first metatarsophalangeal joint; without implant	6.90	6.90	Agree
282X1	Hallux rigidus correction with cheilectomy, debridement and capsular release of the first metatarsophalangeal joint; with implant	8.01	7.81	Disagree
28292	Correction, hallux valgus (bunionectomy), with sesamoidectomy; when performed; with resection of proximal phalanx base, when performed, any method	7.44	7.44	Agree
28296	Correction, hallux valgus (bunionectomy), with sesamoidectomy; when performed; with distal metatarsal osteotomy, any method	8.25	8.25	Agree
282X2	Correction, hallux valgus (bunionectomy), with sesamoidectomy; when performed; with proximal metatarsal osteotomy, any method	8.57	8.25	Disagree
28297	Correction, hallux valgus (bunionectomy), with sesamoidectomy; when performed; with first metatarsal and medial cuneiform joint arthrodesis, any method	9.29	9.29	Agree
28298	Correction, hallux valgus (bunionectomy), with sesamoidectomy; when performed; with proximal phalanx osteotomy, any method	7.75	7.75	Agree
28299	Correction, hallux valgus (bunionectomy), with sesamoidectomy; when performed; with double osteotomy, any method	9.29	9.29	Agree

In the 2017 proposed rule, CMS provided work RVU recommendations for a set of eight codes for bunion procedures. Of the eight codes, two are new codes (282X1 and 282X2) created by CPT to replace three existing bunionectomy codes, and six are existing codes that were revised (CPT codes 28289, 28292, 28296-28299).

CMS accepted the RUC recommended values for the six existing codes, but did not accept the RUC recommended values for the two new codes, even though the RUC recommendations for all eight codes were based on the 25th percent of the survey results.

CMS recommended 7.89 work RVUs for 282X1 and 8.25 work RVUs for 282X2. The RUC recommended 8.01 work RVUs for 282X1 and 8.57 for 282X2. CMS contends that the RUC recommended values overstated the work involved in the procedures. However, the AAOS believes the RUC recommended values and the rank ordering of the codes in the family by the RUC is correct and the CMS recommended values for 282X1 and 282X2 are incorrect and if implemented would create rank order anomalies within the family.

The AAOS disagrees with the CMS crosswalk for 282X1 to CPT code 65780. 282X1 is more complex and intense than 28298 and the relative difference in work and complexity/intensity was reviewed and correctly ranked by the survey respondents. The work RVU of 8.01 correctly values 282X1.

The AAOS also believes that 282X2 is more intense than 28296 and should have a higher work RVU. CPT code 28296 is a metatarsal neck osteotomy and is already exposed at that level and has been operated on. However, CPT code 282X2 requires separate areas of dissection and is more complex than 28296 where the osteotomy and soft tissue procedure are performed at the same anatomic location. This nuance in complexity is the rationale for separate codes and is similar to the rationale for separate cervical versus lumbar spine codes or artery versus vein codes for vascular work. In each of these instances, although the operative time may be the same, the complexity of the procedure is greater for one area versus the other and this is reflected in a difference in work RVUs. Therefore, The AAOS urges CMS to assign a work RVU of 8.57 for CPT code 282X2 in the CY final rule.

Misvalued Code Initiative and Proposed Codes for Survey

For 2017, CMS proposed to flag codes with a 0-day global period that are billed with a separate evaluation and management (E/M) code at least 50 percent of the time on the same claim when the 0-day global code has not been revalued or reviewed in the last five years. CMS proposed a total of 83 codes for review under this screen.

After analysis, it appears that many of the services in the proposed screen do not fit the description as potentially misvalued under the proposed new screen because the services are not billed with an E/M code more than 50 percent of the time or the service has been reviewed in the last five years. The AAOS recommends that CMS revise the list of the misvalued codes to account for all the incorrect codes listed in the table.

Specifically, it appears only 19 services met the criteria for this screen and have not been reviewed to specifically address an E/M performed on the same date. There are 38 codes that do not meet the screen criteria; they were either reviewed in the last 5 years and/or are not typically reported with an E/M. For an additional 26 codes, the current work values already account for the pre-service time associated with same-day E/M services. We do not believe that 0-day global services already adjusted for physician time and work when an E/M is typically performed warrant further review.

The AAOS requests that CMS remove the 64 services identified, including the musculoskeletal services in the table below that do not meet the screen criteria or which have already been valued as typically being reported with an E/M service. The AAOS also requests that CMS condense and finalize the list of services for this screen to the 19 remaining services.

CPT	Long Descriptor	Total with E/M	Most Recent RUC Survey	CPT Year
11000	Debridement of extensive eczematous or infected skin; up to 10% of body surface	45%	Aug95	1997
11100	Biopsy of skin, subcutaneous tissue and/or mucous membrane (including simple closure), unless otherwise listed; single lesion	79%	Aug05	2007

CPT	Long Descriptor	Total with E/M	Most Recent RUC Survey	CPT Year
11300	Shaving of epidermal or dermal lesion, single lesion, trunk, arms or legs; lesion diameter 0.5 cm or less	74%	Apr12	2013
11301	Shaving of epidermal or dermal lesion, single lesion, trunk, arms or legs; lesion diameter 0.6 to 1.0 cm	73%	Apr12	2013
11302	Shaving of epidermal or dermal lesion, single lesion, trunk, arms or legs; lesion diameter 1.1 to 2.0 cm	67%	Apr12	2013
11305	Shaving of epidermal or dermal lesion, single lesion, scalp, neck, hands, feet, genitalia; lesion diameter 0.5 cm or less	48%	Apr12	2013
11306	Shaving of epidermal or dermal lesion, single lesion, scalp, neck, hands, feet, genitalia; lesion diameter 0.6 to 1.0 cm	58%	Apr12	2013

CPT	Long Descriptor	Total with E/M	Most Recent RUC Survey	CPT Year
11307	Shaving of epidermal or dermal lesion, single lesion, scalp, neck, hands, feet, genitalia; lesion diameter 1.1 to 2.0 cm	57%	Apr12	2013
12001	Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); 2.5 cm or less	82%	Apr10	2011
12002	Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); 2.6 cm to 7.5 cm	84%	Apr10	2011
12004	Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); 7.6 cm to 12.5 cm	84%	Apr10	2011

CPT	Long Descriptor	Total with E/M	Most Recent RUC Survey	CPT Year
12011	Simple repair of superficial wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 2.5 cm or less	85%	Apr10	2011
12013	Simple repair of superficial wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 2.6 cm to 5.0 cm	85%	Apr10	2011
20550	Injection(s); single tendon sheath, or ligament, aponeurosis (e.g., plantar "fascia")	76%	Jan16	2017
20552	Injection(s); single or multiple trigger point(s), 1 or 2 muscle(s)	75%	Jan16	2017
20553	Injection(s); single or multiple trigger point(s), 3 or more muscles	66%	Jan16	2017
20600	Arthrocentesis, aspiration and/or injection, small joint or bursa (e.g., fingers, toes); without ultrasound guidance	72%	Oct10	2012

CPT	Long Descriptor	Total with E/M	Most Recent RUC Survey	CPT Year
20604	Arthrocentesis, aspiration and/or injection, small joint or bursa (e.g., fingers, toes); with ultrasound guidance, with permanent recording and reporting	0%	Jan14	2015
20605	Arthrocentesis, aspiration and/or injection, intermediate joint or bursa (e.g., temporomandibular, acromioclavicular, wrist, elbow or ankle, olecranon bursa); without ultrasound guidance	74%	Oct10	2012
20606	Arthrocentesis, aspiration and/or injection, intermediate joint or bursa (e.g., temporomandibular, acromioclavicular, wrist, elbow or ankle, olecranon bursa); with ultrasound guidance, with permanent recording and reporting	0%	Jan14	2015

CPT	Long Descriptor	Total with E/M	Most Recent RUC Survey	CPT Year
20610	Arthrocentesis, aspiration and/or injection, major joint or bursa (e.g., shoulder, hip, knee, subacromial bursa); without ultrasound guidance	65%	Oct10	2012
20611	Arthrocentesis, aspiration and/or injection, major joint or bursa (e.g., shoulder, hip, knee, subacromial bursa); with ultrasound guidance, with permanent recording and reporting	0%	Jan14	2015
29125	Application of short arm splint (forearm to hand); static	78%	Oct10	2012
29515	Application of short leg splint (calf to foot)	71%	Oct10	2012

Collection of Data on Resources Utilization in the Provision of Global Services

In the 2017 MPFS proposed rule, CMS outlined policies related to data collection of resources used in the provision of global services (services in the fee schedule with 010 or 090 day global periods). These policies are in response to language in the Medicare and CHIP Reauthorization Act (MACRA) of 2015 which called on CMS to not implement its previously announced policy to eliminate all 010 and 090 global periods and to collect data related to the resources utilized in these services. CMS has proposed three concurrent initiatives to better identify resources used in the provision of global services. The first proposal is to create eight G-codes that all providers

would be expected to report to capture inpatient, outpatient, office, and non-face-to-face post-operative patient encounters provided in a global period. The second proposal is to conduct a survey of surgeons and providers who commonly perform global services. The third proposal is to conduct field studies in a select number of sites with direct observation of practice patterns.

The AAOS believes the current proposal imposes far too great a burden on physicians and physician practices, in particular the imposition of reporting patient encounters through unpaid G-codes for all work done in the 10-day or 90-day post-operative period. Under the proposed policy, it is distinctly possible a physician following a patient for 90 days might need to submit G-codes 20-50 times per patient. This represents a vastly unnecessary burden on all physician and physician practices.

Furthermore, the proposal to require all physicians to use the G-codes would result in inaccurate and misleading data and most importantly will reduce the efficacy of post-operative patient encounters as physicians will be encumbered with the task of tracking his/her time with the patient, resources used and so forth, rather than engaging in diagnosis and analysis of post-operative healing without regard to how long the encounter may last or the resources used. Only large practices with significant resources already embedded in their practice could track patient encounters with the 10-minute increment model proposed in the rule with any degree of accuracy, particularly by January 1, 2017 as proposed by CMS. These larger, urban or suburban practices also have different patient populations, which are often healthier with fewer co-morbidities. Therefore, practices that would likely under report patient encounters because they would not have the resources to comply with the reporting requirement would have different patient panels. This would result in skewed and biased results from a universal reporting process.

CMS has alternative methods easily available that would yield valid and accurate data on physician resources provided in a global period setting without imposing a huge administrative burden on physicians and their practices. Specifically, CMS could simply use CPT code 99024, Postoperative follow-up visit, normally included in the surgical package, to indicate that an evaluation and management service was performed during a postoperative period for a reason(s) related to the original procedure, in a sample based claims pilot project. This would be much more successful and appropriate as 99024 is already familiar to most participating physicians, does not require tracking time increments, is already recorded by several major health systems, and has already been incorporated onto some EHR systems. This would allow practices and physicians chosen to participate in a pilot project with a much lower burden of reporting.

The AAOS also believes that if survey is necessary to determine the number and level of postop visits, it does not seem practical to survey for all 4200+ CPT codes. We recommend CMS limit any survey to codes which are high-dollar, high-volume, and performed by a large number of physicians. This would greatly reduce the administrative burden and volume of data which

would be collected. The results could be extrapolated to low-volume codes for which it would be difficult to get meaningful survey data.

The AAOS believes CMS can accomplish all its MACRA related mandates, and collect meaningful data on resource use in the global period setting without creating major burdens on physicians and practices. The proposed approach from the proposed rule is far too burdensome given that it includes all providers and all global services. A limited approach through surveys of physicians and practices looking at a targeted selection of services, and using 99024 for the claims based component would yield meaningful and actionable data for the agency and stakeholders. CMS can look at more granular resource components through their field observations, as proposed in the rule, to gain more precise information, as well as through interviews and surveys of common users of global services, also as proposed.

We strongly recommend CMS revise this proposed approach to reviewing global period services and work closely with physician associations to determine a more effective and less burdensome approach to collecting data in claims based forms including the much more simplistic approach of using HCPCS/CPT code 99024 which is an unpaid reporting code for post-operative patient E/M encounters. AAOS also urges CMS to choose a representative sample of physicians and not extend the requirement to all providers. CMS can gain just as statistically valid data via sampling as it can through universal, mandatory requirements.

Lastly, AAOS recommends delaying implementation of the data collection process for at least another full calendar year to January 1, 2018 to allow CMS to develop a proper and valid representative sample(s), educating and preparing the physicians and practices included in the sample(s), and engaging in stakeholder outreach prior to initiating the data collection process.

Appropriate Use Criteria for Advanced Imaging Services

In the CY 2017 proposed rule, CMS addresses the development of a Medicare Appropriate Use Criteria (AUC) program for Advanced Imaging Services such as MRIs, CT scans, ultrasound, and other diagnostic imaging systems. CMS was mandated to develop an AUC program for Advanced Imaging as part of the Protect Access to Medicare Act (PAMA) of 2014. In the 2016 Medicare Physician Fee Schedule, CMS addressed the initial components of the program, outlining evidence-based transparency requirements for the AUC program and establishing a process to define “provider-led entities” (PLEs) which CMS tasks with reviewing and endorsing their proposed AUC requirements for Advanced Diagnostic Imaging. In June 2016, CMS published the list of initial PLEs.

In the 2017 proposed rule, CMS announced they would not begin actual implementation of the Advanced Imaging AUC program until at least CY 2018. CMS also announced exemption criteria, and the initial list of general conditions they would include in the AUC as clinical priority areas: chest pain (includes angina, suspected myocardial infarction and suspected pulmonary embolism); abdominal pain (any locations and flank pain); headache, traumatic and non-traumatic; low back pain; suspected stroke; altered mental status; cancer of the lung (primary or metastatic, suspected or diagnosed); cervical or neck pain.

The AAOS supports the use of AUC as a key tool in promoting cost-effective, quality care for key clinical priority areas such as low back pain. AAOS and other specialty societies that treat low back pain have developed evidence-based guidelines and AUCs, and encourage CMS to closely follow these published recommendations in creating their AUC for advanced imaging. The AAOS is happy to share our guidelines and AUC with CMS and to collaborate with CMS and other medical stakeholders in reviewing and finalizing the Advanced Imaging AUC.

Phase-In of Significant RVU Reductions

In the 2017 proposed rule, CMS proposes to finalize the policy on the phase-in of significant RVU reduction for all codes not new or revised. For the 2016 Physician Fee Schedule CMS implemented a maximum of 19% reduction in a single year for all procedures not new or revised that had a total RVU reduction of 20% or greater. For the 2017 Physician Fee Schedule, CMS proposes to have the 19% reduction in total RVUs continue to be the maximum one-year reduction until the reduction is fully implemented.

AAOS agrees with this proposal and supports the policy. AAOS believes that significant reductions to any service can be disruptive to physicians and physician practices. By phasing in reductions and having a maximum 19% reduction in total RVUs for any year, CMS will mitigate the impact of significant reductions for physicians and practices. AAOS recommends CMS finalize its proposed policy in the CY 2017 Final Rule.

Future Changes to Open Payments Program

In the 2017 MPFS proposed rule, CMS invited stakeholder input on the Open Payments data program for reporting payments and transfers of value made by drug and device manufacturers and group purchasing organization (GPOs) to physicians and teaching hospitals. The information is published on Medicare's Open Payment website. The AAOS supports the Open Payments program, but recommends that CMS focus on streamlining the reporting burden and

assessing the value of the voluminous information collected and reported to date before contemplating additional requirements.

The AAOS also offers the following responses to some of the specific questions posted in the proposed rule.

- *Are the current payment categories inclusive enough to facilitate reporting of all payments or transfers of value to covered physicians and teaching hospitals?*

The AAOS believes the current payment categories, including the scope of reporting for research payments, are sufficient to capture all meaningful payments or transfers of value for providers and teaching facilities. The existing categories have introduced a great deal of information regarding such financial arrangements into the public domain. With respect to research payments, if CMS seeks additional information on how payments may be shared between physicians and hospitals, providers are in the best position to report additional information.

- *Would it be beneficial for CMS to provide operational definitions of “value of interest” and “dollar amount invested” to facilitate interpretation and compliance with the rules on disclosures of payments and ownership?*

The AAOS thanks CMS for offering to better clarify operational definitions of “value of interest” and “dollar amount invested.” Additional clarity in this area would be beneficial for all stakeholders using the data.

- *How should CMS define physician-owned distributors (PODs) for data reporting purposes?*

The AAOS thanks CMS for seeking input on the treatment of PODs under the Open Payments process. As CMS knows, PODs are, in many ways, similar to other manufacturers and distributors of drugs and devices, but have some differences, particularly in the physician investments in the entity. Given these distinctions and the evolving nature and purpose of PODs, AAOS recommends that CMS conduct meetings and discussions between all interested stakeholders to determine how PODs should be treated under the Open Payments program. The AAOS would be happy to be engaged in this process.

Thank you for considering our comments on these important matters. If you have any questions on our comments, please do not hesitate to contact William Shaffer, MD, AAOS Medical Director by email at shaffer@aaos.org.

Sincerely,



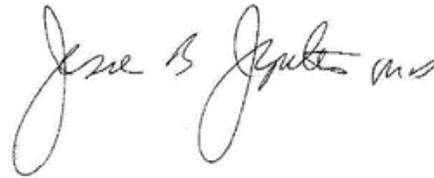
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