2014 Medicare Physician Fee Schedule Final Rule: Impact on Hip/Knee Arthroplasty

Prepared for AAHKS Members December 3, 2013

On November 27, 2013, CMS released the interim final Medicare physician fee schedule (PFS) rule for calendar year 2014. CMS is making cuts in the CY 2014 interim final RVUs for total joint replacement procedures, but the cuts are not as deep as recommended by the AMA Specialty Society Relative Value Update Committee (RUC), thanks to AAHKS advocacy and the Boots on the Ground initiative. In fact, CMS cites specialty society advocacy efforts in convincing it not to adopt the RUC recommended values for total hip and total knee arthroplasty and instead to "take a cautious approach in valuing these services.

Under the final rule, the work relative value unit (RVU) for CPT code 27130 (total hip arthroplasty) is reduced by 4.9% versus the RUC recommendation of -10%, and the work RVU for CPT code 27447 (total knee arthroplasty) is reduced 10.9% versus the RUC recommendation of -15.6%. Although we are disappointed that CMS adopted cuts for 2014 that were not included in the proposed rule, it is significant that these are the only codes for which CMS adopted higher RVU values than the RUC recommended -- in all other cases, CMS adopted the RUC recommendations or reduced values even more than the RUC recommended. Acknowledging the conflicting data on time inputs for these procedures, CMS has requested comments on the most accurate data sources, and AAHKS will weigh in on this issue with the goal to further mitigate the reduction in RVUs for these critical procedures.

Moderating the cuts in the relative values for total joint replacement procedures was a significant accomplishment for AAHKS. It would not have been possible without the concerted efforts of AAHKS Boots on the Ground volunteers and countless other AAHKS members who reached out to their lawmakers to protect patient access for these procedures, along with our congressional allies who weighed in with CMS. While AAHKS will be working to present CMS with the most accurate data on which to base payment for these critical procedures going forward, it is important to stop and acknowledge our success in limiting the RUC-recommended cuts. We should also acknowledge the support provided by the AAOS as well as the efforts by advocates like Free-to-Move.org, supported by Biomet.

The following additional highlights from the interim final rule have been provided by our Government Relations team at Reed Smith (note that the 1000+ page rule continues to be reviewed). Of particular note, AAHKS members – along with all other physicians who accept Medicare patients – are still facing significant reimbursement cuts under the statutory Sustainable Growth Rate (SGR) formula, which Congress hopefully will avert as it has often done in the past.

Hip/Knee Replacement RVUs:

By way of background, CMS announced in the proposed MPFS rule for 2012 that it was asking the RUC to review certain "potentially misvalued codes," including CPT codes 27447 (Total Knee Arthroplasty) and 27130 (Total Hip Arthroplasty). As a result of its review, this spring the RUC forwarded to CMS recommendations for significant reductions in relative value units (RVUs) for these procedures, which we believe were based on flawed survey data. While CMS did not disclose the potential cuts in the

proposed 2014 rule released this summer, we expected CMS to announce the new RVUs for hip and knee arthroplasty in the interim final rule, effective January 1, 2014.

AAHKS conducted a full-scale education and advocacy effort, through which Members of Congress, physicians, and Medicare beneficiaries flooded CMS with letters expressing concern about (1) the lack of transparency in the CMS process, and (2) the potential negative impact of significant cuts on beneficiary access to care.

In the final rule, CMS acknowledges that medical societies "raised several objections to the RUC's recommended values, including the inconsistent data sources used for determining the time for this recommendation relative to its last recommendation in 2005, concerns regarding the thoroughness of the AMA RUC's review of the services, and questions regarding the appropriate number of visits estimated to be furnished within the global period for the codes." After reviewing the specialty society evidence, CMS states in the final rule that "we share concerns raised by stakeholders regarding the appropriate valuation of these services, especially related to using the most accurate data source available for determining the intraservice time involved in furnishing PFS service." CMS notes in particular the "significant variation between the time values estimated through a survey versus those collected through specialty databases," including differing estimates of the value of postoperative visits that typically occur in the global period for these procedures.

Based on the divergent recommendations from the specialty societies and the RUC, CMS decided to "take a cautious approach in valuing these services." While CMS agreed with the RUC's recommendation to value CPT codes 27130 and 27447 equally, CMS concluded that it is "appropriate to modify the AMA RUC-recommended RVU to reflect the visits in the global period as recommended by the specialty societies." This results in a 1.12 work RVU increase for the visits in the global period, which was added to the RUC-recommended work RVU of 19.60 for CPT codes 27130 and 27447, resulting in an interim final work RVU of 20.72 for both services. This represents a 4.91% reduction for total hip arthroplasty and a 10.88% reduction for total knee arthroplasty – more than we would have liked but a substantial improvement over the RUC recommendations. Again, it is important to note that total hip and knee codes were the only codes for which CMS increased the work RVU as a time refinement – in other cases CMS adopted or revised downward the RUC recommendations – making the AAHKS achievement even more significant.

These new values are <u>interim</u> values for 2014. To finalize values for these services for CY 2015, CMS is seeking public comment regarding (1) the appropriate work RVUs for these services, and (2) the most appropriate reconciliation for the conflicting information regarding time values for these services as presented to CMS by the physician community. CMS also invites public comment on the use of specialty databases as compared to surveys for determining time values. CMS is especially interested in potential sources of objective data regarding procedure times and levels of visits furnished during the global periods for the services described by these codes.

AAHKS achieved an impressive accomplishment in moderating the RUC recommendations and convincing CMS of the flaws in the RUC analysis. AAHKS will be analyzing its options and submitting

additional recommendations to CMS during the official comment period to ensure that final values are accurate. We also will be mobilizing our Boots on the Ground volunteers and our allies on the Hill to reinforce our message about proper values for hip/knee replacement procedures. We plan on engaging with our congressional advocates to safeguard these procedures for 2015 and beyond.

Sustainable Growth Rate Formula: 20.1% Across-the Board Cut.

The final rule includes a 20.1% across-the-board rate cut to physician payments that is attributable to the statutory SGR formula (compared to 24.4% under the proposed rule). For 2014, the SGR formula, coupled with other payment policy changes results in a conversion factor of $27.2006, compared to the 2013 CF of $34.0230.

While there is still an expectation that Congress will eventually override this payment cut, the timing and scope of such a "fix" is unclear (it may not happen until next year). CMS commits to continuing to "work with Congress to fix this untenable situation so doctors and beneficiaries no longer have to worry about the stability and adequacy of payments from Medicare under the Physician Fee Schedule."

If Congress includes a freeze in the physician fee schedule update as part of the SGR fix, CMS estimates that the conversion factor would actually be *increased* for 2014 compared to 2013 levels because CMS would still apply a budget neutrality adjustment as mandated by law to prevent RVU adjustments from increasing or decreasing expenditures by more than $20 million. CMS currently anticipates that in the event of a zero percent update, the 2014 conversion factor would be adjusted to $35.6446.

CMS illustrates the potential impact of the various conversion factor scenarios on selected procedures, including hip and knee arthroplasty, in table 29. In this table, payments in the "CY 2013" column are calculated using the 2013 conversion factor of 34.0230, payments in the "CY 2014 (pre update)" column are based on the 2013 conversion factor of 34.0230, adjusted to 35.6446 to include the budget neutrality adjustment, and payment in the "CY 2014 (post update)" column are based on the 2014 conversion factor of 27.2006 (full SGR cut).

			Facility				
CPT/ HCPCS [1]	MOD	Short Descriptor	CY 2013 [2]	CY 2014 [3] (pre update)	% Change (pre update)	CY 2014 [4] (post update)	% Change (post update)
11721		Debride nail 6 or more	$24.50	$25.30	3%	$18.59	-24%
17000		Destruct premalg lesion	$57.16	$53.09	-7%	$39.02	-32%
27130		Total hip arthroplasty	$1,454.48	$1,393.78	-4%	$1,024.43	-30%
27244		Treat thigh fracture	$1,242.18	$1,260.53	1%	$926.49	-25%
27447		Total knee arthroplasty	$1,552.81	$1,393.06	-10%	$1,023.91	-34%

The bottom line is that if CMS adopts a zero percent payment update (which is speculative at this point), CMS expects that, once all other adjustments are applied, reimbursement for total hip arthroplasty will be reduced by approximately 4% and reimbursement for total hip arthroplasty will be reduced by approximately 10%. In the absence of Congressional action, total hip payment would fall by 30% and total knee reimbursement would be cut by 34%.

We are attaching spreadsheet with payment calculations for various hip and knee procedures under the various payment scenarios.

Physician Value-Based Payment Modifier

Under the value-based payment modifier program, CMS will adjust payment to physicians based on the quality of care compared to costs, as mandated by the Affordable Care Act. The value-based payment modifier is being phased in over three years (from 2015 to 2017). CY 2014 is the performance period for the CY 2016 value-based payment modifier.

In the final rule, CMS continues to phase in implementation of the value-based payment modifier by applying it to groups of 10 or more eligible physicians in 2016, as proposed (compared to groups of 100 in 2015). CMS expects this expansion to result in almost 60% of physicians to be included in the value-based modifier program in 2016. CMS also adopted its proposal to increase the amount of payment at risk from 1% to 2% in 2016. CMS also is refining the methodologies used to calculate the value-based payment modifier to better identify both high and low performers for upward and downward payment adjustments. In addition, CMS announced that CY 2015 will be the performance period for the application of the CY 2017 value-based payment modifier; CMS encourages smaller physician practices and solo practitioners to use 2014 as a "practice" year so that they are ready for the value-based payment modifier in 2015.

Cap on Physician Payments at HOPPS/ASC Rate

CMS proposed reducing MPFS rates for more than 200 codes if Medicare physician office payment exceeds the payment in the hospital outpatient department (HOPD) or ambulatory surgical center (ASC) setting. CMS proposed limiting PFS payment in such cases to the total payment that Medicare would make to the practitioner and the facility when the service is furnished in a hospital outpatient department or ASC. Certain services would be exempt from this provision, including services without separate hospital outpatient prospective payment system (OPPS) payment rates and codes already subject to cuts pursuant to the Deficit Reduction Act imaging cap, among others).

CMS is not finalizing this proposal for 2014, even though CMS continues to believe that when Medicare pays more for a specific procedure in a physician's office compared to a HOPD or ASC, it is essentially a result of data anomalies/overpayments under the Medicare physician fee schedule. CMS concedes, however, that the overwhelmingly majority of commenters objected to the proposed policy, and the public provided thoughtful and detailed technical comments that need to be considered. After further consideration of these comments, CMS expects to develop a revised proposal for using OPPS and ASC rates in developing PE RVUs, which CMS will propose through future notice and comment rulemaking.

Sequestration

CMS notes that the 2014 MPFS Update Adjustment Factor (UAF) is not affected by sequestration (p. 525) – in other words, any sequestration reduction is separate from and in addition to any reductions under the statutory update formula. Under the Budget Control Act of 2011, as modified by the American Taxpayer Relief Act of 2012, Medicare fee-for-service (FFS) claims generally will incur a 2% reduction through FY 2021 unless Congress passes legislation that meets specified budget targets or otherwise lifts or modifies the sequestration requirements.

Quality Measures

CMS proposed to modify the minimum amount of measures that may be included in a PQRS measures group from four to six quality reporting measures. As a result, for the total knee replacement measure group for 2014 and beyond, CMS proposed to include four AAHKS-developed total knee replacement measures and two other quality reporting measures: (1) Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention (#226), and (2) Documentation of Current Medications in the Medical Record (#130). While AAHKS accepted increasing the minimum to six measures and agreed with CMS that tobacco use is an important public issue, we commented that it would be more appropriate to include a measure similar to the functional status assessment for knee replacement quality measure to be used in CMS's EHR Incentive Program for Eligible Professionals.

CMS decided not to add additional measures to measures groups that previously contained less than six. CMS specifically noted AAHKS' comment in the interim final rule. In response, CMS stated:

Since we are not finalizing the proposal to increase the number of measures in a measures group from four to six, we are retaining the Total Knee Replacement measures group for 2014 as finalized in the CY 2013 PFS final rule (77 FR 69272), without PQRS #130 and PQRS #226 in the measures group as proposed.

Notably, CMS does still plan to increase the minimum number of measures in a measures group in the future. CMS stated that it "will work with the measure developers and owners of these measures groups to appropriately add measures to measures groups that only contain four measures within the measures group."

Physician Enrollment Period

CMS is extending the annual Medicare participation enrollment period for 2014 through January 31, 2014 (instead of December 31, 2013). During this period, eligible physicians may change their participation status; the effective date for any participation status changes made during the extension remains January 1, 2014.

Additional Information

The text of the rule and the associated payment files are posted at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices-Items/CMS-1600-FC.html The official version of the rule will be published in the Federal Register on December 10, 2013. Comments on limited provisions, including the 2014 interim relative values for hip and knee replacement, will be accepted until January 27, 2014.