Bone Health & Osteoporosis FOUNDATION™

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Submitted electronically

September 12, 2025

Mehmet Oz, M.D., Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Blvd.
Baltimore, MD 21244

RE: CMS-1832-P
Medicare and Medicaid Programs; CY 2026 Payment Policies Under the Physician Fee Schedule (PFS) and Other Changes to Part B Payment and Coverage Policies

Dear Doctor Oz:

On behalf of the undersigned 22 leading patient advocacy and professional societies we submit the following comments on the proposed rule updating the Medicare Physician Fee Schedule (the Proposed Rule) for calendar year 2026. We were heartened by the proposed rule's focus on wellness, prevention and better management of chronic diseases and request for specific examples of Medicare codes that don't sufficiently address services for effective management of chronic diseases like osteoporosis. Our recommendations focus on the prevention of costly repeat fractures caused by poor management of osteoporosis, a highly prevalent and costly chronic disease. Implementation of our recommendations would **reduce Medicare costs and fulfill the mandate in President Trump's February 13th Executive Order, ''Establishing the President's Make America Healthy Again Commission"** for health agencies to ensure the effective management of chronic diseases and to "ensure the availability of expanded treatment options and the flexibility for health insurance coverage to provide benefits that support beneficial lifestyle changes and disease prevention."

Dr. Oz, we greatly appreciate your long-time advocacy for better osteoporosis care and recognition of the importance of building and maintaining strong bones throughout one's lifetime. As you well know, osteoporosis is a chronic and progressive disease characterized by weakened bones leading to an increased risk of fracture. Fully 50 million Americans are impacted by osteoporosis and 1in 2 American women and 1 in 4 American men aged 50 plus will suffer a fracture tied to osteoporosis. Osteoporosis is also a significant cost driver for Medicare and Medicaid. Over 1.8 million Medicare beneficiaries suffered over 2 million osteoporotic fractures at a cost to the nation of over $57 billion. This cost is projected to grow to over $95 billion by 2040 under the status quo. You can make simple, common-sense reforms that will greatly

improve the care given to these Americans, cut their rates of fractures and save billions in Medicare costs. The independent analytics firm Milliman projected that $1.1 billion could be saved in traditional FFS Medicare spending alone by reducing just 20 percent of repeat/secondary fractures.

Prevention and Management of Chronic Disease—Request for Information

In the 2026 PFS draft rule you state: "We welcome feedback from stakeholders and the public on how we could better support management of chronic disease and prevention." Further, you state:

> "We are broadly soliciting feedback to help us better understand how we could enhance our support management for prevention and management of chronic disease. Specifically, we are requesting commenters consider the following information:
>
> - How could we better support prevention and management, including self-management, of chronic disease?
> - *Are there certain services that address the root causes of disease, chronic disease management, or prevention, where the time and resources to perform the services are not adequately captured by the current physician fee schedule code set? If so, please provide specific examples*." (emphasis added)

Our comments below provide a detailed, specific example of how the current Medicare fee schedule code set doesn't adequately capture a set of chronic disease management/ care coordination services provided to beneficiaries after an osteoporotic fracture that have been proven to substantially reduce the rate of costly subsequent fractures. **Further, we request that the agency include in its CY 2026 PFS rule, the set of "G" codes (described in detail below) that appropriately capture these services needed to prevent many subsequent fractures.**

The impact of preventable osteoporotic fractures is staggering:

- 1.8 million Medicare beneficiaries suffered approximately million osteoporotic fractures in 2016. That is about 1 fracture every 16 seconds![1]
- Each initial fracture adds $21,564 in costs to Medicare.
- Having a fracture triples the odds of a subsequent fracture without appropriate management.
- Subsequent fractures are even more expensive, each costing Medicare over $30,000 with total FFS cost along reaching $5.7 billion in 2016.[2]
- 41,900 Medicare FFS beneficiaries with osteoporotic fractures became institutionalized in nursing homes within three years of a new fracture.
- Death rates among women over age 65 with hip fractures are higher than those facing breast cancer.

- A recent study revealed that 23% of opioid-naïve hip fracture patients became chronic opioid users after surgery.[3]
- Total costs associated with osteoporotic fractures were over $57 billion in 2018.[4]
- The number of osteoporotic fractures is projected to increase by 68% and national costs are expected to climb to over $95 billion by 2040.

Preventing just 20% of repeat fractures could have save *$1.1 billion in Medicare FFS alone.*

Unlike many other high-cost, chronic/debilitating conditions, we can significantly improve outcomes in osteoporosis through effective screening, diagnosis and fracture risk assessment, and appropriate treatment that can include therapeutic and lifestyle modification interventions and prescription medications. Ideally, these interventions would be taken early, before decreases in bone density led to an osteoporotic fracture. Unfortunately, for most Medicare beneficiaries, the first sign of osteoporosis is an osteoporotic fracture event. Even then, most patients fail to receive the post-fracture follow-up proven to substantially reduce the risk for additional costly osteoporotic fractures.

Both HEDIS and Medicare Part C STAR Ratings include a measure to rate quality of osteoporosis care: "Osteoporosis Management in Women Who Had a Fracture." The average 2020 Medicare STAR rating for this measure was 3.5/5 stars, indicating that 52% of women ages 67 to 85 **did not** receive a BMD test or prescription for a drug to treat osteoporosis *within 6 months of a fracture*. **Only 23% of Medicare beneficiaries receive osteoporosis medication after an osteoporotic hip fracture**, compared to 96% percent of patients receiving beta blockers after a myocardial infarction.

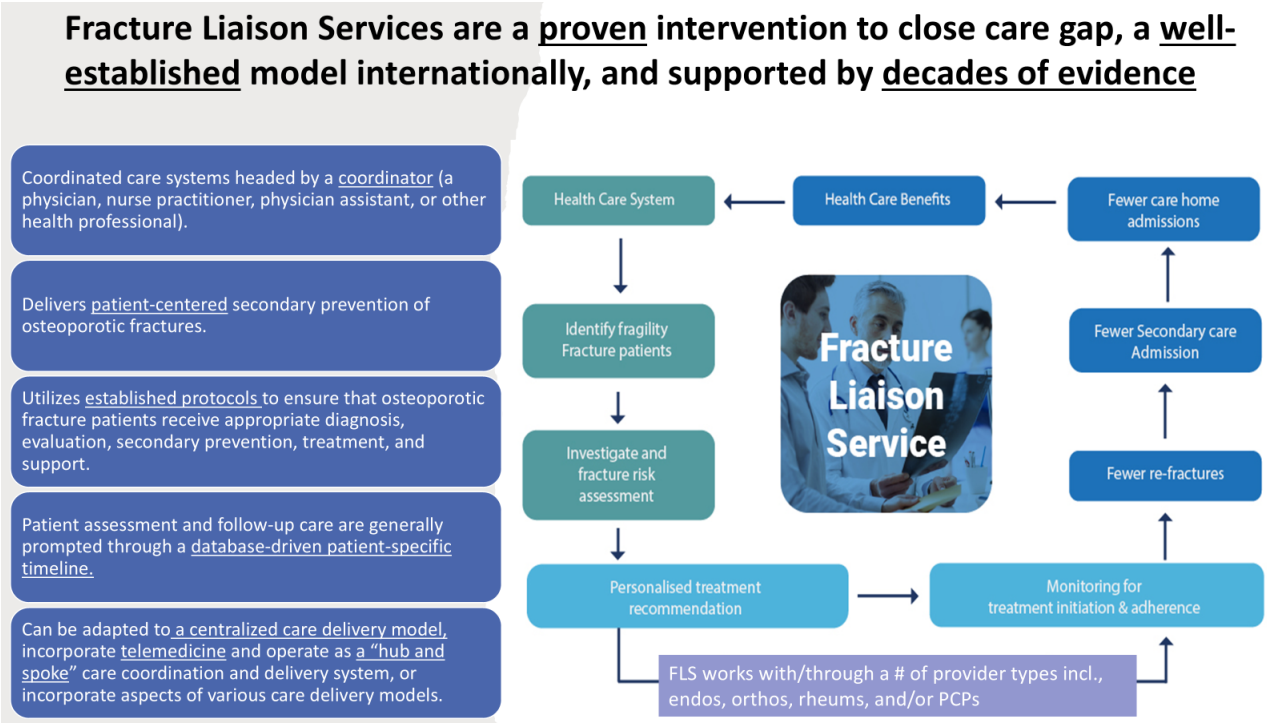
This care gap has persisted despite incremental efforts to reinforce osteoporosis awareness through quality measures directing communication from the clinician treating the fracture to the patient's primary care provider. Unfortunately, primary care physicians, even when informed of a fracture, may not see the patient in the near term or inquire beyond the patient's recovery from the acute episode. Heart attack and fractures are both acute, sentinel events within a chronic condition and both have established care pathways to mitigate the risk of future costly health events.

We Can Provide Effective Post Fracture Care and Prevent Repeat Fractures

We know how to reduce repeat fractures. Fracture Liaison Service (FLS) programs close the osteoporosis care gap by replacing fragmented care delivery with a collaborative, coordinated, protocol-driven care approach proven to reduce repeat fracture risk. Patients at high risk of a future fracture are identified and can receive the standard of care to address their long- and short-term future fracture risk. This coordinated care intervention is usually headed by an FLS coordinator (a physician, nurse practitioner, or physician assistant) who utilizes established protocols to ensure that individuals who suffer a fragility fracture are identified and receive appropriate diagnosis, evaluation, secondary prevention, treatment planning, follow-up, and support. The patient journey starts with identifying suspected fragility fracture patients for

post-acute follow-up, moves through clinician collection of medical history, evaluation and management services, diagnostic testing, and, for patients at high risk of fracture, results in treatment planning and necessary follow-up to ensure that patients wishing to discontinue treatment due to side effects are offered alternative therapeutic options. FLS programs also reach out to other clinicians responsible for the patient's care to ascertain patient needs, including physical therapy, fall risk assessment and prevention, and caregiver support needs with the goal of addressing fracture risk factors. Patient assessment and follow-up care are generally prompted through a database-driven, patient-specific timeline.

FLS programs have been in operation in the U.S for over 20 years and the FLS utility in reducing future fractures has been confirmed through multiple studies. A 2018 meta-analysis of FLS impact identified a total of 159 publications, including 74 controlled studies (16 RCTs; 58 observational studies). Compared with patients receiving usual care (or those in the control arm), patients receiving care from an FLS program **suffered less than half the number of repeat fractures** (13.4% among patients in the control arm and 6.4% in the FLS arm). The cost savings associated with FLS have been well established by nationally recognized leaders in the U.S. as shown below.



US FLS Programs Have Successfully Closed Osteoporosis Care Gap, Reduced Fractures and Lowered Costs

"Closed" systems adopting FLS demonstrate improved outcomes and cost savings

GEISINGER: Prescription treatment rates in FLS were 75.4% among drug-eligible patients, compared to only 13.8% of patients in primary care. Between 2006 and 2010, the percentage of women 65+ who had a BMD test within the prior three years increased from 40% to 74%. Achieved **$7.8 million in cost savings from 1996-2000**

KAISER: Healthy Bones program **reduced the hip fracture rate expected by over 40%** (since 1998) If implemented nationally, Kaiser estimates a similar effort could **reduce the number of hip fractures by over 100,000 (and save over $5 billion/year)**

AOA: Own the Bone program at over 190 sites led to high rates of BMD testing and osteoporosis pharmacotherapy in patients aged 50 and older following an osteoporotic fracture, with **over 60% of patients treated for osteoporosis** after an osteoporotic fracture in 2015.

Despite decades of evidence of demonstrating its effectiveness, as we discuss further below, neither current codes nor those created in the 2025 final PFS rule appropriately capture the set of post-osteoporotic fracture chronic disease care management/care coordination services.

Existing HCPCS codes don't capture cost of delivering evidence-based post-fracture management of osteoporosis (FLS)

FLS Services Require:

QHP non-face-to-face time before (20 mins) and QHP/Staff time after (96 mins) initial visit;

Initial face-to-face encounter (53 minutes) and subsequent face -to-face visits (26 mins)

- E&M codes don't work well because the relatively complex services are performed *in advance of* the patient visit.
- Chronic care management codes don't work b/c clinician is solely focused on the single chronic condition of osteoporosis (rather than the required 'two or more chronic conditions') and b/c the complete set of FLS services is concentrated in about 45 days (rather than over a year);
- Principal care management codes are unavailable b/c patient often/may not have been diagnosed with osteoporosis prior to the initial visit, and b/c untreated osteoporosis is associated with subsequent fractures and increased mortality, the timeline for fracture risk can be relatively long (i.e., extending beyond 1 year)
- Transition care management codes require an inpatient transition, limiting potential utility to hip fracture patients and even this subset of patients are usually unable to receive FLS care within the 14-day timeframe following their inpatient stay.

Existing HCPCS codes don't capture cost of delivering evidence-based post-fracture management of osteoporosis (FLS)

FLS Services Require:

QHP's non-face-to-face time before (20 mins) and QHP/staff time after (96 mins);

Initial (53 mins) and subsequent (26 mins) face-to-face encounters

Initial (53 mins)	Subsquent (26 mins)
E&M codes still don't work well b/c they only capture a limited portion of the work, and b/c they require repeated higher level 5 coding	E&M codes DO work

Chronic care, principal care, and transition care management codes don't work for all the same reasons given on the prior slide.

Current Codes like Principal Care Management or Chronic Care Coordination do Not Sufficiently Describe and Capture the work for FLS coordination

- HCPCS codes 99437, 99490, 99494 require management of multiple chronic conditions which may not apply for FLS patients
- HCPCS codes 99224 and 99225 do not accurately capture the patient encounters and care coordination within FLS. This crosswalk slightly underestimates the intensity and complexity provided in the FLS. However, it does model the total time of the episode fairly well.
- HCPCS code 99227 can only be billed twice, which represents significantly less clinical staff time than was found to be typical for FLS services

Specific codes for FLS services allow for more efficient and accurate coding and reimbursement

- Use of current codes *would require physicians to bill multiple times* and will *increase administrative complexity, denials and appeals*
- Use of current codes could lead to *under-coding because of overlapping global periods*
- New codes would allow accurate tracking of utilization of FLS services and increase certainty that FLS programs can be self-sustaining.
- Increased adoption of FLS is best way to ensure that fracture patients receive standard of care to prevent potentially catastrophic subsequent fracture.

Codes Created in CY25 Rule Don't Solve the Problem

- GPOC1 does not address reimbursement deficiencies associated with the actual delivery of post-fracture care.
- Proposed advanced primary care management codes (GPCM1, GPCM2, and GPCM3) utility in post-fracture care would be severely limited as they are intended for use within advanced payment models and require the clinician to assume all primary care responsibilities for the patient. Moreover, while some post-fracture care programs are provided within PCP practices, ***most reside within other specialties, including orthopedics, rheumatology, and endocrinology.***
- Community Health Integration (CHI) codes – limited to patients with SDOH needs.
- Principal Illness Navigation (PIN) codes – helpful to hip fracture patients but our proposal is to prevent hip fractures
- AAOS agrees with BHOF. It "***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."***

Proposed Coding Reforms to Prevent Costly Osteoporotic Fractures

BHOF worked with the American Society for Bone and Mineral Research (ASBMR) and leading physicians and bone health organizations to develop a set of data-driven proposed "G" codes that capture the post-fracture services typically provided by evidence-based fracture liaison service (FLS) programs for the secondary prevention of osteoporotic fractures. All major stakeholders in bone health collaborated to define this FLS episode, craft descriptors for FLS coding and calculate the cost of care through provider interviews and cross-walk methodologies.

Below are the proposed codes and code descriptors. Cross-walk codes and further detailed discussion of these crosswalk codes are provided at the end of this document, along with methodological details on their crafting. Also, attached is a detailed White Paper signed by detailing further rationale behind the proposed coding. The document identifies a set of FLS quality measures that FLS programs, CMS, and other payers could use for program evaluation and improvement.

Proposed Reimbursement Based on Cross-Walk Methodology

Code	Descriptor	Suggested Total RVUs Based on Crosswalks
G20XX1	Initial 45-day period, patient (initial encounter only)	11.95
G20XX2	Initial 45-day period, complex patient (requiring additional face-to-face encounter time day of and/or subsequent encounters)	14.61

Proposed Code Descriptors Outline Required Services

- **G20XX1:** *Fracture Liaison Services for **45-day period** in a patient with a known or suspected fragility fracture **within the previous 6 months**, including patient identification and intake activities, **initial direct patient encounter between 45-60 minutes** that includes **medical examination** with **physical evaluation** when appropriate and **initial assessment** conducted by a program physician or qualified health care professional that includes a **medically appropriate evaluation** and **patient history**, review of medical history, **assessment planning**, **patient education**, shared decision making in **creation of treatment plan** and follow up that incorporate patient's short-term goals and tasks that must be performed to attain short-term goals for avoiding and reducing fractures. Includes, as appropriate, **assessment of height/weight, balance, gait and fall risk assessment** , **fracture risk assessment**, **fall risk assessment** and plan, shared decision making and development of pharmacological plan including updating current drugs and prescriptions and follow-up, **non-face-to-face physician/QHP and clinical staff services** in the 45-days after the initial encounter that includes appropriate coordination and **communication with patient primary care** provider, **coordination with patient's relevant specialists** (including orthopaedic surgeon, geriatrician, physical rehabilitation, hematologist, oncologists, endocrinologist, psychiatrist, etc.), and **coordination and communication with ancillary providers** (including physical therapy, occupational therapy, speech therapy), ordering and reviewing of imaging studies and laboratory tests as necessary to diagnosis osteoporosis or other condition contributing to bone fragility, updating medical records, patient referrals, review of medical records, data registry entry and review, ongoing program evaluation, caregiver education and coordination, patient education, coordination, and communication via email/portal/text messaging, and direction supervision and oversight of clinical and administrative staff work for each patient.*

- **G20XX2:** *Fracture Liaison Services for 45-day period in a **complex patient** with multiple co-morbidities along with a known or suspected fragility fracture within the previous 6 months, including patient identification and intake activities, either an initial direct patient encounter **greater than 75 minutes** and/or follow-up direct patient encounters . . .*

CMS has effectively employed this "G" code approach to improve care for substance use disorder and pain management. Like providers performing SUD treatment and Chronic Pain Management and Treatment services, FLS programs are comprised of providers acting within the scope of their license to deliver coordinated care in collaboration with other clinicians to ensure that each patient receives the set of services they need. The set of services within our proposed FLS coding mechanism is concentrated within a 45-day episode of care. We proposed that the code would (a) be billable once per beneficiary per fracture episode (rather than on a monthly basis) and (b) describe FLS services over the 45-day period from the initial visit through treatment planning and follow-up.

Through regular consultation with CMS staff throughout the development of this coding framework, CMS established that there is no cost for the "G" code for already covered services.

Broad-Based Stakeholder Support

All the major bone health stakeholders and a broad coalition of patient advocacy organizations have joined BHOF in calling on CMS to adopt this approach to improve osteoporosis care and reduce preventable, costly osteoporotic fractures.

Health Professionals Urge CMS Adoption of Reimbursement Codes for a Post-Fracture Episode of Care Delivered within a Fracture Liaison Service

- American Academy of Nurse Practitioners (AANP)
- American Association of Hip and Knee Surgeons (AAHKS)
- American Association of Orthopaedic Surgeons (AAOS)
- American Academy of Physician Associates
- American Bone Health (ABH)
- American Geriatric Society (AGS)
- American Orthopaedic Association (AOA)
- American Society for Bone and Mineral Research (ASBMR)
- American Society of Endocrine Physician Assistants (ASEPA)
- Bone Health and Osteoporosis Foundation (BHOF)
- Fragility Fractures Alliance (FFxA) – American Academy of Orthopaedic Surgeons (AAOS), American Orthopaedic Association (AOA) & AOA Own the Bone, Orthopaedic Trauma Association (OTA), National Association of Orthopaedic Nurses (NAON), American Geriatrics Society (AGS), International Geriatric Fracture Society (IGFS), American Board of Orthopaedic Surgeons, U.S. Bone and Joint Initiative (UBJI)
- International Society for Clinical Densitometry (ISCD)
- National Spine Health Institute (NSHI)
- North American Spine Society (NASS)
- Orthopaedic Trauma Association (OTA)
- The Endocrine Society (TES)
- US Bone and Joint Initiative (USBJI)

Patient Advocates Urge CMS Adoption of Reimbursement Codes for a Post-Fracture Episode of Care Delivered within a Fracture Liaison Service

- Alliance for Aging Research
- Alliance for Women's Health and Prevention
- American Society for Bone and Mineral Research
- Black Women's Health Imperative
- Bone Health and Osteoporosis Foundation
- Caregiver Action Network
- Carrie's TOUCH
- Celiac Disease Foundation
- Global Healthy Living Foundation
- HealthyWomen
- National Alliance for Caregiving
- National Asian Pacific Center on Aging
- National Caucus and Center on Black Aging
- National Committee to Preserve Social Security and Medicare
- National Council on Aging
- National Menopause Foundation
- National Spine Health Foundation
- National Women's Health Network
- North American Spine Society
- Osteogenesis Imperfecta Foundation
- Society for Women's Health Research

In addition to this broad support, senior members of the Senate Finance and Appropriations Committees led by Senators John Barrasso (R-WY), Shelley Moore Capito (R-WV) and Susan Collins (R-ME) have written to OMB calling on CMS to address the need to better incentivize

model post-fracture care. Congress has three times included language in HHS Appropriations bill reports in support of action by CMS. The FY 2026 Senate report includes the following:

***"Reducing Costly Osteoporotic Fractures**.—The Committee continues to note that current Medicare payment policies may not be adequate to encourage comprehensive care to reduce osteoporosis related bone fractures. Therefore, the Committee encourages CMS to establish a clear payment mechanism for evidence-based post fracture care that has been shown to reduce the rates of costly secondary fractures through improved screening, treatment initiation and adherence, patient and caregiver education and counseling, and comprehensive falls prevention strategies. Further, the Committee is concerned that postmenopausal osteoporosis [PMO] is responsible for nearly 2.0 million fractures every year in the United States for women age 65 and older, and two out of three women with PMO at high risk for fracture will break a bone in their lifetime. However, only one in six women receive osteoporosis treatment in the months following an osteoporotic fracture. The U.S. Preventive Services Task Force [USPSTF] has recommended the use of bone measurement testing to screen both women age 65 and older for osteoporosis and postmenopausal women younger than 65 who are at increased risk of osteoporosis, but nationwide screening of this high-risk population is lacking. The Committee directs CMS to provide recommendations in the fiscal year 2027 CJ for changes to CMS policies that could increase access to PMO care."*

Benefits of Improving Post-Fracture Care

As stated earlier, adoption of our proposed set of secondary osteoporosis fracture prevention "G" codes, will achieve a major win in implementing President Trump's MAHA Executive Order and advance the Trump Administration's objectives to improve government efficiency and reduce waste, put greater emphasis on chronic disease and lower the cost of Medicare for patients and taxpayers. Some specific benefits include:

- Reducing the number of preventable repeat fractures that cost Medicare over $30,000 each and added $5.7 billion in Medicare FFS payments along in 2016.
- Reducing the 41,900 Medicare FFS beneficiaries with osteoporotic fractures who become institutionalized in nursing homes within three years of a new fracture.
- Reducing the number of seniors addicted to opioids. A recent study revealed that 23% of opioid-naïve hip fracture patients became chronic opioid users after surgery.

Conclusion

We appreciate the opportunity to submit our comments and recommendations for inclusion in the final CY 2026 PFS Proposed Rule. Including the codes we recommend would represent the most significant improvement in bone health policy in decades and result in improved care, improved outcomes and reduced Medicare costs for the nearly 2 million Medicare beneficiaries

who suffer osteoporotic fractures annually.

If you have any questions please contact Claire Gill, CEO, Bone Health and Osteoporosis Foundation at cgill@bonehealthandosteoporosis.org.

Please see the important additional information about the requested coding change below as well as further details in the attached White Paper.

Very truly yours,

Bone Health and Osteoporosis Foundation
Alliance for Aging Research
Alliance for Women's Health and Prevention
American Academy of Physician Associates (AAPA)
American Association of Orthopaedic Surgeons (AAOS)
American Association of Nurse Practitioners (AANP)
American Orthopaedic Association (AOA)/Own the Bone®
Arthritis Foundation
California Chronic Care Coalition
Caregiver Action Network
Carrie's TOUCH
Celiac Disease Foundation
Chronic Care Alliance
Family Caregiver Alliance, National Center on Caregiving
Global Healthy Living Foundation
HealthyWomen
National Alliance for Caregiving
National Asian Pacific Center on Aging
National Menopause Foundation
National Spine Health Foundation
Obesity Action Coalition
Society for Women's Health Research

[1] Milliman Research Report, Medicare cost of osteoporotic fractures – 2021 updated report, The clinical and cost burden of fractures associated with osteoporosis. Medicare Cost of Osteoporotic Fracture - 2021 Update (squarespace.com)

[2] Milliman Report (2021 Update).

[3] Hereford, et al., Prevalence of Chronic Opioid Use in the Elderly After Hip Fracture Surgery, Prevalence of Chronic Opioid Use in the Elderly After Hip Fracture Surgery - The Journal of Arthroplasty (arthroplastyjournal.org) (Feb 2022).

[4] Lewiecki EM, Ortendahl JD, Vanderpuye-Orgle J, et al. Healthcare Policy Changes in Osteoporosis Can Improve Outcomes and Reduce Costs in the United States. JBMR Plus. May 2019. doi:10.1002/jbm4.10192.

ADDITIONAL DETAILED INFORMATION ON PROPOSED OSTEOPOROSIS G CODES AND THEIR DEVELOPMENT

Data Collection Informed Our Proposed Reimbursement for FLS Specific Codes

Detailed set of questions was provided to interviewees and interviewers walked through each question and response and recorded interviewee time and resource estimates and descriptions

7 programs were from different regions of the United States and included programs within Academic Medical Centers, Integrated Health Systems, and Private Practices.

- Median program annual volume was approximately 850 new patients a year
- Median number of Physician/QHP providers in practice was 2
- Median years of program experience/age was 8

Methodology/ Background

Using the median times from our survey interviews, we created crosswalk models for the underlying Work, Practice Expense (PE) and Malpractice Relative Value Units (RVU) for G20XX1 and G20XX2 to create a reimbursement range

- We multiplied our estimated RVUs by the Medicare Physician Fee Schedule Conversion Factor as published in the 2022 Medicare Physician Fee Schedule Final Rule on November 2, 2021
- Work RVUs represent the RVUs for the time/resources of the Physician/QHP
  - Combines the face-to-face and non-face-to-face time/resources of the Physician/QHP
- PE RVUs represent the RVU for the time/resources of the clinical/administrative staff

We chose comparable HCPCS codes from the Medicare Physician Fee Schedule with similar descriptions of work and similar times to what our interview surveys estimated as their median times for Fracture Liaison Services

- Principal Care codes crosswalk model
- Transitional Care Management/Chronic Care Coordination Codes crosswalk model

Key Findings

Physician/QHP time

- prior to initial encounter (non-face-to-face): 20 minutes
- initial face-to-face encounter: 53 minutes (either in person or via telehealth)
- 45-day-period-subsequent-to-initial-encounter period (non-face-to-face): 96 minutes
- subsequent face-to-face encounter (when performed): 26 minutes

60% of patients required at least one additional direct (face-to-face) encounter subsequent to the initial encounter within the 45-day period after initial encounter.

- The time for this encounter was incorporated into payment level for both complex and non-complex patients.

Clinical/Admin time

- prior to and on the day of initial encounter (non-face-to-face): 20 minutes
- 45-day-period-subsequent-to-initial-encounter period (non-face-to-face): 145 minutes
- subsequent encounter (when performed) (non-face-to-face): 30 minutes

Crosswalk Codes for G20XX1-Non-complex Patient

Transitional Care Management/Chronic Care Coordination Codes crosswalk model:

- HCPCS code 99495 work RVU + HCPCS code 99491 work RVU+ HCPCS code 99437 work RVU (x2); 2.78 + 1.50 + 2.00= 6.28
- HCPCS code 99495 PE RVU + HCPCS code 99490 PE RVU + HCPCS code 99439 PE RVU (x2); = 3.01 + 0.78 + 1.30 = 3.48
- HCPCS code 99495 malpractice RVU + HCPCS code 99491 malpractice RVU+ HCPCS code 99437 malpractice RVU (x4); 0.19+ 0.07 + 0.32= 0.58

Total RVUs: 11.95 (6.28 work RVU +5.09 PE RVU +0.58 Malpractice RVU)

Crosswalk Codes for G20XX2- Complex Patient (single initial encounter + subsequent encounter(s))

- **Total RVUs: 14.61**
  - **adds an additional 2.49 total RVU with a crosswalk to HCPCS code 99213**

Discussion of Crosswalk Codes for G20XX1- Non-complex Patient

We looked for applicable codes to use to crosswalk and build our RVU and reimbursement models.

We started with the assumption that most of the provider and clinical staff/admin staff work would be similar to that described by CPT/HCPCS codes for cognitive services like evaluation and management codes.

The services provided in Fracture Liaison Service programs are similar to services like the CMS Opioid Use Disorder bundle, Transitional Care Management, Chronic Care Management, Complex Chronic Care Management, and Principal Care Management.

There are dozens of CPT/HCPCS codes in this family of services, and we sought to create our models based on similarity of service(s) and the times assigned to the services in the Medicare Physician Fee Schedule to match the times reported in our interviews for both face-to-face and non-face-to-face provider and clinical/administrative staff work in the 45-day episode.

Discussion of Crosswalk Codes for Physician/QHP work for G20XX1

- The Transitional Care codes and Chronic Care Coordination codes were established in 2017 and updated in 2019. These two sets of codes combine the direct patient encounter care surrounding a patient transitioning from inpatient care to outpatient clinic, along with the non-face-to-face care for coordination surrounding a patient with chronic conditions that require significant care plan management and monitoring. By combining the face -to-face encounter with the non-face-to-face care coordination these codes capture the services involved in the 45-day Fracture Liaison Service care model fully.
  - These four new codes are HCPCS 99495, HCPCS 99491, HCPCS 99437
    - 99495 has 54 minutes of physician/qhp time for a direct encounter which matches the initial face-to-face encounter estimated of 53-minutes from our provider surveys.
    - 99495 also requires a face-to-face patient encounter similar to the FLS patient encounters
    - 99491 and 99437 both describe non-face-to-face work by a physician/qhp
    - We used the initial 30 minutes of time described in 99491 and then added an additional four 30-minutes increments to get close to the 154 minutes time estimated for non-face-to-face fracture care liaison services by a physician or qhp.

Discussion of Crosswalk Codes for Physician/QHP and Clinical Staff work for G20XX1 continued

- A separate code set that was created for CPT 2022 also has similarities to G20XX1.
  - This set of four new codes was created for CPT 2022 and incorporated into the 2022 Medicare Physician Fee Schedule describing provider and clinical staff work done in principal care management.
  - These four new codes are HCPCS 99224-Physician/QHP Primary Initial Encounter, HCPCS 99225-Physician QHP Additional time, HCPCS 99226-Clinical/Admin Staff Initial time, HCPCS 99227-Clinical/Admin Staff Additional time
  - HCPCS codes 99224 and 99225 do not specify in-person patient encounters are required, whereas the initial assessment visit in the Fracture Liaison Services model would be face-to-face and thus this crosswalk slightly underestimates the intensity and complexity provided in the Fracture Liaison model. However, it does model the total time of the episode fairly well.
  - In addition, HCPCS code 99227 can only be billed twice, which represents significantly less clinical staff time than was found to be typical for FLS services

Discussion of Crosswalk Codes for Clinical/Admin staff work for G20XX1

- To model the clinical staff time estimated by our survey of FLS programs, we used the practice expense for the transitional care management code 99495 to capture 100 minutes of clinical staff time and added 99490, *Chronic care management services with the following required elements: multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient, chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline, comprehensive care plan established, implemented, revised, or monitored; first 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month plus* and 99239 (x2) *Chronic care management services with the following required elements: multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient, chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline, comprehensive care plan established, implemented, revised, or monitored; each additional 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month (List separately in addition to code for primary procedure)* to account for an additional 60 minutes of clinical staff time non-to-face.

- This combines to closely match the total clinical staff time from our program survey.

Discussion of Crosswalk Codes for Physician/QHP and Clinical/Admin staff work for G20XX2-Complex Patient

- For the complex patient code, we have used the two base models used for the straightforward patient and added the total RVU value for HCPCS code 99213, *Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and low level of medical decision making.*

- By looking at the time that our surveys estimated is spent in a face-to-face subsequent patient encounter it is a straight crosswalk for the direct face-to-face encounter with 99213 describing 20-29 minutes of a direct patient encounter which our median survey result falls into.

- HCPCS code 99213 has a total RVU of 2.66 (work RVU=1.30; PE RVU=1.26; malpractice RVU=.10) which can be added onto the RVUs in both models for the straightforward patient and creates the proposed range for G20XX2.

Crosswalk Codes for G20XX1- Non-complex Patient

Principal Care codes crosswalk model:

- HCPCS code 99424 work RVU+ HCPCS 99245 work RVU (x4); 1.45 + 4.00= 5.45
- HCPCS code 99426 PE RVU+ HCPCS 99427 PE RVU (x4); 0.75 + 2.56= 3.31
- HCPCS code 99424 malpractice RVU+ HCPCS 99245 work RVU (x4); 0.10 + 0.32= 0.42