EPSTEIN BECKER GREEN

Attorneys at Law

AAHKS AMERICAN ASSOCIATION OF HIP AND KNEE SURGEONS

MEMORANDUM

To: AAHKS **From:** Epstein Becker & Green, P.C.

Date: August 18, 2023

Re: Summary of the Proposed 2024 Medicare Payment Rules: Physician Fee Schedule; Outpatient Prospective Payment System; and Ambulatory Surgical Centers

The Centers for Medicare & Medicaid Services (CMS) recently released both the CY 2024 Medicare Physician Fee Schedule (PFS) proposed rule and the CY 2024 Medicare Hospital Outpatient Prospective Payment System and Ambulatory Surgical Center Payment System (OPPS & ASC) proposed rule. Comments on the proposed rules are due September 11, 2023. The following is a summary of policies in the proposed rules that may affect AAHKS members.

PHYSICIAN FEE SCHEDULE

I. Conversion Factor

- CMS proposes a 2024 conversion factor, upon which all Medicare physician payments are based, of 32.7426, representing a reduction of 3.3% from 2023 levels

- Reductions in the conversion factor are mandated according to the statutory PFS budget neutrality adjustment which requires across the board PFS reductions to offset increases in reimbursement for select services

- The 3.3% reduction in 2024 consists of:
  - 1.25% reduction is part of a Congressional structured phase-in of conversion factor cuts originally scheduled for 2021
  - A 2.1% reduction offsets increases in reimbursement for new E/M codes, including add-on code G2211 which Congress has previously delayed. This add-on code is intended to recognize the resource costs associated with E/M for primary care and longitudinal care of complex patients

II. Impact on Arthroplasty Rates

- CMS proposes to increase total RVUs for CPTs 27130 and 27447 very slightly due to small increases in the estimated practice expense and medical malpractice costs (increase of approximately 0.006%) [see attached chart]

- The small increases in practice expense and malpractice insurance only partially offset the reduction in the conversion factor, leading to an approximate reduction in Medicare reimbursement for CPT codes 27130 and 27447 of 2.8% in 2024

CPT	2022	2023	2024 (proposed)
27130	$1,277.40	$1,300.92	**$1,264.71**
27447	$1,276.06	$1,299.57	**$1,263.07**

- CMS estimates that the total value of all Medicare payments to all orthopedic surgeons for all claims (TJA and other codes) will decrease by 1% in 2024

III. Potentially Misvalued Services

- CMS is required by law to evaluate CPT codes as potentially misvalued at least once every five years. CMS considers "nominations" from the public on potentially misvalued codes and reviews each flagged code on an individual basis

- **CPT 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 CPT 27279 has been nominated as potentially misvalued due to the absence of separate direct PE inputs for this in the non-facility office setting
  - Currently. Medicare only prices CPT 27279 in the facility setting, at about $826.85 for the physician's professional services, but the nominators are seeking separate direct PE inputs for this service to better account for valuation when performed in the nonfacility/office setting
  - CMS is concerned about whether this service can be safely and effectively furnished in the non-facility/office setting (for example, in an office-based surgical suite) and welcomes comments on the nomination of CPT 27279 for consideration as potentially misvalued

IV. Changes to Timeframes for the Functional Status for THA Measure

- CMS continues to add patient-reported outcome measures to the Medicare Quality Payment Program (MIPS Value Pathways (MVP)) and to adjust existing measures for accuracy

- CMS proposes changes to improve the accuracy of quality measure #376, *Functional Status Assessment for Total Hip Replacement,* "measuring the percentage 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 surgery"
  - CMS proposes to revise timeframe for the follow-up assessment *from 270-365 days* after surgery *to 300-425 days* after surgery

- CMS proposes to revise the measure denominator exclusions which are intended to remove non-elective procedures. The current exclusion of patients with "*two fractures present at the time of the procedure"* would be revised to "*one or more specific lower body fractures indicating trauma in the 24 hours before the start of the THA*"

V. Remote Physiologic Monitoring (RPM) and Remote Therapeutic Monitoring (RTM)

- On February 28, 2023, several Medicare Administrative Contractors hosted a Contractor Advisory Committee (CAC) meeting to obtain advice from a select panel of clinicians and experts regarding the strength of published evidence on RPM and RTM for non-implantable devices and any compelling clinical data to assist in defining meaningful and measurable patient outcomes (e.g., decreases in emergency room visit and hospitalizations) for Medicare beneficiaries. Stakeholders were concerned as such CAC meetings are frequently a step towards narrowing Medicare coverage for a particular service in question

- In May 2023, the MACs notified stakeholders that they had decided to not pursue at this time a local coverage determination or other action to limit coverage for RPM and RTM

- Further, CMS now proposes several new policies for 2024, extending coverage for RPM and RTM in certain settings, suggesting that the CAC meeting was effective in reassuring CMS on appropriate clinical use for RPM and RTM
  - PTs and OTs in private practices are currently required to provide *direct supervision* of their therapy assistants. CMS is proposing to allow for *general supervision* of their therapy assistants for RTM services
  - CMS proposes to include RPM and RTM in the general care management HCPCS code G0511 when these services are furnished by Rural Health Centers and Federal Qualified Health Centers
  - CMS also responds to a series of technical questions on RPM and RTM billing scenarios and the appropriate use of the codes in general addressing new vs. established patients, data collection requirements, and use of RPM/RTM in conjunction with other services

VI. Medicare Payment for Dental Services

- Medicare historically has not covered 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. Last year, 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 2022, AAHKS offered guidance to CMS for medically necessary coverage of dental services prior to arthroplasty surgery based on generally accepted clinical principles and standards of care. CMS decided at the time 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 cardiac valve replacement or valvuloplasty procedures, or treatment for head and neck cancers

- CMS stated in 2022 that additional time was necessary to consider evidence for joint replacement surgeries and other surgical procedures

- For 2024, CMS has again acknowledged guidance received from AAHKS but continues to decline to extend coverage of dental services prior to TJA

OUTPATIENT PROSPECTIVE PAYMENT SYSTEM & AMBULATORY SURGICAL CENTER PAYMENT SYSTEM

I. Arthroplasty Rates

- CMS is proposing a 2.8% increase to payment rates under the OPPS and ASC payment systems. This update is based on the projected hospital market basket percentage increase of 3.0%, reduced by a productivity adjustment of 0.2 percentage points

- 2024 OPPS rates:

CPT	2023	2024 (proposed)
27130 & 27447	$13,048.08	**$13,269.40**

- 2024 ASC rates:

CPT	2023	2024 (proposed)
27130	$9,508.60	**$9,646.38**
27447	$9,322.62	**$9,436.56**

- For 2019 through 2023, CMS used the OPPS market basket to update ASC rates. CMS proposes to continue this policy for 2024 and 2025. Prior to 2019, ASCs were updated with the CPI, which had typically trended lower than the OPPS market basket, causing payments to the two sites of care to diverge

- See details in attached chart

II. New Quality Measure

- CMS proposes to adopt the *Risk-Standardized Patient Reported Outcome-Based Performance Measure (PRO-PM) Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA) in the HOPD Setting (THA/TKA PRO-PM)* measure to the Hospital Outpatient Quality Reporting System beginning with voluntary CYs 2025 and 2026 reporting periods in 2025 and 2026, to be followed by mandatory reporting beginning in 2027 reporting tied to a 2030 payment determination

- In 2021, AAHKS provided technical guidance to CMS on the potential addition of this measure to the OPPS

III. Inpatient Only List

- CMS is not proposing to remove any services from the IPO list for 2024

- CMS proposes to add 10 new services to the IPO list

X114T	Revision/replace/removal of thoracolumbar/lumbar vertebral body tethering
2X002	Anterior thoracic vertebral body tethering, including thoracoscopy, up to 7
2X003	Anterior thoracic vertebral body tethering, including thoracoscopy, 8 or more
2X004	Revision, replacement, or removal of thoracic vertebral body tethering
619X1	Insertion of skull-mounted cranial neurostimulator pulse generator or receiver
7X000	Ultrasound, intraoperative thoracic aorta diagnostic
7X001	Intraoperative epicardial cardiac ultrasound for congenital heart disease
7X002	Placement, manipulation of transducer, and image acquisition only
7X003	Interpretation and report only
0646T	Transcatheter tricuspid valve implantation/replacement

IV. Hospital Price Transparency Enforcement Proposals

- CMS proposes to modify the standard hospital price/charge display requirements and enforcement provisions to streamline and improve the transparency of the enforcement process

- As of 2021, price transparency policies required each hospital for each year to establish, update, and make public a list of the hospital's standard charges for items and services provided by the hospital in a comprehensive machine-readable file. Based on a website assessment conducted by CMS in 2022, approximately 70% of hospitals were fully meeting display criteria for the machine-readable file, 27% were partially meeting display criteria, and only 3% failed to post any of the required information online

- CMS seeks comment from the public related to alignment with other price transparency initiatives, specifically the Transparency in Coverage regulation and the No Surprises Act, which contain price transparency requirements designed to ensure that individuals have cost information in advance of getting a healthcare service. CMS is proposing to require hospitals to display the required standard charges data using a CMS template; and that hospitals encode all standard charge information with a set of required data elements. CMS proposes to improve automated accessibility to hospital standard charges information by proposing changes to facilitate a low-burden method that would permit automated access and real-time centralization of the files and standard charges data.

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Medicare Payment Trends for Hip and Knee Surgeries in the United States

Code (DRG/CPT)	2020		2021		2022		2023		2024 (proposed)		% Change from 2023
	Weight/RVUs	Rate	Weight/RVUs	Rate	Weight/RVUs	Rate	Weight/RVUs	Rate	Weight/RVUs	Rate	
IPPS[1],[2]											
469	3.1399	$18,200.84	3.0989	$18,530.61	3.0866	$18,952.62	3.2314	$20,602.57	3.3298	$21,636.27	**+5.0%**
470	1.9684	$11,410.09	1.9104	$11,423.69	1.9015	$11,675.76	1.9119	$12,189.78	1.8817	$12,226.85	**+0.6%**
521	--	--	3.0652	$18,329.99	3.0663	$18,827.97	3.0192	$19,249.63	2.9942	$19,455.62	**+1.1%**
522	--	--	2.1943	$13,121.34	2.1903	$13,449.08	2.1729	$13,853.85	2.1122	$13,724.58	**-0.1%**
OPPS											
27130	147.2988	$11,899.38	148.7344	$12,314.76	149.6049	$12,593.29	152.4576	$13,048.08	151.6711	$13,269.40	**+1.7%**
27447	147.2988	$11,899.38	148.7344	$12,314.76	149.6049	$12,593.29	152.4576	$13,048.08	151.6711	$13,269.40	**+1.7%**
ASC											
27130	--	--	180.4429	$8,833.04	180.8564	$9,027.63	183.3725	$9,508.60	180.6540	$9,646.38	**+1.5%**
27447	180.3081	$8,609.17	179.2409	$8,774.20	179.6492	$8,967.37	179.7859	$9,322.62	176.7245	$9,436.56	**+1.3%**
PFS											
27130	36.0896	$1,415.07	34.8931	$1,322.45	33.5983	$1,277.40	38.39	$1,300.92	38.62	$1,264.71[3]	**-2.8%**
27447	36.0896	$1,413.27	34.8931	$1,320.70	33.5983	$1,276.06	38.35	$1,299.57	38.57	$1,263.07[4]	**-2.8%**

[1] **National Payment Amount** – Projected by CMS of the baseline amount that will be paid nationally for the MS-DRG. This amount **DOES NOT INCLUDE** facility-specific calculation of teaching, disproportionate share, capital, and outlier payments for all cases. *See footnote 2.*

[2] Assumes hospital with wage index greater than 1.0 that reported quality data and is a meaningful EHR user.

[3] **2024 Final PFS Conversion Factor** – Conversion factor (CF) reduction required by statutory budget neutrality adjustment law. May be partially offset by Congressional action before Jan. 2024.

[4] **2024 Final PFS Conversion Factor** – Conversion factor (CF) reduction required by statutory budget neutrality adjustment law. May be partially offset by Congressional action before Jan. 2024.