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AAHKS AMERICAN ASSOCIATION OF HIP AND KNEE SURGEONS

MEMORANDUM

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

Date: December 5, 2023

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

On November 22, 2023, the Centers for Medicare & Medicaid Services (CMS) published the 2024 Medicare Physician Fee Schedule (PFS) final rule, and the 2024 Medicare Hospital Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Center (ASC) Payment System final rule. The following is a summary of policies in the final rules that are, or may be, relevant to AAHKS members.

PHYSICIAN FEE SCHEDULE

I. Conversion Factor

- CMS finalized a 2024 conversion factor of $32.74, a 3.4% decrease from 2023 levels, largely due to the statutory "PFS budget neutrality adjustment" which requires across the board PFS payment reductions to offset increases in reimbursement for select services

- This 3.4% reduction in 2024 consists of:
  - The expiration of the statutory 2.5% payment increase for 2023 included by Congress in the Consolidated Appropriations Act (CAA)
  - A 1.25% statutory payment increase for 2024 included in the CAA
  - A negative 2.2% budget-neutrality adjustment to off-set earlier increases in rates for E/M services

II. Impact on Arthroplasty Rates

Final 2024 Rate Inputs for 27130 & 27447		
Conversion Factor	**$32.74**	**- 3.4%**
Work RVU	**19.60**	No change
Practice Expense RVU	**14.98**	**+ 1%**
MedMal RVU	**4.02**	**-2.3%**

Final 2024 Rates for 27130 & 27447		
27130	**$1,264.64**	**- 2.8%**
27447	**$1,262.68**	**- 2.9%**

- Rates for CPTs 27130 and 27447 in 2024 will be cut due to the reduction in the slightly due to the reduction in the conversion factor. AAHKS and other specialty societies are actively working with allies in Congress towards passing last-minute legislation to mitigate these cuts

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)
    - CPT 27279 was nominated by a stakeholder as potentially misvalued due to the absence of separate direct practice expense data inputs for this code in the non-facility office setting
    - Currently, the Medicare only values CPT code 27279 in the facility setting, at about $826.85 for the physician's professional services, but the nominator was seeking separate direct PE inputs for this service to better reimburse when performed in the non-facility/office setting
    - In the Proposed Rule, CMS expressed concern about whether this service could be safely and effectively furnished in the non-facility/office setting (for example, in an office-based surgical suite)
    - CMS did not finalize CPT 27279 as a potentially misvalued service, because CMS did not hear consensus on whether these services can be safely and effectively provided in the non-facility/office setting

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

- CMS proposed modifying the timeline of the quality measure #376, Functional Status Assessment for Total Hip Replacement, which measures the percentage of certain patients who receive an elective THA and complete a functional status assessment within 90 days prior to surgery and in the 270-365 days after survey
    - CMS proposed to extend the timeline for follow-up assessment from 270-365 days after surgery to 300-425 days after surgery. AAHKS endorsed this change as more realistic for follow-up appointments and as more consistent with timeframes in Hospital PRO-PMs
    - CMS also proposed to revise the measure denominator to be "one or more specific lower body fractures indicating trauma in the 24 hours before the start of the THA". AAHKS endorsed this revision as it is unreasonable to ask such patients to complete a functional assessment prior to surgery. However, AAHKS asked that the exclusion timeframe apply to 48 hours before the start of surgery
    - CMS finalized the two modifications as proposed and encouraged AAKHS to contact the measure steward personnel within CMS regarding the 48 hour the denominator exclusion timeframe

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

- CMS finalized several new policies on standards for billing for RPM and RTM services in certain settings in 2024. These policies confirm that CMS was persuaded on the clinical value of appropriate RPM and RTM that would *extend* coverage for RPM and RTM in certain settings, including:
    - PTs and OTs in private practice are currently required to provide direct supervision of their therapy assistants. CMS finalized its proposal to allow for general supervision of their therapy assistants for RTM services
    - CMS finalized its proposal 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 codes relating to new versus established patient requirements, data collection requirements, use of RPM and RTM in conjunction with other services, and appropriate use of codes in various billing scenarios. Members frequently billing for RPM and RTM should consult their billing coordinators or other consultants on these standards

VI. Medicare Payment for Dental Services

- Medicare historically has not covered general dental care, but Medicare Part B currently pays for dental service 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 could 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 finalized policies to extend coverage for certain dental services inextricably linked to other covered services used to treat cancer patients prior to or during certain types of treatment

- In February 2024, CMS will accept and consider public submissions for potentially analogous clinical scenarios under which Medicare payment could be made for dental services. These submissions will help inform future rulemaking

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OUTPATIENT PROSPECTIVE PAYMENT SYSTEM & AMBULATORY SURGICAL CENTER PAYMENT SYSTEM

I. 2024 OPPS Payment Rates

- In August, CMS proposed increasing Medicare OPPS payment rates for THA and TKA, but in a surprise move, CMS instead finalized cutting these procedure rates by nearly 4%. The following explains why:
    - CMS classifies all OPPS-covered services into groups called ambulatory payment classifications (APCs) on the basis of clinical and cost similarity. All services within an APC have the same payment rate which is the geometric mean of costs for those services as listed on hospital cost reports

    - For example, there are 6 musculoskeletal APCs paying different levels based on clinical and cost similarity
        - The lowest, APC 5111, which includes application or removal of casts, pays $224.92 per service
        - APC 5115, which includes THA and TKA, pays $12,552.87 per service
        - APC 5116, the highest level, which includes reconstruction of elbow joint and reconstruction of jaw joint, pays $18,250.77 per service

    - Following the publication of the proposed rule, CMS received a comment letter from a manufacturer of orthopaedic surgical implants that requested that CMS

reassign CPT code 23472 (Arthroplasty, glenohumeral joint; total shoulder) from APC 5115 to APC 5116. The manufacturer argued that that assignment to APC 5116 would more closely track hospital resources for performing total shoulder replacements and appropriately align with other clinically similar procedures

- CMS agreed and moved CPT 23472 from APC 5115 to 5116 for 2024

- By moving a procedure from one APC to another, CMS necessarily recalculated the geometric mean cost of the procedures in those APCs. As CPT 23472 is a high volume, high-cost procedure, this had the effect of increasing the reimbursement level for APC 5116 and lowering the reimbursement level for procedures remaining in APC 5115, such as THA and TKA, by 3.8%

OPPS					
CPT	**2022**	**2023**	**2024 (proposed)**	**2024 (actual)**	**% change from 2023**
27130	$12,593.29	$13,048.08	$13,269.40	$12,552.87	**-3.8%**
27447	$12,593.29	$13,048.08	$13,269.40	$12,552.87	**-3.8%**

- AAHKS intends to comment to CMS on this change and object that CMS made this change in response to a comment letter without formally and transparently proposing the change. That is, CMS did not allow providers and other stakeholders an opportunity to receive notice or provide comments on the impact of a 3.8% cut to TJA procedure payments

II. 2024 ASC Payment Rates

- Medicare ASC rates are partially based upon OPPS rates. Therefore, as the Medicare OPPS rates for THA and TKA were reduced due to the change in APC for total shoulder replacement, the 2024 ASC rates for THA and TJA were reduced as well. These ASC rate changes were also not reflected in the proposed rule released earlier in the year

ASC					
CPT	**2022**	**2023**	**2024 (proposed)**	**2024 (actual)**	**% change from 2023**
27130	$9,027.63	$9,508.60	$9,646.38	$9,244.39	**-2.7%**
27447	$8,967.37	$9,322.62	$9,436.56	$9,054.68	**-2.8%**

- Just as CMS had received a comment letter to the proposed rule from a manufacturer of orthopaedic surgical implants requesting that CMS reassign CPT 23472 to a higher value APC, CMS also received comment letters from a handful of surgical practices asking that CMS add CPT 23472 (total shoulder replacement) to the list of ASC-covered procedures.

- CMS had not proposed adding shoulder replacement to the ASC-covered procedure list when the proposed rule was published in August, but was persuaded to make the change in the final rule to be effective in 2024

- The final list of orthopaedical procedures added to the ASC-covered procedures list for 2024 is as follows:
    - 21194 (Reconstruction of mandibular rami, horizontal, vertical, c, or l osteotomy; with bone graft (includes obtaining graft))
    - 21195 (Reconstruction of mandibular rami and/or body, sagittal split; without internal rigid fixation)
    - 23470 (Arthroplasty, glenohumeral joint; hemiarthroplasty)
    - 23472 (Arthroplasty, glenohumeral joint; total shoulder (glenoid and proximal humeral replacement (eg, total shoulder))
    - 27006 (Tenotomy, abductors and/or extensor(s) of hip, open (separate procedure))
    - 27702 (Arthroplasty, ankle; with implant (total ankle))
    - 29868 (Arthroscopy, knee, surgical; meniscal transplantation (includes arthrotomy for meniscal insertion), medial or lateral)

III. New Quality Measure

- CMS finalized its proposal 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

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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)		2024 FINAL		% Change from 2023
	Weight/RVUs	Rate	Weight/RVUs	Rate	Weight/RVUs	Rate	Weight/RVUs	Rate	Weight/RVUs	Rate	Weight/RVU	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	3.3607	$21,928.36	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	1.9001	$12,398.03	1.8817	$12,226.85	+0.6%
521	--	--	3.0652	$18,329.99	3.0663	$18,827.97	3.0192	$19,249.63	3.0016	$19,585.25	2.9942	$19,455.62	+1.1%
522	--	--	2.1943	$13,121.34	2.1903	$13,449.08	2.1729	$13,853.85	2.1234	$13,855.05	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	143.6551	$12,552.87	-3.8%
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	143.6551	$12,552.87	-3.8%
ASC													
27130	--	--	180.4429	$8,833.04	180.8564	$9,027.63	183.3725	$9,508.60	180.6540	$9,646.38	172.7471	$9,244.39	-2.7%
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	169.2021	$9,054.68	-2.8%
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	38.63	$1,264.64[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	38.57	$1,262.68[4]	-2.9%

[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.

Prepared By Epstein Becker & Green, P.C. Nov. 6, 2023