



June 9, 2026

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Mehmet Oz, MD
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Blvd
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RE: [CMS: 1849-P](#)

Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals (IPPS) and the Long-Term Care Hospital Prospective Payment System and Policy Changes and Fiscal Year (FY) 2027 Rates; Requirements for Quality Programs; and Other Policy Changes

Dear Doctor Oz,

On behalf of the over 54 million Americans impacted by osteoporosis, we appreciate the opportunity to provide comments on the above proposed rule. Bone Health and Osteoporosis Foundation is the leading health organization dedicated to promoting strong bones for life, preventing and treating osteoporosis and fractures, and optimizing mobility and lifespan following fractures through programs of public and clinician awareness, education, advocacy, and research.

Our comments to this IPPS draft rule focus on CMS' proposal to address high costs associated with hip replacements through a mandatory national application of the "Comprehensive Care for Joint Replacement CJR Expanded (CJR-X)". CJR-X would create a bundled payment model starting October 1, 2027 under which hospitals would be responsible for all Medicare costs for patients with hip, knee and ankle replacement procedures from admission through 90 days after the beneficiary is discharged from the hospital or hospital outpatient procedure. This would include costs associated with surgery, inpatient stay and post-treatment care (including physician, rehab, nursing home and Part B drugs). If finalized, the CJR expansion (CJR-X) would be the first mandatory episode of care pay model in original Medicare.

If finalized without significant change or accompanying policy changes, this draft rule could substantially harm the care of tens of thousands of Americans with osteoporosis who undergo total hip replacement every year. Studies show that up to 60 percent of hip replacement

patients suffer from underlying osteoporosis or osteopenia. They have underlying bone disease that will worsen if untreated. A significant number of hip replacements (about 10 percent) are directly related to a hip fracture. New research findings demonstrate that **those with underlying osteoporosis are frequently undiagnosed prior to surgery, receive grossly inadequate care for their underlying osteoporosis and have poorer outcomes and greater incidence of complications.** We are disappointed that in this proposal CMS seems to be entirely overlooking these important factors. In fact, the proposed rule **includes no references whatsoever to osteoporosis.**

The proposal fails to see the need for hip replacement as a potential sentinel event indicative of a treatable chronic condition (osteoporosis) that dramatically increases the risk of subsequent, preventable fractures. In fact, having a fracture triples the odds of subsequent fracture without appropriate management. We fear that the model will adversely shape the care this predominantly female population receives in the wake of hip replacement – and that any episode-based savings within the CJR-X initiative will be outpaced by the lost opportunity to avoid the cost of subsequent, preventable osteoporotic fractures suffered by beneficiaries. Below we provide greater details on these challenges and present suggested changes that could not only avert potential care setbacks but also substantially improve the care and outcomes of the nearly 2 million Medicare beneficiaries who suffer osteoporotic fractures every year.

Osteoporosis Costs and the Care Gap

Over 54 million Americans are impacted by osteoporosis and 1 in 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. In 2016, over 1.8 million Medicare beneficiaries suffered over 2 million osteoporotic fractures. That is about a fracture every 16 seconds! These fractures cost the nation of over \$57 billion, which is projected to grow to over \$95 billion by 2040 under the status quo. Each initial osteoporotic fracture adds \$21,564 in costs to Medicare and those who have an initial fracture are at triple the risk of a subsequent fractures, which are even more expensive. Each fracture costing Medicare over \$30,000 with total Medicare fee for service (FFS) costs alone reaching \$5.7 billion in 2016.

Unlike many other high-cost, chronic 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.

Effective Post Fracture Care Prevents Secondary Fractures

We know how to reduce subsequent/repeat fractures. Model post fracture care, often referred to as Fracture Liaison Service (FLS) services 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 repeatedly confirmed through many 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. A [2025 New England Journal of Medicine article](#) by Napoli finds that “on the cost side of the equation, FLS offer a return of \$10.49 for every \$1 invested.” [Another analysis by leading experts](#) found that for one million patients who receive the intervention instead of usual care, the expected cost savings for Medicare would be \$418 million.

Despite the proven effectiveness of fracture liaison services in cutting the rate of preventable secondary fractures and reducing costs, only a small portion of the 1.8 million Medicare beneficiaries suffering osteoporotic fractures receive this model care. Thus a major opportunity to improve care and reduce costs is being missed.

Concerns Specific to CJR-X

Given the significant deficiencies U.S. patients experience in both primary and secondary osteoporotic fracture prevention services, it is not surprising that hip replacements were identified as drivers of high costs to the Medicare program and selected for inclusion in the CJR-X initiative. Unfortunately, for those hip replacement patients with underlying osteoporosis, CMS is focusing on the wrong “problem” and devising a solution that could all but halt the efforts patient advocacy stakeholders have prioritized to reduce **both** the costs and suffering associated with fractures through effective delivery of secondary fracture prevention services.

A [2025 study by Emara et al.](#) found that roughly 57 percent of patients receiving total hip replacement had osteoporosis. Yet, there is not even a mention about osteoporosis in the draft rule. While the CJR-X model may allow somewhat higher reimbursement for those with major co-morbid conditions (DRG 521: Hip Replacement with principal diagnosis of hip fracture with MCC), **recent studies show that most of those with osteoporosis are undiagnosed prior to surgery.** For example, a 2021 [retrospective study](#) conducted by Delsmann et al. reported “73% of patients with osteoporosis were undiagnosed prior to surgery, and therefore did not receive appropriate treatment or optimization”. This raises further concerns about this bundled payment approach will have for those with osteoporosis. It could lock in incentives for poor care

including failure to appropriately screen, treat and provide coordinated care via fracture liaison services.

These concerns are heightened by other **recent studies showing inadequate treatment and substantially poorer outcomes for those with total hip replacement patients with osteoporosis**. A [2022 study by Wang et al.](#) found that “among high risk patients undergoing TJA, 90% did not receive any pharmacological treatment for osteoporosis, 45% were not treated with vitamin D or calcium, and 88% did not receive bone density testing in the routine care period. Among patients with pre-existing osteoporosis undergoing TJA, 80% were not treated with any osteoporosis medications and 33% of these patients were not taking vitamin D or calcium.” The [2025 study by Emara et al.](#) also found that those TJA patients with osteoporosis had poorer outcomes. Compared to those who did not have osteoporosis, **those who had osteoporosis were “independently associated with higher odds of prolonged length of stay, nonhome discharge, 90-day readmission, and 1-year reoperation”**.

We share the concerns expressed by the American Association of Orthopedic Surgeons (AAOS) in their comments to this proposed rule. AAOS is “concerned that the bundled payment model’s coverage of all Medicare Part A and Part B services provided under either the 30-day TEAM episode post-discharge window or the 90-day CJR-X post-discharge window would disincentivize the uptake of Fracture Liaison Services (FLS) for osteoporotic patients. Despite their demonstrated value in reducing secondary fractures among osteoporotic patients, FLS are widely underutilized and therefore largely absent from the historical spending data used in setting target prices for LEJR episodes under TEAM and CJR-X. “

Recommendations to Improve Care and Reduce Costs

Fortunately, there are simple steps that CMS can take to both prevent the CJR-X model from substantially harming the care of those with osteoporosis and take a major step forward in improving osteoporosis care while reducing Medicare costs.

First, all hip replacement patients without an existing diagnosis of osteoporosis should be screened for osteoporosis prior to surgery. There is clear evidence that those with osteoporosis are at greater risk of complications and poor outcomes, so it is imperative that the care team be aware of presence of osteoporosis prior to the procedure. The cost of this screening should either be excluded from the bundled rate and paid separately. If CMS doesn’t agree with excluding screening costs from the bundle, the bundled payment rate must be adjusted upward to fully incorporate the costs of screening as it is clear from data that its costs would not adequately be reflected in benchmark costs and incorporated into the bundled rate given the very small percentage of patients currently receiving screening.

Second, all hip replacement patients who are determined to have osteoporosis from screening (in addition to all who are having the replacement as a result of a hip fracture, as we can assume that all of those patients have osteoporosis), should promptly be referred to fracture liaison services or other appropriate evidence-based secondary fracture prevention services and these services should be promptly and appropriately initiated within the 90 day period. The costs of this referral to and provision of these services should be excluded from the bundle and paid separately. As for screening, if CMS doesn't agree with excluding screening costs from the bundle, the bundled payment rate must be adjusted upward to full incorporate the costs of screening as it is clear from data that its costs would not adequately be reflected in benchmark costs and incorporated into the bundled rate given the very small percentage of patients currently receiving screening.

Without these exclusions hospitals may be disincentivized from referring patients to these services or could be inclined to delay the start of services to outside the bundle period, thus resulting in potential patient harm and fragments in the continuity of care. The CJR-X initiative would penalize facilities for the added cost of performing even a cursory inquiry into osteoporosis or other underlying causes of bone fragility, despite acknowledgment among bone health experts that a hip fracture in an individual over age 50 is clearly indicative of osteoporosis warranting timely, aggressive treatment and ongoing disease management.

Third, CMS should include in its 2027 Physical Fee Schedule regulation, new G-Codes that capture the costs of providing evidence-based post fracture care such as fracture liaison services. Such an approach has been developed in consultation with CMS in the past several years and has been endorsed by all major patient and specialty organizations. Attached is a copy of a letter from BHOF and 14 other leading health, aging and family caregiving organizations which provides specific recommendations to the agency for such codes and associated payment rates. Taking this step would be the biggest improvement in federal policy for those with osteoporosis in decades. It would reduce fractures, reduce costs and reduce documented increased opioid addiction rates tied to fracture-related pain.

Fourth, CMS should consider assigning a specialty code to identify FLS practices. This would be a secondary specialty since FLS programs are operated within orthopedic, endocrinology, rheumatology, women's health, primary care, and other practice types. The specialty code would be reported by FLS practices, including those that:

- Participate in AOS' Own the Bone initiative, OR
- Deliver FLS care through participation in AGS CoCare-Ortho, OR
- Have received a certificate of completion for training administered through BHOF or the International Osteoporosis Foundation and deliver FLS care.

Thank you for your attention to our comments and recommendations. We stand ready to answer any questions you may have.

Sincerely,

A handwritten signature in black ink that reads "Claire Gill". The signature is written in a cursive, flowing style. It is positioned above the printed name and title.

Claire Gill

CEO

Bone Health and Osteoporosis Foundation



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Submitted electronically

April 16, 2026

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

RE: Recommendations for Draft CY 2027 Medicare Payment Policies Under the Physician Fee Schedule (PFS)

Dear Dr. Oz:

On behalf of the undersigned 16 leading patient advocacy and professional societies we submit the following suggestions as you prepare a proposed rule updating the Medicare Physician Fee Schedule (the Proposed Rule) for calendar year 2027. We appreciate the agency's focus on wellness, prevention and better management of chronic diseases. We are hopeful that you will revisit your request for specific examples of Medicare codes that don't sufficiently address services for effective management of chronic diseases like osteoporosis.

Last year, we provided you with recommendations focused on the prevention of costly repeat fractures caused by poor management of osteoporosis, a highly prevalent and costly chronic disease. We urge you to include our recommendations in your proposal for calendar year 2027 as their implementation would **reduce unnecessary Medicare chronic disease costs and fulfill the mandate in President Trump's February 13th 2025 Executive Order, "Establishing the President's Make America Healthy Again Commission"**. As you know, this order calls on CMS and other 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. Over 50 million Americans are impacted by osteoporosis and 1 in 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. In 2016, 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 preventable repeat 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 CMS states: “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)

Below we 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. We request that the agency include in its draft CY 2027 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 save \$1.1 billion in Medicare FFS alone.

Unlike many other high-cost, chronic 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 attacks 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. Model post fracture care, often referred to as Fracture Liaison Service (FLS) services, 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 repeatedly confirmed through many 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). As detailed in the attached Appendix 1, the cost savings associated with FLS have been well established by nationally recognized leaders in the U.S. including Kaiser, Geisinger Health and the American Osteopathic Association.

As explained in the slides below, despite decades of evidence of demonstrating its effectiveness, **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.

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 for post-fracture care services provided in an initial 60-day period. Crosswalk codes and further detailed discussion of these crosswalk codes are provided at the end of this document in Appendix @, along with methodological

details on their crafting. Also, attached is a detailed White Paper signed by leading national specialty organizations 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.

Code	Descriptor	Suggested Total RVUs Based on Crosswalks
G2XX1	Initial 60-day period, patient (initial encounter only)	11.95
G2XX2	Initial 60-day period, complex patient (requiring additional face-to-face encounter time day of and/or subsequent encounters)	14.61

G2XX1: *Fracture Liaison Services for 60-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 60-days after the initial encounter that includes appropriate coordination and **communication with patient primary care** provider, **coordination with patient's relevant specialists** (including orthopedic 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.*

G2XX2: *Fracture Liaison Services for 60-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 60-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 60-day period from the initial visit through treatment planning and follow-up.

We also believe that Fracture Liaison Services are separate and distinct from any procedural intervention furnished to repair the fragility fracture, and thus, it is important to note that this service should be allowed to be separately billed if the patient is in a global period to ensure that Fracture Liaison Services are provided at the time most optimal for the patient and that it does not delay the delivery of these services until the global period has ended.

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 and Congressional Support

All the major bone health stakeholders and a broad coalition of patient advocacy organizations have joined BHOFF in calling on CMS to adopt this approach to improve osteoporosis care and reduce preventable, costly osteoporotic fractures. (See Appendix 1 for listing of all supporters)

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 recommendations for inclusion in the final CY 2027 PFS Proposed Rule. Including the recommended codes would represent the most significant advancement in bone health policy in decades, leading to improved care, better patient outcomes, and reduced Medicare costs for the nearly 2 million beneficiaries who experience osteoporotic fractures each year.

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 Association of Orthopaedic Surgeons
Caregiver Action Network
Celiac Disease Foundation
Global Healthy Living Foundation
HealthyWomen
National Alliance for Caregiving
National Asian Pacific Center on Aging
National Council on Aging
National Menopause Foundation
National Spine Health Foundation
Obesity Action Coalition
Society for Women's Health Research
TOUCH, The Black Breast Cancer Alliance

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 \(arthroplastyjournal.org\)](https://arthroplastyjournal.org) (Feb 2022).

⁴ Lewiecki EM, Ortendahl JD, Vanderpuye-Ortle 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.

Appendix 1: FLS Model and Supporting Organizations

Fracture Liaison Services are a proven intervention to close care gap, a well-established model internationally, and supported by decades of evidence

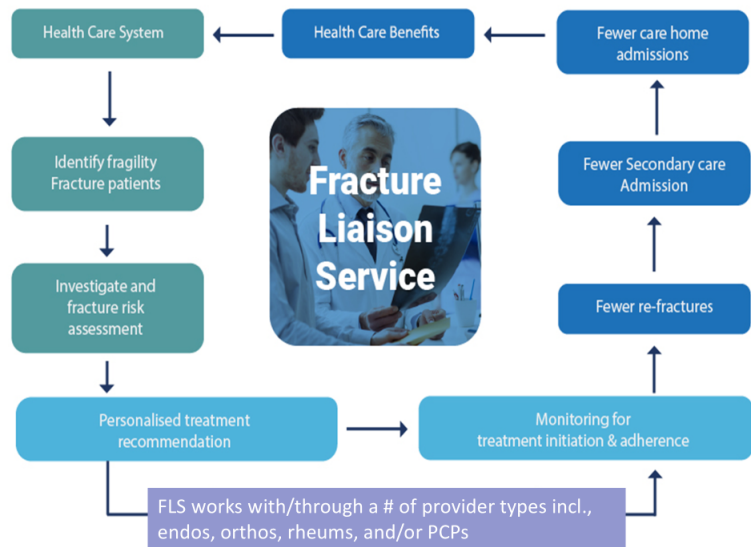
Coordinated care systems headed by a coordinator (a physician, nurse practitioner, physician assistant, or other health professional).

Delivers patient-centered secondary prevention of osteoporotic fractures.

Utilizes established protocols to ensure that osteoporotic fracture patients receive appropriate diagnosis, evaluation, secondary prevention, treatment, and support.

Patient assessment and follow-up care are generally prompted through a database-driven patient-specific timeline.

Can be adapted to a centralized care delivery model, incorporate telemedicine and operate as a “hub and spoke” care coordination and delivery system, or incorporate aspects of various care delivery models.



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.

**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 (BHOFF)
- **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 (USBJI)
- 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

Appendix 2: 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)
- 60-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 60-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
- 60-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); $0.10 + 0.32 = 0.42$
- 