AAOS
AMERICAN ASSOCIATION OF
ORTHOPAEDIC SURGEONS

CY 2024 Medicare Physican Fee Schedule Final Rule

The Calendar Year (CY) 2024 Medicare Physician Fee Schedule (MPFS) final rule was released on November 2, 2023, by the Centers for Medicare & Medicaid Services (CMS). The payment rule sets policy for physicians participating in the Medicare program and makes updates to the Quality Payment Program. AOOS submitted formal comments on the proposed rule on September 9, 2023. The outline below compares what AAOS advocated for to what was finalized. The majority of the regulations will take effect on January 1, 2024.

Topic	**AAOS Comment/Recommendation**	**Finalized Policy**
Conversion Factor	CMS is proposing a conversion factor of $32.75, a decrease of $1.14 (almost 3.26%) to the CY 2023 PFS conversion factor of $33.89. AAOS advocates for Congress to create an inflationary update for the Medicare Physician Fee Schedule to ensure access to specialty care for Medicare beneficiaries. AAOS urged CMS to work with societies to create value-based payment models that include incentives tailored to the distinct needs of patients and practice settings, along with a financially viable fee-for-service model.	CMS finalized the Medicare conversion factor (CF) of $32.74. This represents a decrease of $1.15 (3.39%) from the current FY 2023 CF of $33.89.
Implementation of New Add-on Code for Complexity	AAOS opposes the implementation of HCPCS code G2211 to be used with existing evaluation & management (E/M) visits providing an add-on payment for complex patients. **AAOS strongly urges CMS to indefinitely delay implementation of G2211.**	Beginning January 1, 2024, CMS is "finalizing implementation of a separate add-on payment for healthcare common procedure coding system (HCPCS) code G2211."
Potentially Misvalued Services Under the PFS	Code 27279 was nominated as misvalued due to the absence of separate direct practice expense (PE) inputs for this 090 day global code in the non-facility/office setting. CMS noted that the nominator claims that code 27279 can be safely provided in the non-facility setting and the procedure has a low risk profile**. AAOS strongly objects to valuing code 27279 in the non-facility/office settings as AAOS does not believe the procedure can be safely and effectively performed in the non-facility setting.**	For CY 2024, CMS is not finalizing CPT code 27279 as potentially misvalued and therefore not setting up nonfacility/office payments.
Valuation of Specific CPT Codes	AAOS appreciates CMS' acceptance of the RUC recommended values and practice expense inputs regarding code 2X000 (CPT code 27278)	CMS is "finalizing the RUC-recommended work RVU of 7.86 and direct PE inputs as proposed for CPT code 27278."

• ***Dorsal Sacroiliac Joint Arthrodesis*** • ***Vertebral Body Tethering*** • ***Total Disc Arthroplasty***	but share the same concerns regarding safely performing the procedure in the nonfacility/office setting similar to that of code 27279. CMS accepted the RUC recommended wRVUs and PE inputs for codes 2X002 (CPT codes 22836, 22837, and 22838). **AAOS appreciates CMS' review and acceptance of these codes without refinements.** CMS agreed to maintain the current wRVU of 27.13 for CPT code 22857. However, CMS disagreed with the RUC's recommended survey median wRVU of 7.50 for codes 22860 and is instead recommending the survey 25th percentile (6.88 wRVU). **AAOS disagrees with CMS' relativity comparisons. AAOS strongly urges CMS to accept the RUC recommended work RVU of 7.50 for CPT code 22860.**	CMS is "finalizing their work RVU and direct PE inputs for the codes in the Vertebral Body Tethering family as proposed." CMS is "finalizing a work RVU of 27.13 for CPT code 22857 and a work RVU of 6.88 for CPT code 22860, as proposed. CMS is also finalizing the direct PE inputs as proposed."
Medicare Telehealth Services	AAOS is appreciative of the CMS extension of waivers for telehealth flexibilities until the end of 2024, including separate payments for telephone audio-only codes (99441-99443). **AAOS commends CMS for continuing to pay claims at the PFS facility rate when billed with the place of service code POS 02.**	CMS is "finalizing separate payment for CPT codes 99441-99443 which describe E/M and assessment and management services furnished via telephone. CPT codes 99441 through 99443 are on the Medicare Telehealth Services List and will remain actively priced through 2024."
Split/Shared Services	CMS proposed to extend the use of the current definition of "substantive portion" of time being either one of the three key components (history, exam, or medical decision making [MDM]) or more than half of the total time spent to determine who bills the visit until December 31, 2024. AAOS continues to strongly urge CMS to permanently revise the definition for "substantive portion" to be based on MDM and not time, which coincides with AMA CPT guidelines. AAOS strongly encourages CMS to work with CPT for cohesive guidance on the reporting of split/shared visits in CPT Guidelines and CMS policy.	CMS is revising their definition of "substantive portion" of a split/shared visit to reflect the CPT E/M guidelines. For CY 2024, the definition of "substantive portion" will mean more than half of the total time spent by the physician or NPP performing the visit or a substantive part of the MDM.

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Rebasing and revising the Medicare Economic Index (MEI)	CMS has relied on AMA physician cost data for 50 years in updating the MEI and 30 years in updating the resource-based relative value scale (RBRVS). The current MEI weights are based on data obtained from the AMA's Physician Practice Information (PPI) Survey. Hence, we fully agree with CMS that the MEI weights must be updated. However, the AMA is currently engaged in a process to collect this data again. It is expected that the new data collection efforts will be completed by 2023 and will be based on 2022 cost data. AAOS, therefore, asked CMS to collaborate with AMA and national specialty societies like us and postpone updating the MEI data updates until the AMA survey is complete.	Given that the AMA intends to collect data in the near future and because the methodological and data source modifications to the MEI that were adopted in the CY 2023 PFS final rule would have a major effect on PFS payments, "CMS continues to believe that delaying the implementation of the finalized 2017-based MEI cost share weights for the RVUs is consistent with their efforts to balance payment stability and predictability with incorporating new data through more routine updates. Therefore, CMS did not propose to incorporate the 2017-based MEI in PFS ratesetting for CY 2024."
Appropriate Use Criteria (AUC) for Advanced Diagnostic Imaging	AAOS is pleased to see that CMS is proposing to sunset the Appropriate Use Criteria (AUC) for advanced diagnostic imaging payment penalty. Although AAOS is surely supportive of programs that improve quality and reduce unnecessary testing, we have always been concerned that the implementation of the AUC program will detract from the developments of the Quality Payment Program (QPP) made in the years since the AUC program was signed into law.	CMS is "finalizing the proposal to pause efforts to implement the Appropriate Use Criteria (AUC) program."
Quality Payment Program (QPP)		
Quality Payment Program Alternative Payment Models	AAOS asks that CMS work with Congress to ensure that the advanced APM incentive payment structure is predictable year-over-year and does not leave physicians in a steady state of ambiguity. We urge the Centers for Medicare & Medicaid Services (CMS) to consider the profound impact that interoperability, multi-payer alignment of measures, and administrative burden have on the ability for physicians to successfully participate in alternative payment models. AAOS strongly encourages CMS to only consider voluntary models that have incentives for participation. Mandatory models have historically been unsuccessful in engaging physicians who are	APM Incentive Payment and Transition to Qualifying APM Conversion Factor "In accordance with amendments made by the Consolidated Appropriations Act, 2023, the APM Incentive Payment with respect to payment year 2025 is 3.5% of the clinician's estimated aggregate payments for covered professional services during the incentive payment base period. After the 2023 performance year, the APM Incentive Payment will end. Instead, beginning for the 2024 performance year, QPs will receive a higher Medicare Physician Fee Schedule (PFS) update ("qualifying APM conversion factor") of

	otherwise eager to lead in the shift to value-based care	0.75% compared to non-QPs, who will receive a 0.25% Medicare PFS update, which will result in a differentially higher PFS payment rate for eligible clinicians who are QPs. Eligible clinicians who are QPs for a year will continue to be excluded from MIPS reporting and payment adjustments for the year." CMS is not finalizing the proposal to increase the performance threshold. Therefore, it will remain at 75 points for the 2024 performance year. CMS is not finalizing the proposal to increase the data completeness threshold for reporting quality measures in the 2027 performance period. Therefore, the data completeness threshold will remain at 75 points for the 2024 performance period.
Universal Foundation Measure Set	CMS is proposing to consolidate the Promoting Wellness and Managing Chronic Conditions MVPs to align with the Universal Foundation Measure Set. As we have stated in prior comment letters, streamlining the available measures for quality reporting is essential to reducing administrative burden and increasing physician engagement in the shift to value-based care. AAOS request that CMS consider the value of Patient-Reported Outcomes Measures (PROMs) and incorporate additional PROMs into the Universal Foundation Set	CMS "intends to propose future policies aligning the APP measure set for Sharing Savings Program ACOs with the quality measures under the "Universal Foundation" beginning in performance year 2025. These Universal Foundation measures are proposed to be adopted into the existing the Value in Primary Care MVP."
New MIPS Cost Measure	AAOS is concerned that the proposed MIPS episode-based cost measure 'Low Back Pain', which will be included in the proposed 'Rehabilitative Support for Musculoskeletal Care' MVP, may be unintentionally attributed to orthopaedic surgeons, despite it being a chronic condition measure that includes non-operative patients. This incorrect attribution may also lead to incorrect cost estimates. Thus, we request that orthopaedic surgeons be removed from the list of eligible specialties for attribution.	CMS finalized the MIPS Low Back Pain cost measure with a 20-episode case minimum. The measure will begin with the CY 2024 performance period and is applicable to MIPS and MVPs. CMS disagreed with our "recommendation to remove neurosurgeons and orthopedic surgeons from potential attribution for the Low Back Pain measure. The intent of the Low Back Pain measure is to assess the treatment and management of Low Back

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		Pain and the triggering logic was designed to capture the range of clinicians that have a role in treating and managing this condition. The Clinician Expert Workgroup thoroughly considered the role of the surgeon in the Low Back Pain measure after reviewing the public's feedback on this topic gathered during field testing. The Workgroup discussed this feedback in conjunction with testing from the measure developer to explore the relationship between low back pain care management and spinal surgery. They ultimately recommended that the role of the surgeon was appropriate to include in the measure, and also recommended that the measure take additional steps to minimize the risk of identifying relationships that are only pre-operative or consultative. The measure developer and CMS agreed that it is clinically appropriate to include surgeons in the measure. To help address these concerns, if a spinal surgery occurs 90 days before a trigger code through 60 days after a trigger code, the relationship between the clinician group and patient will not be initiated. More information regarding these discussions are available in the Low Back Pain Post Field Test Meeting Summary available on the QPP Cost Measures Information page at https://www.cms.gov/files/zip/summary-wave-4-post-field-test-refinement-webinar-pftrworkgroup-meetings.zip. Additionally, the Low Back Pain measure further safeguards against these concerns by stratifying episodes into subgroups to ensure that the measure fairly compares clinicians with a similar patient case-mix. For the Low Back Pain measure, we include subgroup surgical episodes with and without history of low

		back pain and non-surgical episodes with and without history of low back pain. The measure is also risk-adjusted for history of spine surgery. The intention of these measure specifications is to make sure that clinically similar patients and episodes of care are being compared to each other. Finally, we do not include data from qualified clinical data registries in this measure, but we will continue to monitor whether the measure includes the appropriate data elements for inclusion in the future."
MIPS Patient Activation Measure	CMS is proposing to include the 'Gains in Patient Activation Measure (PAM) Scores at 12 Months (PAM-PM) in the MIPS Quality category. AAOS appreciates the value that this PRO-PM contributes to MIPS Specialty Sets and MVPs. In addition, it is particularly relevant for the measurement of long-term quality outcomes for orthopaedic surgery and is already in use among our members. Given this measure's value, we ask that CMS consider it for inclusion in the Universal Foundation Measure Set.	CMS is finalizing the Gains in Patient Activation Measure (PAM) Scores at 12 Months PRO-PM (Quality ID #503) via MIPS CQMs for the 2024 Performance Period.
Third Party Intermediaries	AAOS appreciates the opportunity to comment on the proposed updates to the policies related to the use of Qualified Clinical Data Registries (QCDRs) for MIPS submissions. We are particularly supportive of the proposal to modify the requirements for QCDRs and qualified registries to support MVP reporting and increase the flexibility for measures that are supported.	"Existing policy already requires third party intermediaries comply with CMS requests to review data. Attesting to the ability to require clinicians to provide documentation necessary to verify the accuracy of data submitted and to be able to submit that documentation to CMS should not be viewed as broadening the scope of this requirement as it would be a logical component of an audit. Therefore, CMS considers this to be a baseline requirement and not overly burdensome. CMS's ability to access the underlying documentation to verify the accuracy of the data submitted by clinicians is critical to ensuring that all data submitted is true, accurate, and complete."

		CMS clarifies "that a third party intermediary would not be identified for an audit on the basis of communication between the service center and the third party intermediary. However, a pattern of particular third party intermediary users contacting the Quality Payment Program for issues could indicate that the third party intermediary was having trouble meeting our program requirements, which would be a basis for taking corrective action. CMS is finalizing that third party intermediaries may be randomly selected for compliance evaluation or may be selected at the suggestion of CMS if there is an area of concern regarding the third party intermediary." "The addition states that a QCDRs or a qualified registry must support all measures and improvement activities available in the MVP with two exceptions. The first exception to this requirement at § 414.1400(b)(1)(ii)(A) is that if an MVP includes several specialties, then a QCDR or a qualified registry is only expected to support the measures that are pertinent to the specialty of their clinicians. For example, if an orthopedic care MVP includes both surgery and physical therapy measures, and the third party intermediary caters specifically to physical therapists, they are not required to support the surgical measures. The second exception at § 414.1400(b)(1)(ii)(B) is that QCDR measures are only required to be reported by the QCDR measure owner. In instances where a QCDR does not own the QCDR measures in the MVP, the QCDR may only support the QCDR measures if they have the appropriate permissions."

		CMS “finalized the elimination of the health IT vendor category of third party intermediaries, beginning with the CY 2025 performance period, to remove gaps in third party intermediary requirements and improve data integrity.” “After consideration of public comments, CMS is finalizing the proposal as proposed at § 414.1400(b)(1)(iii) to codify that beginning with the CY 2023 performance period/2025 MIPS payment year, QCDRs and qualified registries must support subgroup reporting.” “To submit data on behalf of clinicians, a health IT vendor will need to meet the requirements of and self-nominate to become a qualified registry or QCDR. They can continue to facilitate data collection and support clinicians and groups in the sign in and upload and sign in and attest submission types.” CMS “finalized the following policies related to the self-nomination and approval process for QCDRs and qualified registries, including: • Updating self-nomination requirements to require that QCDRs and qualified registries must include MVP titles and measure and activity identifiers for the improvement activities and Promoting Interoperability performance categories. Specifying requirements for a simplified self-nomination form to existing Qualified Clinical Data Registries (QCDRs) and qualified registries in good standing. • Adding “measures submitted after self-nomination” to our list of reasons for rejecting a QCDR measure. • Implementing a requirement that QCDRs publicly post their approved measure specifications through the

		duration of the performance period and associated submission period. • Specifying the required sampling methodology for third party intermediary data validation audits. • Requiring QCDRs and qualified registries to attest to the accuracy of their information in qualified postings. • Requiring QCDRs and qualified registries to attest that they can provide CMS with access to review the data, upon request." **Support of MVPs** "Given that many third party intermediaries may not support measures for clinicians in all specialty areas that might report a MVP, we clarified that a QCDR or a qualified registry must support all measures and improvement activities available in the MVP with 2 exceptions: 1. If an MVP includes several specialties, then the QCDR or qualified registry is only expected to support the measures that are pertinent to the specialty of their clinicians. 2. QCDR measures are only required to be reported by the QCDR measure owner. In instances where a QCDR doesn't own the QCDR measures in the MVP, the QCDR can only support the QCDR measures if they have the appropriate permissions."
Updates to Lower Extremity Joint Repair MVP	AAOS recognizes the importance of incorporating new measures into existing MVPs. However, we request clarification regarding the new quality measure "Q487: Screening for Social Drivers of Health." Specifically, is this measure considered specialty specific to orthopaedics and thus will require the AAOS QCDR to support? If so, we request that CMS extend the timeline for incorporating this and any future measures	CMS is finalizing the inclusion of Q487 as proposed for the 2024 performance year/2026 payment year and future years. "This is an important process measure that supports the collection of DOH data, which is a foundational step towards defining, addressing, and allocating supportive resources to patients in an

	into MVPs. It takes substantial time and resources for QCDRs to update their data capture capacity and IT resources to capture quality data. It would be nearly impossible for our QCDR to have these updates in place and ready to begin capturing in January 2024, given that the change will likely not be finalized and clarified until the final rule is released in November 2023.	impactful manner while supporting the performance of clinicians. This measure purely focuses on the completion of screening for DOH patient information and is consistent with the priority to advance health equity. We note the information a clinician collects during a DOH screening may be clinically relevant and may not have otherwise been collected by the clinician absent the screening. As such, better scores on this measure are still indicators of the quality of care provided to patients. Because clinicians have the flexibility to choose measures to report, it would be at their discretion whether to report this measure as requirements only include reporting of 4 quality measures; allowing clinicians to delay implementation of measures until their systems and workflows allow for complete data capture. Furthermore, improving the clinician's understanding of the social obstacles their patients face beyond the clinical realm – but which may affect their clinical outcomes – can provide critical insights, catalyze prevention and/or early identification and prompt referral, and improve a patient's overall health and well-being."