

Final 2023 Rate Inputs for 27130 & 27447		
Conversion Factor	\$33.06	- 4.4%
Work RVU	19.60	No change
Practice Expense RVU	14.82	+ 3%
MedMal RVU	3.93	-1.75%

Final 2023 Rates for 27130 & 27447		
27130	\$1,269.13	- 0.07%
27447	\$1,267.87	- 0.06%

- **IMPORTANT TO NOTE** – This small reduction does not account for likely Congressional conversion factor relief legislation expected in December. If Congress ultimately increases the conversion factor for 2023, arthroplasty codes could see a slight increase compared to 2022.
- **CPT 27447**
 - CMS proposed to maintain a work RVU of 19.60 for CPT code 27447: “[T]he RUC reaffirmed the same valuation that it recommended for the CY 2021 PFS rulemaking cycle. Since we did not receive any new information regarding this code, we are not proposing to change our previously finalized values.”
 - CMS’ discussion of the policy in the final rule mentioned the following regarding the AAHKS comment letter:
 - “The commenter noted it continues to work with the AMA and CPT to clarify if there are existing codes to bill for pre-optimization time . . . [we] appreciate the commenters continued engagement with the AMA and the CPT to clarify if there are existing codes to bill for pre-optimization time.”
 - “[The commenter] recommended that CMS adopt a policy to base work RVUs uniformly on the same percentile of physician survey results as the RUC.”
 - “Nevertheless, the ongoing annual increases in Medicare facility payments for arthroplasty present a stark contrast with severely decreasing Medicare physician payments for arthroplasty.”
 - CMS finalized a 2023 work RVU of 19.60 for CPT code 27447.
- **CPT 27130**
 - CMS did not propose any alterations to the RVUs for CPT code 27130.
- **CPT 27446**
 - CMS finalized the RUC-recommended work RVU of 17.13, a reduction from the current RVU of 17.48.

2023 Implementation of MIPS Value Pathways (MVPs)

- CMS will begin implementing the Medicare Merit-based Incentive Payment System (MIPS) Value Pathways (MVPs) in 2023 as an optional means to satisfy MIPS reporting requirements. MVPs are intended to “simplify the MIPS clinician experience, improve value, reduce burden, and better inform patient choice in selecting clinicians”. This 2023

timeframe is intended to provide practices the time to review requirements, update workflows, and prepare their systems as needed to report MVPs.

- For the 2023 and 2024 performance years, “MVP Participants” will mean:
 - individual clinicians,
 - single specialty groups,
 - multispecialty groups,
 - subgroups, and
 - APM entities that are assessed on an MVP for all MIPS performance categories.

- MVP reporting will be optional for 2023 and will likely remain optional through 2027. Reporting in 2023 will impact payments for 2025. CMS is delaying until 2026 the requirement that multispecialty groups form subgroups in order to report MVPs.

Changes to the 2023 MVP Pathway: *Improving Care for Lower Extremity Joint Repair*

- CMS finalized the following measures and activities to comprise the 2023 Pathway:
 - Final Quality Codes
 - Q024: *Communication with the Physician or Other Clinician Managing On-Going Care Post-Fracture for Men and Women Aged 50 Years and Older*
 - Q128: *Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan*
 - Q350: *Total Knee or Hip Replacement: Shared Decision-Making: Trial of Conservative (Non-surgical) Therapy (Collection Type: MIPS CQMs Specifications)*
 - Q351: *Total Knee or Hip Replacement: Venous Thromboembolic and Cardiovascular Risk Evaluation*
 - Q376: *Functional Status Assessment for Total Hip Replacement*
 - Q470: *Functional Status After Primary Total Knee Replacement*
 - Q480: *RSCR following elective primary THA and/or TKA for MIPS*

 - Final Improvement Codes
 - IA_AHE_3: *Promote use of Patient-Reported Outcome Tools*
 - IA_BE_6: *Regularly Assess Patient Experience of Care and Follow Up on Findings*
 - IA_BE_12: *Use evidence-based decision aids to support shared decision-making*
 - IA_CC_7: *Regular training in care coordination*
 - IA_CC_9: *Implementation of practices/processes for developing regular individual care plans*
 - IA_CC_13: *Practice improvements for bilateral exchange of patient information*
 - IA_CC_15: *PSH Care Coordination*

- IA_PCMH: *Electronic submission of Patient Centered Medical Home accreditation*
 - IA_PSPA_7: *Use of QCDR data for ongoing practice assessment and improvements*
 - IA_PSPA_18: *Measurement and improvement at the practice and panel level*
 - IA_PSPA_27: *Invasive Procedure or Surgery Anticoagulation Medication Management*
- The 2023 pathway changes include:
 - **(NEW) Q480:** *Risk-standardized Complication Rate (RSCR) following elective primary THA and/or TKA*
 - **(REMOVAL) Q375:** *Functional Status Assessment for TKA - percentage of patients 18 years of age and older who received an elective primary TKA and completed a functional status assessment within 90 days prior to the surgery and in the 270-365 days after the surgery.*
 - This measure is duplicative to measure Q470: *Functional Status After Primary Total Knee Replacement.*
 - **(REVISION): Q376:** *Functional Status for Total Hip Replacement*
 - This measure is revised to read “[p]ercentage of patients 19 years of age and older who received an elective [THA] and completed a functional status assessment within 90 days prior to the surgery and in the 270 – 365 days after the surgery.” The measure to excludes (1) patients with two or more fractures indicating trauma in the 24 hours before or at the start of the total hip arthroplasty or patients with severe cognitive impairment that starts before or in any part of the measurement period; and (2) patients who are in hospice care for any part of the measurement period.

Improving Global Surgical Package Valuation

- In the proposed rule, CMS expressed “ongoing concerns about whether E/M visits presumed to be furnished in connection with global packages were actually being performed by the physician receiving the global package payment” and sought public comment on strategies to improve the accuracy of payment for the global surgical packages.
- CMS noted several RAND studies, including one that found that, according to claims-based data, the reported number of E/M visits matched the expected number for only 38% of reviewed 90-day global packages. CMS notes it has not received any data suggesting that postoperative E/M visits are occurring more frequently than indicated by RAND.
- AAHKS commented to remind CMS, as it seeks other data sources on global surgical package visits, that RUC-managed procedure-specific physician surveys remain the most

accurate tool to measure actual physician time and value individual procedures. AAHKS expressed concerns over whether one broad CMS policy on valuing all global surgical packages can accurately capture the nuances in postoperative needs across all specialties and procedures.

- AAHKS further commented that if CMS wishes to “improve the accuracy of payment for the global surgical packages”, CMS should (1) require the RUC to recommend wRVUs based upon a consistent percentile level from physician surveys, and (2) appropriately value preservice optimization work.
- CMS shared that it received some comments that postoperative care should be not only paid for separately, but paid at a higher rate. Other commenters stated that global packages continue to be necessary because they reduce administrative burden on practitioners and ensure payment of care provided by NPPs and clinical staff. CMS also noted AAHKS concerns that “not enough attention has been paid to the value of preservice work bundled into the global payment.
- CMS did not receive many comments suggesting alternative data sources to value global surgical package visits, but CMS “will continue to examine whether this specific model of postoperative care is still necessary or relevant for all procedures.”

Dental Services Integration and Joint Replacement Surgery

- Medicare does not cover general dental care, but Medicare Part B currently pays for dental services when that service is integral to medically necessary services required to treat a beneficiary's primary medical condition. CMS sought comment on additional medical conditions where dental services are inextricably linked to the clinical success of clinically related services, such as for joint replacement surgeries, which would justify Medicare payment.
- In response, AAHKS offered guidance for medically necessary coverage of dental services prior to arthroplasty surgery based on generally accepted clinical principles and standards of care.
- CMS has decided in 2023 to commence payment for dental services, such as dental examinations, including necessary treatment, performed as part of:
 - a comprehensive workup prior to organ transplant surgery, or prior to cardiac valve replacement or valvuloplasty procedures; and
 - a comprehensive workup prior to the treatment for head and neck cancers
- CMS is not finalizing, at this time, payment for dental services prior to:
 - joint replacement surgeries (CMS says additional time is necessary to consider evidence);

- other surgical procedures; or
 - initiation of immunosuppressant therapy
- CMS will develop a formal regulatory process to evaluate future proposals of conditions for which dental services may be covered, much as CMS has established a process to evaluate proposals to remove procedures from the inpatient only list

OUTPATIENT PROSPECTIVE PAYMENT SYSTEM & AMBULATORY SURGICAL CENTER PAYMENT SYSTEM

2023 Payment Rates

- *OPPS*: CMS finalized the increase to overall OPSS payment rates by approximately 2.7%. This update is based on the projected hospital market basket percentage increase of 3.1%, reduced by 0.4% productivity adjustment.
- Many commentors thought the 2.7% increase inadequately accounted for increases in costs for labor, equipment, and supplies. CMS responded that the calculation is required to equal the Inpatient Prospective Payment System (IPPS) percentage increase, and the Secretary does not have the authority to adjust OPSS payment amounts.
- THA and TKA payment will increase approximately 3.6% in 2023, an increase that is less than the proposed 5.4% increase in the CY 2023 OPSS proposed rule. The increase is attributable to a 1.9% increase in the relative weight assigned to the procedures.

OPSS					
CPT	2021	2022	2023 (proposed)	2023 (actual)	% change from 2022
27130	\$12,314.76	\$12,593.29	\$13,274.06	\$13,048.08	+3.6%
27447	\$12,314.76	\$12,593.29	\$13,274.06	\$13,048.08	+3.6%

- *ASC Rates*: CMS proposes to increase overall payment rates under the ASC payment system by 2.7%. This update is based on a hospital market basket percentage increase of 3.1% reduced by a productivity adjustment of 0.4%.

ASC					
CPT	2021	2022	2023 (proposed)	2023 (actual)	% change from 2022
27130	\$8,833.04	\$9,027.63	\$9,553.84	\$9,508.60	+5.3%
27447	\$8,774.20	\$8,967.37	\$9,351.90	\$9,322.62	+3.7%

Changes to Medicare Inpatient Only (IPO) Procedure List & ASC Covered Procedure List (CPL)

- CMS removed the following procedures from the IPO list in 2023:

22632 - Arthrodesis, posterior interbody technique, including laminectomy and/or discectomy to prepare interspace (other than for decompression), single interspace; each additional interspace (list separately in addition to code for primary procedure)	21196 - Reconstruction of mandibular rami and/or body, sagittal split; with internal rigid fixation
21141 - Reconstruction midface, lefort i; single piece, segment movement in any direction (eg, for long face syndrome), without bone graft	21366 - Open treatment of complicated (eg, comminuted or involving cranial nerve foramina) fracture(s) of malar area, including zygomatic arch and malar
21142 - Reconstruction midface, lefort i; 2 pieces, segment movement in any direction without bone graft	21347 - Open treatment of nasomaxillary complex fracture (lefort ii type); requiring multiple open approaches
21143 - Reconstruction midface, lefort i; 3 or more pieces, segment movement in any direction, without bone graft	21422 - Open treatment of palatal or maxillary fracture (lefort i type);
21194 - Reconstruction of mandibular rami, horizontal, vertical, c, or 1 osteotomy; with bone graft (includes obtaining graft)	

- CMS did not finalize its proposal to remove CPT code 16036—Escharotomy; each additional incision (list separately in addition to code for primary procedure)—because CMS agreed with a commentator that CPT code 16036 is typically performed in an inpatient setting
- CMS added the following new procedures CPT codes to the IPO list in 2023:

15778 - Implantation of absorbable mesh or other prosthesis for delayed closure of defect(s) (ie, external genitalia, perineum, abdominal wall) due to soft tissue infection or trauma	22860 - Total disc arthroplasty (artificial disc), anterior approach, including discectomy to prepare interspace (other than for decompression); second inter-space, lumbar (List separately in addition to code for primary procedure)
49596 - Repair of anterior abdominal hernia(s) (ie, epigastric, incisional, ventral, umbilical, spigelian), any approach (ie, open, laparoscopic, robot-ic), initial, including placement of mesh or other prosthesis when performed, total length of defect(s); greater than 10 cm, incarcerated or strangulated	49616 - Repair of anterior abdominal hernia(s) (ie, epigastric, incisional, ventral, umbilical, spigelian), any approach (ie, open, laparoscopic, robotic), recurrent, including placement of mesh or other prosthesis when performed, total length of defect(s); 3 cm to 10 cm, incarcerated or strangulated
49617 - Repair of anterior abdominal hernia(s) (ie, epigastric, incisional, ventral, umbilical, spigelian), any approach (ie, open, laparoscopic, robotic), recurrent, including placement of mesh or other prosthesis when performed, total length of defect(s); greater than 10 cm, reducible	49618 - Repair of anterior abdominal hernia(s) (ie, epigastric, incisional, ventral, umbilical, spigelian), any approach (ie, open, laparoscopic, robotic), recurrent, including placement of mesh or other prosthesis when performed, total length of defect(s); greater than 10 cm, incarcerated or strangulated
49621 - Repair of parastomal hernia, any approach (ie, open, laparoscopic, robotic), initial or recurrent, including placement of mesh or other prosthesis, when performed; reducible	49622 - Repair of parastomal hernia, any approach (ie, open, laparoscopic, robotic), initial or recurrent, including placement of mesh or other prosthesis, when performed; incarcerated or strangulated

- CMS added add the following procedure to the ASC Covered Procedure List in 2023:
 - **CPT 38531 – lymph node biopsy or excision**

CMS' Final Action on Addition of a New Service Category for Hospital Outpatient Department (OPD) Prior Authorization Process

- CMS finalized the proposal to require prior authorization for a new OPD service category—Facet Joint Interventions. CMS stated its intent in requiring prior authorization is because of the unnecessary increase in the volume of services in this category.
- Commenters were concerned that prior authorization could lead to increased administrative burdens, delays in care, and higher costs, and might even lead some patients to alternative pain treatment options like opioids. CMS replied that prior authorization for this service line is aligned with both the CMS's Patients Over Paperwork Initiative as well as the HHS Pain Management Best Practices Inter-Agency Task Force Report.

CMS Comments on the Request for Information (RFI) on Use of CMS Data to Drive Competition in Healthcare Marketplaces

- CMS stated that it received 21 pieces of correspondence on the RFI on the use of CMS data to increase competition, and that CMS also received 180 pieces of correspondence related to CMS's hospital price transparency efforts, and CMS's general role in driving competition.
- While CMS received many pieces of correspondence, it did not summarize or address these items specifically in the final rule.
