AAOS
American Association of Orthopaedic Surgeons

September 9, 2024

Hon. Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1807-P
P.O. Box 8016
Baltimore, MD 21244-8016

Submitted electronically via http://www.regulations.gov

Subject: CMS-1807-P
Medicare and Medicaid Programs; CY 2025 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; Medicare Prescription Drug Inflation Rebate Program; and Medicare Overpayment

Executive Summary: On behalf of over 39,000 orthopaedic surgeons and residents represented by the American Association of Orthopaedic Surgeons (AAOS), we appreciate the opportunity to provide feedback on the (CMS-1807-P) CY 2025 Physician Fee Schedule proposed rule.

- **Conversion Factor:** AAOS strongly opposes the proposed reduction in the CY 2025 conversion factor, urging CMS to reconsider this decrease, which exacerbates financial pressures on physician practices and threatens patient access to care. We advocate for a more equitable and sustainable payment system, including an inflationary update to the Medicare Physician Fee Schedule to account for rising healthcare costs.
- **HCPCS Code G2211:** AAOS continues to oppose the implementation of HCPCS code G2211, arguing that it results in overpayments and necessitates reductions in the Medicare conversion factor. We urge CMS to rescind this code, as the current E/M coding structure already sufficiently addresses patient care complexities.
- **Potentially Misvalued Services:** AAOS opposes the revaluation of certain spinal fusion and osteotomy codes, emphasizing the need for accurate coding and valuation. We suggest that CMS continue to monitor these codes and reassess them in three years after further analysis and education efforts.
- **Safety and Cost Concerns for Office-Based Procedures:** AAOS expresses concern about the safety and high costs associated with performing sacroiliac joint fusion in office settings. We request that CMS address the cost implications of high-cost disposables related to this procedure on Part B funds.
- **Valuation of Hand, Wrist & Forearm Repair Codes:** AAOS disagrees with CMS's proposed reductions in the work RVUs for specific hand, wrist, and forearm repair codes. We urge CMS to

accept the RUC-recommended values, which better reflect the work and intensity involved in these procedures.

- **Global Surgical Packages**: AAOS opposes CMS's refusal to apply RUC-recommended work and time increases to global surgical codes. We recommend that CMS adopt these changes to ensure Fee Schedule relativity.
- **Transfer-of-Care Modifiers**: CMS proposes mandatory use of transfer-of-care modifiers for 90-day global surgical packages. AAOS opposes this proposal due to difficulties in predicting scenarios requiring modifier use and its potential complications with Modifier 51.
- **Post-op Care Services E/M Add-on Code**: CMS introduces a new E/M add-on code, GPOC1, for post-operative care by non-surgeons. AAOS strongly opposes, citing concerns over care quality, administrative burden, and potential misuse of Medicare funds.
- **Rebasing and revising the Medicare Economic Index (MEI)**: AAOS supports the delay and the decision to wait for updated AMA practice cost data before proceeding.
- **Opposition to Mandatory MVP Participation (RFI):** AAOS opposes the mandatory participation in MIPS Value Pathways (MVPs) due to the gaps in applicability to specialists and subspecialists. AAOS requests that CMS maintain the traditional MIPS framework, allowing clinicians to select measures, improvement activities, and strategies most relevant to their specific practices.
- **Concerns About Surgical Care MVP:** AAOS reiterates concerns about the Surgical Care MVP, highlighting the lack of consultation with AAOS and other surgical specialties in its development. We request that CMS clarify why the MVP excludes certain surgeries with existing MIPS measures and explain the rationale for combining unrelated surgical specialties, as the current inclusion appears arbitrary and disconnected from clinical practice.
- **RFI on Guiding Principles for Patient-Reported Outcome Measures (PROMs):** AAOS supports the integration of more PROMs into CMS quality programs and models. We recommend CMS to collaborate with measure developers to create a standardized library of PROMs that are applicable across various clinical contexts while emphasizing the need for condition-specific tools in orthopaedics. We also request CMS to ensure these tools are accessible, minimize administrative burden, and support better integration into clinical practice.
- **Alternative Payment Models (APMs) Stability:** AAOS acknowledges CMS's statutory requirements for increasing QP thresholds and replacing the APM incentive payment but urges CMS to work with Congress to ensure stability and predictability in the APM incentive payment structure.
- **RFI on Building MVP Framework to Improve ASC:** AAOS raises concerns about the framework's limitations, advocating for voluntary participation and the development of more comprehensive, specialty-focused payment models. AAOS urges CMS to engage physicians throughout the model development process, ensure adequate payments and flexibility, and prioritize transparency to support high-quality care, particularly for vulnerable populations.

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Dear Administrator Brooks-LaSure,

On behalf of over 39,000 orthopaedic surgeons and residents represented by the American Association of Orthopaedic Surgeons (AAOS), and the orthopaedic specialty societies and state societies that agreed to sign on, we are pleased to provide comments in response to the [CMS-1807-P] RIN 0938-AV33 Medicare and Medicaid Programs; CY 2025 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; Medicare Prescription Drug Inflation Rebate Program; and Medicare Overpayments (CMS 1807-P) published in the Federal Register on July 31, 2024.

AAOS appreciates the ongoing efforts of the Centers for Medicare & Medicaid Services (CMS) to create a more equitable health care system that results in better access to care, quality, affordability, and innovation.

CY 2025 PFS Rate Setting and Conversion Factor

For CY 25, CMS is proposing a conversion factor of $32.36, a decrease of $0.93 (about 2.80%) to the 2024 conversion factor of $33.29.[1] This reduction exacerbates existing financial pressures on physician practices, which have already faced substantial challenges over the past two decades. The American Medical Association (AMA) estimates that Medicare physician payments will have decreased by approximately 20% between 2001 and 2021 due to the cumulative impact of practice cost inflation. This reduction is particularly concerning in light of the fact that, while Medicare spending on physician services per enrollee decreased by 1% between 2010 and 2020, spending on other components of Medicare increased by 3.6% to 42.1%. The ongoing statutory payment cuts and the lingering financial and staffing challenges posed by the COVID-19 pandemic, threaten the long-term sustainability of physician practices. This proposal from CMS further ultimately jeopardizes patient access to physicians who participate in Medicare.[2]

The AAOS, along with the AMA and several other organizations, has called for a rational reform plan[3] for Medicare's physician reimbursement system. This plan emphasizes the need to address critical issues including principles for fixing prior authorization, supporting telehealth, reducing physician burnout, and preventing scope of practice creep.[2] These objectives are integral to the future of healthcare delivery and cannot be fully realized without comprehensive reform of the current Medicare physician payment system. A significant flaw within the current payment structure is the absence of a mechanism for physicians to offset rising costs. Unlike other Medicare providers who benefit from built-in updates, such as a medical economic index or an inflationary growth factor, no such provisions exist for

[1] Centers for Medicare & Medicaid Services (CMS), Department of Health and Human Services (HHS). (2024, July 10). CY 2025 Medicare Physician Fee Schedule Proposed Rule. https://www.federalregister.gov/documents/2024/07/31/2024-14828/medicare-and-medicaid-programs-cy-2025-payment-policies-under-the-physician-fee-schedule-and-other

[2] American Association of Orthopaedic Surgeons. (2022, September 2). AAOS Comments on the 2023 MPFS Proposed Rule. https://www.aaos.org/globalassets/advocacy/issues/aaos-cy-2023-mpfs-rule-comments.pdf

[3] Recovery Plan for America's Physicians https://www.ama-assn.org/amaone/fighting-for-physicians

physicians under the MPFS. AAOS, in collaboration with other physician organizations, has been advocating for the creation of an inflationary update to the Medicare Physician Fee Schedule. Such an update is essential to maintaining access to specialty care for Medicare beneficiaries. As acknowledged in the 2024 Medicare Trustees' report, "Over time, unless providers could alter their use of inputs to reduce their cost per service correspondingly, Medicare's payments for health services would fall increasingly below providers' costs. Providers could not sustain continuing negative margins and would have to withdraw from serving Medicare beneficiaries or (if total facility margins remained positive) shift substantial portions of Medicare costs to their non-Medicare, non-Medicaid payers."[4] We strongly urge CMS to support initiatives to stabilize the MPFS and to advocate for a more equitable and sustainable payment system that reflects the realities of rising costs in healthcare delivery.

Orthopaedic surgeons have consistently demonstrated leadership in providing high-value musculoskeletal care to patients while generating significant cost savings for Medicare. AAOS urges CMS to collaborate with our organization to develop value-based payment models that include incentives tailored to the distinct needs of orthopaedic patients and practice settings. Additionally, it is crucial to maintain a financially viable fee-for-service model that ensures the continued provision of high-quality care.

AAOS strongly opposes any regulatory changes that would further reduce reimbursement under the fee schedule. We urge CMS to reconsider the proposed conversion factor reduction and to explore alternative mechanisms for achieving budget neutrality that do not disproportionately impact physician reimbursement. Ensuring stable and adequate reimbursement is essential for sustaining practice viability, investing in practice improvements, and ultimately ensuring that Medicare beneficiaries have access to the care they need.

Office/Outpatient Evaluation and Management Visit Complexity Add-On Provisions

In CY2024, CMS finalized HCPCS code G2211, which provides an add-on payment for complex patients with existing office/outpatient evaluation and management (E/M) visits. AAOS continues to oppose implementation of code G2211. We recognize CMS' recent proposal to refine its policy on the use of G2211, allowing payment of the O/O E/M visit complexity add-on code when the O/O E/M base code is reported on the same day as an Annual Wellness Visit (AWV), vaccine administration, or any Medicare Part B preventive service furnished in the office or outpatient setting.[1] This proposed flexibility introduces important considerations, particularly concerning the Modifier -25 restriction, which complicates billing for complex cases involving preventive services.

[4] *2024 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds*, p. 189 (May 6, 2024).

However, even with these exceptions, AAOS remains concerned that the use of G2211 results in overpayments and has necessitated reductions in the Medicare conversion factor to maintain budget neutrality under the MPFS. However, even with these exceptions, AAOS remains concerned that the use of G2211results in overpayments and has necessitated reductions in the Medicare conversion factor to maintain budget neutrality under the MPFS. Such reductions disproportionately affect physicians who are unable to bill G2211, especially those in orthopaedics.[5] **We strongly urge CMS to rescind the implementation of HCPCS code G2211**. The current E/M coding structure already provides sufficient flexibility to address patient care complexities without the need for an additional, potentially redundant add-on code. We believe that reimbursement practices should focus on ensuring equitable and sustainable care for Medicare beneficiaries without imposing additional financial burdens on healthcare providers.

Potentially Misvalued Services Under the PFS
Codes 22210, 22212, 22214, 22216

For CY 2025, CMS received a public nomination from an interested party for CPT codes 22210 (*Osteotomy of spine, posterior or posterolateral approach, 1 vertebral segment; cervica*l) (090 day global code), 22212 (*Osteotomy of spine, posterior or posterolateral approach, 1 vertebral segment; thoracic*) (090 day global code), 22214 (*Osteotomy of spine, posterior or posterolateral approach, 1 vertebral segment; lumbar*) (090 day global code), and 22216 (*Osteotomy of spine, posterior or posterolateral approach, 1 vertebral segment; each additional vertebral segment [List separately in addition to primary procedure]*) (add-on ZZZ), as potentially misvalued for six reasons: (1) incorrect global period; (2) incorrect inpatient days; (3) incorrect intraservice work description; (4) overvalued intraservice times; (5) changed surgical practice; and (6) incorrect use of posterior osteotomy codes.

AAOS disagrees with the nominator's claim that this family of codes is misvalued and would like to address the concerns raised by the interested party.

1) Incorrect Global Period

The nominator stated that these posterior osteotomies are always performed as an optional addition to a spinal fusion and should be valued as add-on services and not as 90-day global services. After review of the CMS claims data, we found that a significant majority of claims for codes 22210-22214 are reported without a modifier indicating these codes are the primary or index procedure and not add-on services. This data in combination with the fact that no references were provided by the nominator to support the statement that the service is always performed as an optional addition to a spinal fusion, shows that there is no evidence to support this claim.

[5] American Association of Orthopaedic Surgeons. (2024, September 8). AAOS Comments on the 2024 MPFS Proposed Rule. https://www.aaos.org/globalassets/advocacy/issues/aaos-fy-2024-mpfs-comment-letter.pdf

2) Incorrect Inpatient Days

The nominator stated that the average hospital stay for scoliosis fusion with osteotomy is less than the currently included inpatient days. In the proposed rule CMS noted that the majority of literature submitted by the nominator presented outcome information on adolescent patients, which may be different from the Medicare population. We agree with the Agency that literature was selectively provided to only include information about pediatric patients. The nominator failed to submit a comprehensive list of literature to support this claim and therefore is unreasonable.

3) Incorrect Intraservice Work Description

The nominator stated that the intraservice work description for code 22216 describes removal of the pedicle, which is not a typical part of a Ponte/Schwab II osteotomy. The original description of work from the 22210-22214 family notes that a portion of the pedicle may be removed. These descriptors do not report that the entire pedicle is removed, only enough bone to provide adequate decompression of the nerve roots at the level where the osteotomy is being formed. Complete resection of the involved vertebral body's pedicle would not be routine in performing a posterior element osteotomy. However, complete resection of the pedicle is not included in the original DOW for these codes; this operative procedure has not changed.

4) Overvalued Intraservice Times

The nominator asserted that intraservice times were too high, particularly for these osteotomy services furnished with scoliosis fusion procedures. Again, the literature cited by the nominator referred to pediatric deformity procedures which may not be reflective of adult spinal surgery practice. After review of the data referenced in the letter, we find that the average time of 3.6 minutes cited for performing an osteotomy in the nominator's letter is ridiculously low. Several studies indicated that non-randomization allowed surgeon-specific factors to potentially confound the results as one reason for not observing longer surgical times in patients who underwent Ponte osteotomies. The nominator provided no studies to support a typical scoliosis fusion time in adults. Therefore, we believe the nominator's claim is unsupported.

5) Changed Surgical Practice

We also disagree with the nominator's assertion that surgical practice for these procedures has evolved, indicating that 30 years ago, osteotomies were infrequently performed and usually reserved for addressing completely ankylosed or fused spinal segments. The nominator further asserted that contemporary surgical techniques often involve posterior osteotomies to release multiple stiff vertebral segments, thereby enhancing coronal correction and reducing thoracic hypokyphosis, resulting in notable shifts in the trends regarding the utilization of osteotomies. Once again, the nominator chose select articles that are related to adolescent idiopathic scoliosis. For example, the study sample in one article indicated over 60% were aged 7-12. When looking at the Medicare aged claims, we do not find

an unexpected increase in utilization. With better understanding of spinal alignment parameters and with growth of the Medicare patient population, more osteotomy procedures are being performed, but not at a significant rate of change. In fact, Medicare utilization has flattened over the past eight years. Again, the nominator's claims are not supported.

6) Incorrect use of Posterior Osteotomy Codes
Lastly, the nominator suggested incorrect usage of posterior osteotomy codes, noting instances where facet/soft tissue releases, such as Schwab type I osteotomies, are inaccurately reported with this family of codes. According to the nominator, isolated partial facetectomy and soft tissue release are already included in spinal fusion procedures and should not be separately billed with an osteotomy code.

AAOS acknowledges that previously, osteotomy codes may have been inappropriately reported concurrent with interbody fusion procedures (22630/22633) after CMS restricted the ability to report decompression (63047) at the same level as a lumbar interbody fusion. To remedy this and to improve coding accuracy, new codes were created specifically for decompression when performed at the same level as an interbody fusion (63052-63053). Implementation of these new codes has been difficult due to an erroneous NCCI edit that precluded use of the code 63052 with 22630/22633. This error by NCCI has been corrected, but this may have slowed implementation of the new codes. We anticipate that with correct coding (using 63052) there will be a decrease in use of osteotomy codes at the same level as interbody fusions which will decrease use of the lumbar osteotomy codes overall.

Lastly, CMS has noted that code 22210 is reported with code 22600 (Arthrodesis, posterior or posterolateral technique, single interspace; cervical below C2 segment) approximately 83% of the time and questions whether there should be consideration of consolidating individual services into bundled codes. Code 22210 is a very low volume code (< 400), and utilization has been stable over time, and although this low volume code may be reported often with 22600, the reverse view is that only 1.6% of code 22600 procedures also involve 22210. Code 22210 still needs to be maintained as a stand-alone code.

AAOS strongly urges CMS not to finalize these codes as potentially misvalued as the information provided demonstrates that the nominator's claims are invalid.

Code 27279
Code 27279 *(Arthrodesis, sacroiliac joint, percutaneous or minimally invasive (indirect visualization), with image guidance, includes obtaining bone graft when performed, and placement of transfixing device)* code has been re-nominated based on the absence of separate direct PE inputs for this 90-day global code in the non-facility setting. The nominator is requesting that CMS establish separate direct PE inputs for this service to value the service when performed in a non-facility/office setting (e.g., office-based lab). The nominator added that establishing payment for direct PE inputs in the non-

facility/office setting would increase access to this service for Medicare patients. **AAOS continues to have concerns regarding the safety of performing sacroiliac joint fusion in the office setting and urges CMS not to price CPT code 27279 in a non-facility/office setting.** The procedure requires incision, collection of bone by drilling down through the ilium to the SI joint for grafting as well as placement of titanium implants across the sacroiliac joint. SI joint fusion requires transfixing the joint, which has always been performed under general anesthesia. AAOS believes performing the procedure in the office poses safety issues for the patient and therefore is inappropriate.

Additionally, the AMA CPT Editorial Panel will be considering several proposals at the September 2024 meeting. The proposed changes will better define sacroiliac joint fusion procedures and may provide CMS with better insight on this procedure.

Lastly, AAOS would also like to note concern regarding the high-cost disposable associated with this procedure. If this procedure were to be priced in the non-facility/office setting, it would become one of the most expensive in-office procedures. AAOS respectfully requests CMS to address the high-cost disposable associated with code 27279 and its effect on Part B funds.

Valuation of Specific Codes

Hand, Wrist & Forearm Repair & Recon (CPT Codes 25310, 25447, 2X005, and 26480)

At the May 2023 CPT Editorial Panel Meeting, a bundled code was approved (2X005) to report intercarpal or carpometacarpal joint suspension arthroplasty, including transfer or transplant of tendon with interposition when performed. CPT code 25447 was revised to clarify that the code only included interposition of a tension (not suspension). The family of codes was surveyed for the September 2023 RUC.

Code 25310

AAOS disagrees with CMS' comments regarding decreased intensity of code 25310. The RUC Summary of Recommendation (SOR) form noted changes in time and technology regarding increased work in postoperative visits. The recommended work RVU of 9.50 is supported by the key reference codes 26356, *Repair or advancement, flexor tendon, in zone 2 digital flexor tendon sheath (e.g., no man's land); primary, without free graft, each tendon*, and 23430, *Tenodesis of long tendon of biceps* which represent similar tendon repair work including identical intraoperative time to both codes. Code 25310 also has a similar total time to key reference code 26356 which has a wRVU of 9.56. The change in total work for code 25310 is due to the increased intensity and value of postoperative work. The current wRVU of 8.08 for code 25310 was established in 2008 before the E/M code review and revaluation to recognize increased work and intensity of E/M services. The survey confirmed that the level of visits changed as supported by both MDM and total time on the day of the encounter. The RUC recommended an accurate wRVU based on the survey wRVU estimate and typical survey work as

compared to key reference code 26356. **AAOS urges CMS to accept the RUC recommended work RVU of 9.50 for code 25310.**

Code 25447
AAOS also disagrees with CMS' comment regarding decreased intensity of code 25447. The RUC Summary of Recommendation form for this code provided evidence that the work at each post-operative visit supported the level and intensity based on MDM and time. We disagree with CMS' rationale that the intensity of the intraoperative work has changed and using the change in intraoperative time as a basis to propose a lower wRVU. **AAOS believes that all components of the global codes must be considered and urges CMS to accept the RUC-recommended work RVU of 11.14 for code 25447.**

Code 2X005
AAOS disagrees with CMS proposed wRVU of 11.85 for code 2X005 based on the rationale that the RUC typically values new codes using the 25th percentile wRVU versus the survey median wRVU. The 25th percentile does not represent the typical patient. CMS also stated that their proposed value for 2X005 was more accurate due to the intensity being less than that of key reference code 29828. While AAOS and interested stakeholders agree that the intensity of code 29828 is greater than 2X005, the intensity is not 50% of the intensity of 29828 as suggested by CMS' recommendation.

The importance of the thumb cannot be emphasized enough as it is crucial in performing daily tasks. Without proper functionality, simple tasks such as holding a utensil, writing, or brushing one's teeth can become nearly impossible to complete. Code 2X005 encompasses the work of 25447 and the additional work of drilling and creating a hole through the base of the first metacarpal for passage of the radial half of the Flexor carpi radialis tendon from the second metacarpal to the first metacarpal. The position of the thumb and tension on the tendon transfer are meticulously evaluated before suturing the tendon to itself in the arthroplasty space created by the excised trapezium. This additional operative maneuver is technically demanding, particularly given that the typical patient has arthritis and fragile bones. Consequently, code 2X005 represents a significantly higher level of complexity compared to code 25447. AAOS believes that the CMS proposed wRVU of 11.85 does not appropriately reflect the complexity of the procedure. **We urge CMS to accept the RUC recommended-work RVU of 13.90 for code 2X005.**

Code 26480
AAOS disagrees with the CMS recommended wRVU of 9.00 which does not consider the change in the intensity of postoperative work. The current wRVU for code 26480 is 6.90 which was established in 2009 prior to the E/M code review and revaluation to recognize increased work and intensity of E/M services. The survey confirmed that the level of visits changed as supported by both MDM and total time on the day of the encounter. The RUC recommended an accurate wRVU based on the survey wRVU estimate and typical survey work as compared to key reference code 26356. Code 26356 also has

identical intraoperative time and similar total time to code 26480. We would also like to note that CMS' recommendation of 9.00 wRVU would create a rank order anomaly with recently reviewed codes with the intraoperative time and similar total time. **AAOS urges CMS to accept the RUC-recommended wRVU of 9.50 for code 26480.**

Advanced Primary Care Management (APCM) Services (HCPCS codes GPCM1, GPCM2, and GPCM3)

CMS proposes to establish a set of codes that it believes describe advanced primary care management services broadly, to provide more stability in payment and coding for practitioners in the context of continued evolution in advanced primary care, as well as to provide the agency with a mechanism for continued and intentional improvements to advanced primary care payment. Specifically, CMS proposes to establish and pay for three new G-codes that describe a set of care management services and communications technology-based services (CTBS) furnished under a broader application of advanced primary care that aim to encompass a broader range of services and simplify the billing and documentation requirements, as compared to existing care management and CTBS codes.

Elsewhere in the rule, CMS acknowledges stakeholder concerns about the lack of payment mechanism in the MPFS for comprehensive patient centered fracture management care and concerns that this leads to inadequate "hand-off" when post-discharge fracture care is transferred to practitioners in the community. In this context, CMS asks for input on whether GPCM1, GPCM2, and GPCM3 (as well as the proposed "post-op follow-up" visit add-on G-code GPOC1, discussed below) may be used to bill for managing fractures under a treatment plan. ***AAOS does not believe that that any of the proposed G codes in the CY 2025 proposed rule describe the services of managing fractures under a treatment plan, allow for use of these codes when those services are provided, nor address the longitudinal care management that is required to manage patients' bone health and fracture prevention***. CMS explicitly states that the code is for use by those who "intend to be responsible for the patient's primary care and serve as the continuing focal point for all needed health care services*."* This explicitly eliminates the use of these codes for managing fractures under a treatment plan (a) because specialists provide these services; and (b) because the care team providing fracture care do not intend to take on primary responsibility for primary care/"all needed health care services." Furthermore***, AAOS believes GPCM1, GPCM2, and GPCM3 are poorly defined and describe payment for services that may or may not be rendered during the timeframe for the codes making this proposal a questionable use of Medicare funds when, in the alternative, CMS could assign codes to more directly describe and support evidence-based secondary fracture prevention services.***

Global Surgical Packages

AAOS continues to oppose CMS's failure to incorporate the RUC-recommended work and time incremental increases for the inpatient hospital and observation care visit codes (99231-99233, 99238, 99239) and office/outpatient visit E/M codes (99202-99215) into all global surgical codes. **Again, we strongly urge CMS to apply the RUC-recommended changes to the E/M component of the global codes to maintain the relatively of the Fee Schedule.**

Transfer-of-Care Modifiers
CMS proposes that practitioners (Health Care Professionals (HCPs) will be required to use the appropriate transfer of care modifier for all 90-day global surgical packages in any case where a "practitioner plans to furnish only a portion of a global package "including but not limited to when there is a formal, documented transfer of care as under current policy, or an informal, non-documented but expected, transfer of care." AAOS is concerned about implementation of the proposal and the operational implications for physician practices if CMS moves forward with easing restrictions on the transfer of care and use of modifiers 54 and 55 for all fractures treated externally. Currently, there are formal requirements for a transfer of care.

It is challenging for the HCP providing the follow up care to know if the transferring HCP is reporting the global fracture code with a -54 modifier. For example, it would be difficult to predict the scenario of a treating specialty physician seeing a patient from out of town who then returns to their hometown for follow-up care. If CMS expands the transfer of care proposal, the orthopaedic surgeon following a patient for fracture treatment after being seen by the ER physician (who submits the global fracture care CPT code with a modifier -54 and then transfers the care to an orthopedist), must bill with the -55 modifier thus reducing their reimbursement to only 21% of the global code's fee. The other current option for this scenario allows the orthopaedic surgeon to report itemized E/M visits. Currently, whether reporting with the fracture care CPT code or itemized with E/M visits, one must continue this reporting for the remainder of the treatment. Easing restrictions of the formal requirements for a transfer of care has the potential to remove the option to bill itemized E/M visits.

Furthermore, AAOS believes that that the transfer of care modifier should not be appended to any services that has the multiple procedure reduction modifier 51. Modifier 51 already reduces the payment for the second and subsequent services to remove the payment for post-operative care. A further 50% reduction along with the -54 modifier for surgical care only would be inappropriate.

"Post-op Care Services" E/M Add-on Code
CMS proposes the establishment of a new E/M add-on code, GPOC1, "that would account for resources involved in post-operative care for a global surgical package provided by a practitioner who did not furnish the surgical procedure and does not have the benefit of a formal transfer of care." CMS makes no proposals to narrow the use of this code to procedures where the care of a general practitioner would be appropriate patient care for patients, but rather, in the code descriptor states that the code is available when the practitioner who did not perform the surgery sees a patient whose surgical care is covered by a 90 day global period for a "post-operative follow-up visit" that is "addressing surgical procedure(s)."

Orthopaedic surgeons are proud of the full spectrum of care that they deliver to their patients, including the post-operative follow-up care provided to Medicare beneficiaries. Here, CMS suggests that it is a good use of taxpayer funds to reimburse a non-surgeon for follow-up care from a major surgery without establishing any guidance for what threshold must be crossed for the E/M visit to be truly "addressing" a surgical procedure as opposed to a coincidental history or physician conducted as part of an E/M for a different problem or condition. Further, as part of the code descriptor, CMS states that the compensation

is precisely because the physician billing the code does not know what to look for as post-operative healing or complications: "*Research the procedure to determine expected post-operative course and potential complications."*

CMS even states that in order to bill the add-on code, it would expect "the documentation in the medical record to indicate the relevant surgical procedure, to the extent the billing practitioner can readily identify it . . ." **AAOS opposes the CMS introduction of payment for a service to treat Medicare patients for what CMS is suggesting are "post-operative follow-up visits" when CMS has acknowledged that the provider billing the add-on code might not even know what the exact surgical procedure was.** The proposed introduction of this add-on code is offensive to the care that orthopaedic surgeons provide to their patients, an abuse of the Medicare trust funds, and just plain nonsensical. We are concerned with the disingenuous of rationale for the proposal by suggesting that there is no way for the Medicare Physician Fee Schedule to compensate physicians who perform longer than typical E/M visits when in CY 2021 CMS revalued the office and outpatient E/M visits and new structure for selecting E/M visit levels by time (with an add-on code for prolonged services). At best, this GPOCI is completely unnecessary, and **AAOS urges CMS to withdraw the proposal to begin using Medicare dollars to pay for GPOC1.**

Meanwhile, CMS states that "instituting an add-on code to capture the time and intensity of post-operative work absent a formal transfer of care, would be an essential step in recognizing how the services are currently furnished and make meaningful progress toward 'right-sizing' the structure of the global packages." **This is false**. If CMS finalizes this code and other physicians are willing to begin to take on the liability associated with post-operative outcomes by billing this add-on code and, thus, claims data starts to show utilization of those code, that might provide CMS with data on what other physicians are doing but it will tell CMS *nothing* about the quality care being delivered by orthopaedic surgeons to their patients. When our members continue to see their patients in the global period following an orthopaedic surgery, there will be no competing claims data because our members, of course, submit no claims for those post-operative follow-up visits. So in the end, CMS has proposed an add-on code that will waste Medicare dollars, create administrative burden for the physicians billing it (since the current E/M structure already accounts for increased visit time), and provide CMS with claims data that is meaningless for understanding what care is being provided by the surgeons who performed the procedure.

Rebasing and Revising the Medicare Economic Index

For CY 2025, CMS continues to delay the implementation of the finalized 2017-based Medicare Economic Index (MEI) cost share weights for the relative value units (RVUs). This delay aims to maintain consistency with CMS's efforts to balance payment stability and predictability while incorporating new data through more routine updates.[1] CMS has agreed to pause consideration of other sources for the MEI until the American Medical Association's (AMA) efforts to collect updated practice cost data from physician practices are concluded. This prudent approach helps to avoid potential duplication of efforts and ensures that CMS continues to monitor available data on physician services input expenses.

AAOS appreciates CMS's decision to delay the implementation of the 2017-based MEI, as noted in our FY 2024 comments.[2] We support this proposal, recognizing the importance of incorporating the AMA's updated data collection efforts. Given that the current MEI weights are derived from data collected by the AMA's Physician Practice Information (PPI) Survey from 2006, waiting for the updated survey findings is a prudent course of action. We concur with CMS's approach and look forward to the revised MEI weights that reflect more current practice cost data.

Quality Payment Program (QPP)

MIPS Value Pathways (MVPs)

RFI: Transforming the QPP

In this RFI, CMS seeks feedback on clinician readiness for MVP reporting and MIPS policies needed to potentially sunset traditional MIPS, fully transitioning to MVPs by the CY 2029 performance period/2031 MIPS payment year. Given the ongoing gaps in the applicability of MVPs to specialists and subspecialists, AAOS opposes mandatory MVP participation. It is critical that CMS maintains the traditional MIPS framework, allowing clinicians whose patient populations do not align neatly with an MVP to continue selecting measures, improvement activities, and participation strategies that are most relevant and feasible for their specific practices. Developing broad MVPs to fill these gaps in the interim is not a practical solution, as it would deny specialists access to numerous specialized and meaningful measures that have yet to be incorporated into an MVP. Additionally, MVPs do not address many of the underlying challenges associated with MIPS, including siloed performance categories, the lack of incentives for the development and use of more specialized and robust measures (e.g., patient-reported outcome measures), and the ongoing misalignment between MIPS cost and quality measures.

CMS also seeks feedback on subgroup participation, which becomes mandatory for multispecialty groups reporting an MVP beginning in CY 2026. CMS is considering placing limits on the composition of subgroups to make them more meaningful and to encourage multispecialty groups to report measures most relevant to different segments of their practice. To best balance the increased burden of subgroup reporting with the need for comprehensive reporting on the diverse range of services provided by clinicians within a group, AAOS believes it is critical that CMS maintain flexibility. This includes allowing group practices to determine and inform CMS of their specialty composition and the most appropriate subgroup reporting strategy for their unique practice.

Proposed Surgical Care MVP

AAOS would like to reiterate the concerns expressed during the public feedback period when the Surgical Care MVP was initially presented as a candidate MVP. At that time, we conveyed our disappointment that CMS did not consult AAOS or other surgical specialties in the development of this MVP. We continue to believe that this MVP diverges significantly from the intended goal of MVPs,

which is to create opportunities for relevant teams of clinicians to report on a complementary set of measures. While titled "Surgical Care," only a subset of the measures is relevant to our specialty, and those measures only apply to a narrow segment of our specialty, specifically spine surgeons. Consequently, this MVP offers limited opportunities for participation among a broad range of our members.

We request that CMS clarify why this MVP focuses on specific types of surgery but excludes others for which MIPS measures currently exist (e.g., why did CMS not include measures related to hip/knee surgery?). We also ask CMS to provide a rationale for combining measures from disparate surgical specialties that have little to no overlap in team-based care. The inclusion of measures relevant to spine surgery, cardiothoracic surgery, breast surgery, and general surgery appears arbitrary and disconnected from actual clinical practice.

Additionally, CMS has included general surgery measures in the MVP, presumably under the assumption that they are reportable by any surgical specialist. However, orthopaedic procedures are excluded from the denominator population of the Surgical Site Infection (Q357) and Unplanned Reoperation within the 30-day Postoperative Period (Q355) measures, making these two measures inaccessible to members of our specialty. Even if orthopaedic procedures were included, we question the validity of these measures, as they capture a range of extremely different procedures that vary in complexity and risk of complication yet fail to adjust for these differences.

AAOS is also concerned about the disconnect between the quality and cost measures used to assess spine care in this MVP. The "lumbar surgery" measures focus on lumbar laminectomy and discectomy patients, excluding those who underwent concomitant lumbar fusion. However, the cost measure focuses on lumbar spine fusion patients. These are two distinct patient populations, which means this MVP will not produce an accurate assessment of overall value related to spine surgery.

Finally, AAOS urges CMS to reconsider and broaden the scope of the MVP we previously submitted, initially focused on *"Improving Rotator Cuff Repair Outcomes."* While CMS determined that the original rotator cuff MVP was not feasible due to its narrow focus, we propose expanding this concept into a more comprehensive MVP titled *"Improving Care for Upper Extremity Joint Repair."*

This broader MVP would not only encompass rotator cuff repairs but also include other critical procedures involving the shoulder, elbow, and wrist. By expanding the MVP's scope, we can ensure that it addresses a wider range of clinicians and patient needs, thereby aligning more closely with CMS's goal of creating MVPs with broader applicability.

This expanded MVP could incorporate a mix of Qualified Clinical Data Registry (QCDR) measures and Clinical Quality Measures (CQMs) to facilitate comprehensive data collection and quality improvement

efforts. By doing so, we aim to enhance data collection, including patient-reported outcomes, ultimately supporting better analysis and outcome improvement plans across a broader spectrum of upper extremity joint repairs.

MIPS Performance Threshold

AAOS appreciates CMS's proposal to maintain the 75-point MIPS performance threshold for the 2025 performance period/2027 payment year. We recognize the importance of this decision in providing consistency for MIPS-eligible clinicians, particularly as they continue to navigate the challenges posed by the COVID-19 pandemic. Maintaining the threshold also allows additional time for the integration of more recent data, unaffected by the pandemic, and enables clinicians to gain further experience with cost measure scoring, a category that was not scored during the pandemic.

MIPS Orthopaedic Specialty Measure Set

While CMS has not proposed any changes to the list of measures included in the Orthopaedic Specialty Measure Set, we note that several measures have proposed substantive changes for the 2025 performance year. In particular, we would like to address Measure 376: Functional Status Assessment for Total Hip Replacement, which currently specifies patients aged 19 years and older. To ensure consistency with the Patient-Reported Outcome Performance Measure (PRO-PM) and other orthopaedic measures, AAOS recommends revising the age criterion to include patients 18 years and older. This adjustment would align the measure with existing orthopaedic standards and simplify the tracking process by maintaining a straightforward adult population of 18+, thereby reducing complexity for clinicians and ensuring more accurate data collection across the board.

RFI: Guiding Principles for Patient-Reported Outcome Measures in Federal Models, and Quality Reporting and Payment Models

The AAOS strongly supports CMS' commitment to elevating the patient voice and integrating more patient-reported outcome measures (PROMs) into CMS quality programs and models. Similarly, we appreciate CMS for establishing guiding principles and considerations for selecting and implementing patient-reported outcome measures (PROMs). These principles emphasize the need to minimize the administrative burden of collecting PROMs by making the measures easily accessible to clinicians. They also ensure that PROMs undergo rigorous testing for reliability and validity, are feasible to implement with minimal cost and administrative burden and are meaningful to patients while identifying disparities in response rates and outcomes.

CMS has raised important questions about how best to balance the use of broad PRO-PMs, which can be applied across multiple clinical contexts, against condition-specific PROMs that offer more tailored insights but may lead to a proliferation of tools used across different measures and providers. The Patient-Reported Outcomes Measurement Information System® (PROMIS®) is cited as an example of a unified, non-proprietary PROM repository that may strike this balance. While AAOS acknowledges the

value of PROMIS® tools in assessing patient-reported health status, there are also condition-specific PROMs that may yield more valuable data in certain clinical scenarios.

Both global health assessments and specific functional status evaluations are crucial for assessing the impact of treatment on a patient. PROMIS instruments contribute significantly to risk adjustment and baseline assessments of patient well-being. However, PROMIS has limitations in providing joint-specific assessments that cover functional outcomes relevant to orthopaedic specialties. For instance, PROMIS Upper Extremity is not as widely adopted within our membership's specialty areas. Commonly used assessments in our field include the Hip disability and Osteoarthritis Outcome Score for Joint Replacement (HOOS, JR.), the Knee injury and Osteoarthritis Outcome Score for Joint Replacement (KOOS, JR.), the American Shoulder and Elbow Surgeons (ASES) Standardized Shoulder Assessment Form, the Oswestry Disability Index (ODI) for lumbar outcomes, and the Neck Disability Index (NDI) for cervical outcomes.

AAOS recommends that CMS collaborate with measure developers to create a comprehensive library of resources applicable to each category across PRO-PMs. This should include toolkits for implementation and guidance on use limitations. By working with developers to standardize versions used across similar care settings, CMS could make these tools more accessible, facilitate the validation of instruments, and reduce the need for assessing duplicative types. Such efforts would enhance the overall utility and integration into clinical practice.

Scoring for Topped Out Measures in Specialty Measure Sets with Limited Measure Choice

Under current policy, quality measures that are topped out—meaning performance is so high and unvarying that meaningful distinctions and improvement in performance can no longer be made— for two consecutive years are capped at 7 points, rather than the maximum of 10 points. CMS proposes that for select topped out measures each year, it would remove this cap and subject them to a separate defined benchmark if CMS. To make determinations about which measures would qualify for this special policy each year, CMS would conduct an annual assessment of MIPS Specialty Measure Sets to determine which specialties have limited measure choice and limited opportunity to maximize their MIPS performance score due to the current topped out measure scoring policy.

AAOS appreciates CMS acknowledging that the current topped out measure scoring policy limits opportunities for certain clinicians to maximize their MIPS performance score for reasons outside of their direct control. However, we are concerned with the proposed method for identifying which measures should be exempt from the 7-point cap. Analyses conducted at the Specialty Measure Set level will not always fully capture the extent to which certain subspecialists within a broader specialty face

challenges due to limited measure availability and/or CMS scoring policies. For example, the MIPS Orthopaedic Specialty Measure Set includes a variety of measures, some of which are specific to hip/knee procedures, spine procedures, lower extremity conditions, shoulder conditions, or elbow/wrist/hand impairments. An orthopaedic surgeon focusing on shoulder procedures often will not perform spine or hip/knee procedures and vice versa. Therefore, evaluating the Orthopaedic Specialty Measure Set as a whole may not accurately reflect the measure limitations faced by a shoulder surgeon if it includes measures irrelevant to their practice. **For this reason, AAOS recommends that CMS conduct more granular evaluations of subspecialties and patient subpopulations to determine which measures should not be subject to the 7-point topped out scoring cap. If CMS cannot identify a feasible way to conduct a more thorough analysis, then it should apply its policy to replace the 7-point topped out scoring cap with a defined topped out measure benchmark universally to all impacted measures.**

Additionally, AAOS urges CMS to address measures that continue to lack a benchmark and are not newly introduced. We appreciate CMS' recent policy to subject first and second year measures to a 7-point and 5-point floor, respectively. However, this policy does not incentivize the use of more specialized measures that have been in the program for many years and continue to lack a benchmark. Many of these measures are high priority outcome or patient-reported outcome measures that are often more challenging to collect, but more informative and impactful than process measures. As such, CMS should adopt policies to encourage the reporting of these more robust measures.

Complex Organization Adjustment for Virtual Groups and APM Entities

To encourage APM entities and virtual groups to report electronic clinical quality measures (eCQMs), CMS proposes to apply a complex organization adjustment starting in performance year 2025. This adjustment would add one point for each eCQM submitted by an APM entity or virtual group that meets data completeness and case minimum requirements. The AAOS appreciates CMS' effort to incentivize eCQM reporting. However, we believe that the challenges associated with reporting eCQMs are not limited to APM entities and virtual groups but are also faced by MIPS-eligible clinicians more broadly. We request that CMS extend this policy to any clinician or practice using multiple Electronic Health Records (EHRs) or practicing at multiple sites, regardless of whether they are reporting eCQMs, clinical quality measures (CQMs), or Qualified Clinical Data Registry (QCDR) measures. These clinicians and practices also encounter technological barriers in extracting quality measure data from EHRs and other electronic sources, including difficulties in aggregating patient data across multiple practice sites and IT systems.

Scoring the Cost Performance Category

In response to public concerns that cost performance category scores negatively impact final MIPS scores and CMS observing lower scores in the cost category compared to the quality category since the 2022 performance year, CMS proposes to revise the cost measure scoring methodology starting with the 2024 performance year. Under this proposal, CMS would assess cost performance relative to median performance and consider variation based on standard deviations away from the median. This revision aims to improve cost scores for most MIPS-eligible clinicians or at least prevent a negative impact on clinicians whose average costs are near the median. The AAOS supports this revision but strongly urges CMS to apply this policy retroactively, starting with the 2022 performance year when issues with scoring the cost category first emerged. If CMS is unable to feasibly recalculate scores and payment adjustments retroactively, it should at minimum reweight the cost category to zero for the 2023 performance year/2025 payment adjustment, as those adjustments have not yet been applied. Ideally, this reweighting should also apply to the 2022 performance year/2024 payment adjustment.

Alternative Payment Models

AAOS recognizes that under statute, CMS is required to increase the thresholds for Qualifying APM Participants (QPs) and replace the APM incentive payment with a differential update to the Medicare Physician Fee Schedule conversion factor, starting with the 2025 performance year/2027 payment year. As previously noted, this instability and uncertainty undermines the shift toward a value-based health care system. Physicians are, in many cases, business owners who have a responsibility for ensuring that they are generating the revenue needed to keep that business and its employees afloat. Toward this end, we ask that CMS work with Congress to ensure that the advanced APM incentive payment structure is maintained and predictable year-over-year and does not leave physicians in a steady state of ambiguity. Likewise, AAOS members are eager to share their insight and suggestions as experts on the topic of delivering high-quality, patient-centered musculoskeletal care in the most cost-effective manner. We reiterate our strong opposition to mandatory participation in APMs, and the ongoing need for CMS to consider the impact that interoperability, multi-payer alignment of measures, and administrative burden have on the ability for physicians to successfully participate in APMs.

Regarding QP determinations, CMS proposes to revise the definition of "attribution-eligible beneficiary" to include any beneficiary who has received a covered professional service from the eligible clinician, starting with the 2025 QP performance period. Currently, this definition is based solely on Evaluation and Management (E/M) services, which has inadvertently led APM Entities to exclude specialists from their Participation Lists, as non-E/M services do not contribute to QP threshold scores. AAOS appreciates CMS' proposal to move away from using E/M services as the default basis for attribution and recognizes the negative impact this policy has had on specialist eligibility for the QP

track of the Quality Payment Program (QPP). We agree that this proposal will result in a QP calculation that more accurately reflects eligible clinicians' actual participation in Advanced APMs.

RFI on Building Upon the MVP Framework to Improve Ambulatory Specialty Care

In this Request for Information (RFI), CMS is seeking input on designing a potential ambulatory specialty care model that would use MIPS Value Pathways (MVPs) to increase specialty engagement in value-based care and expand incentives for primary and specialty care coordination. While this is not yet a formal proposal, CMS envisions a model where participants would receive a payment adjustment based on their performance against clinically relevant MVP measures and their peers within the same specialty and clinical profile, instead of a MIPS adjustment payment. CMS also mentions the possibility of mandating such a model through notice and comment rulemaking, with the earliest implementation potentially in 2026.

The AAOS has ongoing concerns with the MVP framework, as it does not resolve many issues related to MIPS, such as siloed performance categories, misaligned quality and cost measures, and difficulties in developing and using specialized and robust measures like patient-reported outcome measures. Consequently, MVPs do not capture or drive value-based care in the comprehensive way envisioned by the CMS Innovation Center. We strongly believe there is a need to test more specialty or patient-focused payment and delivery models, as the MVP framework alone does not address these ongoing gaps. As we have recommended before, AAOS encourages CMS to consider models beyond the limited scope of MVPs, such as longitudinal care episodes where non-operative management of chronic musculoskeletal conditions is managed and attributed to orthopaedic surgeons. Orthopaedic surgeons have the educational background, expertise, and experience to handle both non-operative and operative care of chronic musculoskeletal conditions.

Given the ongoing gaps in the applicability of MVPs to specialists and subspecialists, AAOS opposes mandatory MVP participation and urges CMS to make it voluntary. Payment models that adequately support high-quality care will naturally attract physician participation without the need for mandates. Conversely, mandatory participation could threaten the viability of small, rural, independent, and safety net practices, potentially limiting access for vulnerable patients. We also recommend that CMS engage relevant physicians throughout all stages of model development and implementation by providing sufficient data and methodological details. This transparency will allow physicians and other stakeholders to fully understand the proposed models, assess their impacts, and offer informed feedback.

Additionally, AAOS urges CMS to seek public input on critical aspects such as payment amounts, risk requirements, and quality measures well before they are formalized. It is important for CMS to publicly

address all feedback to ensure transparency and responsiveness in the process. Furthermore, we emphasize the importance of placing physicians at the center of decision-making within any new payment model. Physicians should have the resources and flexibility to deliver high-quality care without being subjected to financial risks for outcomes or costs beyond their control. This includes ensuring that prospective payments support the true costs of care and that regulatory barriers to effective care delivery are removed.

We stress the need for adequate payments and flexibility within the model to ensure that patients with higher needs can access high-quality care. Additionally, CMS should commit to annual payment increases to account for inflation, technological advancements, changes in evidence-based practices, and new requirements. Finally, any payment model should be designed to sustain high-quality, financially viable medical practices, ensuring that physicians can continue delivering care amid growing concerns about a potential physician shortage.

Thank you for your time and attention to the concerns of the American Association of Orthopaedic Surgeons (AAOS) on the significant proposals made in the CY 2025 MPFS proposed rule. The AAOS looks forward to working closely with CMS on further improving the payment system, and to enhancing the care of musculoskeletal patients in the United States. Should you have questions on any of the above comments, please do not hesitate to contact Lori Shoaf, JD, MA, AAOS Office of Government Relations at shoaf@aaos.org.

Sincerely,

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AAOS
American Association of Orthopaedic Surgeons

This letter has received sign-on from the following orthopaedic societies:

American Association of Hip and Knee Surgeons (AAHKS)
American Association for Hand Surgery (AAHS)
American Orthopaedic Society for Sports Medicine (AOSSM)
American Orthopaedic Foot & Ankle Society (AOFAS)
American Shoulder and Elbow Surgeons (ASES)
American Society for Surgery of the Hand Professional Organization (ASSH)
Campbell Clinic Orthopaedics
Cervical Spine Research Society (CSRS)
Orthopaedic Rehabilitation Association (ORA)
Orthopaedic Trauma Association (OTA)
OrthoSC
Pediatric Orthopaedic Society of North America (POSNA)
Scoliosis Research Society (SRS)

Arizona Orthopaedic Society
California Orthopaedic Association
Colorado Orthopaedic Society
Georgia Orthopaedic Society
Illinois Association of Orthopedic Surgeons
Massachusetts Orthopaedic Association
Michigan Orthopaedic Society
Minnesota Orthopaedic Society
Missouri State Orthopaedic Association
New Hampshire Orthopaedic Society
New York State Society of Orthopaedic Surgeons
New Jersey Orthopaedic Society
North Dakota Orthopaedic Society
Oregon Association of Orthopedic Surgeons
Ohio Orthopaedic Society
South Dakota State Orthopaedic Society
Tennessee Orthopaedic Society
Texas Orthopaedic Association