AAOS
American Academy of Orthopaedic Surgeons
American Association of Orthopaedic Surgeons

2019 Medicare Physician Fee Schedule Summary

On November 1, 2018, the Centers for Medicare & Medicaid Services (CMS) issued a final rule that includes updates to payment policies for services furnished under the Medicare Physician Fee Schedule (MPFS) on or after January 1, 2019.

Conversion Factor

With the budget neutrality adjustment to account for changes in RVUs, all required by law, the final 2019 PFS conversion factor is $36.04, a slight increase above the 2018 PFS conversion factor of $35.99.

Streamlining Evaluation and Management Payment and Reducing Clinician Burden: Summary

For CYs 2019 and 2020, CMS is implementing several documentation policies to provide immediate burden reduction, while other changes to documentation, **coding, and payment would be implemented in CY 2021**.

For CY 2019 and CY 2020, CMS will continue the current coding and payment structure for E/M office/outpatient visits and practitioners should continue to use either the 1995 or 1997 E/M documentation guidelines to document E/M office/outpatient visits billed to Medicare. For CY 2019 and beyond, CMS is finalizing the following policies:

- Elimination of the requirement to document the medical necessity of a home visit in lieu of an office visit;
- For established patient office/outpatient visits, when relevant information is already contained in the medical record, practitioners may choose to focus their documentation on what has changed since the last visit, or on pertinent items that have not changed, and need not re-record the defined list of required elements if there is evidence that the practitioner reviewed the previous information and updated it as needed. Practitioners should still review prior data, update as necessary, and indicate in the medical record that they have done so;
- Additionally, for E/M office/outpatient visits, for new and established patients for visits, practitioners need not re-enter in the medical record information on the patient's chief complaint and history that has already been entered by ancillary staff or the beneficiary. The practitioner may simply indicate in the medical record that he or she reviewed and verified this information; and

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

- Removal of potentially duplicative requirements for notations in medical records that may have previously been included in the medical records by residents or other members of the medical team for E/M visits furnished by teaching physicians.

Specifically for CY 2021, CMS is finalizing the following policies:

- Reduction in the payment variation for E/M office/outpatient visit levels by paying a **single rate for E/M office/outpatient visit levels 2 through 4** for established and new patients while maintaining the payment rate for E/M office/outpatient visit level 5 in order to better account for the care and needs of complex patients;

- Permitting practitioners to choose to document E/M office/outpatient level 2 through 5 visits using medical decision-making or time instead of applying the current 1995 or 1997 E/M documentation guidelines, or alternatively practitioners could continue using the current framework;

- Beginning in CY 2021, for E/M office/outpatient levels 2 through 5 visits, CMS will allow for flexibility in how visit levels are documented— specifically a choice to use the current framework, MDM, or time. For E/M office/outpatient level 2 through 4 visits, when using MDM or current framework to document the visit, CMS will also apply a minimum supporting documentation standard associated with level 2 visits. For these cases, Medicare would require information to support a level 2 E/M office/outpatient visit code for history, exam and/or medical decision-making;

- When time is used to document, practitioners will document the medical necessity of the visit and that the billing practitioner personally spent the required amount of time face-to-face with the beneficiary;

- Implementation of add-on codes that describe the additional resources inherent in visits for primary care and particular kinds of non-procedural specialized medical care, though they would not be restricted by physician specialty. These codes would only be reportable with E/M office/outpatient level 2 through 4 visits, and their use generally would not impose new per-visit documentation requirements; and

- Adoption of a new "extended visit" add-on code for use only with E/M office/outpatient level 2 through 4 visits to account for the additional resources required when practitioners need to spend extended time with the patient.

CMS believes these policies will allow practitioners greater flexibility to exercise clinical judgment in documentation, so they can focus on what is clinically relevant and medically

necessary for the beneficiary. CMS intends to engage in further discussions with the public to potentially further refine the policies for CY 2021.

After consideration of concerns raised by commenters in response to the proposed rule, CMS is not finalizing aspects of the proposal that would have: (1) reduced payment when E/M office/outpatient visits are furnished on the same day as procedures, (2) established separate coding and payment for podiatric E/M visits, or (3) standardized the allocation of practice expense RVUs for the codes that describe these services. AAOS had commented against all three of these proposed changes.

CMS also stated they will consider allowing separately billable E/M visits for physicians in the same practice who provide E/M services to established patients of another physician in the same practice.

New or Revised CPT codes for the 2019 Medicare Physician Fee Schedule

Orthopaedic codes reviewed for the 2019 MPFS are listed in the table below.

CPT Tracking Code	Descriptor	RUC Recommended Work RVU	CMS Proposed Work RVU	CMS Final Work RVU
20551	Injection tendon origin/insertion	0.75	0.75	0.75
209X3	Allograft, includes templating, cutting, placement and internal fixation when performed; osteoarticular, including articular surface and contiguous bone	13.01	13.01	13.01
209X4	Allograft, includes templating, cutting, placement and internal fixation when performed; hemicortical intercalary, partial (ie, hemicylindrical)	11.94	11.94	11.94
209X5	Allograft, includes templating, cutting, placement and internal fixation when performed; intercalary, complete (ie, cylindrical)	13.00	13.00	13.00

29105	Application of long arm splint	0.80	0.80	0.80
64455	Injection Digital Nerves	0.75	0.75	0.75
72100	X-Ray Exam L-S Spine, 2 or 3 views	0.22	0.23	0.22
72020	X-Ray Exam Spine, 1 view, specify level	0.15	0.23	0.15
72114	X-Ray Exam L-S Spine, Complete w/ bend, 6 views	0.31	0.23	0.31
72120	X-Ray Exam L-S Spine, bending only, 2 or 3 views	0.22	0.23	0.22
72200	X-Ray Exam SI Joints, less than 3 views	0.17	0.23	0.17
72202	X-Ray Exam SI Joints, 3 or more views	0.18	0.23	0.18
72220	X-Ray Exam Sacrum- Coccyx, minimum 2 views	0.17	0.23	0.17
73070	X-Ray Exam Elbow, 2 views	0.15	0.23	0.15
73080	X-Ray Exam Elbow, Complete, minimum 3 views	0.17	0.23	0.17
73090	X-Ray Exam Forearm, 2 views	0.16	0.23	0.16
73650	X-Ray Exam Heel, minimum 2 views	0.16	0.23	0.16
73660	X-Ray Exam Toe(s), minimum 2 views	0.13	0.23	0.13

Determination of Practice Expense (PE) Relative Value Units (RVUs)

Low Volume Services

CMS finalized a proposal in the CY 2018 PFS final rule to use the most recent year of claims data to determine which codes are low volume for the coming year (those that have fewer than 100 allowed services in the Medicare claims data). For a procedure infrequently performed on the Medicare population, low volume status would subject its code to year-to-year fluctuation in the dominant specialty. This creates substantial year-to-year

variability in PE RVUs. To address this issue, codes falling into this category are assigned to a dominant specialty based on medical review and input from expert stakeholders. The AAOS will continue to collaborate with the American Medical Association (AMA) Relative Value Scale Update Committee (RUC) on annual maintenance of the list and urges CMS to continue to utilize this list for developing PE and Professional Liability Insurance (PLI) RVUs. This is consistent with AAOS comments to the 2018 MPFS proposed rule highlighting the work being done by the AMA RUC in reviewing low volume codes. We also recommend that CMS follow that same logic for all codes subject to dominant-specialty variation due to low Medicare utilization.

The procedure described by Current Procedural Terminology (CPT) code 22857 (*Total disc arthroplasty (artificial disc), anterior approach, including discectomy to prepare interspace (other than for decompression), single interspace, lumbar)* is missing from the proposed list published by CMS. Since CMS has a National Coverage Decision that precludes performing the procedure on patients over sixty-five, the number of Medicare claims has remained well below

100. In fact, Medicare claims have not exceeded 10 for the past several years. A small change in claims data between 2015 and 2016, led to an 18 percent decrease in PE RVUs. To maintain payment stability and exempt it from annual fluctuation, **we request that CMS include CPT code 22857 in the low utilization category and permanently assign it to the orthopaedic surgery specialty.**

Final Rule Response

CMS agreed, adding 22857 to low volume services list and assigned under Orthopaedic Surgery for dominant specialty.

Changes to Direct PE Inputs for Specific Services

Market-Based Supply and Equipment Pricing Update

CMS is proposing to adopt the updated direct PE input prices for supplies and equipment as recommended by StrategyGen. CMS proposes to phase in the new pricing over a 4-year period. The AAOS has serious concerns with the validity of pricing updates with such dramatic shifts, such as increases for a patient gown (SB026) from $0.53 to $3.54. Additionally, SA081 (pack, drapes, ortho, small) includes 4 units of SB019 (drape-towel, sterile 18in x 26in) are currently priced at 1.128 and 0.282, respectively. However, StrategyGen recommended pricing SA081 (four towels) at 1.000 and SA019 (one towel) at 0.920. With such large variation in pricing changes, StrategyGen should supply more granular data for each recommendation, including greater specificity of items and source of

pricing. **We urge CMS to delay a pricing update until the information requested above is made available and stakeholders have ample time to produce invoices which may refute the proposed amounts.**

Final Rule Response

CMS did not agree, and is implementing updated price changes for 2019 final rule with variation on a code-by-code basis.

Digital Radiography (DR) PE Inputs

The AAOS would like to raise the issue of the PE inputs for radiology rooms. The 2018 payment year began to apply a 7 percent reduction to the technical component of those services not performed using digital radiography. This action will have a negative impact on orthopaedic physician offices, where computerized radiography (CR) is most commonly used. Currently, PE inputs are based on the less costly CR systems. If CMS presumes that DR is the "standard", we would argue that **PE inputs should be updated to reflect the cost of digital systems**. This increase should be applied to all x-ray codes, retroactive to January 1, 2018.

Final Rule Response

CMS did not address the issue in the final rule.

Modernizing Medicare Physician Payment by Recognizing Communication Technology-Based Services

New technology has vastly changed how information is gathered and shared between the patient and provider. The AAOS appreciates the efforts to address these changes through the introduction of communication technology-based telehealth services and supports the addition of the GVCI1 and GRAS1 codes. Communication between visits and coordination of care are essential and overlooked activities. Yet, resting outside of evaluation and management, neither are reimbursed. Patient Portals are an entirely new work stream that are not captured by current guidelines, although they often serve as a means of patient-provider communication addressing medical decision-making and alterations in care plans. Often, these are check-ins that provide simple instruction or needed reassurance in lieu of a visit. We support reimbursing all means of patient contact work (i.e., telephone, e-mail, patient portal, fax). The AAOS does feel that the limitation of these services to those that are patient-initiated undervalues recent increases in care coordination efforts. Provider outreach to established patients could obviate the need for unexpected follow up visits.

The AAOS believes care coordination is an implicit necessity for value-based care. We commend CMS for expanding telehealth options to include interprofessional communication with the creation of CPT codes 994X0 and 994X6. **We agree with the RUC that these codes should have work RVUs valued at 0.50 and 0.70, respectively.**

Final Rule Response

CMS finalized the values for the final rule

CY 2019 Identification and Review of Potentially Misvalued Services

Public Nominations

CMS received a public nomination for potentially overvalued codes based on the opinion that previous RUC review did not result in appropriate reductions in surveyed times and valuation. This nomination included total hip arthroplasty (27130) and total knee arthroplasty (27447). The submitter requested that the codes be prioritized for review under the potentially misvalued code initiative.

While there is no definitive proposal by CMS to review these codes, the AAOS does not believe any further action on this nomination is warranted. In 2013, the RUC and CMS reviewed and validated the current RVU values. There is no data to indicate a change in the work of performing the procedure or the number of post-op follow up visits since that time. This nomination was not received during the proposed or final rule comment period and is, therefore, not publicly available in the Federal Docket Management System. **The AAOS asks for transparency in these types of nominations by requiring nominations to supply the source and be submitted through the comment period.**

CMS Response

CMS did not agree with commenters stating 27130 and 27447 do not require review and moved 27130 and 27447 into the officially potentially misvalued code status and asked for a review.

In the final rule, CMS stated they agreed with commenters, including the original nominating stakeholder, that for many of the codes identified, including 27130 and 27447, when the codes were most recently reviewed and revalued that times were reduced substantially but the work RVU reductions were relatively less. CMS stated they are concerned with the resulting increase in the intensity of work. Hence CMS finalized these codes as potentially mis-valued and asked for further review of these high-volume codes by the RUC and other stakeholders. *CMS reiterated that the inclusion of a code on a potentially misvalued code list does not necessarily*

means that a particular code is misvalued. Instead, the list is intended to prioritize codes to be reviewed under the misvalued code initiative.

Update on the Global Surgery Data Collection

CMS believes the minimal 99024 reporting during 10-day global periods suggests that post- operative visits are not typically being furnished. CMS requested feedback on alternative explanations for the low percentage of reporting of this code.

The AAOS appreciates the intention to use the data already gathered to further evaluate an explanation for low reporting, but we do not have the raw data for the procedures, beneficiaries, and specialties that CMS used for analysis. In the presentation of statistics, CMS notes that "multiple procedures performed on a single day and procedures with overlapping global periods were excluded because matching may be unclear in these circumstances." Although CMS indicates it excluded records where more than one code was reported on the same date, we wonder if codes reported with modifiers were considered. For example, a 10-day global code, reported almost exclusively by orthopaedic surgeons, was also reported with modifier 58 (Unplanned Return to the Operating/Procedure Room by the Same Physician or Other QHP Following Initial Procedure for a Related Procedure During the Postoperative Period) 50 percent of the time. Modifier 58 does not reset the global period of the primary procedure and is paid at a reduced rate. This is also true for several other 10-day global codes reported by orthopaedic surgeons. It is possible that a post-op visit was performed, but not reported in conjunction with procedures reported with modifier 58. Instead, the visit would have been related to another 90- day global primary procedure that may or may not have been on the list of codes under review by CMS.

Alternatively, the measured low frequency of post-operative visits in the 10-day global period could be explained by system and process errors. CMS conducted research and collected data to assess whether global codes are correctly valued. If there were accurate and valid data to indicate that a visit is “not typical”, the code should be revalued using a standard RUC process. However, the data did not show that global codes are misvalued and we believe CMS has met its statutory requirements.

Regarding “transfer of care” modifiers (-54, -55), it is our opinion that the formal transfer of care policy is clear and should be used when postoperative office visits are transferred to another provider. For orthopaedic surgeons, this might occur if a patient is treated for a fracture, while on vacation or in an emergency department, but follow-up is assumed by another provider. We believe orthopaedic surgeons understand how to report the correct modifiers and that a change in policy is unnecessary.

Final Rule Response

CMS indicated they will consider potential changes to global period packages and assignments in future rulemaking but did not propose changes for the 2019 MPFS

Valuation of Specific Codes

Injection Tendon Origin/ Insertion *(20551)*

The RUC recommended direct PE inputs of 3 minutes for "Education and consent" and 2 minutes for "Review home care instructions" for this procedure. These clinical staff activities are not included in an E/M service. This injection is more involved and invasive than a vaccination (90470, 90471), which was allowed 3 minutes for "F/u on physician's discussion w/patient/parent & obtain actual consent signature" and an additional 3 minutes for home care instructions and recording vaccine information in the medical record (expiration, lot number), in addition to the inputs for an E/M service that would be reported on the same day. We urge CMS to accept the RUC recommended times for these clinical staff activities.

CMS Response

CMS accepted the recommended values as final for 2019

Application of Long Arm Splint *(29105)*

CMS did not accept the RUC- recommended direct PE inputs for equipment used in the application of a long arm splint. CMS does not indicate what service period time was removed from the calculation. This makes it difficult to determine if this is accurate or not. Since CMS is present and corrects times at the RUC meeting, we do not know what further corrections were made. **We request more information about this change and that CMS publish the specific calculations used to determine time for different pieces of equipment.**

CMS Response

CMS accepted the recommended values as final for 2019

X-Ray Codes *(72020, 72040, 72050, 72052, 72070, 72072, 72074, 72080, 72100, 72110, 72114,*
72120, 72200,72202, 72220, 73070, 73080, 73090, 73650, and 73660)

The RUC reviewed twenty x-ray codes employing a "crosswalk methodology," in which they derived physician work and time components for CPT codes by comparing them to similar CPT codes. CMS chose not to accept the RUC recommendation because the crosswalk was applied to several codes that have not been surveyed since 1995. Since all twenty of the CPT codes in this group have very similar intraservice time (3-5 minutes) and total time (5-8 minutes), instead CMS calculated the utilization weighted average RUC-recommended work RVU for the codes as an alternative to the crosswalk. We disagree with this methodology, as it is not resource-based.

More physician time is required to review five to six views, when compared with one to two views. A greater number of views also utilizes more clinical staff time, supplies, and equipment time. Lastly, beneficiaries' out of pocket expenses will not be reflective of the particular service they received. **We urge CMS to accept the RUC recommendations which differentiate work and practice expenses between these services.**

CMS also did not accept the RUC-recommended time for the basic radiology room for x-ray codes 72020, 72040, 72050, 72052, 72070, 72072, 72074, 72080, 72100, 72110, 72114, and

72120. However, CMS does not indicate what service period was removed from the calculation for equipment time. This makes it difficult to determine if this is accurate or not. Since CMS attends and corrects times at the RUC meeting, we do not know what further corrections were made. **We request more information about this change and that CMS publish specific calculations that it uses to determine time for different pieces of equipment.**

Regarding code 73660, X-Ray Exam Toe, the specialties and the RUC PE Subcommittee agreed that the typical patient for this service would not require a patient gown. This is different than other codes in the family where the patient may need to be rotated lateral and prone for different views. The RUC PE Subcommittee pays special attention to resource-based differences between codes. The AAOS was included in the review of PE inputs for 73660 and agrees that a patient gown for this code is not typical.

CMS Response

CMS revised the values from the proposed rule for the 2019 MPFS and is maintaining current (2018) work and PE RVUs while AAOS, ACR, and other societies conduct surveys and present survey data to RUC and CMS for 2020 Physician Fee Schedule.

Evaluation and Management (E/M) Visits

The AAOS applauds CMS' attempt at reducing the administrative burden on physicians by proposing to reduce documentation requirements for office visit E/M codes, as described in the 2019 MPFS proposed rule. We acknowledge the importance of this opportunity to make a generational and fundamental change to guidelines that provide clarity, consistency, and simplicity. We agree that, if constructed correctly, updating guidelines will be beneficial to patients, physicians, and overall quality. Moreover, the guidelines, which were last updated in 1997, do not reflect the significant changes in the workstream of today's physicians. As we continue to focus on value-based care, increase our reliance on technology, and explore the utilization of team-based care, we must re-evaluate our methods of documentation. The AAOS is pleased to provide comment on multiple components of E/M updates under consideration in this proposed rule.

CMS states that a thorough analysis was undertaken to inform the proposed changes to the guidelines. An independent AMA evaluation of the effect on specialties of a single payment rate was inconsistent with CMS' results. We question the reliability of the analysis and are concerned that savings in labor costs have been miscalculated. We believe that most of the time and labor saved on documentation will be after hours and on weekends, which does not equate to savings in "work time".

Documentation Changes for Office or Other Outpatient E/M Visits

AAOS appreciates the efforts of CMS to comprehensively apply the tenets of the Patients Over Paperwork initiative. The AAOS supports a history and physical exam with documentation guidelines that exclude unnecessary data points and redundant information. Interim history and physical documentation for established patients should be focused and relevant. We believe that the history and physical and Medical Decision Making (MDM) are both necessary components of E/M. However, the point system for history and physical documentation remains time consuming despite the use of electronic health records (EHR). Components of patient history are stored and remain available in the electronic health record; re-entering data serves no purpose.
We also encourage CMS to support team-based care by finalizing the proposal to allow non-physician staff to enter clinical information into the health record. Physician attestation should be sufficient to support the documentation requirement.

The AAOS maintains that the MDM component of E/M is exceedingly complicated. E/M should be based on intensity, complexity, and time. MDM should account for the complexity of the diagnoses discussed, regardless of whether treatment is required, complexity of the treatments discussed, and level of risk associated with the medical conditions and treatment options. Time alone does not sufficiently account for the intensity, complexity, or medical necessity of the visit, as intense or complex conversations don't necessarily take much time.

Under current guidelines, a new patient with a straightforward problem, such as tendonitis, will have a higher level of service than an established patient discussing alternative options after failed treatment due to the limited history and physical that may be documented. New guidelines should address this inconsistency.

The AAOS questions whether the perceived burden reduction is entirely attainable. The minimum standard of Level 2 documentation requirements is a welcome change. However, one of our concerns involves the creation of disparate Medicare, commercial payer, and legal documentation requirements. Implementation of any new guidelines would require significant and time-consuming changes. The incorporation of the new add-on codes would require staff training and novel activities to defend against audits. Additionally, many EHR and institutional billing systems are currently programmed to code visits based on documentation elements.

We believe it is essential that the agency adhere to the multi-year timeline described in the proposed rule with the goal of creating the most current and appropriate set of E/M guidelines. CMS should work closely with medical specialty societies to ensure that the guidelines reflect levels of E/M services. It is critical that all providers be involved throughout the process. Of note, the AMA has convened a CPT/RUC E/M Workgroup to tackle this complicated issue. The AAOS will certainly follow their progress. We expect that it will appropriately represent the interests of both proceduralists and non-proceduralists. Importantly, the January 2019 timetable is too aggressive and unrealistic and should be slowed to allow time for an optimal update. Thus, the **AAOS urges CMS to delay any changes to the E/M.**

Minimizing Documentation Requirements by Simplifying Payment Amounts
CMS has stated that it wishes to decrease the documentation burden of physicians. The modification of documentation to correctly reflect work is a worthwhile goal, but compensation must reflect the work being done. A proposal that inextricably links decreased burden with a reduction in provider reimbursement is unacceptable. The AAOS believes any guideline update must ensure appropriate valuation of work and decreased reporting burden.

The AAOS does not believe that the proposal to provide a single payment for Level 2-5 E/M visits is acceptable. This proposal is not resource-based for the provider or the patient. A single payment based on a snap shot calculation of all providers and all Medicare patients disregards the complexity of a patient or intensity of a service and does not conform to the resource-based relative value scale (RBRVS) methodology used since 1992. The “average” visit level cannot be presumed on a granular level. Certain orthopaedic subspecialties (i.e., trauma, oncology, spine) and tertiary care subspecialists who see more complex patients or

those with multiple conditions and tend to bill a higher percentage of Level 4 and 5 visits will be negatively affected. We believe this issue is ubiquitous for all medical specialties and would result in unfair compensation. We anticipate that visits will become more focused and patients will be required to attend additional appointments for multiple issues. This will lead to the provision of more E/M services, a greater number of copayments, and decreased access for more complex patients.
Ultimately, charging healthy patients a higher copay for the provision of a low-level service creates a de facto subsidy for those consuming a greater number of health care resources.

It may be necessary to uncouple documentation and payment for acceptable updates to the guidelines. Whatever the outcome, commercial payers must accept any changes made to E/M. Additionally, the AAOS is very concerned about how these changes will affect our surgeons who currently receive RVU-based compensation.

CMS Response

See separate summaries for full final rule update on E/M proposals

Education Initiatives on E/M Updates

Two sets of guidelines currently exist and regional claims processors, often interpret the guidelines subjectively. Lack of uniformity and inconsistency in Medicare Administrative Contractors (MAC) requirements have created confusion and increased administrative burden. Regardless of whether changes are made to the guidelines now or in the future, there must be clarity and consistency to prevent subjective interpretation by MACs. We appreciate that CMS states that it will work with OIG and begin educating MACs, which may not have an orthopaedic surgeon to prevent misinterpretation. However, we have grave concern that education efforts cannot fully prevent fallout.

Since 2010, the National Correct Coding Initiative (NCCI) software has incorrectly defined the shoulder as a single joint. The AAOS, Association of Shoulder and Elbow Surgeons (ASES), American Orthopaedic Society for Sports Medicine (AOSSM), and Arthroscopy Association of North America (AANA) have worked tirelessly to correct the error in educational materials, as it directly influences coverage denials by commercial payers. Despite multiple discussions and agreements on the need for the correction, CMS has not altered the CCI edits and coverage denials continue.

Additionally, the recent removal of TKA from the inpatient only list has demonstrated the difficulty in controlling the activities of the Quality Improvement Organizations (QIO). We are more than halfway through the year and have not made progress on efforts to stem forced outpatient TKA by hospitals ill-equipped to manage those patients. In a recent poll of the American Association of Hip and Knee Surgeons (AAHKS) membership, over 60

percent orthopaedic surgeons continue to experience forced outpatient TKAs for Medicare recipients, regardless of comorbidities or other factors. Recent reports in the lay press have highlighted severe complications in sleep apnea patients. We urge CMS to correct this behavior to prevent further patient injury.

For these reasons, **we cannot support the proposed E/M updates, which would rely so heavily on educational efforts for proper implementation.**

CMS Response

See separate summaries for full final rule update on E/M proposals

Eliminating Prohibition on Billing Same-Day Visits by Practitioners of the Same Group and Specialty

The AAOS supports the elimination of the prohibition on same-day billing by practitioners of the same group and specialty. It is common for a patient to be seen for shoulder pain, which turns out to be caused by a neck issue. This requires referral from the shoulder specialist to a different orthopaedic surgeon in the practice specializing in spine. The current instruction precludes an additional visit on that day, creating a burden for patients, particularly in rural areas or when seeing specialists. Ultimately, the patient only perceives the inconvenience and treatment delay.

CMS Response

See separate summaries for full final rule update on E/M proposals

Accounting for E/M Resource Overlap between Stand-Alone Visits and Global Periods CMS claims that there are significant overlapping resource costs when a standalone E/M visit occurs on the same day as a 0-day global procedure. Using the surgical multiple procedure payment reduction (MPPR) as a template, CMS is proposing to reduce payment by 50 percent for the least expensive procedure or visit that the same physician (or a physician in the same group practice) furnishes on the same day as a separately identifiable E/M visit, currently identified on the claim by an appended modifier -25. There is no corollary between multiple global surgical procedures performed on the same day and multiple office E/M services. For example, an orthopaedic surgeon provides a shoulder injection on the same day as an E/M visit for low back pain. In this instance, the work and PE are not overlapping and should not be discounted. The AAOS reminds CMS that the RUC has already subtracted the resource cost overlap from the RVU when modifier -25 is typically applied. CMS is proposing a double reduction, which we oppose. We do agree that there may be some overlapping resources and

that some payment reduction may be appropriate. However, **we believe that a 50 percent reduction is inappropriate and excessive.** If this proposal is finalized the overlap in codes that have been previously addressed by the RUC and CMS will need to be adjusted again to add back the duplicative resources.

CMS Response

See separate summaries for full final rule update on E/M proposals

Proposed Add-on G-Codes for Different Types of E/M Visits
CMS has proposed three new add-on codes to account for additional costs beyond the typical resources accounted for in the single payment rate for the levels 2 through 5 visits. These codes are an arbitrary movement of funds to offset disproportionately negative payment adjustments under the proposed payment collapse.

CMS Response

See separate summaries for full final rule update on E/M proposals

The AAOS has several concerns regarding the development of these codes. Most notably, the creation of multiple "add-on" codes negates any decrease in documentation burden. The methodology CMS used to value these codes is neither transparent nor resource-based. It does appear to be an attempt to artificially transfer funds to a specific group of providers by reassigning the RVUs resulting from the proposed changes.
Although CMS clarified that the add-on codes are open to all specialties, by restricting use of this code to services that address “conditions” common to specific specialties, there is a de facto increase in payment for certain specialists. There is little understanding of how this would look in practice. As explained by
CMS, an orthopaedic surgeon treating a patient with knee arthritis caused by rheumatoid arthritis could report this code. However, a rheumatoid diagnosis alone is not sufficient for reporting the code. Causality and relatability of conditions is beyond what can be expected of MACs.
Therefore, the codes cannot reasonably be reported or audited in their current form. We continue to recommend that CMS work through the CPT and RUC process to define and value work.

GPC1X (*Visit complexity inherent to primary care services*): We are not aware of any

literature to support the premise that an E/M associated with a primary medical care service is always more complex than those associated with specialties. Primary care providers treat a wide variety of patients. In fact, the majority of these patients are without comorbidities and are not Medicare- aged.

GCG0X (*Visit complexity inherent to endocrinology, rheumatology, hematology/oncology, urology, neurology, obstetrics/gynecology, allergy/immunology, otolaryngology, or interventional pain management-centered care)*: CMS states that this code is intended to address the additional resource costs for specialists for whom E/M codes, rather than procedural codes, make up a large percentage of overall charges and who bill a high number of Level 4 and 5 visits. However, there is no evidence that the selected specialties have "inherent complexity that require extra work." In addition, the proposal does not address the Agency's concern about "code-creep". This accepts that any provider who typically reported a Level 4 or 5 visit did so appropriately. CMS notes that there was no cutoff percentage for determining the specialties which provide more Level 4 and 5 codes, making inclusion on this list a bit arbitrary. Creating different payment for a subset of specialties is prohibited by statute and we oppose any action that singles out a particular specialty.

GPRO1 *(Prolonged evaluation and management)*: The AAOS is concerned at the significant reduction of the required time to report additional face to face time. Time-based codes only require 50 percent plus one minute of the stated time. Therefore, this new code may be reported when 16 minutes of additional face-to-face time occurs. The similar codes (99354 and 99355) were created in 1993 and include a full 60 minutes in the inputs, based on the typical physician face to face time for a 20-year old asthmatic being monitored in the office over a 2- to 3-hour period. No specific physician work other than periodic checking is indicated. The typical patient requiring this additional face-to-face monitoring of hypertension, diabetes and heart disease is not yet known. Nor do we know what procedure is being performed and monitored. Perhaps, it would be more appropriate to review the current codes and create a new Category I code for time and typical patient.

CMS Response

See separate summaries for full final rule update on E/M proposals

Podiatric Evaluation and Management Services (HCPCS codes GPD0X and GPD1X) CMS believes that the majority of podiatric visits are billed at lower E/M levels and will not be accurately represented by the proposed consolidated E/M payment structure. For this reason, CMS is proposing to create two HCPCS G-codes to describe podiatric E/M services. CMS references separate E/M codes for ophthalmology as a precedent, but does not acknowledge that the basis for this differential coding, even before the fee schedule was implemented, was the acceptance of allowing significant practice expense equipment as

standard for every ophthalmology E/M service. In fact, the ophthalmology base code for an established patient (92012) includes three "lanes" that total over $60,000 for every one of the 6.7 million Medicare visits in 2017. Given this information, **the AAOS does not agree that separate E/M codes are justified.** We believe the E/M structure is properly designed to describe services provided by all providers and adequately describes the services provided by podiatry.

CMS Response

See separate summaries for full final rule update on E/M proposals

Proposed Adjustment to the PE/HR Calculation

The AAOS strongly disagrees with the proposal to create a new Evaluation and Management "specialty", for purposes of calculating a PE/HR for the ten office E/M codes. The specialty PE/HR is based on the AMA Physician Practice Expense Information Survey (PPIS) and information within the survey is not based on a percentage of E/M provided by each specialty. The calculation that CMS performed to create a single $136 PE/HR value for the 10 office visits is based on statistically unsound methodology, opaque analytics, and is not resource-based. The change would also result in significant upset to the indirect practice cost index (IPCI) for specialties, as it applies to the PE RVU methodology equation. **The AAOS does not support this proposal and urges CMS to abandon this change.**

CMS Response

See separate summaries for full final rule update on E/M proposals

CY 2019 Updates to the Quality Payment Program

New Types of Eligible Clinicians, Low Volume Threshold, and New Opt-In Scenarios

Our comments supported these expansions of the types of eligible clinicians, the new LVT criterion, and the new opt-in scenarios.

CMS Response

- **New Types of Eligible Clinicians**: "Beginning with the 2021 MIPS payment year, a physical therapist, occupational therapist, qualified speech-language pathologist; a qualified audiologist; clinical psychologist; and registered dietician or nutrition professional; and a group that includes such clinicians."
- **Low Volume Threshold**: "We are finalizing our proposal to modify the definition of low-volume threshold, to mean that for the 2021 MIPS payment year and future years, that eligible clinicians or groups who meet at least one of the following three criteria during the MIPS determination period will not exceed the low-volume threshold: (1) those who have allowed charges for covered professional services less than or equal to $90,000; (2) those who provide covered professional services to 200 or fewer Part B enrolled individuals; or (3) those who provide 200 or fewer covered professional services to Part B-enrolled individuals."
- **New Opt-In Scenarios:** "We are finalizing an opt-in policy that allows some clinicians, who otherwise would have been excluded under the low-volume threshold, the option to participate in MIPS."

Virtual Group Election Process

AAOS encouraged CMS to explore building the online portal in such a way as to facilitate these types of connections and group-building.

CMS Response

"We are finalizing our proposal to continue to apply the previously established policies regarding the virtual group election process for the 2022 MIPS payment year and future years, with the exception of providing for an election to occur in a manner specified by CMS, such as a web-based system developed by CMS." ***In short:*** CMS acknowledged our comments and will consider it for future development: "A few commenters noted that the web-based system linked to the existing portal could give interested participants an easier means of connecting with other possible virtual group members. The commenters recommended that CMS explore the inclusion/development of a platform within the portal that would facilitate interactions and connections between parties interested in forming or joining a virtual group."

Quality—Topped Out Measures:

AAOS urged CMS to revisit its proposal regarding removal of 'extremely topped out' measures.

CMS Response

CMS finalized its proposal that once a measure has reached an extremely topped out status, it may propose the measure for removal in the next rulemaking cycle, regardless of whether or not it is in the midst of the topped out measure lifecycle, due to the extremely high and

unvarying performance where meaningful distinctions and improvement in performance can no longer be made, after taking into account any other relevant factors. ***In short:*** CMS finalized it; we asked that they not do so.

Quality—Categorizing Measures by Value:

We encouraged CMS to shelve this proposal for a future date when the MIPS program is more fully developed and tested.

CMS Response
CMS isn't implementing this type of system currently; "We thank commenters for their input and may take this input into consideration in future years."

Quality—Small Practice Bonus:

We asked them to delay reducing this and moving it to the Quality Category at the same time; "the AAOS encourages CMS to keep it at five points before further reducing it in future program years."

CMS Response
Instead of the proposal, CMS is "finalizing [that] beginning with the 2021 MIPS payment year, a small practice bonus of 6 measure bonus points in the numerator of the quality performance category for MIPS eligible clinicians in small practices if the MIPS eligible

clinician submits data to MIPS on at least 1 quality measure." ***In short:*** CMS isn't finalizing the proposal as included in the Proposed Rule. CMS acknowledged our concerns and one comment in particular: "One commenter recommended that if the bonus is applied in the quality performance category, 5 points should be awarded."

Quality—Measures Impacted by Clinical Guidance Changes:

AAOS wrote that we would appreciate clarity on several terms used in the proposal, including: what would constitute "significantly impacted"; and what "other changes" beyond clinical guideline changes would CMS consider sufficient to suppress a measure without rulemaking?"

CMS Response
CMS finalized the proposal but provided some answers to our concerns.

- Provided some clarification on "significant" impact – "Clinical guideline changes that occur between rulemaking cycles would need to be significant enough that the change in the most up-to-date clinical evidence could result in patient harm if the clinician does

not follow these new guidelines or otherwise provide misleading results as to what is measured as good quality care."

- "We envision that this policy would be applied in two circumstances: First, there is a newly issued or updated guideline where there is wide consensus that would result in a significant change to a quality measure. Second, we envision using this policy in rare cases where there is a new or revised guideline, even if there is no broad consensus within the specialty, because some clinicians will begin to adopt the new guideline which would not be consistent with the quality measures and scoring the measure could cause misleading results for those clinicians."

In short: We didn't oppose the proposal outright. CMS finalized it and provided some answers to the concerns we raised.

Cost:

AAOS appreciated that the Cost category weight is not being increased to 30 points… "we believe that raising its weight before CMS and providers can more fully digest and analyze the outcome of the program's first year is imprudent."

CMS Response
CMS finalized the 15-point cost weight.

Promoting Interoperability (formerly ACI):

What we asked for:

- A) "The reduction in the Provider to Patient Exchange objective percentage between 2019 and 2020 is a move in the right direction, but we still believe 35 points on this objective is over-weighted. If a provider claims two exclusions under the Public Health and Clinical Data Exchange objective, these 10 points are reassigned to the Provider to Patient Exchange objective, further raising it to 50 points in 2019 and 45 in 2020. Obviously, not all the measures under the Public Health and Clinical Data Exchange objective may be applicable to all MIPS eligible clinicians."
- B) "Substituting the base, performance, and bonus scores for an "all-or-nothing plus performance" system is premature this early in the MIPS program."
- C) "The AAOS encourages CMS to make clear whether providers can choose two of the same measures under the objective, for example, by reporting to two Clinical Data Registries."

CMS Response

- A) "The Provide Patients Electronic Access to Their Health Information measure will be worth up to 40 points beginning in CY 2019. We had proposed that the measure would

be worth up to 35 points beginning in CY 2020, but we are not finalizing that proposal because we are not requiring the Verify Opioid Treatment Agreement measure beginning in CY 2020 as proposed, which would have been worth up to 5 points."

- B) "We do not agree that this scoring structure is an all or nothing approach due to the reduction of measures, the requirement of a one in the numerator for numerator/denominator measures or a "yes" for yes/no measures, and the redistribution of points when an exclusion is claimed."
- C) "We believe that a clinician who is in active engagement with two different public health agencies or clinical data registries for purposes of the same measure would accomplish the same policy goal as our proposal to report on two measures."

Improvement Activities—CEHRT Bonus:

The AAOS disagreed with CMS' decision to end its bonus for performing an improvement activity using CEHRT."

CMS Response
"We are not continuing the bonus points for completing improvement activities using CEHRT."

In short: We asked them not to, they did anyway – their rationale: "One [possible alternative] we have identified is to establish several sets of new multi-category measures that would cut across the different performance categories and allow MIPS eligible clinicians to report once for credit in all three performance categories." They expect a better arrangement – TBD.

Improvement Activities—Complex Patients Bonus:

We supported CMS' decision to maintain consistent policies for the complex patient bonus in the 2021 MIPS payment year until sufficient evidence and new data sources are available.

CMS Response
"We are finalizing our proposal to continue the complex patient bonus for the 2019 MIPS performance period/2021 MIPS payment year as proposed." ***In short:*** They finalized as proposed; we supported this.

Facility-based Measurement:

The AAOS welcomed the regulatory relief that facility-based scoring will provide for these physicians.

CMS Response

CMS finalized "for the Cost or Quality performance categories, providing the option to use facility-based scoring for facility-based clinicians." ***In short:*** They finalized as proposed; we supported this.

Performance Threshold:

What we asked for:

- "The AAOS believes a more modest increase (e.g. 20 points) would still allow for a meaningful increase compared to the current threshold as providers adjust to the other simultaneous changes contained in the Year 3 proposed rule."
- "The AAOS understands CMS' desire to incentivize and reward extraordinary performance and appreciated CMS' willingness to maintain the additional threshold at 70 points last year. If the proposal to increase the additional threshold beginning with Year 3 is finalized, we would encourage CMS to increase it by a more modest five points, rather than the proposed 10."

CMS Response

"The performance threshold for the 2021 MIPS payment year is 30 points"; they also raised the additional performance threshold to 75. ***In short:*** We asked them not to raise it to 30/70 this year, they raised them anyway (and raised AP threshold from 70 in the proposed rule to 75 in the final rule).

Advanced APM CEHRT Threshold:

We did not support raising the Advanced APM CEHRT threshold by 25% as proposed.

CMS Response

"Updating the Advanced APM Certified Electronic Health Record Technology (CEHRT) threshold so that an Advanced APM must require that at least 75% of eligible clinicians in each APM Entity use CEHRT, and for Other Payer Advanced APM, as of January 1, 2020, the number of eligible clinicians participating in the other payer arrangement who are using CEHRT must be 75%." ***In short:*** We asked them not to raise it 25% this year, they raised it anyway.