AAOS
American Academy of Orthopaedic Surgeons
American Association of Orthopaedic Surgeons

March 01, 2016

Andrew M. Slavitt, Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8016
Baltimore, MD 21244-1850
Submitted electronically via episodegroups@cms.hhs.gov

Subject: Solicitation of Comments by the Centers for Medicare & Medicaid Services (CMS) on Episode Groups as Required by §101(f) of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA)

Dear Acting Administrator Slavitt:

On behalf of over 18,000 board-certified orthopaedic surgeons represented by the American Association of Orthopaedic Surgeons (AAOS), we appreciate the opportunity to provide feedback on episode groups as required by §101(f) of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). CMS is mandated to create patient condition groups and related classification codes to measure resource use. Also under §101(f) of the MACRA, CMS is required to develop classification codes to identify patient relationship categories that define the relationship and responsibility of the physician with the patient at the time of furnishing an item or service.

Introduction

AAOS commends CMS for seeking stakeholder input on episode groups and is generally supportive of CMS' efforts to improve patient care by linking quality measurement and care coordination to payment. Episode groups bundle all care for a condition or treatment (also referred to as "care") into a single unit and are intended to provide comparative performance data on the costs and consequences of medical care delivered to clinically similar patients. However, for such data to be useful and actionable, the episode groups must be clinically meaningful to improve and ultimately optimize patient care, particularly in regards to quality and coordination, while considering costs.

AAOS recognizes the importance of condition episode groups which include services for a particular condition over time and across settings and providers. However, our comments focus primarily on treatment or care episode groups, which more narrowly focus on major procedures and are thus germane to the practice of orthopaedic surgery and related procedures. AAOS does recognize the overlap of these episode groups and addresses condition episode groups as related to resource use and orthopaedic surgery when applicable.

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According to CMS, episodes are opened, or triggered, by the incidence of a trigger event. Trigger events may be identified by particular condition (diagnosis) or procedure codes. Condition trigger events may be identified by an evaluation and management (E&M) service, which is represented by an International Classification of Diseases, Ninth Edition diagnosis code (ICD-9-CM), or a Medicare Severity Diagnosis Related Group (MS-DRG) code for inpatient stays. Procedural episodes are opened by the occurrence of the procedure and identified by one or more procedure codes, such Common Procedural Technology (CPT) codes and the ICD-9 Procedure Coding System (ICD-9-PCS) to open procedural episodes in the inpatient setting. Healthcare Common Procedure Coding System (HCPCS) codes are utilized by CMS for outpatient procedures.

AAOS strongly recommends CMS transition to and implement the use of the ICD-10 Diagnosis (ICD-10-CM) and Procedure Coding Systems (ICD-10-PCS). After several delays, hospitals, physician practices, and other healthcare entities were required to begin using ICD-10-CM and ICD-10-PCS codes on October 1, 2015. To assist healthcare providers with the transition, CMS, in coordination with organizations such as the American Hospital Association (AHA), created General Equivalency Mappings (GEMS) which provide “maps” from the outdated ICD-9-CM and PCS codes to the more extensive and robust ICD-10-CM and PCS codes.

The 2016 ICD-10-CM and PCS files are available on CMS’ Medicare Coding Website and should be utilized by CMS to address the transition from ICD-9 as related to condition and procedure episode groups. While CMS states there is no one “gold standard” for constructing episode groups, the transition will ensure the agency is in compliance with its own mandate while maintaining coding uniformity with providers and other healthcare organizations who are complying with CMS’ ICD-10 final rule (FR).

I. Comment Request: Episode Group Focus

Within a specialty, a limited number of conditions and procedures account for the bulk of spending. Focusing on these top conditions and procedures, CMS requests stakeholder identification of these top episode groups.

AAOS Response

Excluding procedures related to the spine, AAOS identified the following ten procedures (treatment episode groups) that accounted for the bulk of CMS spending in 2014:

Top Orthopaedic Episode Groups (Spending)		
CPT Code	**Procedure**	**CMS Reimbursement (2014)**
1. 27447	Total Knee Arthroplasty (TKA)	$398,987,073
2. 27130	Total Hip Arthroplasty (THA)	$201,427,918
3. 27245	Treatment of Hip Fracture with Intramedullary Implant	$101,932,108
4. 27236	Open Treatment of Femoral Neck Fracture	$78,305,111
5. 29827	Arthroscopic Rotator Cuff Repair	$69,395,867
6. 23472	Total Shoulder Arthroplasty	$62,535,838
7. 64721	Carpal Tunnel Release	$43,685,942
8. 27487	Total Knee Arthroplasty (TKA): Revision	$27,608,638
9. 29880	Arthroscopic Meniscectomy	$24,961,832
10. 27134	Total Hip Arthroplasty (THA): Revision	$22,758,553

We look forward to working with CMS and other professional societies in assisting in the development of orthopaedic episode groups that are led by the surgeon, risk-adjusted, and include appropriate resource utilization and orthopaedic-related quality measures, which will ultimately lead to better care coordination, lower costs, and improved patient outcomes. Considering the wide range of orthopaedic procedures, AAOS has initially chosen the following three procedures as care episode groups of focus:

- Rotator cuff repairs;
- Knee arthroscopies; and
- Repair of hip fractures.

It is important to note that AAOS included hip fracture repairs not only because the procedure itself is costly, but because those beneficiaries who suffer hip fractures are more likely to have comorbidities or "conditions" which oftentimes increase the length of the inpatient stay and warrant post-acute care. These conditions are often chronic and existed prior to the injury – examples include hypertension, type I or II diabetes, and dementia – and can significantly increase patient resource use, yet are unrelated to the procedure. Such conditions are beyond the control of

the orthopaedic surgeon and thus AAOS contends that in these situations, the condition episode group is separate from the care or treatment episode group and should be "carved out" of the post-operative care episode group or a robust risk stratification scheme be applied. Other members of the healthcare team such as primary care physicians generally treat these conditions and the resources used to treat these conditions should not be attributed to or included in the care episode group which should include only those resources utilized to repair the hip fracture and subsequent post-operative care. In effect, co-morbidities such as dementia, heart disease, and diabetes should trigger their own unique path in parallel with the surgical procedure. This can be accomplished by the use of ICD-10 Z codes.

We do not feel that all 44 measures in the set as presented in CMS' Episode Groups Request for Information (RFI) need to be employed at this time. It will be important for CMS to work with specialties and consult with Qualified Clinical Data Registries (QCDRs) and Medicare to identify episode groups for conditions in which physicians can have a reasonable expectation of identifying excess costs which can be controlled.

II. Variables Used to Classify Patients into Episode/Condition Groups

CMS solicits comments on what specific clinical criteria and patient characteristics should be used to classify patients into care episode and patient condition groups, what rules should be used to aggregate clinical care into an episode group, when should an episode be split into finer categories, and whether multiple, simultaneous episodes should be allowed.

AAOS Response

AAOS supports allowing multiple, simultaneous episodes for all patients, particularly for the patient with comorbid and often chronic conditions. However, the attribution of such episodes must be appropriate. Furthermore, the distinction should be made between outpatient care of chronic conditions and the care and impact of these conditions in association with an acute event such as a hospitalization.

For example, primary care physician reimbursement for diabetes management should *not* preclude payment to the orthopaedic surgeon for repairing a hip fracture. However, multiple episode groups should not be permitted for a single episode, such as a hospital admission. To illustrate, it would be inappropriate to classify a patient into one episode group for a hip fracture repair and also into another episode group for a myocardial infarction (MI) the patient suffered after the hip fracture was repaired. AAOS is concerned that separate episode groups in such a scenario would essentially reduce payment to both the cardiac and orthopaedic surgery teams. Rather, risk adjustment should be used for the patients' comorbidities in this setting.

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AAOS recommends that CMS partner with specialty societies regarding clinical criteria and patient characteristics for patient classification, while allowing for flexibility for variation in patient care models across the Medicare population. The important consideration is to identify conditions in which there is moderate agreement on appropriate care, the physician has active control, and there are readily identifiable start and stop points in the care of the patient.

III. Condition Group Development for Patients with Multiple Chronic Conditions

As Medicare beneficiaries often have multiple comorbidities, distinguishing the services furnished for any one condition is challenging. CMS requests feedback on how to approach developing patient condition groups for patients with multiple chronic care conditions.

AAOS Response

AAOS suggests there should be outpatient episode groups that provide for the care and/or treatment of the chronic condition(s) – diabetes, rheumatoid arthritis, chronic atrial fibrillation, etc. – in the outpatient setting. These conditions will need continuous care in the outpatient setting regardless of any acute orthopaedic hospitalization or surgical procedure. In the instance a disparate event/injury occurs which necessitates a procedure such as an arthroplasty be performed, the episode group should be based on the acute event.

To account for the patient's chronic conditions, the treatment episode group should be appropriately risk-adjusted to account for the factors outside of the orthopaedic surgeon's control, which in this case are the chronic conditions from which the patient suffers.

Alternatively, it may be appropriate for a patient to be involved in multiple care episodes concurrently, such as one treatment episode for hip fracture, a condition episode for diabetes, and another for congestive heart failure (CHF). The effectiveness of the grouper will determine if this is possible.

IV. Interrelated Comorbidities

As comorbidities are often interrelated, CMS seeks approaches that can be used to determine whether a service or claim should be included in an episode.

AAOS Response

One potential approach to this issue may be to exclude patients with certain comorbidities and/or diagnoses from an episode group due to excessive and additional expenses and beneficiary variability – for instance, a patient admitted with sepsis who also suffers from a hip fracture.
Another potential approach is to designate the hip fracture as a separate episode from the patient's sepsis, which could be classified as a condition episode. Furthermore, AAOS believes outpatient

and inpatient episode groups should be discrete from each other – outpatient payment for a patient's diabetes care should not cover an inpatient admission for an infection. Outpatient care providers are oftentimes not the same providers who care for the patient in the inpatient setting for such chronic conditions.

Alternatively, orthopaedic surgeons often provide care across the healthcare setting continuum and in such cases where care is provided by the surgeon in both the inpatient and outpatient settings, the provider should be responsible for resource utilization/expenses related to the diagnosis. Whether the same physician typically manages the underlying condition and the comorbidities may affect the choice of approach. Under the Merit-based Incentive Payment System (MIPS), there may be overlap between episodes for different chronic diseases as payment will still be disbursed to the provider who delivered the service.

V. Patient Condition Group Duration for Chronic Conditions

CMS asks about the duration of patient condition groups for chronic conditions and whether it should be longer or shorter than one year.

AAOS Response

While AAOS believes the duration of *one year* for patient condition groups for chronic conditions is generally acceptable, there are several factors that must be considered. For instance, the physician responsible for patient care of the condition may depend whether the chronic condition is short- or long-term. For a short-term orthopaedic-related chronic condition, the orthopaedic surgeon and/or team should be responsible for the patient's management and for resources such as crutches or a walker for the beneficiary whose condition lasts for less than one year. However, if the condition is not resolved and is considered long-term, attribution may need to be re-evaluated as other members of the healthcare team may be more appropriate in addressing the patient's chronic condition beyond the timeframe considered to be "short-term." In this instance, the Supplemental Quality and Resource Use Reports (QRURs) may be useful in assisting, for instance, an orthopaedic surgery practice, in evaluating their resource use for a procedure that is prevalent in the Medicare Fee for Service (FFS) population and has become both chronic and costly.

VI. Care Coordination and Resource Use Measurement

CMS solicits feedback on how care coordination can be addressed in measuring resource use.

AAOS Response

Under MIPS, "points" are provided for care coordination. AAOS believes documented and proven coordination of patient care at the system level – not at the level of the individual patient – should

be incentivized to increase reimbursement for MIPS-eligible professionals (EPs). Care coordination should be promoted among providers of services. Support for care coordination for chronically ill patients at high-risk of hospitalization can be provided through provider networks that include care coordinators, chronic disease registries, and home telehealth technology. In many cases, care coordination will be rewarded by higher payment because it will lead to lower resource use and generate payment bonuses.

VII. ***Alignment of Resource Use and Clinical Quality Measures***

CMS has received public comments encouraging the agency to align resource use measures – which utilize episode grouping – with clinical quality measures and is requesting feedback on how episodes can be designed to achieve this goal.

AAOS Response

AAOS supports the use of evidence-based performance measures – those developed after a systematic review of the literature as opposed to consensus-based measures which are all too common in current practice – and has an established program for developing evidence-based guidelines. Using a standardized methodology and ensuring results are transparent in developing performance or quality measures would permit the alignment of clinical quality measures to those measures that address resource utilization. To this end, AAOS urges CMS to create adequate infrastructure based on the variables above and developed with quality and patient safety as guiding principles to achieve alignment of the two types of measures. In addition, the desired outcome of aligning resource measures with clinical quality measures would need to be defined appropriately for each episode group and also based on systematic review of the medical literature.

VIII. ***Episode Validity in the Absence of Claims Data***

Information unavailable in claims data may be necessary to create a more reliable episode. CMS is inviting responses on how the validity of an episode can be maximized without relevant clinical information.

AAOS Response

Episode groups should include the flexibility necessary for clinicians to have the ability to add modifiers to the episode groups. At the discretion of the clinician, the ability to include modifiers would account for the unavailable claims data. Additionally, ICD-10 Z codes offer a wide range of comorbidity documentation that would be reported via the standard claims form. Such flexibility would create a more reliable and robust episode group, with the potential to provide adequate reimbursement for services that reflect the increased complexity of the episode and would provide a more complete picture of the patient's condition as related to the episode. CMS should

conduct evaluations on the reliability of the episodes and share these results with the specialties that provide the service. These clinicians could then provide expert advice on the validity of the measure and any concerns they may have with the reliability scores.

IX. Incorporating Patient Variability in Measuring Resource Use

CMS solicits information on how complications, illness severity, potentially avoidable occurrences, and other consequences of care can be addressed in measuring resource use.

AAOS Response

To account for patient characteristics and variables such as complications and illness severity for measuring resource use within an episode group, AAOS supports the utilization of risk adjustment for payments within the episode group based on the factors noted above.

X. Resource Measure Reliability

Reliability of resource use measures are impacted by sample size. CMS requests feedback on how low volume patient condition groups and care episodes should be handled.

AAOS Response

This issue could be addressed by granting the clinician the ability to add a modifier to the episode group to account for low volume patient condition episode groups. If designed appropriately, adding a modifier would have the effect of varying the episode group payment according to sample size for such low volume episode groups. Additionally, ICD-10 Z codes offer a wide range of comorbidity documentation that would be reported via the standard claims form.

Additional Comments

After examining the orthopaedic treatment episode groups developed using the CMS-developed Methods A and B, AAOS submits the following concerns:

- Assigning treatment of hip and femur fractures or dislocations (Method A) to the same episode group is inappropriate as the process of treating fractures is entirely different from how dislocations are addressed. Therefore, this episode group should encompass the treatment of hip fractures *only*. A dislocation may be either prosthetic or natural and each requires separate and distinct resource use and treatment;

- Under Method A, the hip replacement or repair episode group should be parallel to a knee arthroplasty. The treatment episode group should read as “hip arthroplasty” and the group should *not* include any type of repair;

- The definition of the knee joint repair episode group under Method B is unclear. For example, does "repair" refer to an open reduction and internal fixation (ORIF) of a fracture of the tibial plateau? The treatment(s) that comprise this episode group need to be explicitly defined as "knee joint repair" can be interpreted/defined in a number of ways; and

- The spinal fusion episode group which uses Method B is extremely vague and should, at a minimum, specify the number of levels fused. For example, the episode group should separate one to two levels into one group, and those greater than two levels should comprise a separate episode group for spinal fusion. The complexity of the procedure as well as resource utilization varies considerably by the number of levels fused, and therefore it would be erroneous to place all levels of spinal fusion into a singular episode group.

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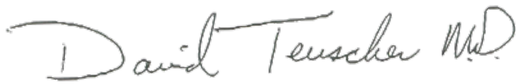
Thank you for your time and consideration of the American Association of Orthopaedic Surgeons' (AAOS') responses to CMS' solicitation of comments on episode groups as required by the MACRA. AAOS looks forward to working closely with CMS to ensure those episode groups designated for orthopaedic-related procedures and treatment accurately reflect care provided to the patient and the resources utilized in this care to allow for robust data collection and analyses to ultimately improve the care of musculoskeletal patients. Should you have questions on any of the above responses or concerns, please do not hesitate to contact AAOS' Medical Director, William O. Shaffer, MD, at 202-548-4430 or via email at shaffer@aaos.org.

Sincerely,



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