AAOS
American Association of Orthopaedic Surgeons

Summary for Fiscal Year (FY) 2025 Medicare Inpatient Prospective Payment System (IPPS) and Long-Term Care Hospital (LTCH) Prospective Payment System (PPS) Proposed Rule

On April 10, 2024, the Centers for Medicare & Medicaid (CMS) published the fiscal year 2025 Medicare hospital inpatient prospective payment system (IPPS) and long-term care hospital prospective payment system (LTCH PPS) proposed rule. This proposed rule aims to make changes which will update fee-for-service payment rates and policies for inpatient hospitals services. It also encompasses quality reporting programs pertinent to inpatient hospital services. Additionally, it aligns with the agency objectives, prioritizing the advancement of promoting health equity and enhancing the safety and quality of care.

Read the AAOS 2025 IPPS/LTCH Full Summary here and the AAOS TEAM Model Proposed Rule Executive Summary here.

Transforming Episode Accountability Model

CMS released a proposed implementation and testing of the Transforming Episode Accountability Model (TEAM). This mandatory model would begin on January 1, 2026, and end on December 31, 2030. TEAM is considered the successor to BPCI-A and CJR, with episode-based pricing linked to quality measure performance for five surgical episode categories, three of which are orthopedic. This model is being released following CMS' Innovation Center's (CMMI) review of comments submitted in response to the July 2023 Request for Information on Episode-Based Payment Models.

AAOS strongly opposes any mandatory model and will be working to make the necessary changes prior to the model implementation date. We have compiled a comprehensive overview of the model encompassing its essential proposed features and provisions.

Proposed Changes to Medicare Severity Diagnosis-Related Groups (MS-DRGs)

For FY 2025, CMS is proposing to delete MS-DRGs 453, 454, and 455 and proposing to create 8 new MS-DRG:

- MS-DRG 426 (Multiple Level Combined Anterior and Posterior Spinal Fusion Except Cervical with MCC),
- MS-DRG 427 (Multiple Level Combined Anterior and Posterior Spinal Fusion Except Cervical with CC),
- MSDRG 428 (Multiple Level Combined Anterior and Posterior Spinal Fusion Except Cervical without CC/MCC),
- MS-DRG 402 (Single Level Combined Anterior and Posterior Spinal Fusion Except Cervical),

- MS-DRG 429 (Combined Anterior and Posterior Cervical Spinal Fusion with MCC),
- MS-DRG 430 (Combined Anterior and Posterior Cervical Spinal Fusion without MCC),
- MS-DRG 447 (Multiple Level Spinal Fusion Except Cervical with MCC) and
- MS-DRG 448 (Multiple Level Spinal Fusion Except Cervical without MCC)

Add-on Payments for New Services and Technologies for FY 2025

- Restor3d submitted an application for the **restor3d TIDALTM Fusion Cage**. This device facilitates healing for fractures, bone voids, absent bone, or surgical resections in conjunction with an intramedullary nail for TTC fusion. Additionally, the manufacturer noted that the restor3d TIDALTM Fusion Cages also serve to support and contain bone graft materials that aid in arthrodesis. This new technology received Breakthrough Device designation from FDA on June 26, 2023.
  - **CMS invites public comments on whether the restor3d TIDAL™ Fusion Cage meets FY 2025 cost criteria, pending FDA Breakthrough Device approval by May 1, 2024.**
- Icotec Medical, Inc. submitted an application for **VADER® Pedicle System**. This device is a pedicle screw system for standard posterior fixation of the spinal column used to provide stabilization of infected spinal segments after debridement of infectious tissues. This new technology received Breakthrough Device designation from FDA on July 31, 2023.
  - **CMS invites public comments on whether the VADER® Pedicle System meets cost criteria and proposes approving new payments for FY 2025. It's intended to stabilize the thoracic and/or lumbar spinal column in patients with active spinal infections to prevent deterioration and neurological issues.**

Graduate Medical Education

CMS clarified the definition of a "new" residency program and established criteria to determine if a program qualifies as "new" for hospitals to receive additional direct GME and/or IME cap slots. This clarification aims to prevent instances where a program is transferred from an existing to a new teaching hospital, resulting in duplicate cap slots. To be considered "new," a program must meet criteria including:

1. **New Residents:** The program must have new residents.
2. **New Program Director:** A new program director must be appointed.
3. **New Teaching Staff:** The program must have new teaching staff.

CMS emphasized that the majority of residents or staff should not come from existing programs in the same specialty to maintain a program's newness. CMS aims to establish additional criteria through

rulemaking to ensure the appropriate creation of newly funded cap slots**. However, CMS is uncertain about some criteria and is seeking comments to gain clarity on best practices in this area.**

CMS is "soliciting comments on what should be considered a "small" program and what percentage threshold or other approach regarding new resident trainees should be applied to these programs. CMS solicits comment on defining a small residency program as a program accredited for 16 or fewer resident positions, because 16 positions would encompass the minimum number of resident positions required for accredited programs in certain specialties, such as primary care and general surgery, that have historically experienced physician shortages, and therefore have been prioritized by Congress and CMS for receipt of slots under sections 5503 and 5506 of the Affordable Care Act. CMS also seeks comments on the variable involved in examining newness of teaching staff."

Advancing Patient Safety and Outcomes Across the Hospital Quality Programs- Request for Comments

CMS is "seeking ways to build on current measures in several quality reporting programs that account for unplanned patient hospital visits to encourage hospitals to improve discharge processes.

CMS invites public comment on how these programs could further encourage hospitals to improve discharge processes, such as by introducing measures currently in quality reporting programs into value-based purchasing to link outcomes to payment incentives.

CMS is specifically interested in input on adopting measures which better represent the range of outcomes of interest to patients, including unplanned returns to the ED and receipt of observation services within 30 days of a patient's discharge from an inpatient stay.

Hospital Inpatient Quality Reporting (pg. 956)

CMS is proposing to remove four clinical episode-based payment measures from the Hospital IQR Program beginning with the FY 2026 payment determination including:

- Hospital-level, Risk-Standardized Payment Associated with a 30-Day Episode of Care for Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA) (CBE #3474) (THA/TKA Payment). This measure assesses hospital risk-standardized payment (including payments made by CMS, patients, and other insurers) associated with a 90-day episode-of-care for elective primary THA/TKA for any hospital participating in the Hospital IQR Program and includes Medicare FFS patients aged 65 or older.