Lessons Learned From the RUC: What is the Future of Reimbursement for TJA?

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Disclosures

AAOS: Board or committee member
AJRR: Board or committee member
American Association of Hip and Knee Surgeons: Board or committee member
Apple: Research support
Biomet: Paid consultant; Research support
Corin U.S.A.: Paid consultant; Research support; Stock or stock options
DePuy: IP royalties; Paid consultant
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Hip Society: Board or committee member
Journal of Arthroplasty: Editorial or governing board
Knee Society: Board or committee member
Porosteon: Stock or stock Options
Wolters Kluwer Health - Lippincott Williams & Wilkins: Publishing royalties
Yale CORE/CMS: Paid consultant
Zimmer: Paid consultant; Research support

Overview

- What is the RUC ?
- How we got RUC'd
- Principal Care Management Codes
- Bundles: CJR, BPCI, and condition-based bundles
- AAOS NOLC 2022 initiatives
  - Payment Reform
  - Prior Authorization
  - SAVES Act
  - Scope Creep

Medicare RBRVS

- Medicare implemented the Resource-Based Relative Value Scale (RBRVS) on January 1, 1992
- Payments determined by resource costs needed to provide service
- Most public and private payers utilize the Medicare RBRVS
- AMA RUC (RVS Update Committee) delegated by CMS to advise on appropriate relative values for procedures

The RUC: Secret Society

Anesthesiology
Cardiology
Dermatology
Emergency Medicine
Family Medicine
General Surgery
Geriatric Medicine
Infectious Diseases*
Internal Medicine

Neurology
Neurosurgery
Obstetrics/Gynecology
Ophthalmology
Orthopaedic Surgery
Otolaryngology
Pathology
Pediatrics
Plastic Surgery

Primary Care*
Psychiatry
Radiology
Rheumatology*
Thoracic Surgery
Urology
Vascular Surgery*

** indicates rotating seat*

31 voting members

RUC Cycle

CPT Editorial Panel or CMS Requests

Level of Interest

Specialty Society Survey

Specialty RVS Committee

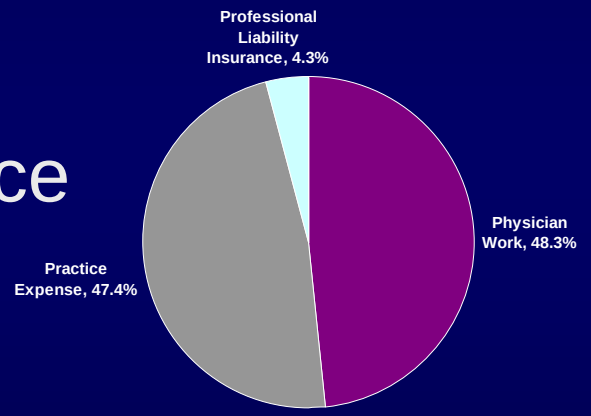
The RUC

CMS

Medicare Payment Schedule

Medicare RBRVS

- Cost of providing each service is divided into three components
  1. Physician Work
  2. Practice Expense
  3. Professional Liability Insurance



Geographic modifiers to reflect costs associated with different regions

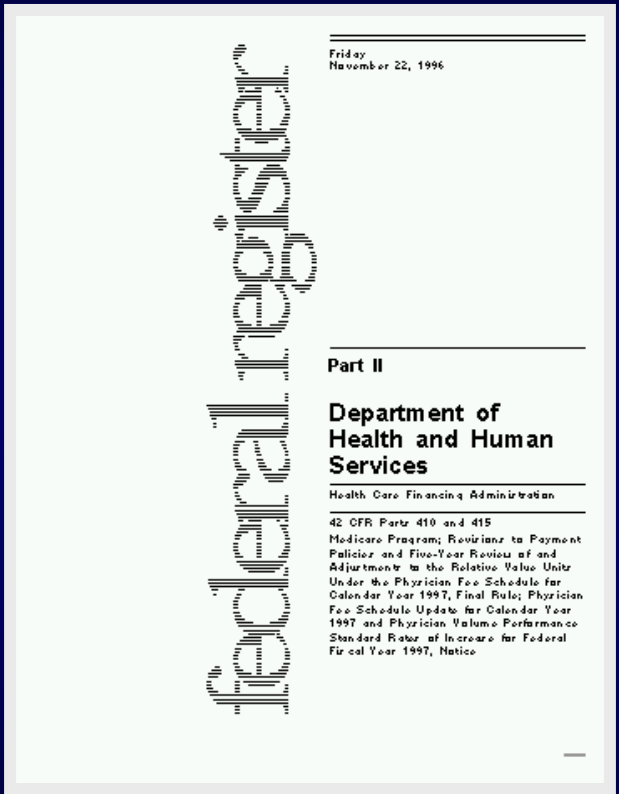
Physician Work

- Determined by:
  - Time it takes to perform the service
    - Prep/positioning time
    - OR time
    - Post-op in hospital and office visits
  - IWPUT (intensity)= RVU/time
    - Technical skill and physical effort
    - Required mental effort and judgment
    - Stress due to potential risk to patient

The Survey

- Sent by specialty society (AAOS) to wide array of surgeons
  - Specialists and generalists
- Standardized instrument with patient vignettes
- Surgeons are to self-report on times for:
  - Prep for surgery
  - Surgical time—entire case
  - Waiting time/positioning
  - Post-op discussion with family and dictation
  - Hospital and office visits
- What procedures can it be compared to?

Confidentiality


Federal Register

Friday
November 22, 1996

Part II

Department of Health and Human Services

Health Care Financing Administration

42 CFR Parts 410 and 415
Medicare Program; Revisions to Payment Policies and Five-Year Review of and Adjustments to the Relative Value Units Under the Physician Fee Schedule for Calendar Year 1997, Final Rule; Physician Fee Schedule Update for Calendar Year 1997 and Physician Volume Performance Standard Rates of Increase for Federal Fiscal Year 1997, Notice

- All RUC materials are confidential
- Cannot publish RVU recommendations until CMS publishes *Federal Register*
- CMS publishes Proposed Rule with comment period and then Final Rule

How We Were RUC'd

- Anonymous source triggered review (Anthem)
- Data source to support review request flawed (Urban Institute)
  - 4 surgeons, small # of cases, payed for by CMS!
- Weren't allowed to use modified survey to capture preop work
  - "no compelling data" to justify modification
  - Precedent in AAA and kidney transplant
- Recommended value <20% from survey!! (20.72 → 19.6 RVU)
  - One less post-op visit
- E+M survey 50% !!

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How We Were RUC'd

- RUC and CMS: "you are doing the work, we just can't capture it, help us capture it"
  - Modified survey rejected
  - New CPT code rejected and CMS member of CPT panel voted no !!
- Finally CPT said OK to use principal care management codes

Principal Care Management

Principal Care Management Services: General

- Treatment of beneficiaries with single, serious, chronic condition
- Diagnosis expected to last between three months, a year or until death of patient
  - May have led to recent hospitalizations
  - Places patient at significant risk of death, acute exacerbation, decompensation or functional decline

National Government Services

NGS MU

Principal Care Management – MD/PA/NP

2022 Coding

- For CY 2022, the RUC resurveyed the CCM code family including PCM
  - 99424: PCM services for a single high-risk disease first 30 minutes provided personally by a physician or other qualified health care professional, per calendar month
  - 99425: PCM services for a single high-risk disease each additional 30 minutes provided personally by a physician or other qualified health care professional, per calendar month. List separately in addition to primary

National Government Services

NGS MU

Principal Care Management - Staff

2022 Coding

- 99426: PCM, for a single high-risk disease first 30 minutes of clinical staff time directed by physician or other qualified health care professional, per calendar month
- 99427: PCM services, for a single high-risk disease each additional 30 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month. List separately in addition to primary

National Government Services

NGS MU

Principal Care Management

Principal Care Management Services: Billing

- Patient or primary care practitioner may involve another clinician to provide care
  - Specialist eventually returns patient to primary care practitioner once condition is stable
- Goal is to manage condition benefiting from non-face-to-face services
- Time accumulates throughout month
  - Once threshold met, claim may be submitted

National Government Services

NGS MU

Principal Care Management

TABLE 19: CY 2022 CCM/CCCM/PCM Values

CPT Code	Short Descriptor	Current Work RVU	RUC-recommended Work RVU	CMS Proposed Work RVU
99490	CCM clinical staff first 20 min	0.61	1.00	1.00
99439	CCM clinical staff each add 20 min	0.54	0.70	0.70
99491	CCM physician or NPP work first 30 min	1.45	1.50	1.50
99437	CCM physician or NPP work each add 30 min	new	1.00	1.00
99487	CCCM clinical staff first 60 min	1.00	1.81	1.81
99489	CCCM clinical staff each add 30 min	0.50	1.00	1.00
99424 (currently G2064)	PCM physician or NPP work first 30 min	new	1.45	1.45
99425	PCM physician or NPP work each add 30 min	new	1.00	1.00
99426 (currently G2065)	PCM clinical staff first 30 min	new	1.00	1.00
99427	PCM clinical staff each additional 30 min	new	0.71	0.71

Health Policy & Economics

Medicare Reimbursement for Hip and Knee Arthroplasty From 2000 to 2019: An Unsustainable Trend

Cory K. Mayfield, BS [a], Jack M. Haglin, BS [b], Brett Levine, MD [c], Craig Della Valle, MD [c], Jay R. Lieberman, MD [a], Nathanael Heckmann, MD [a,*]

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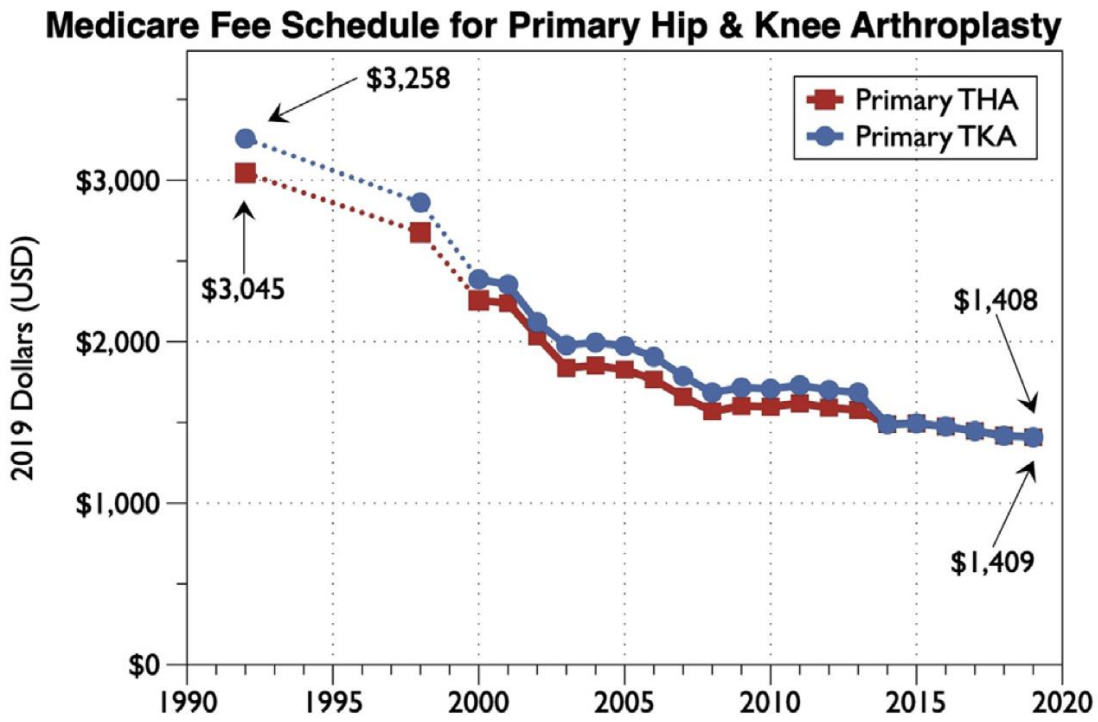
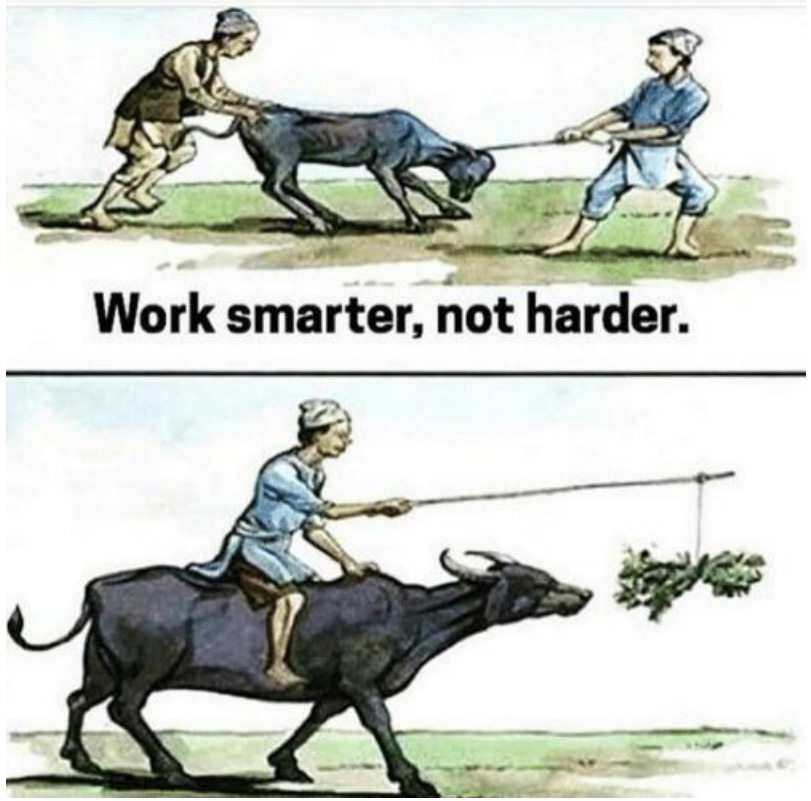


Fig. 3. Inflation-adjusted physician fees for primary THA (CPT 27130) and primary TKA (CPT 27447) from 1992 through 2019. Dotted lines represent data from Hariri et al [3].

Bundles

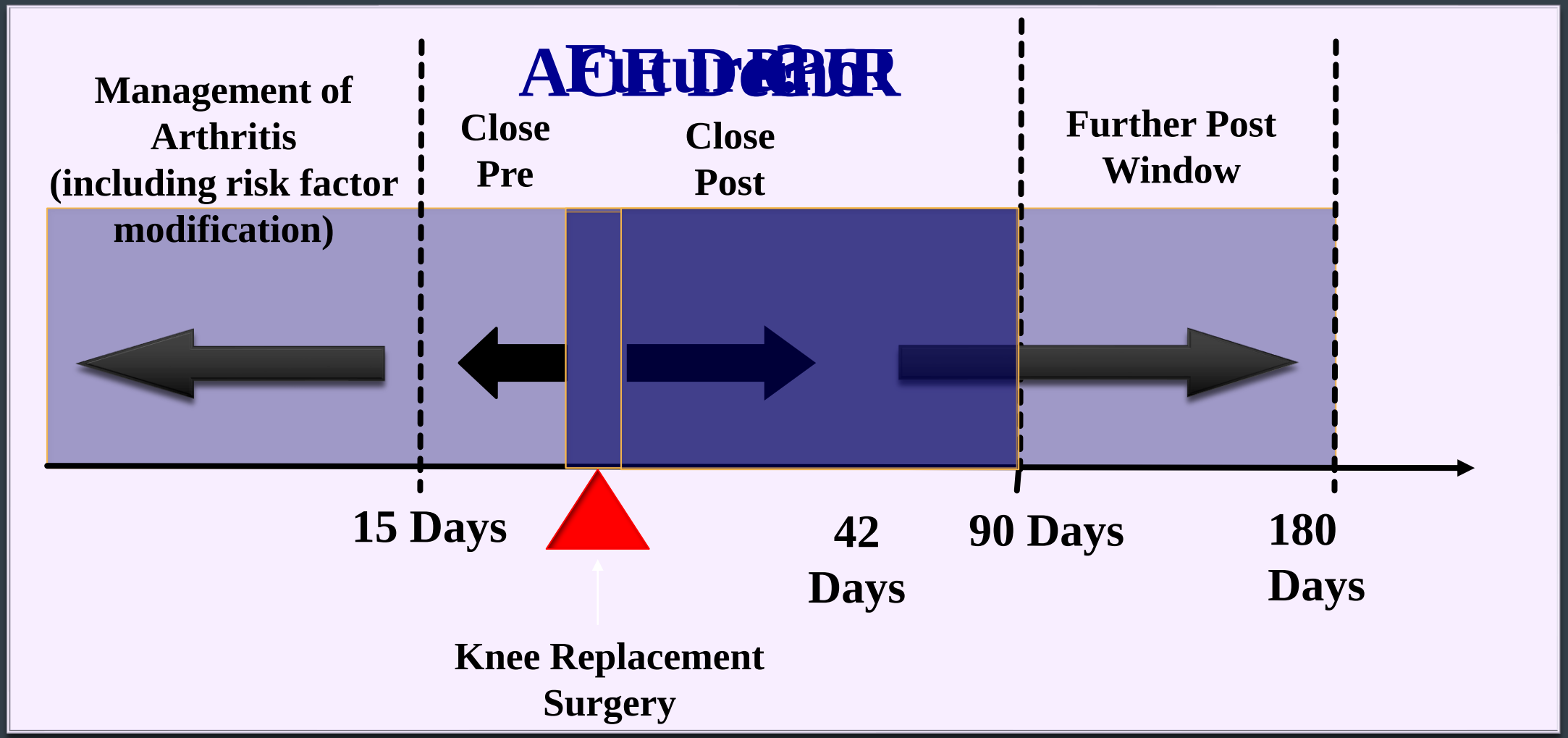
- Our way out of the RUC!
- Comprehensive Care for Joint Replacement (CJR)
  - Saved CMS @ $400 million!
  - Mandatory, hospital conveners
  - Hurts safety-net hospitals most
- Bundled Payment Care Initiative Advanced (BPCI-A)
  - Low participation due to ”race to the bottom” (low reference $)
- Osteoarthritis disease-based bundle coming soon!

Orthopaedists need a change in attitude!

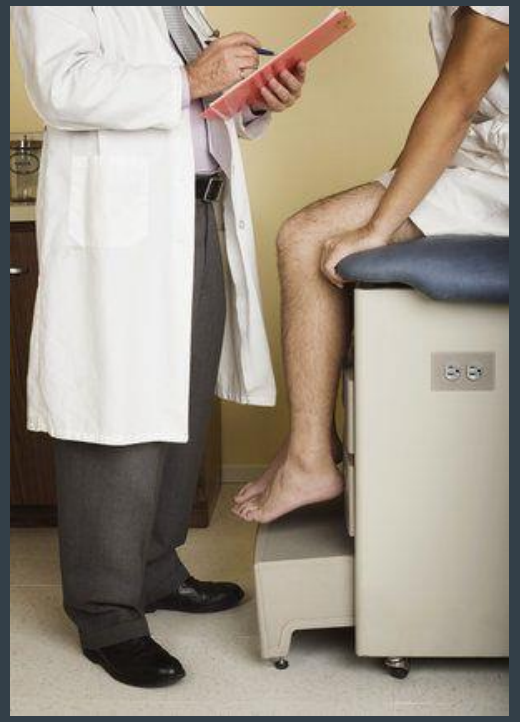


Slide courtesy of Bill Jiranek, MD

Evolution of Value-Based Payment Models



Longitudinal Management of Hip/Knee OA



Primary care physician

Opportunity Gap

Orthopaedic surgeon

Treatment of hip or knee arthritis

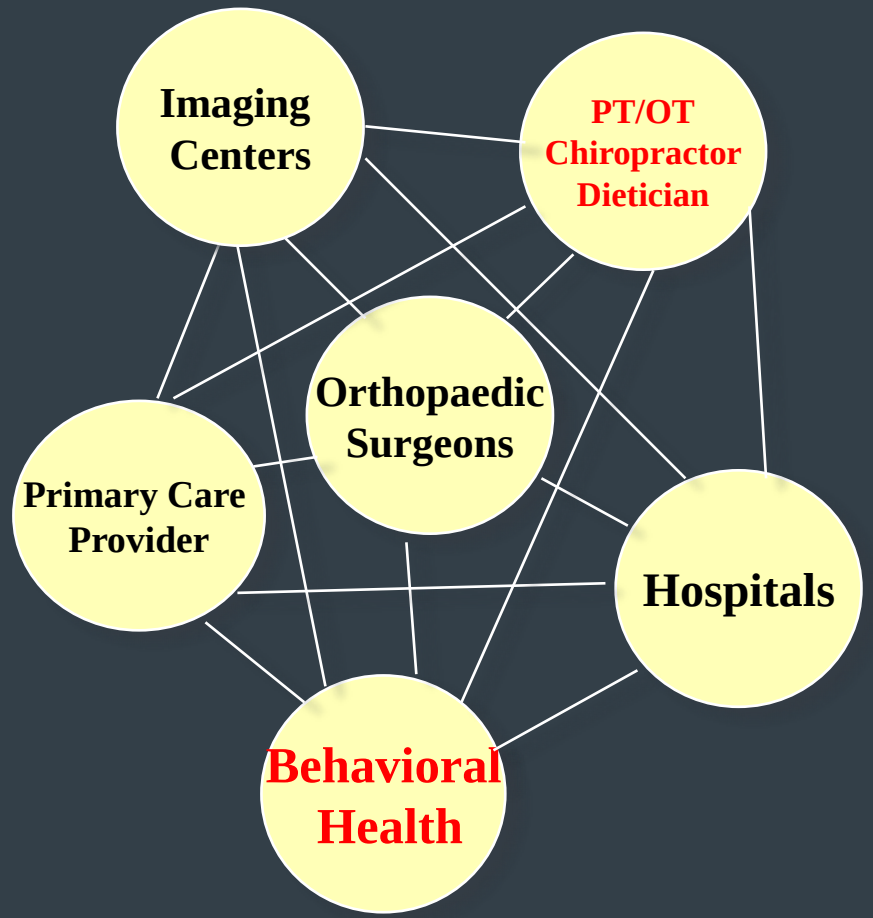
Payment Model Drives Delivery System Reform

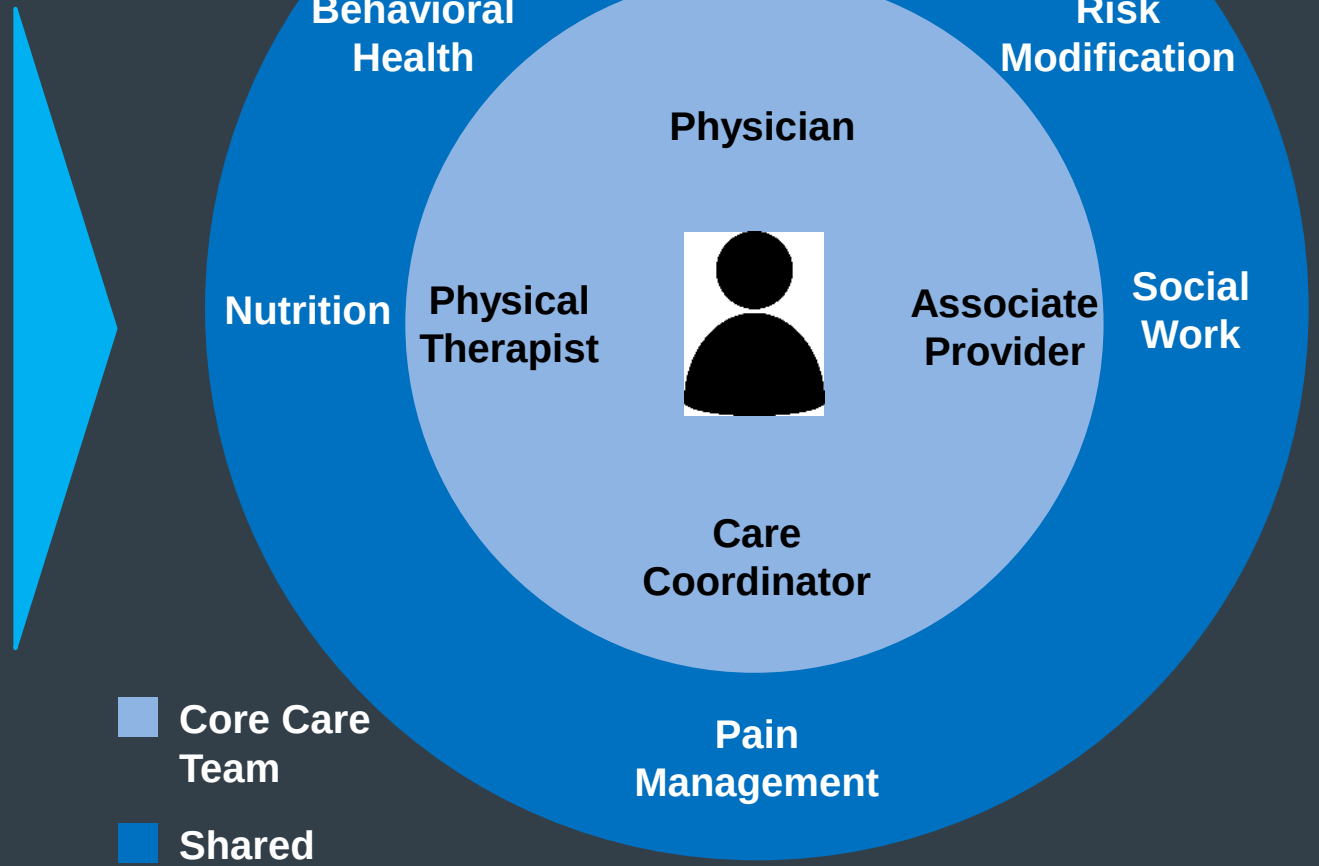
TJR Bundles

Arthritis Bundles

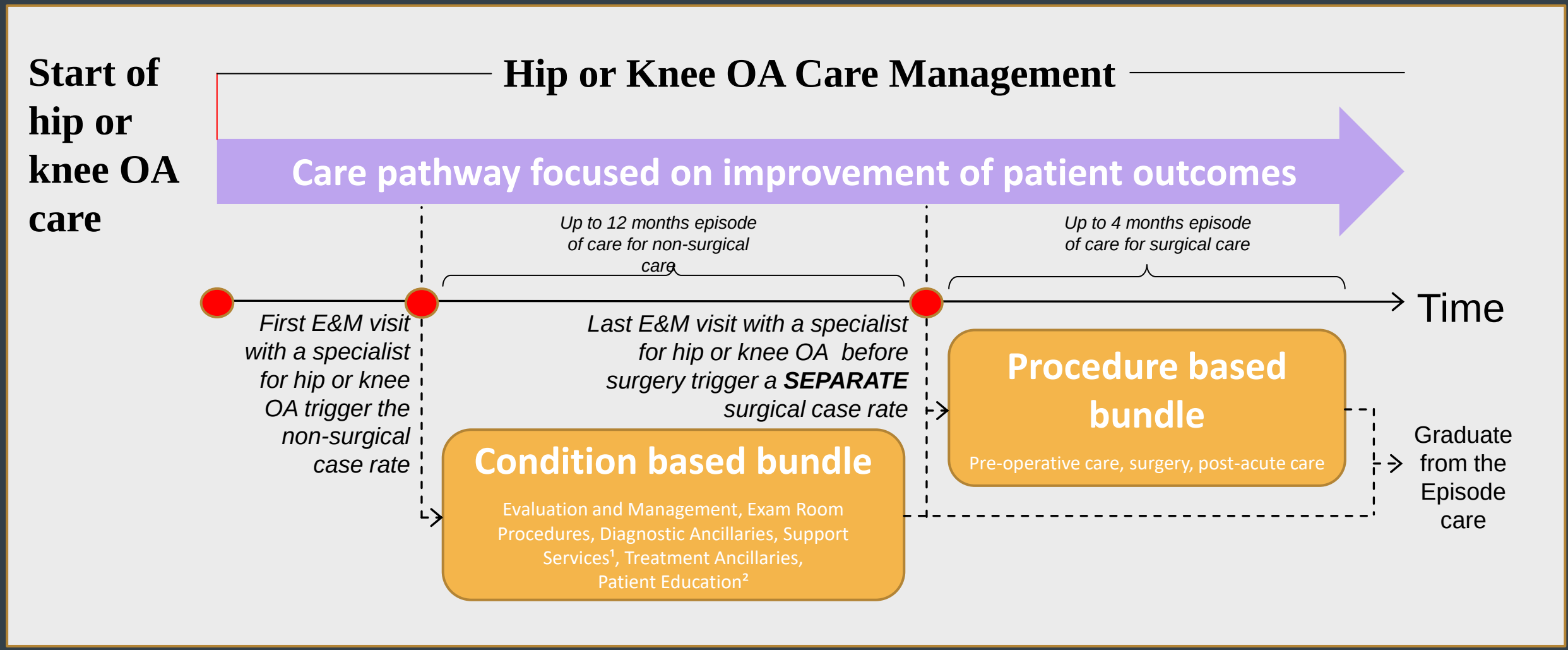
Changing the Delivery Model

Existing Model
Organize by Specialty and Discrete Service





Alternative Payment Models for Hip and Knee OA



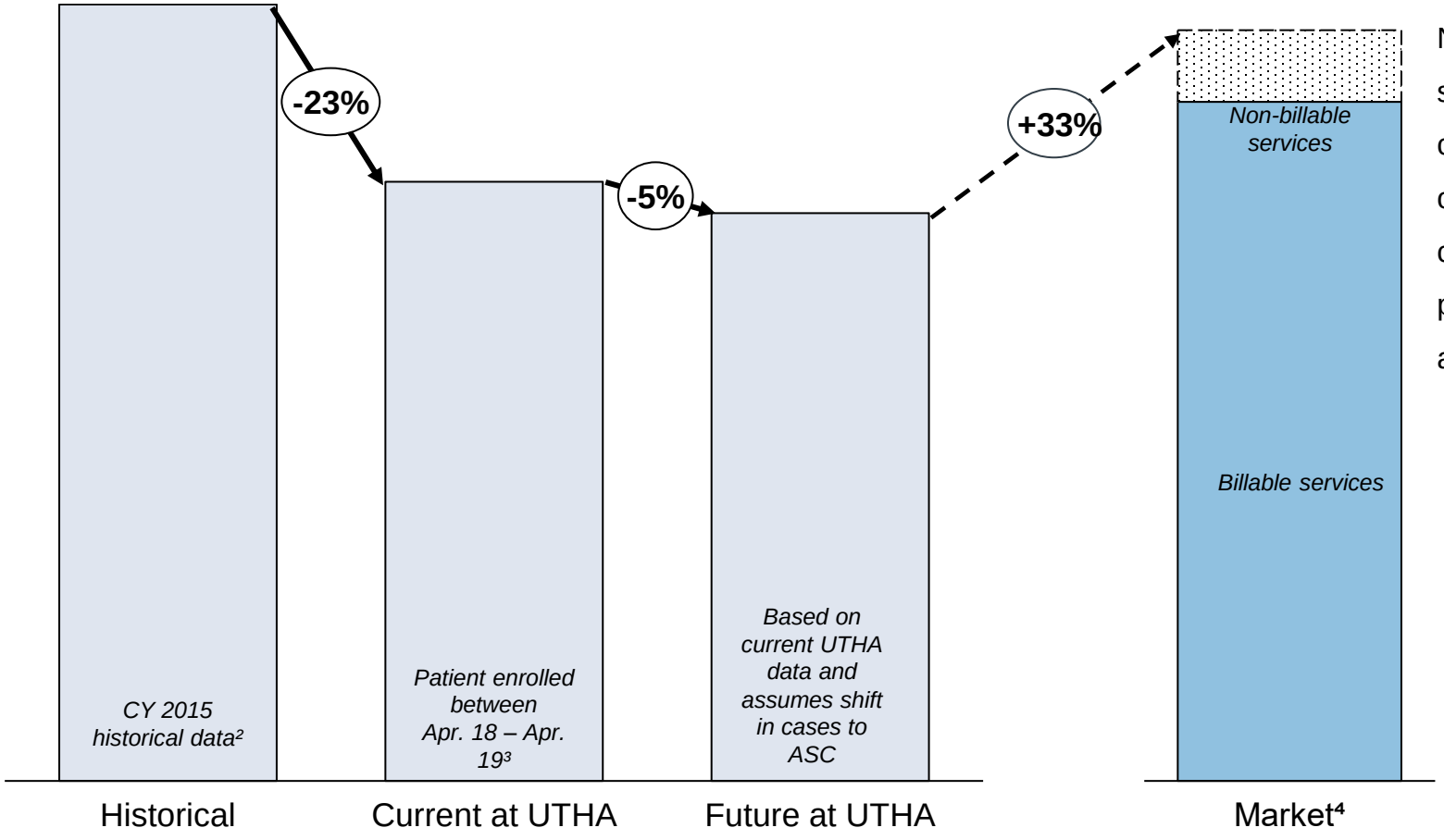
1. Support Services include DME, immunization/vaccine, etc. (only will be given if it is necessary);
2. Patient education includes service & materials fees, patient's history, registration, education, etc.

Our team of experts connects patients to the right level of care at the right time

MSK Treatment Utilization				
	Traditional Care Model		UTHA MSKI Care Model	
Treatment Modalities	**% of patients**	**# per patient**	**% of patients**	**# per patient**
Office visits / telehealth	100%	4.8	100%	2.8
Integrated behavioral health	0%	0	21%	1.8
Physical therapy	18%	8.7	67%	4.8
Simple imaging	67%	1.6	50%	1.3
Advanced imaging	8%	1	2%	1
Injections	75%	1.2	18%	1.5
Laboratory	18%	1.9	15%	1.4
Durable medical equipment	29%	1.8	6%	1.0
Inpatient / outpatient surgery	18%	1.0	15%	1.0

Based on historical Austin/Central Texas commercial utilization and internal UTHA utilization data

New care model reduces cost of care (per 1,000 patients)

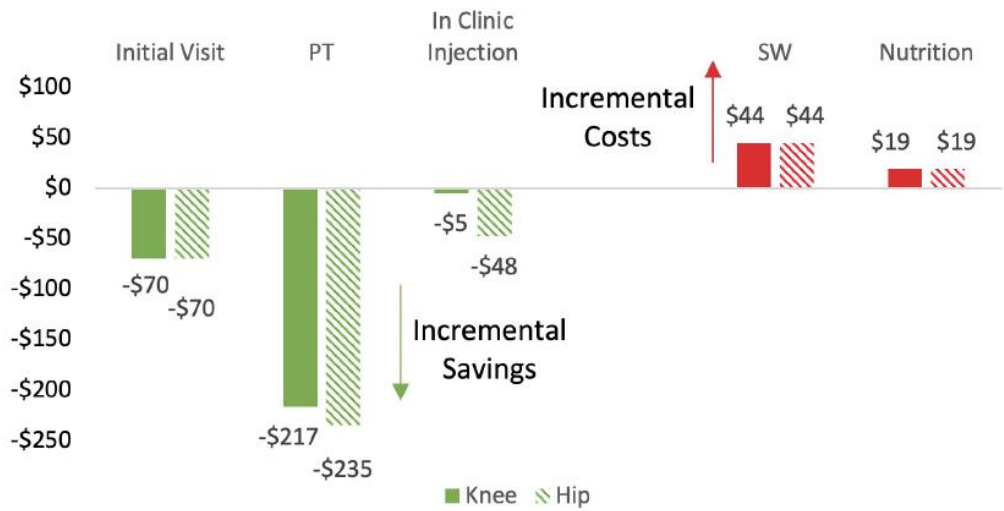


Non-billable services includes care coordination, outcomes collection, and program administration.

Notes:
1. All costs are per 1,000 patients; 2. Historical data is trended up by 3% annual rate for 4 years; 3. Current at UTHA represents CCC case rate patients who enrolled between April 2018 – April 2019, Holt-winters forecasting model is applied to predict spend and surgical patient volume for Sep. 19 – Apr 20. UE surgeries are not included in this model as clinically, most UE surgeries are done within 6 months after the initial visit. 4. UTHA surgical rates are used for the market calculation, it's likely that the rates of surgery would be higher if truly purchased outside of our care model

	IPU Non-Operative Management			Traditional Non-Operative Management	IPU Operative Management			Traditional Operative Management
	Low	High	Average		Low	High	Average	
Hip OA	$421	$1,687	$611	$868	$14,845	$17,239	$15,204	$15,405
Knee OA	$316	$1,421	$481	$803	$15,576	$17,790	$15,908	$16,169

TDABC: Costs and Incremental savings of IPU-based care versus usual care for hip and knee OA



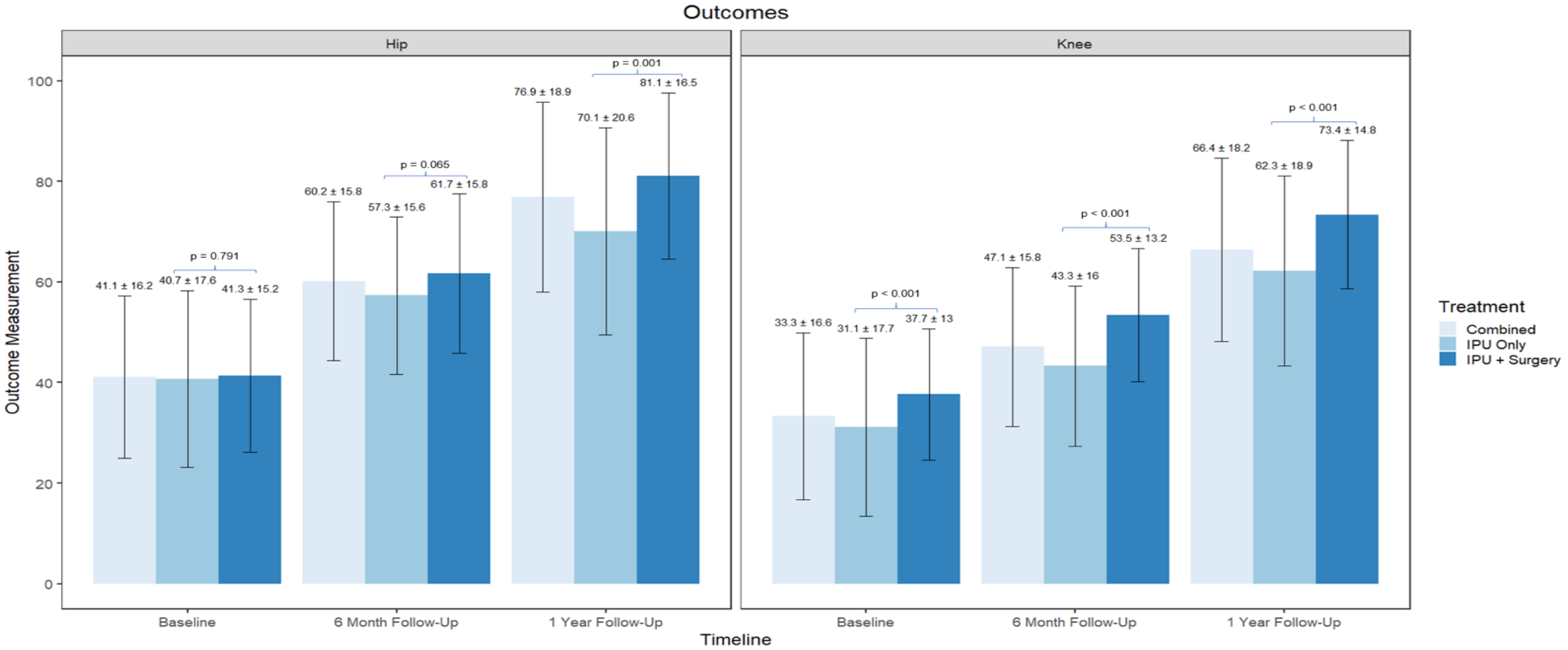
Duke | MARGOLIS CENTER for Health Policy

The University of Texas at Austin Dell Medical School

Duke Orthopaedic Surgery
Duke University School of Medicine

The University of Texas at Austin
UT Health Austin

Patients enrolled in our Hip and Knee OA care program achieve lasting improvements to their health outcomes



The University of Texas at Austin
UT Health Austin

Our surgical outcomes consistently beat national averages for quality and patient safety, while simultaneously reducing episode costs

Total Knee Arthroplasty	**72%** of UTHA patients go home the same day vs. national average of 38%	**Discharge Locations** Home with Self-Care: **UTHA 93%** vs. National Average 35%	**Readmission Rates** 30-day **0.00%** vs. **5.07%** 90-day **0.00%** vs. **8.48%**
Total Hip Arthroplasty	**59%** of UTHA patients go home the same day vs. national average of 29%	**Discharge Locations** Home with Self-Care: **UTHA 86%** vs. National Average 43%	**Readmission Rates** 30-day **1.69%** vs. **3.74%** 90-day **1.69%** vs. **7.55%**

The University of Texas at Austin
UT Health Austin

Note: Data comparison between UTHA and 2018 National Truven Surgeon Data.

Duke JHP: A Model for Orthopaedic Disease Based Bundles?

William Jiranek MD FACS

Emily Berend Adult Reconstruction Symposium

April 8-9, 2022

Duke Orthopaedics

Adult Reconstruction

Joint Health Program (JHP) : *OA home Delivered by a Physical Therapist with additional training - Primary OA Provider (POP)*

Key Features

- Surgeon-led model
- POP
  - Geographic reach
  - Community Integration
  - Development of relationship & trust
  - Foundational Treatment + coordination
  - Portable, easier to establish
- Expand concept of optimization

Key Activities & Sources of Value

- Building formal partnerships
- Standardizing care
- Engaging patients and enhancing the patient experience
- Measuring outcomes
- Assessing appropriateness of surgery
- Expanding surgical optimization & moving upstream
- Better funnel

Evaluation by POP for treatment needs in the following areas:

Exercise Prescription
(Strengthening, stretching, aerobic, neuro re-ed, manual therapy)

Functional Training
(Gait , mobility, ADL, work, sport, leisure training)

Education
(OA, pain, self management strategies)

Cognitive behavior theory based strategy
(Pain coping skills)

Sleep
(hygiene, positioning, pain management, behavioral modification)

Nutrition/Weight management
(education, support, accountability)

Primary treatment provided by POP as needed

Primary treatment provided by POP as needed *OR* referred to another provider if needs extend beyond POP scope of practice

Criteria for referral

Criteria for referral to Orthopedic Surgeon/Specialist

- Presence of red flags
- 4-6 weeks of worsening pain in primary joint being treated (hip and/or knee)
- 8-10 weeks of no change in pain from initial visit or after a period of progress (plateau) and has not yet met their goals
- New injury/trauma/pain with unclear dx
- Patient is a candidate for surgery and has met optimization goals for surgery
- Patient request

Referral to behavioral health

- Documented mental health history and/or associated medication, not following up with BH specialist, and elevated yellow flags on OSPRO-YF
- No documented mental health history, but patient reports signs and symptoms of depression, anxiety, and/or emotional/stress at home or work
- When mental health issue is limiting ability to participate in other aspects of the JHP (exercise, weight, nutrition)
- Patient request

Referral to sleep specialist

- Medical condition impacting sleep
- Subjective assessment suggesting sleep issues associate with medical condition (sleep apnea, restless leg syndrome, insomnia, etc.)
- Patient request

Referral to behavioral health

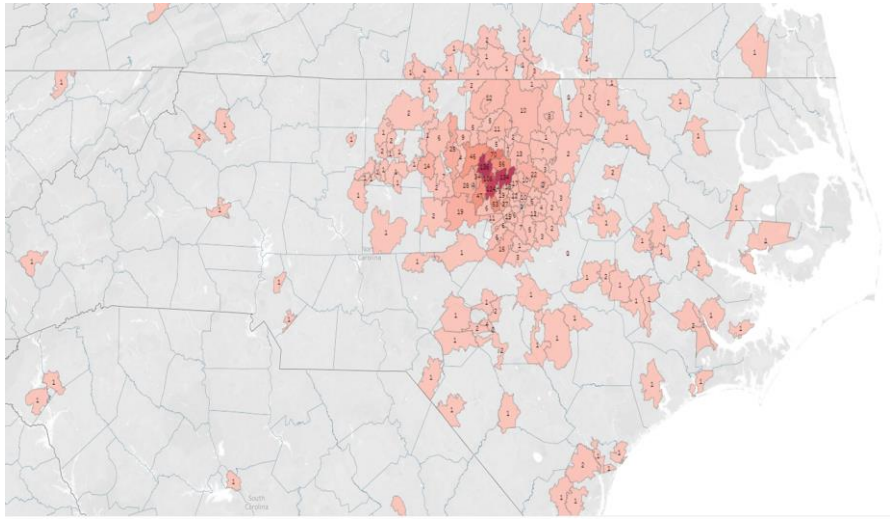
- Behavioral health modification for sleep associated issues
- Patient request

Referral to nutrition

- BMI > 25 and goals for specific weight loss/nutrition guidance
- High BMI (>40), uncontrolled DM, cardiac, pulmonary, kidney, GI, endocrine and/or liver disease and evidence of poor eating habits on DETERMINE Nutrition Screen
- BMI > 40 and upcoming surgery with no success with self-managed weight loss
- Refer to physician-led program if no success after meeting w/ RD and BMI >40 and upcoming surgery
- Patient request

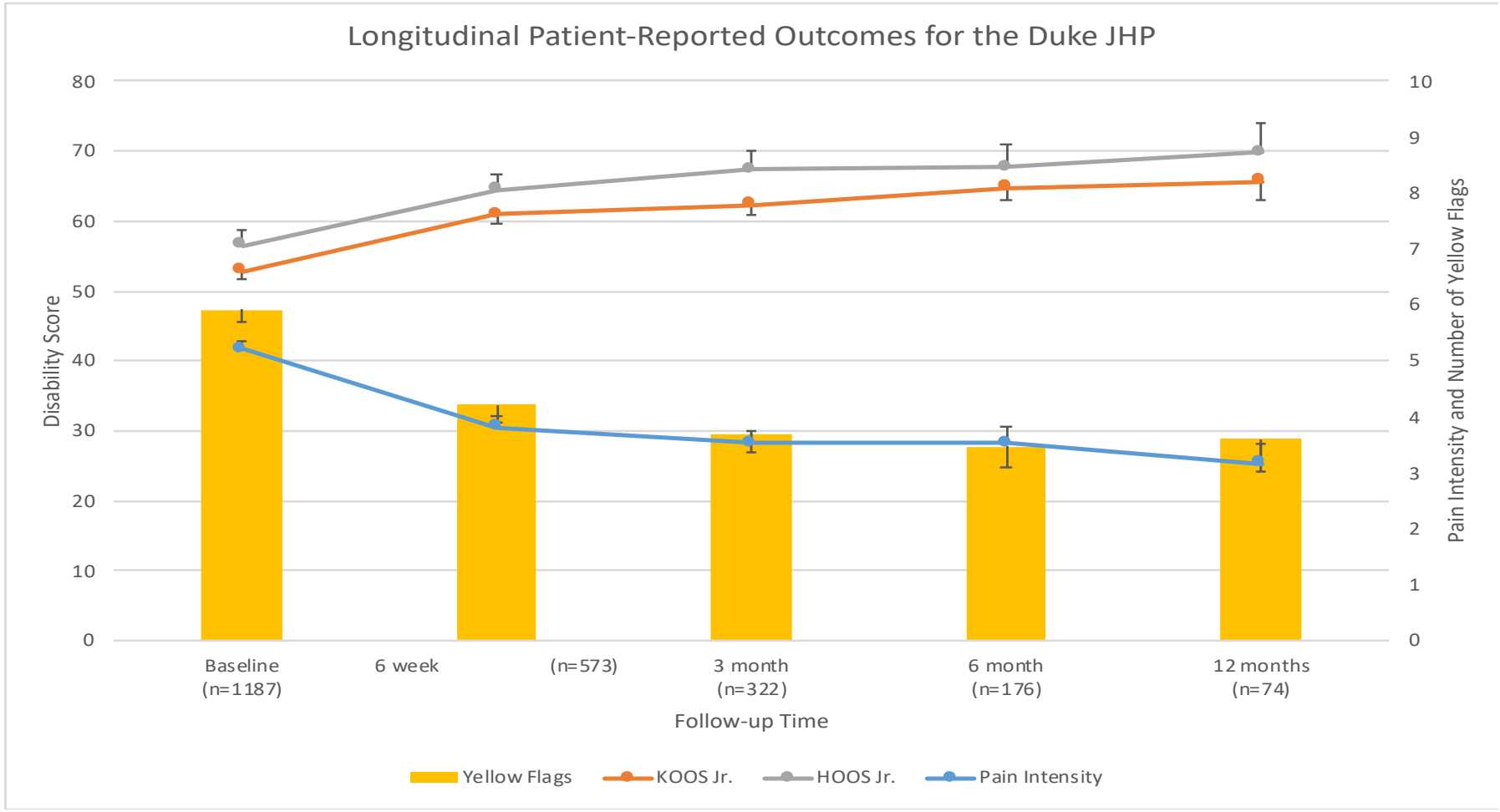
Results - Joint Health Program (JHP) Launched in 2017

- Started with 1 POP (primary osteoarthritis provider)



- Now with 25 POPs in 17 locations (going to 26 in May)
- 7,469 patients referred
- 5188 patients (70%) were seen for an initial evaluation
- 3372 (65%) knees and 1815 (35%) hips.
- 4461 (86%) nonop during the subsequent two years, and 726 (14%) underwent arthroplasty surgery.
- The mean number of visits with a POP per patient was 3.65 (1-14).

Good Outcomes (non-surgical pts)



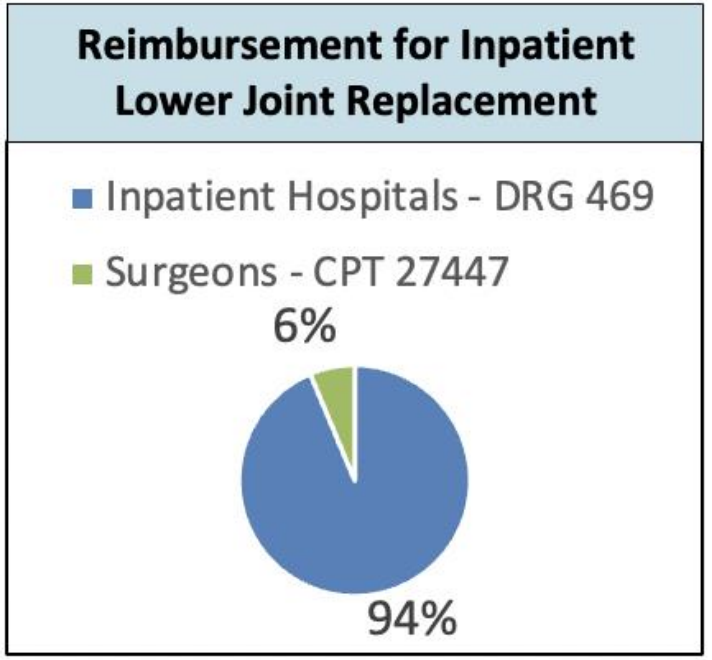
***Error bars are 95% confidence interval.**

Disability, Pain Intensity and Yellow Flag values over time for NON-SURGICAL patients in the JHP

AAOS/AAHKS NOLC Initiatives 2022 #1 Payment Reform

PROTECTING PHYSICIAN SERVICES & VALUE FROM HARMFUL CUTS

Hip and knee surgeons have improved patient outcomes and saved Medicare hundreds of millions through value-based care. This has been achieved through additional work to optimize patient pre-operative health and other surgical advancements. Hip & knee surgeons are driving the MOST value to the patient and Medicare Trust Funds, while accounting for less than 10% of the cost of the surgery!



Despite increased work, hip and knee surgeons are facing multiple cuts to Medicare, including:

- 5.4% Cut to Hip & Knee Replacement (2021-present)
- 2% Medicare sequestration (April/July 2022-present)
- 4% PAYGO sequestration (December 31st, 2022)
- Expiration of 3% relief to Medicare Physician Fee Schedule (December 31st, 2022)

AAHKS AMERICAN ASSOCIATION OF HIP AND KNEE SURGEONS

AAOS/AAHKS NOLC Initiatives 2022 #1 CF

- Conversion factor: $/RVU, complex formula, economy
  - 2023 MPFS Proposed Rule - 4.5 % cut
  - 2021 MPFS Final Rule – 3% cut deferred until 2022

- Tuesday 9-13-22 – Drs. Bera (D-CA) and Buschon (R-IN)
  - Bill will defer 4.5% cut to CF for one year

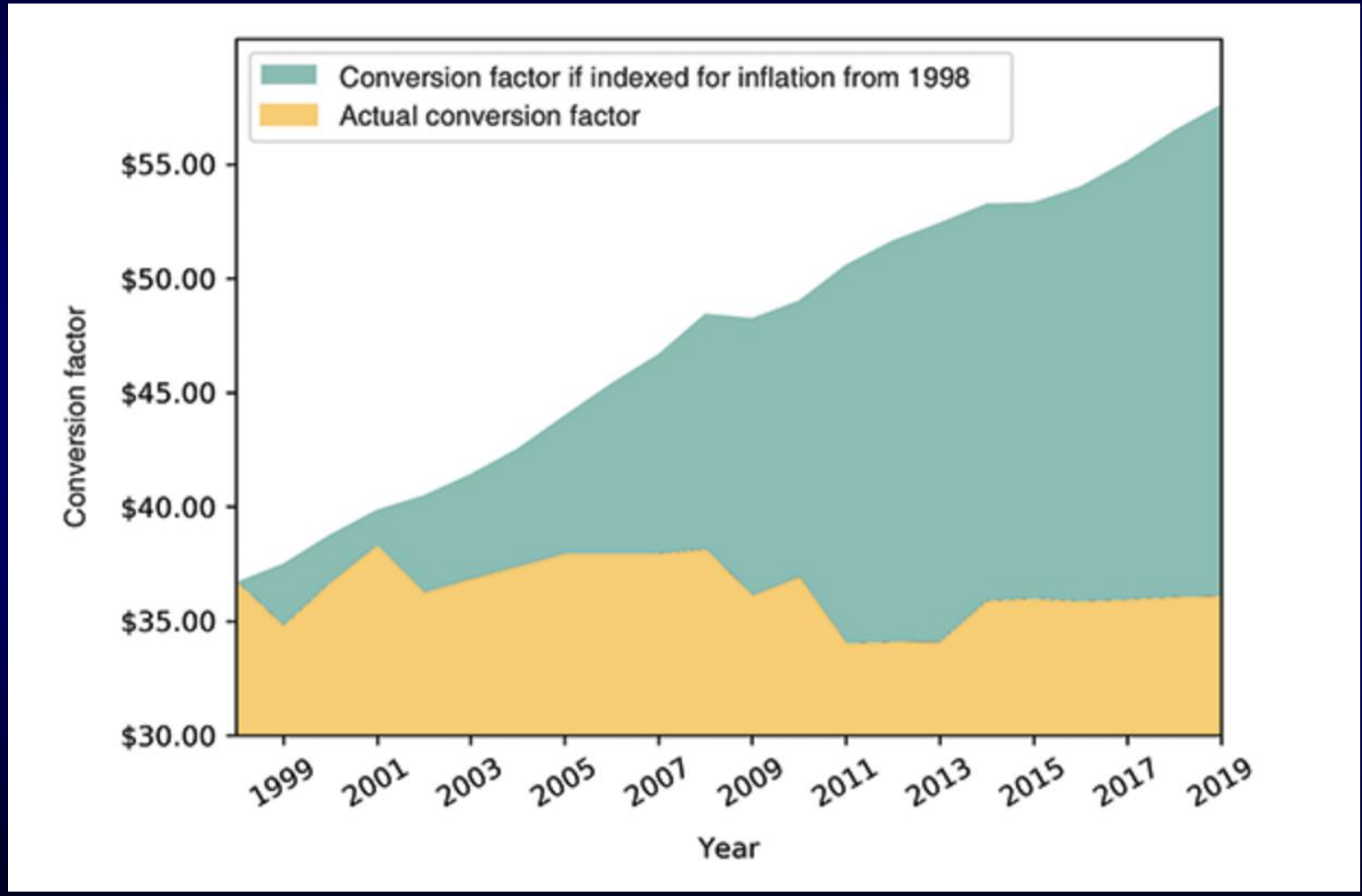
AAOS/AAHKS NOLC Initiatives 2022 #1 BCA Sequestration

- Limit on discretionary appropriations as outlined by the 2011 Budget Control Act 2013-2021
- Mandatory 2% reduction in Medicare spending annually once certain level of spending reached
- Suspended in 2021 by CARES Act but extended to 2031
- Restarted 2022 Q2
- Not expected to be postponed in 2023

AAOS/AAHKS NOLC Initiatives 2022 #1 PAYGO

- Statutory PAYGO 2010 - budget enforcement mechanism
- Legislation affecting spending and revenues will not add to the federal deficit
- 4% cut to Medicare reimbursement in 2023
- Can be waved by unanimous vote by Congress

AAOS/AAHKS NOLC Initiatives 2022 #1 Inflationary Update



AAOS/AAHKS NOLC Initiatives 2022 #2

- Improving Seniors' Timely Access to Care Act (H.R. 3173)
  - Aka "Prior Authorization" bill
  - Creates electronic system w/ adjudication in 7 days
  - Transparency metrics TBD in rulemaking (CMS)
  - Language on site-of-service added yesterday AM
  - Bill passed yesterday PM!
  - Will pass Senate later this year or early next year

AAOS/AAHKS NOLC Initiatives 2022 #3

- Safety from Violence for Healthcare Workers Act (H.R 7961)
  - Aka “SAVE” bill
  - 63% increase in violence against HCPs 2011-2018 (BLS)
  - Establish federal, criminal penalties for assault/intimidating hospital employees
  - $25 million grants over 10 years
  - Outcome TBD

AAOS/AAHKS NOLC Initiatives 2022 #4

- Improving Access to Workers' Compensation for Injured Federal Workers Act (H.R 6087)
- Aka "Scope Creep" bill
- Would allow NPs and PAs to take care of federal worker's comp
- AAOS strongly opposes
- Outcome TBD

Summary

- We got RUC'd !!!
- Procedure-based bundles saved $ and improved quality
- Condition-based bundles should provide even more value
- Expect announcement from CMMI this Fall

Thank You