

September 15, 2021

Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1753-P
P.O. Box 8010, Baltimore, MD 21244-1850.
Submitted electronically via <http://www.regulations.gov>

**Subject: CMS-1753-P
Medicare Program: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center
Payment Systems and Quality Reporting Programs; Price Transparency of Hospital Standard
Charges; Radiation Oncology Model; Request for Information on Rural Emergency Hospitals**

Dear Administrator Brooks-LaSure:

On behalf of over 34,000 orthopaedic surgeons and residents represented by the American Association of Orthopaedic Surgeons (AAOS) and the orthopaedic specialty societies that agreed to sign on, we are pleased to provide comments on the Medicare Program: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs; Price Transparency of Hospital Standard Charges; Radiation Oncology Model; Request for Information on Rural Emergency Hospitals (CMS-1753-P) published in the Federal Register on August 4, 2021.

The AAOS appreciates the ongoing efforts of the Centers for Medicare and Medicaid Services (CMS) to ensure patient safety, enforce price transparency and address the health equity gap during the COVID-19 public health emergency. We request continued support from the Department of Health and Human Services (HHS) as physicians navigate the ongoing pandemic accompanied by the continuous needs for personal protective equipment, financial support, vaccines and access to testing and therapeutics.

Reinstatement of the Medicare Inpatient Only (IPO) List

In the calendar year (CY) 2021 Outpatient Prospective Payment System/Ambulatory Surgical Center (OPPS/ASC) final rule, CMS finalized a policy to eliminate the Medicare IPO List over a three-year period, removing 298 musculoskeletal services from the IPO List in the first year. Given concerns over patient safety, for CY 2022 CMS is now proposing to halt this policy and add back all these 298 procedures to the list.

The AAOS believes that CMS must maintain the IPO List but streamline it systematically to allow for the removal of procedure codes, or groups of codes, that can safely and effectively be performed on a typical Medicare beneficiary in the hospital outpatient setting and subsequently in the ambulatory surgical center setting. However, we would like to discuss some concerns and considerations around this proposal.

Abrupt Policy Reversals Endangers the Lives of Medicare Beneficiaries

In an unprecedented move, CMS has proposed to put back on the IPO List all 298 procedures that were removed effective January 1, 2021. As you know, this sweeping policy change mostly impacts orthopaedic surgeons and our patients since CMS decided to start the elimination with musculoskeletal procedures in the first year. This is a complicated clinical and policy decision, and we had urged the agency in our comments and meetings with HHS and the White House Office of Management and Budget leadership last year to consider the associated risks to Medicare beneficiaries before finalizing this drastic proposal. CMS chose to disregard our comments last summer and now with this abrupt policy reversal, has again made it extremely difficult for our surgeons and their patients to re-adjust their plans. We are especially concerned about the impact on our patients' health outcomes and out-of-pocket financial responsibilities. For example, since there are still five months left in this calendar year, we are not clear on adequate responses to the policy change in the next few months while CMS finalizes this proposal. Given the audit moratorium, should surgeons now admit all cases as inpatient, or should surgeons continue to take on the complex decision-making process on the setting of surgery? Hence, here are our specific recommendations on the policy change process:

- **We urge CMS to not make such wide swings in complicated policy decisions within short time periods.**
- **Moreover, CMS should only make such sweeping policy changes in a gradual fashion and be fully transparent with the decision-making process to enable all affected stakeholders, including Medicare beneficiaries, to prepare ahead of such changes. Otherwise, the rule making process is rendered defunct.**
- **Finally, technical expert panels must be formed to advise the HHS Secretary and the agency on such policy changes with wide impact. For example, if musculoskeletal procedures were identified as the first group to be eliminated from the IPO List, CMS should have consulted with orthopaedic surgeons to determine the suitability of specific procedures, its impact on Medicare beneficiaries and on the delivery of health care services.**

Considerations for Policy Changes Regarding the IPO List

We are encouraged to see that CMS is proposing to codify the criteria for removal of procedures from the IPO List to make clear in regulatory text how procedures for removal will be evaluated in the future. The AAOS acknowledges that a change in policy regarding the IPO List is imminent, but it must be made judiciously. With developments in the practice of medicine, some musculoskeletal procedures can safely be done in the outpatient setting. These procedures, such as total shoulder arthroplasty and total ankle arthroplasty are currently being safely performed in outpatient settings for

non-Medicare patients right up to Medicare eligibility age. We have regularly commented to CMS highlighting these procedures. Below and in the attached addendum, you will find extensive recommendations on specific musculoskeletal procedures that can be removed from the IPO list and those that must stay on the IPO list for now.

For policy change in this regard, the AAOS reiterates that **CMS set general criteria for procedure selection based upon peer-reviewed evidence, patient factors including age, co-morbidities, social support, and other factors relevant to positive patient outcomes. Specifically, we support the following social factors to consider when determining the best setting for musculoskeletal procedures: “lives alone,” “pain,” “prior hospitalization,” “depression,” “functional status,” “high risk medications,” and “health literacy.”**^{1, 2} In some cases, a patient may be clinically stable but lack the resources to care for themselves once they go home. This can lead to an increased risk for adverse events or accidents that end in hospital readmission. We have stated in our Outpatient Joint Replacement position statement³ that social support and environmental factors (family or professional outpatient support) must be considered to determine if the outpatient setting is indeed the safest and most appropriate setting for a patient. As we recommend to our members, a *“full discussion with the patient and family as to the risks and potential benefits of same-day discharge after hip and knee replacement be carried out.”* Several institutions proactively use predictive tools to inform discharge planning after critical surgeries, including orthopaedic procedures. We propose that CMS and its contractors either recommend an existing tool or provide guidance on using such a tool so that it is easier for surgeons and the hospitals to establish risk profiles of patients.

We ask that CMS consider these criteria and social determinants when forming guardrails around the performance of procedures in the outpatient setting. **We believe that without socio-demographic considerations, patients, surgeons and hospitals in underserved communities will bear a disproportionate burden and unintended consequence of this policy change.**

Another unintended consequence of change in recommended setting for surgery is the out-of-pocket costs to patients in traditional Medicare. As CMS states on their website, “the copayment for a single outpatient hospital service can’t be more than the inpatient hospital deductible.” However, a patient’s total copayment for the cumulative cost of all outpatient services may be equal to an amount greater than the inpatient hospital deductible.⁴

¹ Cancienne, J. M., Brockmeier, S. F., Gulotta, L. V., Dines, D. M., & Werner, B. C. (2017). Ambulatory total shoulder arthroplasty: a comprehensive analysis of current trends, complications, readmissions, and costs. *JBJS*, 99(8), 629-637.

² Ohta, B, Mola, A, Rosenfeld, P and Ford, S 2016 Early Discharge Planning and Improved Care Transitions: Pre-Admission Assessment for Readmission Risk in an Elective Orthopedic and Cardiovascular Surgical Population. *International Journal of Integrated Care*, 16(2): 10, pp. 1–10, DOI: <http://dx.doi.org/10.5334/ijic.2260>

³ Endorsed by The American Academy of Orthopaedic Surgeons, The Hip Society and The Knee Society: Position of the American Association of Hip and Knee Surgeons. Outpatient Joint Replacement. Available: <http://www.aahks.org/position-statements/outpatient-joint-replacement/>

⁴ Inpatient or outpatient hospital status affects your costs. Medicare.gov. Available at: <https://www.medicare.gov/what-medicare-covers/what-part-a-covers/inpatient-or-outpatient-hospital-status>

Overall, AAOS believes that determining the appropriate setting of care should be done through the lens of patient safety and peer-reviewed evidence, and that physicians are best qualified to lead this individualized decision-making process with their patients.

Updates to the Two-Midnight Rule

Last year, as you are aware, CMS finalized a policy to allow for indefinite exemption from the site-of-service claim denials, Beneficiary and Family Centered Care-Quality Improvement Organizations (BFCC-QIO) referrals to Recovery Audit Contractors (RACs), and RAC reviews for patient status/site-of-service until there was enough Medicare claims data to show that a particular procedure was more frequently performed in the outpatient setting than in the inpatient setting. **We urge CMS to maintain this policy of indefinite exemption, as finalized, and not consider the proposal to revise the medical review exemption period to two years.** This is especially significant in light of the sweeping reversal of policy regarding the IPO list and given the challenges, as discussed below.

Challenges in Providing Orthopaedic Surgeries Under the Two-Midnight Rule

The AAOS would like to reshare with CMS some of the challenges musculoskeletal patients and their orthopaedic surgeons faced when total knee and total hip arthroplasties were earlier removed from the IPO list within the last few years. In 2018-19, AAOS and the American Association of Hip and Knee Surgeons (AAHKS) worked closely with CMS staff to develop additional guidance in this regard.⁵ We have always supported removal of procedures from the IPO List so long as physicians would maintain control over most clinically appropriate admission status for patients.

- ***Hospital Response.*** Hospitals have responded differently to the prospect of future RAC reviews. Some hospitals interpreted the new policy correctly and consistent with CMS statements. Others, however, implemented policies stating that they will not submit claims for any exceptions to the Two-Midnight Rule for procedures that include hospital stays spanning for more than 24 hours, but less than two midnights. Still other hospitals have expressed to surgeons their expectation that most surgeries for Medicare beneficiaries will be performed on an outpatient basis. As you are aware, outpatient surgeries are assumed to be less resource intensive and hence reimbursed less. For hospitals, making the outpatient setting the default for surgeries implies less staff and resource allocation, thereby violating one of the critical requirements for such complicated surgeries where the outcomes are dependent on myriad factors including patient health status and socio-demographic conditions. Most of these factors are not controlled by the surgeon. Hence, surgeons should not be forced away from patient care by burdening them with additional paperwork to justify exceptions to this rule. Hospitals may switch to default outpatient status, regardless of the patient's clinical status, in the interest of administrative simplicity. This can lead to patients being forced into discharge when they may be clinically stable, but physically unable to care for themselves. This in

⁵ <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE19002.pdf>

turn significantly increases the risk of an adverse event or accident that will lead to a readmission.

- ***CMS Contract Reviewers Lack Transparent Standards.*** Physicians and other providers are unclear how Medicare’s contracted reviewers such as RACs and BFCC-QIOs were interpreting and applying the Case-by-Case Exceptions Policy to the Two-Midnight Rule. Such information would better inform providers of when an exception is or is not justified and worth the time and effort to appeal.
- ***Inappropriate Denial of Coverage by Medicare Advantage for Inpatient Surgeries.*** There were widespread denials of payment for inpatient stays, especially from Medicare Advantage (MA) plans, that spanned less than two midnights. CMS must provide strong and appropriate oversight of MA plans. CMS should make clear to MA plans that the IPO List should not be used to justify coverage policies. Rather, MA plans are obligated to provide the same Parts A & B benefits to enrollees as are received by fee-for-service beneficiaries.

Recommendations on specific musculoskeletal procedures included in the Medicare IPO List

To help the agency with policy around the IPO List, AAOS has developed recommendations on specific musculoskeletal procedures. This is by no means exhaustive, and we would still request for a technical expert panel to develop detailed recommendations on this topic. The AAOS would also like to discuss these recommendations with CMS leadership. We have grouped IPO List procedures under three distinct categories:

1. Should be removed from the IPO List
2. Should stay on the IPO List
3. Decision-making should be left to the surgeon and patient

Should be removed from the IPO List

Procedures such as CPT code 27702, “*Under Repair, Revision, and/or Reconstruction Procedures on the Leg (Tibia and Fibula) and Ankle Joint*” and CPT code 26556, “*Under Repair, Revision, and/or Reconstruction Procedures on the Hand and Fingers*” can be safely performed in the outpatient setting and need not be on the IPO List.

Should stay on the IPO List

Amputation procedures such as CPT code 27888, “*Amputation of foot at ankle*” and CPT code 28800, “*Amputation of midfoot*” must remain on the IPO List for now. Similarly, there are some trauma procedures such as CPT code G0415, “*Open treatment of posterior pelvic bone fracture and/or dislocation, for fracture patterns which disrupt the pelvic ring, unilateral or bilateral, includes internal fixation, when performed (includes ilium, sacroiliac joint and/or sacrum)*” and CPT code G0414, “*Open treatment of anterior pelvic ring fracture and/or dislocation for fracture patterns which disrupt the pelvic ring, unilateral or bilateral, includes internal fixation when performed*”

(includes pubic symphysis and/or superior/inferior rami)” that must have mandatory coverage in the inpatient setting.

Decision-making should be left to the surgeon and patient

Procedures specified by CPT code 27457, *"Under Repair, Revision, and/or Reconstruction Procedures on the Femur (Thigh Region) and Knee Joint"* and CPT code 27486 *"Revise/replace knee joint"* can have varied outcomes depending on patient’s health status and socio-demographic situation and must be left for shared decision making by the surgeon and the patient. Surgeons know their patients the best and it is ineffective and even harmful to have payors or compliance experts decide on the setting of care without full understanding of the individual situation.

Note: Please refer to the attached addendum for more details on these recommendations. This list is indicative only.

Physician-Owned Hospitals

The AAOS applauds CMS for lifting the prohibition on the expansion of Physician-Owned Hospitals (POHs) for high Medicaid facilities in CY2021 OPPI/ASC Final Rule. We view this as a positive step toward providing high quality care by value-driven physicians. Thinking ahead to further expansion, we encourage CMS and HHS to explore all regulatory avenues for lifting the arbitrary ban on new and expanding POHs. Considering the ongoing issues brought to the forefront as a result of the COVID-19 pandemic, the value of POHs has never been as evident. They contribute to local economies, meet a growing demand for health care services, and can shift focus and address frontline issues without the administrative red tape that cripples larger hospital systems. A comprehensive peer-reviewed study published in the British Medical Journal found that, overall, physician-owned hospitals have similar proportions of Medicaid patients and racial minorities as other hospitals and perform comparably to other hospitals on benchmarks for quality of care.⁶

The Secretary has broad authority in creating a new demonstration project for POHs through the Center for Medicare and Medicaid Innovation, which would include a waiver or exemption to allow POHs to expand if they are accepted into the program. Moreover, based on legal analysis of the relevant statutes, regulations, and guidance regarding Section 1115 waivers, the Secretary has broad authority to lift the POH moratorium. **AAOS asks that all the regulatory options are thoroughly explored to allow POH expansion as the healthcare ecosystem continues to diversify to meet the needs of our nation’s most vulnerable beneficiaries.**

Prior-authorization in the Outpatient Setting

⁶ Blumenthal, D. M., Orav, E. J., Jena, A. B., Dudzinski, D. M., Le, S. T., & Jha, A. K. (2015). Access, quality, and costs of care at physician owned hospitals in the United States: observational study. *BMJ*, 351.

AAOS has serious concerns with the continuation of prior authorization in the outpatient setting. These concerns were previously raised in our comments on the 2020 and 2021 OPSS proposed rule and remain at present given that this year's proposed rule while not expanding prior authorization requirements did not withdraw the program. We are concerned that the continued use of these requirements will supersede physician autonomy, increase administrative burden, and negatively impact patient care. AAOS is concerned that requiring prior approval from a third-party removed from clinical decision-making erodes the doctor-patient relationship, and the ability to make decisions that are in the best interest of the patient. Moreover, necessary patient care could be significantly delayed, which could lead to adverse patient outcomes. Additional resources and energy may be diverted away from optimizing patient care and towards fulfilling these new administrative requirements. Practitioners already face significant operational challenges to ensure patients receive appropriate, timely and effective care. Indeed, the unrelenting public health emergency has only exacerbated prior-authorization related burden. Hence, we urge CMS to withdraw this program and request for stakeholder comment especially considering the proposal to reverse the elimination of the IPO List.

Future Inclusion of Hospital-Level, Risk Standardized Patient Reported Outcomes Measure Following Elective Primary Total Hip and/or Total Knee Arthroplasty (NQF# 3559) in the Hospital IQR/OQR Programs

CMS is considering future inclusion of Hospital-Level, Risk Standardized Patient Reported Outcomes Measure Following Elective Primary Total Hip and/or Total Knee Arthroplasty (NQF# 3559) to the Hospital IQR and OQR Programs and is seeking stakeholder feedback on numerous aspects of implementation. Most significant for orthopaedic surgeons is the idea of expanding the measure to non-inpatient settings, which is an important consideration given the recent removal of TKA and THA procedures from the Inpatient Only List in the CY 2018 and CY 2020 OPSS/ASC final rules, respectively.

In general, AAOS is supportive of the recommended measure, NQF# 3559. We appreciate the inclusion of orthopaedic surgeons in the Technical Expert Panel and Expert Clinical Consultants behind the development of this measure. Additionally, we are pleased to see adoption of recommendations from the 2015 Patient Reported Outcomes Summit for Total Joint Arthroplasty, particularly the selection of the PROMIS-Global or The VR-12 Health Survey to measure general health in addition to disease-specific instruments, the Hip dysfunction and Osteoarthritis Outcome Score for Joint Replacement (HOOS, JR) and the Knee injury and Osteoarthritis Outcome Score for Joint Replacement (KOOS, JR).

There is a long history of using PROMs in orthopaedic research and clinical care, from which invaluable insight into the barriers to successful measurement and quality improvement can be gained. According to the AAOS Position Statement 1188 on Principles for Musculoskeletal Based Patient Reported Outcome-Performance Measurement Development, "efforts to incorporate PRO measurement into routine clinical practice have been more challenging, though significant progress has been made in developing and validating PROMs for specific musculoskeletal disorders or

treatments and those that give a broader picture of general health status.”⁷ Some specific challenges to applying PRO measurement in routine clinical care are implementation and response rates.

AAOS strongly supports the use of registries for collection, standardization, and submission of PROMs to CMS. The Agency may ease implementation and improve response rates by encouraging use of clinical data registries that aid participant hospitals in PRO data collection. For example, participant sites in the AAOS American Joint Replacement Registry (AJRR) can collect Veterans RAND 12 Item Health Survey (VR-12), Patient-Reported Outcomes Measurement Information System (PROMIS) Global-10 generic PRO survey, the Hip disability and Osteoarthritis Outcome Score (HOOS)/Knee injury, and Osteoarthritis Outcome Score (KOOS) Jr. data via our PRO portal.

AJRR participant sites and individual surgeons can view dashboards for their patients’ PROMs and compare them to national scores, which allows clinicians to spend more time focusing on improving patient outcomes instead of dealing with PRO survey collection and follow-up activities. For registry-based PROMs reporting, CMS should seek to ensure that measures are reported via QCDRs with demonstrated capabilities to report the specific PROM.

The importance of risk adjustment in measuring and comparing PRO-PMs cannot be overstated. We support the risk adjustment model utilized in NQF #3559, which calculates a hospital-specific risk-standardized improvement rates (RSIRs) that produces a performance measure per hospital and accounts for patient case mix.⁸ However, it should be noted that dual eligibility is not included in the risk adjustment model for NQF# 3559. An analysis of Comprehensive Care for Joint Replacement Model Program Year 2 data showed hospitals with a high percentage of dual-eligible beneficiaries (patients with both Medicare and Medicaid insurance) were more likely than low-dual hospitals to be penalized (24.3% vs 13.7%).⁹ Financial penalties as a result of caring for more clinically and/or socio-economically complex patients further reinforces a system that provides fewer resources to safety-net hospitals and capitulates healthcare outcome disparities. **In this way, we ask that CMS consider additional socio-economic risk stratification in measure implementation to avoid unintended consequences.**

In summary, we applaud the Agency for taking this important step towards implementing performance measures based on outcomes that matter most to our patients and look forward to working with you to

⁷ American Academy of Orthopaedic Surgeons. (2018, March). *Principles for Musculoskeletal Based Patient Reported Outcome-Performance Measurement Development*. AAOS Position Statement 1188.

<https://www.aaos.org/contentassets/1cd7f41417ec4dd4b5c4c48532183b96/1188-principles-for-musculoskeletal-based-patient-reported-outcome-performance-measurement-development.pdf>

⁸ Yale New Haven Health Services Corporation – Center for Outcomes Research and Evaluation. (2021, March). *Patient-Reported Outcomes (PROs) Following Elective Primary Total Hip and/or Total Knee Arthroplasty: Hospital Level Performance Measure Version 1.0 Methodology Report*.

⁹ Kim, H., Meath, T. H., Dobbertin, K., Quiñones, A. R., Ibrahim, S. A., & McConnell, K. J. (2019). Association of the Mandatory Medicare Bundled Payment With Joint Replacement Outcomes in Hospitals With Disadvantaged Patients. *JAMA network open*, 2(11), e1914696-e1914696.

implement these measures in an effort to provide feedback to clinical teams and ultimately improve patient health outcomes following these life altering procedures.

Request for Information on Closing the Health Equity Gap in CMS Hospital Quality Programs

AAOS appreciates the opportunity to comment on the Agency’s request for information on closing the health equity gap in CMS Hospital Quality Programs. As we have stated in prior comments, AAOS is supportive of gathering meaningful patient data to support both the individual and population-level mitigation of health disparities. We request that CMS consider the following determinants which are of particular relevance to musculoskeletal care:

- Body Mass Index (BMI) – The actual height and weight should be recorded. The BMI should not be captured from the administrative data. The height and weight are currently being recorded in many electronic health records (EHR).¹⁰
- Smoking Status – Smoking status may be reported through administrative data, but additional information may be provided from the EHR.¹¹
- Age – Age is reported in administrative data.¹²
- Sex – Sex is reported in administrative data.¹³
- Back Pain – Back pain would be a patient-reported variable and recorded in the EHR. It has been noted to influence outcomes of joint replacement patients.¹⁴
- Pain in non-operative lower extremity joint – Pain in a non-operative lower extremity joint would be a patient-reported variable and recorded in the EHR. It has been noted that pain in other extremities can influence the outcome of a total joint replacement.¹⁵
- Health Risk Status – The actual comorbidities that should be included need further investigation. Both the Charlson morbidity index and the Elixhauser morbidity measure may identify appropriate comorbid conditions.¹⁶ In order to identify the patient’s comorbid conditions, it is recommended that all inpatient and outpatient diagnosis codes for the prior year be evaluated.¹⁷

¹⁰ ASPE (2016). Report to Congress: Social Risk Factors and Performance Under Medicare's Value-Based Purchasing Programs. Available: <https://aspe.hhs.gov/pdf-report/report-congress-social-risk-factors-and-performance-under-medicares-value-based-purchasing-programs>

¹¹ Ibid.

¹² Ibid.

¹³ Ibid.

¹⁴ Karran, E. L., Grant, A. R., & Moseley, G. L. (2020). Low back pain and the social determinants of health: a systematic review and narrative synthesis. *Pain*, 161(11), 2476–2493. <https://doi.org/10.1097/j.pain.0000000000001944>

¹⁵ Perruccio, A. V., Power, J. D., Evans, H. M., Mahomed, S. R., Gandhi, R., Mahomed, N. N., & Davis, A. M. (2012). Multiple joint involvement in total knee replacement for osteoarthritis: Effects on patient-reported outcomes. *Arthritis care & research*, 64(6), 838–846. <https://doi.org/10.1002/acr.21629>

¹⁶ Austin, S. R., Wong, Y. N., Uzzo, R. G., Beck, J. R., & Egleston, B. L. (2015). Why Summary Comorbidity Measures Such As the Charlson Comorbidity Index and Elixhauser Score Work. *Medical care*, 53(9), e65–e72. <https://doi.org/10.1097/MLR.0b013e318297429c>

¹⁷ National Alliance to Impact the Social Determinants of Health. (2019). (issue brief). *Identifying Social Risk and Needs in Health Care*. Retrieved from <https://www.nasdoh.org/wp-content/uploads/2019/01/NASDOH-Social-Risks-Issue-Brief.pdf>

- Depression/Mental Health Status – The Patient-Reported Outcomes Measurement Information System (PROMIS) Global or VR-12 will collect this variable, as well as the administrative data.¹⁸
- Chronic Narcotic or Pre-operative Narcotic Use – These variables affect patient outcomes and requires additional consideration. The information should be available in the EHR.¹⁹

In addition to the above clinical factors which impact outcomes on the individual level, we ask that CMS also consider access to transportation, social support, and health literacy.²⁰ These factors all contribute to a patient’s successful treatment and lead to improved outcomes for both chronic and acute musculoskeletal care. Particularly in light of the disparities made evident during the pandemic, it is essential that patients and physicians have the tools to support a robust model of shared decision-making.

Moreover, AAOS has developed comprehensive definitions of quality and value in orthopaedics. Whereas quality is defined as the successful delivery of appropriate, evidence-based musculoskeletal healthcare in an effort to achieve sustained patient-centered improvements in health outcomes and quality of life exemplified by a physician-led musculoskeletal team focused on the individual patient’s preferences in the delivery of care that is safe, accessible, equitable, and timely; and that fosters evidence-based innovation essential for the advancement of professional and scientific knowledge.

The AAOS has defined ‘value’ of health care as the relationship of a patient-centered health outcome to the total cost required to reach that outcome, given that care is: evidence-based, appropriate, timely, sustainable, and occurs throughout a full cycle of musculoskeletal care for a patient’s condition; and that cost of musculoskeletal care is an investment and includes consideration of greater lifestyle and economic impacts.

We encourage CMS to consider these definitions vis-à-vis the goals of assessing quality and value in an equitable health care environment.

Thank you for your time and attention to the concerns of the American Association of Orthopaedic

¹⁸ Oak, S. R., Strnad, G. J., Bena, J., Farrow, L. D., Parker, R. D., Jones, M. H., & Spindler, K. P. (2016). Responsiveness Comparison of the EQ-5D, PROMIS Global Health, and VR-12 Questionnaires in Knee Arthroscopy. *Orthopaedic Journal of Sports Medicine*, 4(12), 232596711667471. <https://doi.org/10.1177/2325967116674714>

¹⁹ Kidner, C. L., Mayer, T. G., & Gatchel, R. J. (2009). Higher opioid doses predict poorer functional outcome in patients with chronic disabling occupational musculoskeletal disorders. *The Journal of bone and joint surgery. American volume*, 91(4), 919–927. <https://doi.org/10.2106/JBJS.H.00286>

²⁰ Artiga, S., & Hinton, E. (2018). (issue brief). *Beyond Health Care: The Role of Social Determinants in Promoting Health and Health Equity* Kaiser Family Foundation. Retrieved from <https://files.kff.org/attachment/issue-brief-beyond-health-care>

Surgeons (AAOS) on the significant proposals made in the CY 2022 OPPTS/ASC proposed rule. The AAOS looks forward to working closely with CMS on further improving the payment system, and to enhancing the care of musculoskeletal patients in the United States. More specifically, we would like to have a focused discussion on musculoskeletal procedures in the Medicare IPO List while CMS develops policy around it. Should you have questions on any of the above comments, please do not hesitate to contact Shreyasi Deb, PhD, MBA, AAOS Office of Government Relations at deb@aaos.org.

Sincerely,



Daniel K. Guy, MD, FAAOS
President, AAOS

cc: Felix H. Savoie, III, MD, FAAOS, First Vice-President, AAOS
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Alabama Orthopaedic Society
American Association for Hand Surgery
American Association of Hip and Knee Surgeons
American Orthopaedic Foot & Ankle Society
American Orthopaedic Society for Sports Medicine
American Osteopathic Academy of Orthopedics
American Society for Surgery of the Hand
American Shoulder and Elbow Surgeons
Arizona Orthopaedic Society
Arkansas Orthopaedic Society
Arthroscopy Association of North America
Atlantic Orthopaedic Specialists
California Orthopaedic Association
Connecticut Orthopaedic Society
Delaware Society of Orthopaedic Surgeons
Georgia Orthopaedic Society
Iowa Orthopaedic Society
Kansas Orthopaedic Society

Maryland Orthopaedic Association
Massachusetts Orthopaedic Association
Michigan Orthopaedic Society
Midlands Orthopaedics & Neurosurgery
Minnesota Orthopaedic Society
Missouri State Orthopaedic Association
New York State Society of Orthopaedic Surgeons
North Dakota Orthopaedic Society
Ohio Orthopaedic Society
OrthoAtlanta
The OrthoForum
OrthoVA
Orthopaedic Rehabilitation Association
Orthopaedic Trauma Association
Pediatric Orthopaedic Society of North America
Pennsylvania Orthopaedic Society
Rhode Island Orthopedic Society
Scoliosis Research Society
South Dakota State Orthopaedic Society
Tennessee Orthopaedic Society
Virginia Orthopaedic Society
Washington State Orthopaedic Association
West Virginia Orthopaedic Society
Wyoming Orthopaedic Society

Table 48 – Services Removed from the Inpatient Only (IPO) List for CY 2021

CPT codes and descriptions only are copyright 2020 American Medical Association. All Rights Reserved. Applicable FARS/DFARS Apply.

CY 2021 CPT Code	CY 2021 Short Descriptor	CY 2021 OPPTS APC Assignment	Should be removed from the IPO	Should stay on the IPO	Should be left to the surgeon and patient for decision-making
00192	Anesth facial bone surgery	N/A			
00474	Anesth surgery of ri	N/A			
00604	Anesth sitting procedur	N/A			
00904	Anesth perineal surger	N/A			
0095T	Rmvl artifice disc addl crvcl	N/A			
0098T	Rev artifice disc add	N/A			
01140	Anesth amputation at pelvis	N/A		x	
01150	Anesth pelvic tumor surgery	N/A		x	
01212	Anesth hip disarticulation	N/A		x	
01232	Anesth amputation of femur	N/A		x	
01234	Anesth radical femur surg	N/A		x	
01274	Anesth femoral embolectomy	N/A			
01404	Anesth amputation at knee	N/A		x	
01486	Anesth ankle replacement	N/A	X		

0163T	Lumb artif diskectomy addl	N/A			
01634	Anesth shoulder joint amput	N/A			x
01636	Anesth forequarter amput	N/A			
01638	Anesth shoulder replacement	N/A	x		
0164T	Remove lumb artif disc add	N/A			
0165T	Revise lumb artif disc addl	N/A			
01756	Anesth radical humerus sur	N/A			x
0202T	Post vert arthrplst 1 lumbar	5115			
0219T	Plmt post facet implt cerv	5115			
0220T	Plmt post facet implt thor	5115			
20661	Application of head brace	5113			

20664	Application of halo	5113			
20802	Replantation arm complete	5116			
20805	Replant forearm complete	5116			
20808	Replantation hand complete	5116			
20816	Replantation digit complete	5114			
20824	Replantation thumb complete	5114			
20827	Replantation thumb complete	5114			
20838	Replantation foot complete	5116			
20955	Fibula bone graft microvasc	5114			
20956	Iliac bone graft microvasc	5114			
20957	Mt bone graft microvasc	5114			
20962	Other bone graft microvasc	5114			
20969	Bone/skin graft microvasc	5114			
20970	Bone/skin graft iliac crest	5114			
21045	Extensive jaw surgery	5165			
21141	Refort i-1 piece w/o graft	5165			
21142	Refort i-2 piece w/o graft	5165			
21143	Refort i-3/> piece w/o graft	5165			
21145	Refort i-1 piece w/ graft	5165			

21146	Defort i-2 piece w/ graft	5165			
21147	Defort i-3/> piece w/ graft	5165			
21151	Defort ii w/bone grafts	5165			
21154	Defort iii w/o lefort i	5165			
21155	Defort iii w/ lefort i	5165			
21159	Defort iii w/fhdw/o lefort i	5165			
21160	Defort iii w/fhd w/ lefort i	5165			
21179	Reconstruct entire forehead	5165			
21180	Reconstruct entire forehead	5165			
21182	Reconstruct cranial bone	5165			
21183	Reconstruct cranial bone	5165			

21184	Reconstruct cranial bone	5165			
21188	Reconstruction of midface	5165			
21194	Reconst lwr jaw w/graft	5165			
21196	Reconst lwr jaw w/fixation	5165			
21247	Reconstruct lower jaw bone	5165			
21255	Reconstruct lower jaw bone	5165			
21268	Revise eye sockets	5165			
21343	Open tx dprsd front sinus fx	5165			
21344	Open tx compl front sinus fx	5165			
21347	Open tx nasomax fx multiple	5165			
21348	Open tx nasomax fx w/graft	5165			
21366	Open tx complx malar w/grft	5165			
21422	Treat mouth roof fracture	5165			
21423	Treat mouth roof fracture	5165			

21431	Treat craniofacial fracture	5165			
21432	Treat craniofacial fracture	5165			
21433	Treat craniofacial fracture	5165			
21435	Treat craniofacial fracture	5165			
21436	Treat craniofacial fracture	5165			
21510	Drainage of bone lesion	5114	x		
21602	Exc ch wal tum w/o lymphadec	5114			
21603	Exc ch wal tum w/lymphadec	5114			
21615	Removal of rib	5114			
21616	Removal of rib and nerves	5114			
21620	Partial removal of sternum	5114			x
21627	Sternal debridement	5114			x
21630	Extensive sternum surgery	5114			
21632	Extensive sternum surgery	5114			
21705	Revision of neck muscle/rib	5114			
21740	Reconstruction of sternum	5114			
21750	Repair of sternum separation	5114			
21825	Treat sternum fracture	5114			
22010	Exc d p-spine c/t/cerv-thor	5114			x
22015	Exc d abscess p-spine l/s/l	5114			x

22110	Remove part of neck vertebra	5114		x	
22112	Remove part thorax vertebra	5114		x	
22114	Remove part lumbar vertebra	5114		x	
22116	Remove extra spine segment	N/A		x	
22206	Incis spine 3 column thorac	5114		x	
22207	Incis spine 3 column lumbar	5114		x	
22208	Incis spine 3 column adl seg	N/A		x	
22210	Incis 1 vertebral seg cerv	5114		x	
22212	Incis 1 vertebral seg thorac	5114		x	
22214	Incis 1 vertebral seg lumbar	5114		x	
22216	Incis addl spine segment	N/A		x	
22220	Incis w/discectomy cervical	5114		x	

22222	Incis w/discectomy thoracic	5114		x	
22224	Incis w/discectomy lumbar	5114		x	
22226	Revise extra spine segment	N/A		x	
22318	Treat odontoid fx w/o graft	5115	x		
22319	Treat odontoid fx w/graft	5115	x		
22325	Treat spine fracture	5115	x		
22326	Treat neck spine fracture	5115	x		
22327	Treat thorax spine fracture	5115			x
22328	Treat each add spine fx	N/A			x
22532	Pat thorax spine fusion	5116	x		
22533	Pat lumbar spine fusion	5116	x		

22534	Flat thor/lumb addl seg	N/A	x		
22548	Neck spine fusion	5116			x
22556	Thorax spine fusion	5116			x
22558	Lumbar spine fusion	5116			x
22586	Prescr1 fuse w/ instr l5-s1	5116			x
22590	Spine & skull spinal fusion	5116			x
22595	Neck spinal fusion	5116			x
22600	Neck spine fusion	5116			x
22610	Thorax spine fusion	5116			x
22630	Lumbar spine fusion	5116			x
22632	Spine fusion extra segment	N/A			x
22800	Post fusion </6 vert seg	5116		x	
22802	Post fusion 7-12 vert seg	5116		x	

22804	Post fusion 13/> vert seg	5116		x	
22808	Ant fusion 2-3 vert seg	5116		x	
22810	Ant fusion 4-7 vert seg	5116		x	
22812	Ant fusion 8/> vert seg	5116		x	
22818	Typhectomy 1-2 segments	5116		x	
22819	Typhectomy 3 or more	5116		x	
22830	Exploration of spinal fusion	5115	x		
22841	Insert spine fixation device	N/A	x		
22843	Insert spine fixation device	N/A		x	
22844	Insert spine fixation device	N/A		x	
22846	Insert spine fixation device	N/A		x	
22847	Insert spine fixation device	N/A		x	
22848	Insert pelv fixation device	N/A		x	
22849	Reinsert spinal fixation	5116			x
22850	Remove spine fixation device	5115			x
22852	Remove spine fixation device	5115		x	

22855	Remove spine fixation device	5115		x	
22857	Lumbar artif disectomy	5116		x	
22861	Revise cerv artific disc	5116			x
22862	Revise lumbar artif disc	5116			x
22864	Remove cerv artif disc	5115			x
22865	Remove lumb artif disc	5115			x
23200	Resect clavicle tumor	5114	x		
23210	Resect scapula tumor	5114	x		
23220	Resect prox humerus tumor	5114	x		
23335	Shoulder prosthesis removal	5073	x		
23472	Reconstruct shoulder joint	5115	x		
23474	Revis reconst shoulder joint	5115	x		
23900	Amputation of arm & girdle	5115			x
23920	Amputation at shoulder joint	5115			x
24900	Amputation of upper arm	5115			x
24920	Amputation of upper arm	5115			x
24930	Amputation follow-up surgery	5114			x
24931	Amputate upper arm & implant	5115			x
24940	Revision of upper arm	5115	x		
25900	Amputation of forearm	5115	x		
25905	Amputation of forearm	5115	x		
25915	Amputation of forearm	5114	x		
25920	Amputate hand at wrist	5114	x		

25924	Amputation follow-up surgery	5114	x		
25927	Amputation of hand	5113	x		
26551	Great toe-hand transfer	5114			x
26553	Single transfer toe-hand	5114			x
26554	Double transfer toe-hand	5114			x
26556	Toe joint transfer	5114	x		
26992	Drainage of bone lesion	5114	x		
27005	Incision of hip tendon	5114	x		
27025	Incision of hip/thigh fascia	5114	x		
27030	Drainage of hip joint	5114	x		
27036	Excision of hip joint/muscle	5114	x		
27054	Removal of hip joint lining	5113	x		
27070	Part remove hip bone super	5114			x
27071	Part removal hip bone deep	5114			x
27075	Resect hip tumor	5114			
27076	Resect hip tum incl acetabul	5114			
27077	Resect hip tum w/innom bone	5115			
27078	Resect hip tum incl femur	5115			
27090	Removal of hip prosthesis	5073			
27091	Removal of hip prosthesis	5073			

27120	Reconstruction of hip socket	5115			
27122	Reconstruction of hip socket	5115			
27125	Partial hip replacement	5115			
27132	Total hip arthroplasty	5115			
27134	Revise hip joint replacement	5115			
27137	Revise hip joint replacement	5115			
27138	Revise hip joint replacement	5115			
27140	Transplant femur ridge	5115		x	
27146	Incision of hip bone	5114		x	
27147	Revision of hip bone	5114		x	
27151	Incision of hip bones	5114		x	
27156	Revision of hip bones	5114		x	
27158	Revision of pelvis	5114		x	
27161	Incision of neck of femur	5114		x	
27165	Incision/fixation of femur	5114		x	
27170	Repair/graft femur head/neck	5114			
27175	Treat slipped epiphysis	5114			
27176	Treat slipped epiphysis	5115			
27177	Treat slipped epiphysis	5114			
27178	Treat slipped epiphysis	5114			
27181	Treat slipped epiphysis	5114			

27185	Revision of femur epiphysis	5114			
27187	Reinforce hip bones	5114			x
27222	Treat hip socket fracture	5111		x	
27226	Treat hip wall fracture	5114		x	
27227	Treat hip fracture(s)	5114		x	
27228	Treat hip fracture(s)	5114		x	
27232	Treat thigh fracture	5112		x	
27236	Treat thigh fracture	5114		x	
27240	Treat thigh fracture	5112		x	
27244	Treat thigh fracture	5114		x	
27245	Treat thigh fracture	5114		x	
27248	Treat thigh fracture	5114		x	
27253	Treat hip dislocation	5113		x	
27254	Treat hip dislocation	5113		x	

27258	Treat hip dislocation	5113			
27259	Treat hip dislocation	5113			
27268	Ortx thigh fx w/mnpj	5113		x	
27269	Orptx thigh fx	5112		x	
27280	Fusion of sacroiliac joint	5116		x	
27282	Fusion of pubic bones	5115		x	
27284	Fusion of hip joint	5116		x	
27286	Fusion of hip joint	5116		x	
27290	Amputation of leg at hip	5116		x	
27295	Amputation of leg at hip	5116		x	
27303	Drainage of bone lesion	5114			x
27365	Resect femur/knee tumor	5114			
27445	Revision of knee joint	5115			
27448	Incision of thigh	5114			x
27450	Incision of thigh	5114			x
27454	Realignment of thigh bone	5114		x	
27455	Realignment of knee	5114			
27457	Realignment of knee	5114			x
27465	Shortening of thigh bone	5114			x
27466	Lengthening of thigh bone	5114			x

27468	Shorten/lengthen thighs	5114		x	
27470	Repair of thigh	5114			x
27472	Repair/graft of thigh	5114			x
27486	Revise/replace knee joint	5115			x
27487	Revise/replace knee joint	5115			
27488	Removal of knee prosthesis	5114			
27495	Reinforce thigh	5114		x	
27506	Treatment of thigh fracture	5114		x	
27507	Treatment of thigh fracture	5114		x	
27511	Treatment of thigh fracture	5114		x	
27513	Treatment of thigh fracture	5114		x	
27514	Treatment of thigh fracture	5114		x	
27519	Treat thigh fx growth plate	5114		x	
27535	Treat knee fracture	5114			x
27536	Treat knee fracture	5114		x	

27540	Treat knee fracture	5114			x
27556	Treat knee dislocation	5114		x	
27557	Treat knee dislocation	5114			x
27558	Treat knee dislocation	5114			x
27580	Fusion of knee	5115			x
27590	Amputate leg at thigh	5116		x	
27591	Amputate leg at thigh	5116		x	
27592	Amputate leg at thigh	5116		x	
27596	Amputation follow-up surgery	5114		x	
27598	Amputate lower leg at knee	5115		x	
27645	Resect tibia tumor	5114			
27646	Resect fibula tumor	5114			
27702	Reconstruct ankle joint	5115	x		
27703	Reconstruction ankle joint	5115	x		
27712	Realignment of lower leg	5115	x		
27715	Revision of lower leg	5115	x		
27724	Repair/graft of tibia	5114	x		
27725	Repair of lower leg	5114	x		
27727	Repair of lower leg	5114	x		
27880	Amputation of lower leg	5116		x	
27881	Amputation of lower leg	5114		x	
27882	Amputation of lower leg	5114		x	
27886	Amputation follow-up surgery	5114			x

27888	Amputation of foot at ankle	5115		x	
28800	Amputation of midfoot	5113		x	
G0412	Open tx iliac spine uni/bil	5114			x
G0414	Pelvic ring fx treat int fix	5115		x	
G0415	Open tx post pelvic fxcture	5115		x	
35372	Rechanneling of artery	5184			
35800	Explore neck vessels	5184			
37182	Insert hepatic shunt (tips)	5193			
37617	Ligation of abdomen artery	5183			
38562	Removal pelvic lymph nodes	5362			
43840	Repair of stomach lesion	5331			
44300	Open bowel to skin	5302			
44314	Revision of ileostomy	5055			

44345	Revision of colostomy	5341			
44346	Revision of colostomy	5341			
44602	Suture small intestine	5303			
49010	Exploration behind abdomen	5341			
49255	Removal of omentum	5341			
51840	Attach bladder/urethra	5415			
56630	Extensive vulva surgery	5415			
61624	Transcath occlusion cns	5194			