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AAHKS AMERICAN ASSOCIATION OF HIP AND KNEE SURGEONS

MEMORANDUM

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

Date: July 22, 2026

Re: **Summary of the Proposed 2027 Medicare Physician Fee Schedule - PHASE I**

The Centers for Medicare & Medicaid Services (CMS) recently released the CY 2027 Medicare Physician Fee Schedule (PFS) proposed rule. Comments on the proposed rule are due September 14, 2026. We expect the final 2027 rates to be published in late-October/ early-November. This is the first of two summaries for AAHKS on the highest-profile items in the proposed rule impacting total joint arthroplasty. A second summary will follow later in July.

Recall, last year the Trump administration finalized a 7.5% cut to THA and TKA codes due to reductions in practice expense RVUs and an across-the-board reduction in work RVUS for most surgical procedures through an "efficiency adjustment". For 2027, the administration is proposing even deeper cuts to THA and TKA payments specifically. Many rationales and data-based justifications are proffered by CMS for these changes but CMS' philosophy was expressed most directly as follows:

"We think primary care is underfunded. Investing in primary care is shown to drive down health care costs. Therefore, we took money from specialties and gave it to primary care."

Dr. Mehmet Oz, CMS Administrator
Speaking to America's Physician Groups Fall Conference, Nov. 5, 2025

I. Proposed Changes to Arthroplasty RVUs

Recall, Medicare payment for a CPT Code = Conversion Factor x ((work RVUs based on time and intensity of service) + (practice expense RVUs based on surveyed direct and indirect office costs) + (malpractice insurance RVUs)).

CMS estimates that the total value of all Medicare payments to all orthopedic surgeons nationally for all facility-based claims (TJA and other orthopedic surgery codes) will decrease by 7% in 2027. This figure is for what CMS considers to be an average orthopedic surgery practice and does not represent the impact likely felt by AAHKS members.

The following charts present the 2027 Medicare THA and TKA proposed rate changes for RVU inputs and the national base rate. The Phase II summary will include examples of regional rates in subject to geographic adjustments in various regions.

	2026	2027 (Proposed)	Change
QP Conversion Factor	$33.56	$33.16	**-1.2%**
Non-QP Conversion Factor	$33.40	$32.84	**-1.7%**
27130 -Work RVU	19.11	15.37	**-19.5%**
27130 -Practice Expense RVU	11.61	9.67	**-17%**
27130 - MedMal RVU	4.03	3.22	**-21%**
27447 -Work RVU	19.11	15.94	**-16.5%**
27447- Practice Expense RVU	11.61	8.92	**-23%**
27447- MedMal RVU	4.03	3.22	**-21%**

a. Conversion Factor

Due to the expiration of Congress' temporary 2.5% statutory payment increase from 2026, the baseline conversion factors are dropping across the board.

Beginning in 2026, there are two separate conversion factors for two classes of physicians: Qualifying APM Participants (QPs) and non-QP clinicians. To become a QP, physicians must receive at least 75% of Medicare payments or see at least 50% of Medicare patients through an "Advanced APM Entity" (i.e., BPCI-A, CJR, TEAM, or certain managed care contracts, etc.).

b. Work RVU Reductions

The AMA RUC recommended reducing THA and TKA work RVUs from 19.11 to 16.70. The RUC recommended reducing 10 minutes in intraservice time, decreasing from a full to one half discharge visit, and eliminating two inpatient hospital visits. The RUC noted that more than half of these procedures are now performed outpatient.

CMS believes the RUC recommendations do not go far enough. CMS critiques the RUC for not recommending a one-for-one reduction in wRVUs to match the RUCs observed reduction in minutes for THA and TKA. CMS disagrees with the RUCs for increasing the intensity for THA and TKA which would partially offset the reduction in minutes. CMS disagrees that there has been an observable change in intensity for these procedures because the AMA has not altered the code descriptions. CMS observes that the RUC recommended wRVUs are higher than nearly all other 90-day surgical codes with similar times.

Because of these concerns, CMS proposes to set new work RVU values by crosswalking the values from other procedures CMS considers comparable. CPT 27130 will receive the work value of CPT 67108 (*Repair of retinal detachment; with vitrectomy, any method, including, when performed, air or gas tamponade, focal endolaser photocoagulation, cryotherapy, drainage of subretinal fluid, scleral buckling, and/or removal of lens by same technique*). CPT 27447 will receive the work value of 67108 (*Repair of retinal detachment; with vitrectomy, any method, including, when performed, air or gas tamponade, focal endolaser photocoagulation, cryotherapy, drainage of subretinal fluid, scleral buckling, and/or removal of lens by same technique*).

c. Practice Expense RVU Reductions

CMS continues to express concerns over the AMA RUC's reliance for practice expense values on "resource-intensive but ultimately unreliable surveys with low response rates asking for expert estimates that present significant discrepancies with alternative empirical data sources." CMS says this dynamic is particularly problematic for specialty-level practice expense data. CMS is engaged in a multi-year effort to transition the PE methodology away from reliance on the AMA's data and toward an approach that relies on "objective, routinely updated and auditable cost data." CMS believes this change will lead to PFS payments being more sensitive to market pressures, open broader possibilities for right-sizing payments across outpatient care settings and make payments more transparent for practitioners and beneficiaries.

d. Overall Rates as Proposed

Qualifying APM Participant			
	2026	**2027 (Proposed)**	**Change**
27130	$1,167	$934	**-20%**
27447	$1,165	$931	**-20%**
Non-Qualifying APM Participant			
	2026	**2027 (Proposed)**	**Change**
27130	$1,161	$925	**-20%**
27447	$1,159	$922	**-20%**

II. Arthroplasty Codes Separately Nominated as "Misvalued Services"

In 2012, CMS established a process for public stakeholders to secretly nominate particular CPT codes as misvalued and worthy of further review of RVU amounts. AAHKS later successfully persuaded CMS to make the stakeholder nomination letters public. This was after Anthem/Elevance nominated THA and TKA as misvalued in 2018 leading to work RVU reductions in 2021.

This year, the Maryland Healthcare Commission has nominated THA and TKA as misvalued based on a 2016 Urban Institute study of observed procedure time in one facility. This is the same study that Anthem/Elevance used as the basis of their recommendation for cuts in 2018. AAHKS will respond to CMS pointing out the errors in the Urban Institute study, the fact that its authors explicitly warned that the study should not be used as the basis to reduce work RVUs, and that CMS already made reductions based on this report in 2021.

III. Request for Information on Medicare Program's Use of Current Procedural Terminology (CPT) Coding System

CMS uses the CPT under a royalty-free licensing agreement with the AMA. The CPT coding system was introduced by the AMA in 1966,in part to ''encourage the use of standard terms and descriptors to document procedures in the medical record." In 1983, the Medicare program adopted the use of the CPT for physician services. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) directed the Secretary of HHS to designated nationally required medical data code sets for electronic health transactions. The Secretary designated the CPT as the national required code set for physician services.

CMS notes "longstanding concern expressed over the Federal reliance on a private organization with such an obvious conflict of interest as providing information on the time and resource requirements to conduct physician services when this information may influence their own payment." The Medicare Payment Advisory Commission (MedPAC) has also criticized the influence of the AMA RUC to value services, specifically noting that CMS has ''over-relied on specialty societies with a financial stake in the process."

Given these concerns, CMS asks the public to comment on the following questions regarding the CPT and the influence of the AMA:

- What, if any, evidence is there for CMS to consider regarding the harms or challenges associated with AMA's monopoly over CPT–4 licenses for health care entities? "Please cite potential improvements to patient care diverted or delayed due to AMA'S monopoly over CPT codes, including inhibited innovations and acquisition or maintenance costs of CPT licensure.
- What, if any, evidence is there that the generation of CPT–4 codes follows a process of identification of medical necessity? What opportunities or examples from other populations, sites of care, or international health systems could instruct a process of identification of medical necessity in the CPT–4 code development process?
- A combination of CPT–4 and HCPCS codes were formally adopted by HHS as the legal standard for national coding for physician and other services as part of implementing HIPAA. If CMS were to revisit this standard in future rulemaking, which if any alternatives exist to CPT–4 for CMS to consider as part of the national coding standard for physician services? Would CMS need to specify a separate legal standard, or could CMS allow for private competition to supplement the existing CPT–4 coding standard?

- What objective alternatives exist, or could be developed, to maintain a more objective process to the current AMA CPT and RUC committee processes? How would these alternatives support or inhibit innovation?
- What are the benefits and drawbacks of paying for physician procedural services on the basis of the underlying ICD–10 procedure code, as an alternative to CPT–4 code? How could ICD–10–PCS services be grouped or bundled into payment categories, similar to MS–DRGs, or OPPS Ambulatory Payment Classifications (APCs)? What other alternatives exist for bundling or grouping procedural services?

IV. Redesigning Primary Care to Make America Healthy Again

CMS seeks comments on how it might reconsider primary care service valuation to "better support our objectives of shifting the U.S. healthcare system toward a focus on preventive rather than reactive medicine." CMS states it wants primary care valuation in the PFS, as well as CMS Innovation Center Models. CMS seeks input on three main topics:

- Reconsidering relative primary care payment in the PFS;
- Understanding the payment implication of including technology in primary care;
- Establishing prospective primary care payments in the Medicare Shared Savings Program and potentially in the Original Medicare program broadly.

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