

September 6, 2016

VIA E-MAIL FILING

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1654-P
P.O. Box 8013
Baltimore, MD 21244-8013

RE: CY 2017 Medicare Physician Fee Schedule Proposed Rule

The American Association of Hip and Knee Surgeons (“AAHKS”) appreciates the opportunity to submit comments to the Centers for Medicare & Medicaid Services (“CMS”) on its Medicare Physician Fee Schedule (“MPFS”) proposed rule for calendar year 2017 (hereinafter referred to as “CY 2017 MPFS proposed rule” or “proposed rule”).

AAHKS is the foremost national specialty organization of 2,900 physicians with expertise in total joint arthroplasty (“TJA”) procedures. Many of our members conduct research in this area and are experts on the evidence based medicine issues associated with the risks and benefits of treatments for patients suffering from lower extremity joint conditions. AAHKS offers these comments in anticipation of continued close collaboration with CMS to ensure Medicare physician payment reforms benefit from our expertise and experience in TJA procedures.

Our comments focus on the following provisions of the CY 2017 MPFS proposed rule:

I. Collecting Data on Resources Used in Furnishing Global Services – Section II.D.6

In 2015, CMS adopted a proposal to transform all 10-day and 90-day global codes to 0-day global codes in 2017 and 2018, respectively. However, in section 523(a) of the Medicare Access and CHIP Reauthorization Act of 2015 (“MACRA”), Congress prohibited CMS from implementing the policy, and instead required CMS to collect data to value surgical services. Such data collection must begin no later than January 1, 2017, and must include the number and level of medical visits furnished during the global period and other items and services related to the surgery and furnished during the global period. Beginning in 2019, CMS must use the information collected as appropriate, along with other available data, to improve the accuracy of valuation of surgical services under the MPFS.

For 2017, CMS proposes a three-pronged approach for data collection related to the volume and costs of the resources typically used in pre- and post-operative care in order to accurately value the 4,200 codes with a 10-day or 90-day global period. The proposed three-pronged approach includes:

- (1) Claims-based reporting about the number and level of pre- and post-operative visits furnished for 10-day and 90-day global services.
- (2) A survey of a representative sample of practitioners about the activities involved in and the resources used in providing a number of pre- and post-operative visits during a specified, recent period of time, such as two weeks.
- (3) A more in-depth study, including direct observation of the pre- and post-operative care delivered in a small number of sites, including some accountable care organizations (“ACOs”).

AAHKS Comments: Section 523 of MACRA adds a new paragraph (8) to Section 1848(c) of the Social Security Act. The new statutory language in Section 1848(c)(8)(B)(i) states that “the Secretary shall through rulemaking develop and implement a process to gather, from a representative sample of physicians, beginning not later than January 1, 2017, information needed to value surgical services.” CMS’s proposal to require reporting from all physicians who furnish services subject to the 10-day and 90-day global periods exceeds Congress’s mandate for the agency to collect information “from a representative sample of physicians.” Requiring all such physicians to report a new set of codes to document the type, level and number of pre- and post-operative visits furnished during the global period, for each 10-minute increment of service provided, for every global surgery procedure is unduly burdensome to surgical practices and to CMS itself. On top of that, CMS also proposes to survey “a large, representative and random sample of practitioners and their clinical staff” who bill for 10-day and 90-day global surgery procedures, thereby adding another layer of administrative burden on these surgical practices subject to the extra survey.

The global period is an important concept for orthopaedic surgical procedures, encouraging appropriate follow-up care, providing a settled bundled payment structure for surgeons, and ensuring co-payment certainty for patients. In fact, the concept of a bundle of follow-up services that are typically associated with surgery is one of the reasons major orthopaedic procedures such as TJA procedures have been featured in the earliest bundled payment initiatives, including the Bundled Payments for Care Improvement (“BPCI”) Initiative and the Comprehensive Care for Joint Replacement (“CJR”) Model.

Post-operative hospital and office visit resources are currently part of the Relative Value Scale Update Committee (“RUC”) valuation process. Accordingly, CMS should address concerns about the accuracy of post-surgical visit assumptions for particular procedures by working with impacted specialty societies and undertaking reviews of those procedures using the existing

review framework, rather than creating an overly burdensome new coding structure for reporting such information for every global surgery procedure.

II. Improving Payment Accuracy for Primary Care, Care Management Services, and Patient-Centered Services – Section II.E.

CMS is proposing a number of changes to coding and payment policies to improve how Medicare pays for services provided by primary care physicians and other practitioners for patients with multiple chronic conditions, mental and behavioral health issues, as well as cognitive impairment or mobility-related impairments.

AAHKS Comment: We support CMS’s efforts to recognize and pay for the care coordination and management activities that physicians engage in for complex patients. CMS should consider broadening coverage of and payment for alternative means of physician follow-up with surgical patients, such as allowing physicians to bill for all post-surgical telephone consultations, post-operative check ins, and clinical care-related email communication with patients.

III. Appropriate Use Criteria for Advanced Diagnostic Imaging Services – Section III.C.

Section 218(b) of PAMA requires CMS to establish a program to promote the use of appropriate use criteria (“AUC”) for advanced diagnostic imaging services. In the 2016 MPFS final rule, CMS specified how applicable AUC will be identified through provider-led entities (“PLEs”) that become qualified by CMS to develop, modify or endorse AUC. In the 2017 MPFS proposed rule, CMS outlines requirements and processes for specification of qualified clinical decision support mechanisms (“CDSMs”) under the Medicare AUC program; the initial list of priority clinical areas; and exceptions to the requirement that ordering professionals consult specified applicable AUC when ordering applicable imaging services.

AAHKS Comments:

CMS proposes a list of priority clinical areas that may be used in the determination of outlier ordering professionals in future phases of the Medicare AUC program. The following clinical groupings identified as priority clinical areas account for roughly 40 percent of Part B advanced diagnostic imaging services paid for by Medicare in 2014:

- Chest pain (including 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

We believe that suspected pulmonary embolism should be a separate priority clinical area. Further, we believe that the list of priority clinical areas should be expanded to include “Joint Pain”, including the use of advanced diagnostic imaging, such as MRIs, to identify joint disease in the knee, such as osteoarthritis.

IV. Medicare Advantage Provider Enrollment – Section III.I.

Currently, Medicare Advantage plans may include in their networks providers and suppliers that are not enrolled in Medicare. However, CMS proposes to require providers and suppliers to enroll in Medicare in order to provide healthcare items or services to Medicare enrollees receiving benefits through a Medicare Advantage organization. The proposed rule would require locum tenens suppliers, incident-to suppliers and suppliers participating in demonstration and pilot programs to enroll in Medicare. The new enrollment requirements would also apply to Medicare Advantage organizations that provide drug coverage.

AAHKS Comment: We support CMS’s efforts to protect Medicare beneficiaries and Medicare trust fund dollars from fraud, waste and abuse. However, it is overly burdensome and infeasible to require all providers and suppliers to enroll in Medicare in order to provide healthcare items or services to Medicare enrollees receiving benefits through a Medicare Advantage organization.

AAHKS appreciates your consideration of our comments. If you have any questions, you can reach me at mzarski@aahks.org, or you may contact Joshua Kerr at jkerr@aahks.org.

Sincerely,



Michael J. Zarski, JD
Executive Director
AAHKS