AAOS
American Association of Orthopaedic Surgeons

September 8, 2023

Hon. Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1784-P
P.O. Box 8013
Baltimore, MD 21244-1850

Submitted electronically via http://www.regulations.gov

Subject: CMS-1784-P

Medicare and Medicaid Programs; CY 2024 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; Medicare Advantage; Medicare and Medicaid Provider and Supplier Enrollment Policies; and Basic Health Program

Dear Administrator Brooks-LaSure,

On behalf of over 39,000 orthopaedic surgeons and residents represented by the American Association of Orthopaedic Surgeons (AAOS), and the orthopaedic specialty societies and state societies that agreed to sign on, we are pleased to provide comments in response to the Medicare and Medicaid Programs; Calendar Year (CY) 2024 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; Medicare Advantage; Medicare and Medicaid Provider and Supplier Enrollment Policies; and Basic Health Program (CMS-1784-P) published in the Federal Register on July 13, 2023.

AAOS appreciates the ongoing efforts of the Centers for Medicare & Medicaid Services (CMS) to create a more equitable health care system that results in better access to care, quality, affordability and innovation.

CY 2024 PFS Ratesetting and Conversion Factor

For CY 2024, CMS is proposing a conversion factor of $32.75, a decrease of $1.14 (almost 3.26%) to the CY 2023 PFS conversion factor of $33.89.[1] The American Medical Association (AMA) estimates that Medicare physician payments will decrease by 20% between 2001 and 2021 as a result of practice cost inflation. Although Medicare spending on physician services per enrollee decreased by 1%

between 2010 and 2020, spending on other parts of Medicare increased by 3.6% to 42.1%. [2] With inflation soaring to 40-year highs this year, on-going and scheduled statutory payment cuts, and many physician practices still dealing with pandemic-related financial and staffing issues, the current proposal from CMS undermines the long-term sustainability of physician practices while threatening patient access to physicians participating in Medicare.[2]

The AAOS joined the American Medical Association (AMA) and several other organizations to call for a rational reform plan[3] for Medicare's physician reimbursement system which includes principles for fixing prior authorization, supporting telehealth, reducing physician burnout and stopping scope of practice creep. [2] This progress is impossible without reforming the current physician payment system in Medicare. One of the biggest problems under the current payment system is the fact that other Medicare providers benefit from built-in updates, such as a medical economic index or an inflationary growth factor, that help offset increases in the cost of providing services – but no such offset exists for physicians. AAOS (along with other physician organizations) has been advocating to Congress on creating an inflationary update for the Medicare Physician Fee Schedule. We urge CMS to support this initiative and ensure access to specialty care for Medicare beneficiaries. [2]

Orthopaedic surgeons have been leaders in providing high-value musculoskeletal care to patients, while generating cost savings for Medicare. AAOS urges CMS to work with us to create value-based payment models that include incentives tailored to the distinct needs of our patients and practice settings, along with a financially viable fee-for-service model. **Reforming the current physician reimbursement system together is the only way that we can ensure high quality care and equitable access to such care for Medicare beneficiaries.** [2]

Implementation of New Add-On Code for Complexity

AAOS continues to oppose implementation of HCPCS code G2211 to be used with existing evaluation & management (E/M) visits providing an add-on payment for complex patients. AAOS believes implementation of this code will negatively impact surgeons and patients.

Code G2211 is unnecessary due to the new office or outpatient E/M coding structure. Physicians and other qualified health professionals have the flexibility to report a higher-level E/M code to account for increased medical decision-making or total time for the encounter. Existing codes are available for reporting the work and time across various complexity levels which make code G2211 duplicative of work that is already represented in the CPT code set.

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1. Centers for Medicare & Medicaid Services (CMS), Department of Health and Human Services (HHS). (2023, July 13). *CY 2024 Medicare Physician Fee Schedule Proposed Rule.* https://www.federalregister.gov/documents/2023/08/07/2023-14624/medicare-and-medicaid-programs-cy-2024-payment-policies-under-the-physician-fee-schedule-and-other
2. American Association of Orthopaedic Surgeons. (2022, September 2). *AAOS Comments on the 2023 MPFS Proposed Rule.* https://www.aaos.org/globalassets/advocacy/issues/aaos-cy-2023-mpfs-rule-comments.pdf
3. Recovery Plan for America's Physicians

AAOS strongly urges CMS to indefinitely delay implementation of G2211. Implementing this unnecessary code may result in overpayments as well as penalize all physicians due to the reduction in the Medicare conversion factor which will be required to maintain budget neutrality under the Physician Fee Schedule.

Potentially Misvalued Services Under the PFS

Code 27279 *(Arthrodesis, sacroiliac joint, percutaneous or minimally invasive (indirect visualization), with image guidance, includes obtaining bone graft when performed, and placement of transfixing device) (090 day global code))* has been nominated as misvalued due to the absence of separate direct practice expense (PE) inputs for this 090 day global code in the non-facility/office setting. AAOS shares CMS' concerns as to whether this service can be safely and effectively furnished in the non-facility/office setting.

AAOS believes that it is not safe to perform code 27279 in an office setting. The procedure requires incision, collection of bone by drilling down through the ilium to the SI joint for grafting as well as placement of titanium implants across the sacroiliac joint.

CMS noted that the nominator claims that code 27279 can be safely provided in the non-facility setting, and that the procedure has a low risk profile, similar to kyphoplasty (CPT codes 22513, 22514, and 22515), which is currently furnished in the non-facility setting. **AAOS disagrees with the nominator's statement.** As previously noted, code 27279 involves incisions with placement of titanium implants across the SI joint whereas kyphoplasty utilizes large Jamshidi needles with cement (i.e., polymethylmethacrylate) filled needles for injection.

AAOS strongly objects to valuing code 27279 in the non-facility/office setting as we do not believe the procedure can be safely and effectively performed in the non-facility setting.

Valuation of Specific Codes

Dorsal Sacroiliac Joint Arthrodesis (CPT Code 2X000)

AAOS appreciates CMS' acceptance of the RUC recommended values and practice expense inputs regarding code 2X000 *(Arthrodesis, sacroiliac joint, percutaneous, with image guidance, including placement of intra-articular implant(s) (eg, bone allograft[s], synthetic device[s]), without placement of transfixation device)* but share the same concerns regarding safely performing the procedure in the nonfacility/office setting similar to that of code 27279. While we understand that the valuation of 2X000 has been processed by the RUC, we find performance of both codes 2X000 and 27279 in the non-facility setting troubling. Furthermore, the high-volume performance of such procedures with extremely high implant costs will dilute the value of the RVUs in Medicare Part B which will adversely affect all providers.

AAOS requests that CMS consider the recommendation from the January 2023 RUC Meeting in which the Practice Expense Subcommittee discussed the issue of high-cost supply items. The Subcommittee requested that the "RUC recommend that CPT consider including a question on high-cost

disposable supplies on its Coding Change Application (CCA)." AAOS supports this recommendation and agrees that a discussion may be warranted by the CPT Editorial Panel regarding implications on coding.

At that same meeting, the Practice Expense Subcommittee also expressed its support for the long-standing RUC recommendation that "CMS separately identify and pay for high-cost disposable supplies using the appropriate HCPCS codes due to the impact on the indirect practice expense RVUs and the ability to appropriately update the cost on a more frequent basis." **AAOS agrees with this recommendation and urges CMS to consider this request.**

Vertebral Body Tethering (CPT codes 2X002, 2X003, 2X004)
CMS accepted the RUC recommended wRVUs and PE inputs for codes 2X002 *(Anterior thoracic vertebral body tethering, including thoracoscopy, when performed; up to 7 vertebral segments),* 2X003*(8 or more vertebral segments)* and 2X004 *(Revision (eg, augmentation, division of tether), replacement, or removal of thoracic vertebral body tethering, including thoracoscopy, when performed)*. **AAOS appreciates CMS' review and acceptance of these codes without refinements.**

Total Disc Arthroplasty (CPT Codes 22857 and 22860)
CMS agreed to maintain the current wRVU of 27.13 for CPT code 22857 *(Total disc arthroplasty (artificial disc), anterior approach, including discectomy to prepare interspace (other than for decompression); single interspace, lumbar).* However, CMS disagreed with the RUC's recommended survey median wRVU of 7.50 for codes 22860 *(Total disc arthroplasty (artificial disc), anterior approach, including discectomy to prepare interspace (other than for decompression); second interspace, lumbar (List separately in addition to code for primary procedure)* and is instead recommending the survey 25th percentile (6.88 wRVU).

CMS proposed the 25th percentile, stating it is still appropriately supported by RUC key reference service codes (i.e., 22552, 22208, 22226, 22216). CMS further stated that the RUC recommended wRVU falls on the high end of the 46 ZZZ codes with an intra-service time of 60 minutes and that the 25th percentile is more relative amongst those services.

AAOS disagrees with CMS' relativity comparisons. Key reference survey codes 22552 and 22208 demonstrate the relativity of the RVU, intra-service time, and intensity of similar surgical spine add-on codes. The RUC-recommended wRVU of 7.50 for the code 22860 establishes a value slightly greater than the key reference code 22552. The top key reference service code is also an anterior approach. While it requires less time, survey respondents indicated that the surveyed code is 91% somewhat more and 9% much more intense than the key reference service. Additionally, code 22860 has an

appropriately lower wRVU than the second key reference service code (22208) which is a posterior or posterolateral approach typically performed by a single surgeon. Survey respondents indicated that the surveyed code is 33% somewhat more and 50% much more intense/complex than the second key reference service which describes a less complex posterior approach. Given the lower intra-service time of the surveyed code albeit higher complexity when compared to the second key reference code, we believe the RUC recommended wRVU of 7.50 is appropriate.

AAOS strongly urges CMS to accept the RUC recommended work RVU of 7.50 for CPT code 22860.

Payment for Medicare Telehealth Services

AAOS is appreciative of the CMS extension of waivers for telehealth flexibilities until the end of 2024, including separate payments for telephone audio-only codes (99441-99443). We commend CMS for continuing to pay claims at the PFS facility rate when billed with the place of service code POS 02.

Split (or Shared) Visits

AAOS is appreciative of CMS' proposal to extend the use of the current definition of "substantive portion" of time being either one of the three key components (history, exam, or medical decision making [MDM]) or more than half of the total time spent to determine who bills the visit until December 31, 2024.

AAOS continues to strongly urge CMS to permanently revise the definition for "substantive portion" to be based on MDM and not time, which coincides with AMA CPT guidelines. Having two differing definitions will create confusion amongst practitioners on how to document and report split/shared services. It is important that physicians can focus on one consistent set of guidelines in reporting their services. Therefore, we continue to strongly encourage CMS to work with CPT for cohesive guidance on the reporting of split/shared visits in CPT Guidelines and CMS policy.

Rebasing and Revising the Medicare Economic Index

AAOS is pleased with the proposal to delay implementation of the 2017-based Medicare Economic Index (MEI) that was finalized in 2023. As you acknowledge in this proposed rule, the AMA is in the process of collecting more recent data and those findings must be considered especially given the redistributive effects on PFS spending among specialties and geographical locations. 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. This survey was last conducted in 2007/2008 and collected 2006 data. 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. Thus, waiting for the updated survey findings is much appreciated.

Appropriate Use Criteria (AUC) for Advanced Diagnostic Imaging

AAOS is pleased to see that CMS is proposing to sunset the Appropriate Use Criteria (AUC) for advanced diagnostic imaging payment penalty. Although AAOS is surely supportive of programs that improve quality and reduce unnecessary testing, we have always been 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.

Quality Payment Program Alternative Payment Models

AAOS understands that CMS is statutorily bound to increase the thresholds for Qualifying APM Participants (QP) and that the 3.5% APM incentive payment for 2025 is the result of the Consolidation Appropriations Act, 2023. Yet, we are compelled to reiterate that this instability and uncertainty is counterproductive to the goals of shifting health care to a value-based system. Physicians are, in many cases, business owners who have a responsibility for ensuring that they are generating the revenue needed to keep that business and its employees afloat. Toward this end, we ask that CMS work with Congress to ensure that the advanced APM incentive payment structure is predictable year-over-year and does not leave physicians in a steady state of ambiguity.

Likewise, AAOS members are eager to share their insight and suggestions as experts on the topic of delivering high-quality, patient-centered musculoskeletal care in the most cost-effective manner. We urge the Centers for Medicare & Medicaid Services (CMS) to consider the profound impact that interoperability, multi-payer alignment of measures, and administrative burden have on the ability for physicians to successfully participate in alternative payment models. It is incumbent upon CMS to ensure that these perennial barriers are resolved in any future model.

AAOS strongly encourages CMS to only consider voluntary models that have incentives for participation. Mandatory models have historically been unsuccessful in engaging physicians who are otherwise eager to lead in the shift to value-based care. As in our earlier comments on the Comprehensive Care for Joint Replacement (CJR) Model and subsequent extension, a mandate to include all episodes, physicians, and facilities in a designated Metropolitan Statistical Area severely disadvantaged those surgeons, non-physician providers, and facilities that either did not have the proper infrastructure to optimize patient care under episodes-of-care payment models and/or lacked adequate patient volumes to create sufficient economies of scale. A voluntary program that allows surgeons, facilities, and non-surgical providers to tailor their episode-of-care models to their unique patient population would lead to far better patient outcomes as well as more accurate and efficient payments.

CMS should create incentives for interested participants that would reward innovation and high-value patient care. We believe the program should be voluntary and on a nationwide basis for any set of surgeons, facilities, and providers who seek to collaborate in innovative ways to bring higher quality, improved care coordination, and to lower costs for musculoskeletal care and who have the infrastructure necessary to carry out an episode of care approach to payment and delivery. A key component of this is

ensuring that any payment structure used is one that accounts for inflation and other changes that have a direct impact on the financial viability of physician practices.

Universal Foundation Measure Set

AAOS applauds CMS for their initiative to consolidate the Promoting Wellness and Managing Chronic Conditions MVPs to align with the Universal Foundation Measure Set. As we have stated in prior comment letters, streamlining the available measures for quality reporting is essential to reducing administrative burden and increasing physician engagement in the shift to value-based care. With this in mind, we request that CMS consider the value of Patient-Reported Outcomes Measures (PROMs) and incorporate additional PROMs into the Universal Foundation Set.

New MIPS Cost Measure

AAOS is concerned that the proposed MIPS episode-based cost measure 'Low Back Pain', which will be included in the proposed 'Rehabilitative Support for Musculoskeletal Care' MVP, may be unintentionally attributed to orthopaedic surgeons, despite it being a chronic condition measure that includes non-operative patients. This incorrect attribution may also lead to incorrect cost estimates. Thus, we request that orthopaedic surgeons be removed from the list of eligible specialties for attribution.

Instead, AAOS urges CMS to consider creating longitudinal care episodes where non-operative management of chronic musculoskeletal conditions are managed and appropriately attributed to orthopaedic surgeons. As we have stated in our recently submitted response to the agency's RFI on Episode-Based Payment Models, orthopaedic surgeons are the only healthcare professionals who have the educational background, expertise, and experience to manage both the non-operative and operative care of chronic musculoskeletal conditions. Using this model, they will be able to provide the highest quality care to patients and thus ensure that the subsequent and ancillary care provided by the practitioners covered under the Rehabilitative Support for Musculoskeletal Care MVP would be provided in the best form at the right time.

MIPS Patient Activation Measure

AAOS is supportive of the proposal to include the 'Gains in Patient Activation Measure (PAM) Scores at 12 Months (PAM-PM) in the MIPS Quality category. We appreciate the value that this PRO-PM contributes to MIPS Specialty Sets and MVPs. In addition, it is particularly relevant for the measurement of long-term quality outcomes for orthopaedic surgery and is already in use among our members. Given this measure's value, we ask that CMS consider it for inclusion in the Universal Foundation Measure Set.

Third Party Intermediaries

AAOS appreciates the opportunity to comment on the proposed updates to the policies related to the use of Qualified Clinical Data Registries (QCDRs) for MIPS submissions. We are particularly supportive of the proposal to modify the requirements for QCDRs and qualified registries to support MVP reporting and increase the flexibility for measures that are supported. The AAOS Registry Program is primarily

focused on quality measurement and performance improvement. In particular, AAOS is very supportive of the proposal to allow QCDRs to support only those MVP measures that are pertinent to the MVP participants on whose behalf they submit MIPS data. Particularly as it relates to the Improving Care for Lower Extremity Joint Repair MVP, we appreciate the opportunity to submit and support the surgical measures. This flexibility affords the AAOS Registry Program the opportunity to continue supporting orthopaedic surgeons who use the QCDR as a means of both engaging in the shift to value-based care and seek to have a more individualized approach to quality reporting and improvement. We encourage CMS to make additional flexibility available to QCDRs, and to consider how the addition of appropriate incentives for adoption among QCDRs and surgeons would increase participation in the MVP program.

However, the proposal to require that a QCDR or a Qualified Registry attest that it has required each MIPS eligible clinician to permit the QCDR or qualified registry to provide the information requested by CMS to ensure that data can be accessed by the third-party intermediary for auditing purposes would add significant burden. If finalized as proposed AAOS registries would be forced to update the agreement they have with sites, as they do not currently request to have additional chart data for audits. **Should such a requirement be finalized, we request that CMS consider the financial and administrative burden of such a request and provide the resources to QCDRs that would be needed to implement this.**

Likewise, AAOS is troubled by the proposed language surrounding the terms of audits for QCDRs. In the proposed rule, CMS states that "a continuing pattern of Quality Payment Program Service Center inquiries or support call questions, and/or CMS concerns regarding the third-party intermediary" may be an area of concern that would lead to an audit. This statement suggests that QCDRs are discouraged from engaging with the CMS support team. If CMS wishes to continue building robust QCDR relationships, such action would be counterproductive. We strongly encourage CMS to remove this language from the proposal regarding audits. Instead, CMS should focus their attention on ensuring that QCDRs have all the tools necessary to successfully engage their clients in quality reporting that is minimally burdensome.

Updates to the Lower Extremity Joint Repair MVP

AAOS recognizes the importance of incorporating new measures into existing MVPs. However, we request clarification regarding the new quality measure "Q487: Screening for Social Drivers of Health." ***Specifically, is this measure considered specialty specific to orthopaedics and thus will require the AAOS QCDR to support?***

If so, **we request that CMS extend the timeline for incorporating this and any future measures into MVPs.** It takes substantial time and resources for QCDRs to update their data capture capacity and IT resources to capture quality data. It would be nearly impossible for our QCDR to have these updates in place and ready to begin capturing in January 2024, given that the change will likely not be finalized and clarified until the final rule is released in November 2023.

Thank you for your time and attention to the concerns of the American Association of Orthopaedic Surgeons (AAOS) on the significant proposals made in the CY 2024 MPFS proposed rule. The AAOS looks forward to working closely with CMS on further improving the payment system, and to enhancing the care of musculoskeletal patients in the United States. Should you have questions on any of the above comments, please do not hesitate to contact Shreyasi Deb, PhD, MBA, AAOS Office of Government Relations at deb@aaos.org.

Sincerely,

Kevin J. Bozic, MD, MBA, FAAOS
AAOS President

cc: Paul Tornetta III, MD, PhD, FAAOS, First Vice-President, AAOS
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This letter has received sign-on from the following orthopaedic societies:

American Association for Hand Surgery (AAHS)
Arthroscopy Association of North America (AANA)
American Orthopaedic Foot & Ankle Society (AOFAS)
American Orthopaedic Society for Sports Medicine (AOSSM)
American Osteopathic Academy of Orthopedics (AOAO)
American Shoulder and Elbow Surgeons (ASES)
American Society for Surgery of the Hand Professional Organization (ASSH)
Musculoskeletal Tumor Society (MSTS)
Orthopaedic Rehabilitation Association (ORA)
Orthopaedic Trauma Association (OTA)
OrthoVirginia – Virginia Orthopedics
OrthoSC
Peachtree Orthopedics
Pediatric Orthopaedic Society of North America (POSNA)
Premier Orthopaedic Sports Medicine Associates

Alabama Orthopaedic Society
Arizona Orthopaedic Society
California Orthopaedic Association
Connecticut Orthopaedic Society
Colorado Orthopaedic Society
Delaware Society of Orthopaedic Surgeons
Florida Orthopaedic Society
Georgia Orthopaedic Society
Iowa Orthopaedic Society
Massachusetts Orthopaedic Association
Minnesota Orthopaedic Society
Missouri State Orthopaedic Association
Montana Orthopedic Society
Nebraska Orthopedic Society
New Hampshire Orthopaedic Society
New Mexico Orthopaedic Association
Ohio Orthopaedic Society
Puerto Rico Orthopaedic and Traumatology Society
South Carolina Orthopaedic Association
South Dakota State Orthopaedic Society
Tennessee Orthopaedic Society
Texas Orthopaedic Association
West Virginia Orthopaedic Society
Wisconsin Orthopaedic Society