

June 30, 2009

Charlene Frizzera  
Acting Administrator  
Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
*Attention:* CMS-1406-P  
P.O. Box 8011  
Baltimore, MD 21244-1850

Dear Ms. Frizzera:

The American Association of Orthopaedic Surgeons (AAOS), the American Association of Hip and Knee Surgeons (AAHKS), the Orthopaedic Trauma Association (OTA), and the Pediatric Orthopaedic Society of North America (POSNA) appreciate the opportunity to comment on the fiscal year (FY) 2010 Inpatient Prospective Payment System (IPPS) proposed rule<sup>1</sup>. These organizations represent over 17,000 board-certified orthopaedic surgeons and have been committed partners to the Centers for Medicare and Medicaid Services (CMS) in patient safety and quality health care. We look forward to providing input on MS-DRG classifications, hospital-acquired conditions, new quality measures, graduate medical education (GME), and EMTALA.

#### **I. Proposed Changes to Specific MS-DRG Classifications: MDC 8**

The AAOS and AAHKS would like to take the opportunity to express our appreciation for CMS working with our organizations to ensure the accuracy of Medicare payments related to hip and knee replacement procedures. We look forward to future opportunities to work with CMS to further refine MS-DRGs and other hospital payment policies. The AAOS and AAHKS fully support CMS' proposal related to infected total joint arthroplasty procedures to:

- Move ICD-9-CM procedure code 80.05 (Arthrotomy for removal of hip prosthesis) out of MS-DRGs 480-482 (Hip and femur procedures except major joint) and into MS-DRGs 463-465 (Wound debridement and skin graft except hand)
- Move ICD-9-CM procedure code 80.06 (Arthrotomy for removal of knee prosthesis) out of MS-DRGs 495-497 (Local excision of internal fixation device except hip and femur) and into MS-DRGs 463-465 (Wound debridement and skin graft except hand)

The members of AAOS and AAHKS strive to ensure that patients have access to the highest quality musculoskeletal care. Unfortunately, the previous level of hospital

---

<sup>1</sup> *Federal Register*, "Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and Fiscal Year 2010 Rates and to the Long-Term Care Hospital Prospective Payment System and Rate Year 2010 Rates," Vol. 74, No.98 (05/22/2009).

reimbursement for the treatment of infection following hip and knee arthroplasty left patients, physicians, and hospitals in a vulnerable position. The considerable resources required to care for these patients and the corresponding inadequate hospital reimbursement created a system that disincentivized hospitals from providing these services, thereby placing pressure on physicians to limit the number of patients admitted with infected total joint replacements. As deep infection is one of the most devastating complications associated with hip and knee arthroplasty, we appreciate CMS' analysis and proposed MS-DRG reassignment that will allow the necessary access for patients with infected total joint arthroplasties to appropriate expertise and treatment in a more timely manner. Peri-prosthetic joint infection often results in the need for multiple re-operations, prolonged use of intravenous and oral antibiotics, extended inpatient and outpatient rehabilitation, and frequent follow-up visits. It is our hope that by moving these procedures to more appropriate MS-DRGs, reflecting the true resource intensity of these treatments, will decrease the economic burden on tertiary care referral centers and minimize treatment delays as patients with infected joint replacements seek providers who are willing and able to care for them.

## **II. Preventable Hospital-Acquired Conditions (HACs), Including Infections**

*General comments.* The AAOS and POSNA are both very supportive of CMS' efforts to encourage the adoption of evidence-based treatment guidelines which could improve the quality of care for our patients. However, several aspects of the HAC policy are concerning to us. The AAOS would like to take this opportunity to start a dialogue with CMS in regard to the future hospital value based purchasing (HVBP) program and the current hospital-acquired conditions policy. As discussed in the Senate Finance Committee options paper, language may be included in the larger health reform legislation on a Medicare HVBP program. We have specific recommendations if the HAC policy is not replaced by a more comprehensive HVBP program. We understand and support the value of not paying for "never events" but would encourage a slightly different approach to conditions that CMS defines as "reasonably preventable." The AAOS recommends that CMS remove conditions from their list of HACs that are addressed through outcome based quality measurement. Making payment adjustments based on both policies would unnecessarily capture the condition twice. Based on the current legislation, CMS is required to have two conditions on the HAC list. Therefore, if legislation does not replace the HAC policy, CMS still has the ability to appropriately measure quality and encourage value through the HVBP program.

*Pediatric specific comments.* Both AAOS and POSNA have previously submitted comments related to CMS' HAC policy, but we would like to take this opportunity to reinforce our concerns with the unintended consequences of the HAC policy on the pediatric population, one of our most vulnerable populations. We would also like to express our appreciation to CMS staff for recently meeting with POSNA and previously with the AAOS on this issue. We understand that pediatrics is not included in the typical Medicare population but we are experiencing similar policies through Medicaid as a result of the Medicare policy.

We are concerned with the presumption that these "hospital-acquired conditions" could be "reasonably prevented" through the use of evidence-based guidelines, specifically infection following orthopaedic procedures. While evidence-based guidelines can reduce, they can not eliminate the risk of certain hospital-acquired adverse events. Pediatric orthopaedic surgery is frequently performed on children with multi-system disease and even with the application of evidence-based guidelines, many children will have post-operative infections. This recommendation has the potential for hospitals to discourage physicians from treating complicated pediatric patients and thereby limiting care for this particularly at-risk population. The AAOS and POSNA believe that risk adjustment is an indispensable component of an equitable hospital-acquired condition policy. We also believe that to be reasonably preventable, there should be solid evidence, published in peer-reviewed literature, that by following certain guidelines, the occurrence of an event can be reduced to zero, or near zero, among a typically broad and diverse patient population, including high-risk patients.

### **III. RHQDAPU: New Quality Measures for FY 2012 Payment Determination and Subsequent Years**

The AAOS and AAHKS would like to take the opportunity to express our support for a movement toward developing clinically relevant quality measures which recognize the importance of measuring both process and outcome. In particular, we are encouraged by the VTE-6 measure proposed for future payment determination years. By identifying patients who develop a VTE who have NOT received appropriate prophylaxis, the measure accounts for compliance with evidence-based guidelines while providing actionable information for quality improvement. We would also encourage ongoing evaluation of these measures as new knowledge becomes public such as the recent Food and Drug Administration (FDA) Blood Products Advisory Committee meeting on Hereditary Antithrombin III deficiency.

We would also like to stress the importance of risk adjustment when outcome measures are publicly reported and/or used in future value based purchasing programs. Both of these quality tools rely on accurate, valid, and reliable data to inform stakeholders and improve quality. Without risk adjustment, comparisons are not equitable. The AAOS and AAHKS encourage CMS to focus on the ultimate goal of providing the highest quality care to each patient with their unique needs.

The AAOS and AAHKS have dedicated considerable human and financial resources to developing evidence-based process and outcome measures and encouraging the adoption of evidence-based practice guidelines for the prevention, diagnosis, and management of musculoskeletal disease, and we invite CMS to call on us as a partner and expert in performance and quality measurement in musculoskeletal care.

### **IV. Graduate Medical Education (GME)**

The AAOS appreciates the proposed changes that would allow hospital residency training programs that are new after July 1, 2009 to receive a temporary adjustment to their FTE

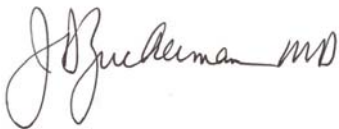
resident caps. This adjustment will allow new programs to train new physicians which are desperately needed. The AAOS thanks CMS for their recognition of the vital role GME plays in our nation's health care.

**V. Hospital Emergency Services Under EMTALA (§489.24)**

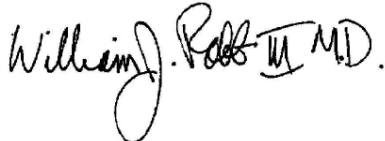
The AAOS and the OTA appreciate the changes CMS has made over the last several years to address requirements under the Emergency Medical Treatment and Labor Act (EMTALA) in the event of an emergency or disaster declared by the President or a public health emergency declared by the Secretary of Health and Human Services. While we continue to have concerns about implementation in the fast-changing moments of an emergency or disaster, we believe that CMS is taking the steps necessary to address some of the regulatory hurdles that could serve as administrative burdens in emergency or disaster situations.

In addition, we support the proposed language that states that it is the *transfer* that must arise out of the circumstances of the emergency, not that the *medical condition* must arise out of the circumstances of the emergency. To have the nexus with the emergency circumstances based on something other than the *transfer* would lead to an unworkable triage and enforcement system.

Sincerely,



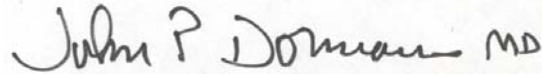
Joseph D. Zuckerman, MD  
President, American Association of  
Orthopaedic Surgeons



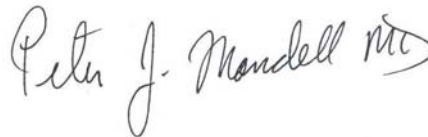
William J. Robb, III, MD  
President, American Association of Hip  
and Knee Surgeons



David C. Templeman, MD  
President, Orthopaedic Trauma  
Association



John P. Dormans, MD  
President, Pediatric Orthopaedic Society  
of North America



Peter J. Mandell, MD  
Chair, Council on Advocacy  
American Association of Orthopaedic  
Surgeons



Kevin J. Bozic, MD, MBA  
Chair, Health Care Systems Committee  
American Association of Orthopaedic  
Surgeon