AAHKS
AMERICAN ASSOCIATION OF HIP AND KNEE SURGEONS

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September 14, 2026

VIA E-MAIL FILING

Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS-1848-P
P.O. Box 8016
Baltimore, MD 21244-8016

RE: Medicare 2027 Physician Fee Schedule Proposed Rule – *Comment Letter 2 of 2*

The American Association of Hip and Knee Surgeons (AAHKS) appreciates the opportunity to submit comments to the Centers for Medicare & Medicaid Services (CMS) on its Medicare physician fee schedule (PFS) proposed rule for calendar year 2027 (hereinafter referred to as "CY 2027 PFS proposed rule" or "proposed rule").

This is the second of two comment letters that AAHKS has submitted on the proposed rule. The first comment letter exclusively addressed the proposed 20% reduction in reimbursement for CPTs 27130 and 27447. We are deeply concerned that this proposed cut, which is more than double the size of the next largest specialty reimbursement cut in the proposed rule, will negatively impact innovation, system-wide cost savings, wait times, access and outcomes for the 1.5 million Medicare beneficiaries that rely on this surgery every year to free them from the pain of osteoarthritis and return them to healthier and mobile lifestyles.

Our comments below reflect the following AAHKS principles:

- The costs to patients and the Medicare program of untreated osteoarthritis are far greater than the savings generated from these cuts;
- Reductions in physician reimbursement by public and private payers drives provider consolidation;
- Driving resources out of joint replacement will increase wait times and degrade patient experience for necessary, life improving services by reducing the number of surgeons who are able to provide care for Medicare beneficiaries; and
- CMS overlooks independent data that Medicare currently *undervalues* TJA.

AAHKS is the foremost national specialty organization of more than 5,600 physicians with expertise in total joint arthroplasty (TJA) procedures. Many of our members conduct research in this area and are experts in using evidence based medicine to better define the risks and benefits of treatments for patients suffering from lower extremity joint conditions.

AAHKS agrees with CMS that the physician valuation system should be modernized, and we are prepared to help develop that future. Rather than relying on historical assumptions,

isolated administrative datasets, or any single stakeholder methodology, we encourage CMS to work with the physician community to build and validate a contemporary, transparent, evidence-based approach. Hip and knee arthroplasty offers an ideal opportunity to demonstrate how such a methodology could work.

I. Request for Information on Medicare Program's Use of Current Procedural Terminology (CPT) Coding System (Sec. II.H)

Regarding the AMA CPT coding system, 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." CMS seeks comment on the influence of the CPT coding system and the AMA's physician payment recommendation process. AAHKS believes coding, coverage, medical necessity, and valuation are related but distinct functions. Clinical experts should remain central to accurately defining medical services, while coverage decisions should remain grounded in evidence and individual clinical circumstances.

a. 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?

i. Addressing Conflicts of Interest and Transparency

We support an objective process to value physician services based on actual independently observed work time of surgeons performing these procedures in a recent timeframe, as opposed to inference or assumptions based on data for other procedures. CMS notes that MedPAC has 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." A Rand research report on surgical procedures times cited a similar concern of "potential bias in survey responses: RUC surveys lack independence and rely on input from physicians who could benefit financially from higher time values assigned to their services."[1]

1. Physician Interests Against Physicians

In reality, there are broader financial incentives that must be recognized and addressed for any valuation system. First, it is not merely a question of whether physicians try to *increase the values assigned to their services.* Because Congress created the Medicare Physician Fee Schedule to be budget-neutral and without an inflation adjustment, all medical specialties have a financial incentive to *reduce the values of other medical specialties' services*. Specialties know it easier to increase the values assigned to their services if they simultaneously reduce other services' values. Therefore, regardless of whether values are set by the RUC, CMS or some other process, all physician specialties have a financial incentive to reduce other services' values, regardless of objectively observed time.

[1] https://www.rand.org/pubs/research_reports/RRA3470-1.html

Second, physician specialties are incentivized to take the most direct path to generating new value: targeting high-volume, high value codes for reduction, regardless of objective data. MedPAC and RAND are mistaken that specialty societies benefit from higher times under the RUC process. Hip and knee replacements are among the most complex and physically intense surgeries that is also widely popular with Americans due to its life improving outcomes. Yet, these services have been the constant target of payers and other specialties for reduction for decades. If CMS' proposed RVUs for hip and knee replacement are finalized for 2027, the wRVUs for these procedures will have been cut more than 30% in 20 years.

2. Payer Interests in Lower RVUs

Private payers play an active role in working to reduce the RVUs assigned to high value or high-volume services, regardless of objectively observed time. Because many network contracts pay providers a percentage of the Medicare physician rate, commercial payers frequently nominate codes as potentially misvalued, based on shoddy and poorly understood alleged studies. For example, previously a party nominated seven high volume codes for review, including 27447 and 27130. The anonymous submitter stated that a number of reports by media and federal advisory agencies found "a systemic overvaluation of work RVUs." The submitter was later revealed as private insurance company Anthem Inc. with a financial interest in lower RVUs. The RUC then placed CPT codes 27130 and 27447 on its agenda for review at the April 2019 RUC meeting based on the Anthem nomination.

3. An Objective System Requires Consideration of All Data, Not Only Data that Supports Value Reductions

A flaw in the current process is that, with all the incentives of physician societies and public and private payers to reduce RVUs for high-volume, high-value procedures, emphasis and attention are given to studies alleged to support RVU reduction, regardless of what the studies actually contain and regardless of alternative studies supporting level or increased RVUs.

For example, it was eventually revealed that Anthem based its recommendation above on the Urban Institute report (the Report), "*Collecting Empirical Physician Time Data*," which itself was based on a collection of empirical time data derived from electronic health records (EHRs) and/or direct observation at only three multispecialty health care systems.[2] AAHKS pointed out to the RUC that (1) only two of the three sites in the Report provided data from EHRs, which forms the basis for the analysis of total hip arthroplasty and total knee arthroplasty, (2) important characteristics of the sites are not specified (e.g. size, procedure volume, academic medical center or teaching hospital, urban or rural, government entity, not-for profit or for-profit), and (3) data was collected for only 6 or 12 months. In fact, the Report authors acknowledged the limitations of the project, "We recognize that these three sites were very much a sample of convenience and should not necessarily be viewed as representative of other health systems."[3]

[2] See *Collecting Empirical Physician Time Data: Piloting an Approach for Validating Work Relative Value Units*, Urban Institute (Dec. 2016). Available at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Downloads/Collecting-Empirical-Physician-Time-Data-Urban-Report.pdf.
[3] Id. at pg. 4.

In contrast, CMS and payers seem to disregard independent reports that support higher values. A study published in JAMA by researchers from Rand compared estimated intraservice times and the PFS wRVU time for a variety of procedures in 2018. CMS cited this study in the preamble to the 2026 PFS Proposed Rule as an important source regarding anesthesia and the need for an efficiency adjustment. Yet, in proposing a 20% cut to hip and knee replacements in 2027, CMS seems to have overlooked the part of the study that found that total hip arthroplasty took 5% longer than the PFS valued time, while total knee arthroplasty had an equal duration. Thus, based on time valuations alone, the physician fee for total hip and knee arthroplasty should not be cut.

ii. Work Directly with Specialty Societies

Under law and regulations, AMA RUC recommendations are advisory and non-binding on CMS. Rather, section 1848(c)(2)(B)(iii) of the Social Security Act requires the Secretary to "consult . . . with organizations representing physicians" when adjusting RVUs for physician services.

We propose a new formal collaboration on RVU measurement with stakeholders that will amount to true and meaningful collaboration with medical societies, and not just a proforma opportunity for notice and comment on the proposed rule. AAHKS can convene the different perspectives of our affected surgeons and other stakeholders to determine the best way to establish total hip and knee replacement RVUs based on contemporary empirical measures of physician time, intensity, complexity, clinical responsibility, care coordination, and work across the full episode of care.

AAHKS proposes that CMS establish a formal collaborative initiative with AAHKS and other relevant physician stakeholders to develop and validate a contemporary methodology for measuring physician work and value. Hip and knee arthroplasty could serve as an ideal demonstration area because of its large Medicare population, mature clinical registries, standardized procedures, measurable outcomes, extensive experience with alternative payment models, and demonstrated influence on total episode cost.

We have prior experience in bringing together such stakeholders with mutual interests in efficient and quality Medicare services. On August 31, 2015, AAHKS convened a Patient Reported Outcomes Summit for Total Joint Arthroplasty in Baltimore, Maryland. Representatives from orthopaedic organizations (AAHKS, AAOS, The Hip Society, The Knee Society and American Joint Replacement Registry), CMS, Yale-New Haven Health Services Corporation Center for Outcomes Research and Evaluation (Yale/CORE), private payors and other stakeholders participated in the Summit. The Summit's goal was to obtain a consensus regarding the patient-reported outcomes (PRO) and risk variables suitable for total hip and knee arthroplasty performance measures, particularly for use in the CJR.

b. Which if any alternatives exist to CPT–4 for CMS to consider as part of new national coding standards for physician services?

Establishing any national code system for physician services requires considering many important factors. Chief among these are (1) the financial incentives of the code set developer, and (2) the role of independent clinicians in accurately defining the medical services they alone provide. While there have been criticisms of the incentives and motivation of the CPT Editorial

Panel, and whether it generates too many or too few codes, any potential alternative code system must be also examined for countervailing adverse incentives and motivations.

If code systems are developed by or for payers, the payers will have financial incentives to overrule clinical judgement, to limit payments for services, and use the system as an end-run around unpopular coverage denials. CMS must ensure that physicians have a role in appropriately and accurately describing the work of physicians. How would CMS ensure clinical expertise and clinical judgement are represented in any national coding standards so that is it does not become a "system that puts special [payer] interests ahead of the American people[?]"[4]

II. Potentially Misvalued Services Under the PFS: Request for Revaluation of Physician Work Time Based on Empiric Data (CPT 27130 27447) (Sec. II.D.4.a.9)

a. Additional Revaluation is Untimely and Unwarranted

The Maryland Healthcare Commission (MHCC) nominated CPTs 27130 and 27447 as potentially misvalued. No action is needed to revalue CPTs 27130 and 27447 as these codes were just reviewed/resurveyed for the September 2025 AMA RUC meeting and given new, inappropriately low values in the Proposed Rule. Furthermore, if CMS and the Secretary have persistent doubts about the transparency and objectivity of the AMA/RUC in proposing wRVUs, then CMS should cease referring service codes to them for revaluation.

b. CMS Should Disregard Nominations Explicitly Motivated to Increase Patient Wait Times

In its nomination letter to CMS, MHCC defines its mission as "ensuring appropriate access to the right services at the right time to improve the health and well-being of Marylanders", including by addressing "services that are overvalued by the PFS [which] can lead to oversupply."[5] Given that MHCC has nominated these codes as overvalued, it is the apparent position of the MHCC that surgeon reimbursement for hip and knee replacement is overvalued and that there is an *oversupply of orthopedic surgeons in Maryland*. If this is the case, then it seems to be the position of the MHCC that that patient wait times to see an orthopaedic surgeon and to receive joint replacement surgery in Maryland should be longer. AAHKS cautions against assuming that utilization above a predetermined level necessarily represents oversupply. For procedures such as total hip and knee arthroplasty, utilization must be evaluated in the context of clinical need, disease burden, patient outcomes, geographic access and appropriate indications.

[4] See Secretary Robert F. Kennedy Jr. Video, HHS Secretary RFK Jr. Announces Plan for 'More Affordable Medical Billing System', Forbes Breaking News (Aug. 27, 2026).
[5] MHCC letter to CMS Regarding Potentially Misvalued Codes, pg. 1 (Feb. 9, 2026) https://mhcc.maryland.gov/sites/default/files/reports/potentially_misvalued_codes.pdf

c. CMS Should Disregard Any Data from the Flawed Urban Institute Study.

It is far past time for CMS and other payers to cease distributing and highlighting the flawed 2016 Urban Institute report (the Report), "*Collecting Empirical Physician Time Data*."[6] The report and its underlying data are far too old to be relevant for current valuation and its authors stated at the time that the Report's findings were not representative of the health care system at large.

The timeframe of the Report is too long in the past to be of any contemporary value. The Report is based on data that was collected more than 13 years ago. wRVUs for CPTs 27130 and 27447 have been reduced 28.5% from that time to the proposed 2027 values.

The Report was based on a collection of empirical time data derived from electronic health records (EHRs) and/or direct observation at only three multispecialty health care systems.[7] Only two of the three sites in the Report provided data from EHRs, which forms the basis for the analysis of CPTs 27130 and 27447. Important characteristics of the sites are not specified (e.g. size, procedure volume, academic medical center or teaching hospital, urban or rural, government entity, not-for profit or for-profit). Further, the data was collected over only 6 or 12 months.

The Report authors acknowledged the limitations of the project, "We recognize that these three sites were very much a sample of convenience and should not necessarily be viewed as representative of other health systems."[8] Even the AMA RUC acknowledged "physician interviews in [the Report] were limited; only five physicians from five multispecialty group practices were interviewed for Orthopaedic Surgery. There is no information available to confirm that these physicians perform total hip arthroplasty and/or total knee arthroplasty and their level of experience and clinical volume is not specified."[9]

d. Recent CMS-Cited JAMA Study States that Joint Replacement wRVUs are Appropriately Valued or Undervalued, Not Overvalued

A study published in JAMA by researchers from Rand compared estimated intraservice times and the PFS wRVU time for a variety of procedures in 2018. CMS cited this study as an important source regarding wRVUs in the preamble to the 2026 PFS Proposed Rule.[10] The study found that total hip arthroplasty took 5% longer than the PFS valued time, while total knee arthroplasty had an equal duration.[11] Notably, when the authors made these conclusions in 2018,

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[6] See Collecting Empirical Physician Time Data: Piloting an Approach for Validating Work Relative Value Units, Urban Institute (Dec. 2016). Available at https://www.urban.org/sites/default/files/publication/87771/2001123-collecting-empirical-physician-time-data-piloting-approach-for-validating-work-relative-value-units_0.pdf

[7] Id.

[8] Id. at pg. 4.

[9] *AMA/Specialty Society RVS Update Committee, Meeting Minutes*, AMA, pg. 33 (Apr. 2019). Available at https://www.ama-assn.org/system/files/2020-11/apr-2019-ruc-meeting-minutes.pdf

[10] *See* 90 Fed. Reg. 32401.

[11] Crespin et al., *Variation in Estimated Surgical Procedure Times Across Patient Characteristics and Surgeon Specialty*, 157 JAMA SURG. e220099 (2022), https://doi.org/10.1001/jamasurg.2022.0099.

these procedures were higher than today, valued at 20.72 wRVUs, far above CMS' proposed 15.3 wRVUs in 2027.

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AAHKS appreciates your consideration of our comments. If you have any questions, you can reach Mike Zarski at mzarski@aahks.org or Joshua Kerr at jkerr@aahks.org.

Sincerely,

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