AAOS
American Association of Orthopaedic Surgeons

CY 2023 Medicare Physician Fee Schedule Final Rule

The Calendar Year (CY) 2023 Medicare Physician Fee Schedule (MPFS) final rule was released on November 1, 2022, by the Centers for Medicare & Medicaid Services (CMS). The annual payment rule sets policy for physicians participating in the Medicare program and makes updates to the Quality Payment Program. AAOS submitted formal comments on the proposed rule to CMS on September 2, 2022. The outline below compares what AAOS advocated for to what was finalized. The majority of the regulations will take effect on January 1, 2023.

Topic	AAOS Comment/Recommendation	Finalized Policy
Conversion Factor	AAOS urged CMS to work with societies to create value-based payment models that include incentives tailored to the distinct needs of patients and practice settings, along with a financially viable fee-for-service model.	CMS finalized the Medicare conversion factor (CF) of $33.06. This represents a decrease of 4.5% from the 2022 CF of $34.61. The decrease is a result of the expiring 3% increase and budget neutrality requirements from the revised E/M changes.
Valuation of Specific CPT Codes • ***Arthrodesis Decompression,*** • ***Lumbar Laminotomy with Decompression***	CMS did not agree with the RUC-recommended work RVUs for arthrodesis CPT codes 22630, 22633, 22634 as well as laminectomy codes 63052 and 63053. CMS proposed new recommendations based on various time calculations or code crosswalks. **AAOS urged CMS to accept the RUC-recommended wRVUs for all the codes.**	CMS did not accept the RUC-recommended work RVUs, instead finalizing their proposed work values for 22630, 22633, 22634 as well as codes 63052 and 63053. 22630 = 20.42 wRVU 22633 = 24.83 wRVU 22634 = 7.30 wRVU 63052 = 4.25 wRVU 63053 = 3.78 wRVU
Payment for Skin Substitutes	CMS proposes to treat skin substitutes (including synthetic) as incident-to supplies as described under section 1861(s)(2)(A) of the Act when furnished in a non-facility setting. CMS is also proposing to include the costs of these products as resource inputs in establishing practice expense RVUs for associated physician's services effective January 1, 2024. **AAOS strongly opposes this proposal and urges CMS not to include skin substitute products as incident-to CPT codes.**	For CY 2023, CMS will transition to finalize their proposal to treat skin substitutes (including synthetic) as incident-to supplies when furnished in a non-facility setting effective January 1, 2024. Additionally for 2024, CMS is proposing to discontinue use of the term "skin substitute", instead referring to these products as "wound care management products".
Telehealth Payment	Audio-only telephone E/M Services (CPT codes 99441, 99442, and 99443), which are reimbursed equal to the number of in-person visits during the PHE, will end after the PHE	CMS finalized that the telephone E/M services are not comparable to in-person care and will not remain on the Medicare Telehealth Services List after the end of the

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	expires. CMS maintains that after the PHE expires, all telehealth services, other than mental health care, must have two-way, audio/video communications for telehealth services. **AAOS urged CMS to maintain coverage for audio-only coverage beyond the expiration of the PHE.**	PHE and the 151-day post-PHE extension period.
Evaluation and Management (E/M) Visits	AAOS strongly urged CMS to adopt and reimburse new 2023 CPT code 99418 for prolonged services and disagreed with the usage of new HCPCS G codes. Requiring physicians to report different code sets for Medicare patients prolonged services and non-Medicare patients creates another layer of administrative burden. AAOS also urged CMS to accept the long-standing industry standard CPT definition for billable units of time, (considered to have been attained when the *midpoint is passed)*. Again, having different reporting requirements for Medicare patients related to treatment time will cause undue administrative burdens on physicians.	CMS finalized the creation of Medicare-specific G codes for payment of Other E/M prolonged services. These services will be reported with three separate Medicare-specific G codes. CMS will not adopt the general CPT rule where a billable unit of time is considered to have been attained when the midpoint is passed.
Split/Shared Services	In the CY 2022 rule, CMS finalized a policy for E/M visits furnished in a facility setting (hospital), to allow payment to a physician for a split (or shared) visit (including prolonged visits), where a physician and NPP provide the service together (not necessarily concurrently) and the billing physician personally performs a "*substantive portion*" of the visit. CMS proposed the definition of "substantive portion" to be "more than half of the total time". After industry pushback, CMS proposed to delay implementation of the definition of the "substantive portion" as more than half of the total time until January 1, 2024. AAOS strongly urged CMS to consider revising the definition for "substantive portion" to be based on medical decision making (MDM) and not time.	For CY 2023 CMS finalized that clinicians who furnish split (or shared) visits will continue to have a choice of history, or physical exam, or medical decision making, *or* more than half of the total practitioner time spent to define "substantive portion" until CY 2024. However, starting January 1, 2024, the term "substantive portion" for split/shared visits will be defined as "more than half the total time."

Solicitation on Global Surgical Services	AAOS, along with our surgical colleagues, responded to CMS questions about improving the global surgical package valuation through comments, letters, and meetings since 2012. AAOS strongly encouraged CMS to disregard the RAND recommendations for revaluation of the global codes given that the RAND methodology is not only flawed but is based on numerous assumptions that are not transparent to the public and encouraged CMS to release the underlying data and assumptions used by RAND. AAOS strongly opposed CMS' failure to incorporate the RUC-recommended work and time incremental increases for the revised office/outpatient visit E/M codes in all the global codes, and strongly urged CMS to apply the RUC-recommended changes to the E/M component of the global codes to maintain the relativity of the Fee Schedule. Further AAOS recommended that CMS: a. Continue to collect data from a subgroup of physicians by having them submit tracking codes for post-operative visits, CMS to reach out to EHR vendors and Medicare Administrative Contractors (MACs) to obtain actual data on the number of postoperative visits actually provided. b. Re-survey high-value procedures with a focus on post-operative visits. c. Consider eliminating the 10-day global period and review codes with that global period to determine if a 0-day or 90-day global period is most appropriate, but this must only be done by engaging stakeholders and reviewing the codes for relative valuation, not by using a formulaic building block valuation approach. d. Continue to work with specialty societies as it moves forward, to weigh in on the Agency's policy considerations related to revaluation of global surgical packages.	CMS stated it has not received data suggesting that postoperative E/M visits are being performed more frequently than indicated by the data collected and analyzed in the RAND reports. CMS continue to be concerned that current valuations of the global packages reflect certain E/M visits that are not typically furnished in the global period, and thus, are not occurring. CMS further stated that RAND has adequately responded to critiques of its methodologies and findings. CMS is still soliciting comment on whether changes to health care delivery, including changes in coordination of care and use of medical technology over the past 3 decades, as well as during the recent PHE, have impacted: the number and level of postoperative E/M visits needed to provide effective follow-up care to patients; the timing of when postoperative care is being provided; and who is providing the follow-up care. CMS is also soliciting comments on whether, or how, recent changes in the coding and valuation of separately billable E/M services may have impacted global packages. CMS continues to believe that: (1) there is strong evidence suggesting that the current RVUs for global packages are inaccurate; (2) many interested parties agree that the current values for global packages should be reconsidered, whether they believe the values are too low or too high; and (3) it is necessary to take action to improve the valuation of the services currently valued and paid under the PFS as global surgical packages. Therefore, CMS would like to re-engage with the public about whether the

		global packages are indeed misvalued, and if so, what would be an appropriate approach to valuation.
Rebasing and revising the Medicare Economic Index (MEI)	CMS has relied on AMA physician cost data for 50 years in updating the MEI and 30 years in updating the resource-based relative value scale (RBRVS). The current MEI weights are based on data obtained from the AMA's Physician Practice Information (PPI) Survey. Hence, we fully agree with CMS that the MEI weights must be updated. However, the AMA is currently engaged in a process to collect this data again. It is expected that the new data collection efforts will be completed by 2023 and will be based on 2022 cost data. AAOS, therefore, asked CMS to collaborate with AMA and national specialty societies like us and postpone updating the MEI data updates until the AMA survey is complete.	CMS has finalized new Medicare Economic Index (MEI) weights. The current MEI weights are based primarily on results from the AMA's PPI survey, based on 2006 data. CMS used data from the Census Bureau's Service Annual Survey (SAS) as the primary source for the new weights. CMS will not implement the MEI changes in 2023 due to the significant impact on physician payments. CMS also states that they will be interested to compare the results of the AMA practice expense data collection effort to the data used in their new MEI calculation.
Appropriate Use Criteria (AUC) Policy	AAOS is pleased to see that CMS is indefinitely delaying the Appropriate Use Criteria (AUC) for advanced diagnostic imaging payment penalty. Although AAOS is supportive of programs that improve quality and reduce unnecessary testing, we are concerned that the implementation of the AUC program will detract from the developments of the Quality Payment Program (QPP) made in the years since the AUC program was signed into law. Meanwhile, the continued delays create unnecessary costs at a time when reimbursement continues to face cuts and	CMS did not make any comments on the AUC policy.

	expenses rise as a result of inflation and the pandemic. As AAOS commented in the past, given the many issues with implementation, we urge CMS to consider ending this program altogether.	
Updates to the Quality Payment Program	AAOS supports this proposed rule's interest in accelerating the use of open APIs to improve the exchange of health information to improve patient satisfaction and care. As discussed above, such moves will enable faster implementation of PRO-PMs and other quality improvements. AAOS supports the proposal to use the FHIR standards as a baseline for the newly defined API standards criteria, as well as a new proposed patient and population services API criteria. Additionally, AAOS supports replacing the Common Clinical Data Set (CCDS) for information exchange for the more robust United States Core Data for Interoperability (USCDI). However, AAOS is concerned that API Data Providers may be unfairly burdened by several fees that an API Technology Supplier can charge, but there is no similar mechanism for API Data Providers to recoup such costs.	CMS thanked commenters for their feedback and will consider it in future rulemaking.
Quality Payment Program (QPP)		
Previously Finalized Quality Measures Proposed for Removal in the CY 2023 Performance Period/2025 MIPS Payment Year	AAOS is concerned that CMS is proposing to remove four quality measures which are reported through our qualified clinical data registry (QCDR). While we understand that CMS is proposing to remove measure numbers 375 (Functional Status Assessment for Total Knee Replacement), 460 (Back Pain After Lumbar Fusion), 469 (Functional Status After Lumbar Fusion), and 473 (Leg Pain After Lumbar Fusion) in order to decrease	Based on the review of updates made to the existing quality measures set, CMS is finalizing the proposal to remove these four measures for the CY 2023 performance period/CY 2025 MIPS payment year and future years. (Table B.29)

	the number of duplicative measures, we are dismayed by the churn of measures the MIPS program. Significant time has been expended to test these measures and include them among the data that the AAOS QCDR captures for our members.	
Third party intermediaries (e.g., Qualified Clinical Data Registries (QCDRs)) support within the MVP	AAOS appreciates the opportunity to provide feedback on the question of whether third-party intermediaries, including QCDRs, should have the flexibility to choose the measures they will support within the MVP. Should this flexibility be granted, we would be in favor of choosing which MVP measures we support to ensure that sites are able to achieve data completeness and reduced burden in their reporting. CMS is proposing that beginning with the CY 2022 performance period/CY 2024 payment year, CMS will approve QCDR measures with face validity. For the CY 2024 performance period/CY 2026 payment year and onward, QCDR measures approved for an earlier performance year will be required to be fully developed and tested, including complete testing results at the clinician level, prior to self-nomination. AAOS supports this delay and appreciates CMS' recognition of the resources required to complete full measure testing at the clinician level.	CMS is finalizing the proposal to revise the QCDR measure self-nomination and measure approval requirements, including the delay of QCDR measure testing requirements for traditional MIPS until the CY 2024 performance period/CY 2026 MIPS payment year.
Remedial Action and Termination of Third-Party Intermediaries	AAOS appreciates the remedies CMS has provided for QCDRs to maintain engagement in the program through self-nomination participation plans in cases where performance data has not yet been submitted. However, we disagree with the proposal to terminate QCDRs that,	CMS is finalizing the addition of new grounds for termination beginning with the CY 2024 performance period/CY 2026 MIPS Payment year for QCDRs and qualified registries that submit a participation plan as required but do not submit MIPS data for the applicable

	beginning with the CY 2024 performance period, do not submit MIPS data for the performance period for which they self-nominated. In practice, as a specialty registry, having the ability to support MVPs will be our strongest path forward for reporting on behalf of our participants given that they typically report traditional MIPS measures outside of the orthopedic setting. Thus, until there is an opportunity for the MVP program to gain traction, we request that CMS delay the termination of QCDRs.	performance period for which they self-nominated.
Promoting Wellness MVP	AAOS is pleased to see the inclusion of 'Q039: Screening for Osteoporosis for Women Aged 65-85 Years of Age' measure in the proposed "Promoting Wellness" MVP. This MIPS quality measure assesses women, 65-85 years of age, who have ever received a dual-energy x-ray absorptiometry (DXA) test to evaluate for the disease osteoporosis." While this is a good start with CMS acknowledging that osteoporosis is "an important public health issue requiring attention as it can lead to co-morbidities and decreased quality of life", we join our colleagues in urging CMS to prioritize payment mechanisms in the Medicare program to support a proven coordinated, collaborative care model – Fracture Liaison Service (FLS) - that is recognized internationally as the "gold standard" for secondary prevention of osteoporotic fractures. Thus, we urge CMS to create a reliable payment mechanism to support FLS programs to encourage preventive care for osteoporosis patients thereby simultaneously addressing a major public	CMS is finalizing Q039: 'Screening for Osteoporosis for Women Aged 65-85 Years of Age' for inclusion in the Promoting Wellness MVP Quality Measures set. Per CMS, this MIPS quality measure assesses women, 65-85 years of age, who have ever received a dual-energy x-ray absorptiometry (DXA) test to evaluate for the disease osteoporosis.

	health problem and a high-cost area for the Medicare program.	