AAOS
American Academy of Orthopaedic Surgeons
American Association of Orthopaedic Surgeons

November 8, 2017

Subject: (CMS–1676–F)
Summary of the Centers for Medicare and Medicaid Services Revisions to Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY 2018 Final Rule

Final Rule CMS-1676-F was released on November 2, 2017 and finalized policies first proposed in the Medicare Physician Fee Schedule Proposed Rule CMS-1676-P.

Below is a summary of major points from the rule, with summary of AAOS' comments/ recommendations if made and the final rule response to AAOS comments. CMS estimates no net change in reimbursements to Orthopaedic Surgeons in the Medicare Physician Fee Schedule for 2018*. Comments on the final rule are due December 31, 2017.

Low Volume Service Codes

Proposed Rule
In the July proposed rule, CMS proposed to override claims data for low volume services with an expected specialty for both the practice expense and professional liability insurance valuation process. This proposal was consistent with a long-standing AMA RUC recommendation to use the expected specialty for services performed less than 100 times per year.

AAOS Comment
AAOS agreed with the CMS proposal to use expected specialty settings for low volume Medicare procedures. AAOS provided the AMA RUC with input on the RUC recommended specialties and agreed with the recommendations made by the RUC.

Final Rule
In the final rule, CMS accepted the RUC recommended specialty settings and finalized their proposal to use expected specialty settings for Practice Expense and Malpractice RVUs for Medicare low volume services. The result for the affected codes commonly used by orthopaedic surgery will be positive adjustments.
*note that this does not mean specific services under the 2018 MPFS will not be decreased or increased only that the net impact of changes is estimated to be 0%

Preservice Clinical Labor for 0-Day and 10-Day Global Services

Proposed Rule

317 Massachusetts Avenue NE
Suite 100
Washington, D.C. 20002-5701
PHONE 202.546.4430
www.aaos.org/dc

In the proposed rule, CMS sought comment on whether the standard preservice clinical labor time of zero minutes should be consistently applied for all 0-day and 10-day global codes in future rulemaking. CMS indicated that for the 1142 total 0-day global codes, 741 of the codes had preservice clinical labor of some kind (65 percent). CMS also noticed a general correlation between preservice clinical labor time and when the code was reviewed.

AAOS Comment
AAOS commented that CMS should not apply pre-service clinical labor time settings of 0 for all 0 and 10 global codes. AAOS argued that for many 0 and 10 day global services, clinical staff may be appropriate, and that for those instances pre-service clinical labor time should be maintained, but that it should be on a code by code basis.

Final Rule
In the final rule, CMS did propose to remove clinical labor time and agreed with the AAOS and other stakeholder recommendations to review clinical labor inputs for 0 and 10 day global codes on a code-by-code basis for pre-service clinical labor inputs.

Malpractice RVU Methodology Changes

Proposed Rule
In the proposed rule, CMS proposed changing the methodology for assigning malpractice RVUs under the Physician Fee Schedule. Specifically, CMS proposed using a different methodology than under current policy that would rely on regional data rather than national data, and other changes.

AAOS Comment
In a joint specialty society letter, AAOS commented that CMS should not apply the updated methodology for malpractice RVUs and should instead delay the implementation in order to study and better refine the underlying assumptions. The comment pointed out the significant negative impacts on many major surgical specialties, although orthopaedics was estimated to see a slight improvement on average in Malpractice RVUs.

Final Rule
In the final rule, CMS accepted the recommendation by stakeholders to delay implementation of the malpractice RVU methodology changes until at least 2019 and work on refinements with the RUC and other stakeholders.

Physician Work and Practice Expense Recommendations

As part of the Medicare Physician Fee Schedule, CMS proposes and finalizes Relative Value Units (RVU) for Work, Practice Expense (PE), and Malpractice. The AAOS comments on, and tracks values, for services commonly performed by orthopaedic surgeons.

Bone Marrow Aspiration

Proposed Rule
CMS reviewed CPT code 2093X, Bone marrow aspiration for bone grafting, spine surgery only, through separate skin or fascial incision and a work RVU of 1.16 for 2018. The AAOS supports the proposed work RVU of 1.16 which is what was recommended by the RUC and by the surveying societies.

AAOS comments/recommendations
AAOS supported the CMS recommended value and recommended CMS finalize in final rule.

Final Rule
CMS finalized 2093X, Bone marrow aspiration for bone grafting, spine surgery only, through separate skin or fascial incision with a work RVU of 1.16 for 2018.

Application of Long Leg Cast

Proposed Rule
CMS reviewed CPT code 29445, Application of rigid total contact leg cast and recommended a wRVU of 1.78. The AAOS supports this work RVU which is also the current wRVU for 29445 and was the recommended value at the RUC, thereby reinforcing the appropriateness of this value for 29445.

For the Practice Expense RVUs for 29445, CMS stated they were considering a reduction in clinical labor time for cast removal from the 22 minutes recommended by the AAOS and the RUC to 11 minutes. CMS indicates this is appropriate because the cast removal is only done at the beginning of the service prior to initial casting and that the clinical time for subsequent cast removal is not appropriate.

AAOS comments/recommendations
AAOS commented that the CMS analysis of practice expense is a misunderstanding by the agency of the standard approach to casting codes like 29445. AAOS comments stated that cast removal time in a casting code like 29445 is for a single cast removal technically done post-service. This seems counterintuitive, but the way the work is structured assumes the cast removal will be done subsequent and not included in the initial casting, but also not separately billable. If the practice expense inputs are revised to 11 minutes, physicians providing the service would be losing compensation for standard work done as part of the procedure. AAOS recommended adopting the RUC recommended clinical staff time for cast removal of 22 minutes and the work RVU recommendation.

Final Rule
CMS finalized the recommended wRVU of 1.78 and based on AAOS comments did not reduce the clinical labor time as they had stated they were considering.

Suprascapular Nerve Injection

Proposed Rule
CMS reviewed CPT code 64418, Injection, anesthetic agent; suprascapular nerve and proposed a wRVU of 1.10. This is the work RVU recommended at the RUC and accepted by the RUC.

AAOS Comment
AAOS supported the proposed value.

Final Rule
CMS finalized wRVU of 1.10 for 64418.

Nerve Repair with Nerve Allograft

Proposed Rule
CMS reviewed four CPT codes, two new and two existing, 64910 Nerve repair; with synthetic conduit or vein allograft (eg, nerve tube), each nerve, 64911 with autogenous vein graft (includes harvest of vein graft), each nerve, 64X91 with nerve allograft, each nerve, first strand (cable), 64X92 with nerve allograft, each additional strand (List separately in addition to code for primary procedure).

Two new CPT codes were created to report repair of a nerve using a nerve allograft. Codes 64910 and 64911 were added as family codes for review, even though there was no change in the descriptors for these codes. For code 64910: CMS noted a decrease in preservice time (7 minutes) for code 64910 and considered an alternate work RVU of 10.15, crosswalking to CPT code 15120 (Split-thickness autograft, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; first 100 sq cm or less, or 1 percent of body area of infants and children (except 15050)), which has similar service times. CMS asked for comments on whether an alternative work RVU of 10.15 for CPT code 64910 would better reflect relativity among PFS services with similar service times.

For CPT codes 64X91 and 64X92 CMS questioned the coding structure for these new services which increases granularity by including an add-on code for each strand of nerve repair. CMS acknowledges that while additional granularity may be important and useful for purposes of data collection, the advantages to Medicare for such granularity for purposes of payment are unclear, especially since CMS stated they were considering proposing a bundled status to the new add-on

codes and incorporating the relative resources in furnishing the add-on code (CPT code 64X92) into the base code (CPT code 64X91) based on the utilization assumptions that accompanied the RUC recommendations.

AAOS Comment
The AAOS recommended using the RUC recommended wRVU for 64910 and 64911 rather than the values recommended in the proposed rule.

AAOS commented the correct relative value for code 64910 is 10.52 work RVUs and recommended CMS finalize 10.52 as the work RVU for 64910.

AAOS recommended a work RVU of 14.00, not 13.50 for CPT code 64911 to match the RUC and specialty society recommended wRVUs.

The AAOS commented that CPT coding should define distinct physician work, for appropriate reimbursement (both physician work and practice expense) and for data collection relative to outcome and risk and that bundling the add-on service as CMS proposed would undermine the premise of coding and relative reimbursement.

The AAOS also commented that in fact there is the payment-related reason for this coding structure, specifically that bundling the service as CMS suggests would also place a financial burden on the patients who do not require multiple strands because they would be paying 120% of what they would otherwise pay. Lastly, the AAOS noted that the codes are not typically reported for Medicare-aged patients, but instead is a service for younger patients that have better nerve healing capacity.

Final Rule
CMS did not accept AAOS recommendations for CPT codes 64910 and 64911 but did agree to not to create a single, bundled code the two new codes.

CMS finalized values of 10.15 for 64910, 13.50 for 64911, 12.00 for 649X1 and 3.00 for 649X2.

Wrist, Hand, and X-Ray Codes

Proposed Rule
CMS reviewed CPT codes 73100, Radiologic examination, wrist; 2 views, 73110, Radiologic examination, wrist; complete, minimum of 3 views, 73120, Radiologic examination, hand; 2 views, 73130, Radiologic examination, hand; minimum of 3 views; and 73140, Radiologic examination, finger(s), minimum of 2 views, which were recommended for maintaining current wRVUs by the RUC.

AAOS Comment

The AAOS supported the recommendation to maintain the wRVUs for all these codes.

Final Rule
CMS finalized wRVUs of 0.16 for CPT code 73100, 0.17 for CPT code 73110, 0.16 for CPT code 73120, 0.17 for CPT codes 73130, and 0.13 for CPT code 73140 as recommended by AAOS and the RUC and as described in the proposed rule.

Ultrasound Extremity Exam codes

Proposed Rule
CMS reviewed 76881, Ultrasound extremity general and 76882, Ultrasound extremity limited and agreed with the RUC recommendations to maintain current wRVU and changed equipment setting for a general ultrasound room from 76881 to 76882 which shifts the PE RVUs from 76881 to 76882, lowering 76881 and raising 76882 RVUs. CMS sought comments on whether it is more reasonable to assign portable ultrasound machine to both codes. There was significant discussion regarding this issue at the RUC and the RUC's written recommendations discuss this issue in detail. The anatomic specific code (76882) describes a service most commonly performed by radiologists.

AAOS Comments
The AAOS recommended accepting the RUC recommended Practice Expense inputs for 76881 and 76882 and noted that at the time of RUC and CMS review that 56% of the claims for 72882 were submitted by radiologists and that the CMS statement that "the dominant specialty for both of these services is podiatry" was inaccurate when taking into account services that are split by professional and technical components. The AAOS also noted that in addition to the change in PE, AAOS and ACR were concerned that the definition of "complete" and "limited" was not clear in CPT and accordingly, recommended guidelines be added to CPT to clarify the intended reporting of each code. Additionally, changes were made to the descriptors for CPT 2018. Based on these changes, the AAOS recommended accepting the RUC recommended Practice Expense inputs for 76881 and 76882.

Final Rule
For the final rule, CMS maintained their recommendation to lower the Practice Expense RVUs for CPT code 76881. In addition, CMS disagreed with AAOS' recommendation to increase the Practice Expense RVUs for CPT code 76882 and instead set the equipment inputs for both 76881 and 76882 to the lower, portable ultrasound machine which is what 76882 had originally had as an equipment input. This change was the result of comments from other stakeholders, including other professional physician societies, asking that 76882 not be assigned higher PE RVUs than 76881. In the final rule, CMS stated they re-reviewed utilization figures and found that Podiatry is the dominant provider of both 76881 and 76882 and therefore the portable ultrasound machine is the appropriate equipment setting for both codes. CMS also stated they would phase in the

large reduction in total RVUs for 76881 over three years, with 10% RVU reduction for CY 2018 and additional annual 7% reductions for CY 2019 and CY 2020.

Evaluation and Management (E/M) Guidelines

Proposed Rule
In the proposed rule, CMS indicated they asked for a multi-year effort to revise the CMS Evaluation and Management Guidelines which have not been updated since 1997. The agency indicates a desire to use this effort to reduce administrative burden to physicians and streamline E/M guidelines. CMS suggests a focus on eliminating guidelines related to history and physical examination, with greater importance placed on medical decision making and time spent performing the service.

AAOS Comment
The AAOS agreed that streamlined guidelines and requirements for E/M codes would be beneficial to physicians and practices and the AAOS supported the effort by CMS to review and update these guidelines. The AAOS indicated interest and availability to participate in the multi-stakeholder effort.

Final Rule
In the final rule, CMS indicated they are preparing to move forward with the multi-year effort to revise the CMS Evaluation and Management Guidelines which have not been updated since 1997. The agency reiterated their desire to use this effort to reduce administrative burden to physicians and streamline E/M guidelines with a focus on eliminating guidelines related to history and physical examination, and with greater importance placed on medical decision making and time spent performing the service. CMS also thanked stakeholders for their support and interest in participating in the effort.

Appropriate Use Criteria (AUC)

Proposed Rule
In the Proposed Rule, CMS state their intent to delay implementation of The Protecting Access to Medicare Act (PAMA) requirement that CMS create a program that effective January 1, 2017 would have denied payment for advanced imaging services unless the physician ordering the service had consulted appropriate use criteria. In previous rulemaking, CMS had delayed implementation of the advanced imaging AUCs until 2018 and in the 2018 proposed rule the agency is proposing to further delay the requirement until January 1, 2019. This first year of reporting would be regarded as an opportunity for testing and education and would not affect payment to the physician providing the imaging and proposing that physicians who wished to

begin testing earlier could participate in a voluntary reporting period expected to begin on July 2018.

AAOS Comment
The AAOS supported this delay as appropriate and timely and supported the recommended actions. The AAOS also encouraged CMS to provide data from testing as quickly as possible to allow the agency and stakeholders to review the testing and access potential future revisions based on actual data and supported the increased education in this space as outlined in the proposed rule. Lastly, the AAOS recommended additional delay of the implementation of the program and possibly permanently delaying implementation,

Final Rule
In the final rule, CMS increased the delay by another year and finalized the delayed implementation of the AUC for Advanced Imaging program until January 1, 2020.

Physician Quality Reporting System (PQRS)

Proposed Rule
For CY under PQRS 2016, physicians were required to report 9 measures across 3 National Quality Strategy Domains, with one cross-cutting measure included. In the proposed rule, CMS proposed to revise CY 2016 PQRS quality reporting requirements to only require physicians to report 6 measures with no domain or cross-cutting measure requirements. This proposal aligned with the PQRS quality reporting requirements with the new quality reporting requirements for physicians under the Quality Payment Program (QPP) M.

In addition, CMS also proposed to make the CAHPS for PQRS survey optional under GPRO for practices of 100 or more eligible clinicians in 2016.

AAOS comment
The AAOS strongly supported the proposal and the effort to align the current quality programs with the standards for QPP which will take effect for CY 2019.

Final Rule
CMS finalized the retroactive revisions CY 2016 PQRS quality reporting requirements to only require physicians to report 6 measures with no domain or cross-cutting measure requirements. It also finalized making the CAHPS for PQRS survey optional under GPRO for practices of 100 or more eligible clinicians in 2016.

Value-based Modifier

Proposed Rule
In addition to the PQRS changes, CMS also proposed revisions to the value-based modifier (VM) which is designed to incentivize physicians to provide high quality care with lower costs. The agency proposed to hold all groups and solo practitioners who met 2016 PQRS reporting requirements harmless from any negative VM payment adjustments in 201 and halve penalties for those who did not meet PQRS requirements to -2 percent for groups with 10 or more eligible professionals, and to -1 percent for smaller groups and solo practitioners.

AAOS Comments
The AAOS supported the changed to the value-based modifier outline in the proposed rule.

Final Rule
CMS finalized the proposal to hold providers harmless for negative updates for performance year 2016 if they met 2016 PQRS requirements.

<u>Payment incentive to Transition from Traditional X-ray imagine to Digital Radiography and Other Imaging Services</u>

Proposed Rule
In the proposed rule, CMS addressed the requirement under the 2016 Consolidated Appropriations Act which directed CMS to implement a 7 percent reduction in payments for the technical component (TC) for imaging services made under the PFS that are X-rays (including the technical component portion of a global service) taken using computed radiography technology furnished during CYs 2018 through 2022, and for a 10 percent reduction for the technical component of such imaging services furnished during CY 2023 or a subsequent year. Computed radiography technology was defined as cassette based imaging that utilizes an imaging plate to create the image involved. CMS proposed to establish a new modifier to be and that this modifier would be required to be used when reporting imaging services for which payment is made under the PFS that are X-rays (including the X-ray component of a packaged service) taken using computed radiography technology. The modifier would be required on claims for the technical component of the X-ray service, including when the service is billed globally because the PFS payment adjustment is made to the technical component regardless of whether it is billed globally, or billed separately using the –TC modifier. The proposal called for the modifier to be used to report the specific services that are subject to the payment reduction and stated that accurate use is subject to audit. These proposed changes were also included in the 2018 OPPS/ASC proposed rule.

AAOS Comments
In comments to the OPPS proposed rule, AAOS stated the reimbursement reduction for those using CR technology was not fair, inappropriate and would not increase care quality. AAOS

further recommended against requiring a modifier be reported by those using CR technology arguing that this added a significant reporting burden on top of the reimbursement reduction instead recommending a modifier be used to report imaging done with digital technology so as not to add additional burdens onto providers already receiving reduced reimbursements.

Final Rule
CMS finalized the proposal to implement the reduction for 2018 stating they do not believe they have the authority to further delay or eliminate the reduction. They also disagreed with AAOS' recommendation to create a modifier for digital imaging services rather than services done with CR.

Survey of CPT code 27279

Proposed Rule
In the proposed rule, CMS stated they had received input through public comment that CPT code 27279, Arthrodesis, sacroiliac joint, percutaneous or minimally invasive (indirect visualization), with image guidance, includes obtaining bone graft when performed, and placement of transfixing device was potentially misvalued and recommended its RVU inputs be reviewed for CY 2019.

AAOS Comments
In collaboration with AANS/CNS and NASS, AAOS worked with the AMA RUC to recommend delay of the review/revaluation of 27279 until it came up for RUC review in October 2018 as opposed to early in 2018. This would result in any updates being in effect for the Medicare Physician Fee Schedule for CY 2019.

Final Rule
CMS agreed to defer to the RUC and standard RUC review processes for review/revaluation of 27279 but stated they continue to believe 27279 may be misvalued. They indicated that if the RUC provided an updated review in time for the 2018 Medicare Physician Fee Schedule they would incorporate those recommendations into the 2018 CY Physician Fee Schedule, however they left timing up to the RUC leaving open the possibility of reviewing for CY 2019 or future years as an option.