AAOS
American Academy of Orthopaedic Surgeons
American Association of Orthopaedic Surgeons

November 7, 2017

Subject: (CMS–1678–F-C)
Summary of the Centers for Medicare and Medicaid Services Fiscal Year 2018 Outpatient Prospective Payment Systems (OPPS) and Ambulatory Surgery Payment System (ASC) Final Rule with Comment Period

On November 1, 2017, the Centers for Medicare and Medicaid Services (CMS) released the OPPS Final Rule (*CMS-1678-F-C*) with comment period. Although this rule does have a comment period, CMS is only inviting comments on the new level II and III HCPCS codes.

Important issues within the rule include:

- Removal of Total Knee Arthroplasty from the Inpatient Only List (IPO)
- Delay on removing Total and Partial Hip Arthroplasty from IPO
- Computed Radiography payment reductions
- Consideration of future removal of hip, shoulder, and ankle arthroplasty from IPO and addition to Ambulatory Surgery Center covered procedures
- Addition of two cervical disk arthroplasty procedures to ASC covered procedures
- Consideration of hospital market basket for annual ASC payment rates

Removal of Total Knee Arthroplasty (TKA) from the Inpatient-Only List (IPO)

CMS finalized the removal of TKA from the IPO. The AAOS had supported this move, but with certain caveats. CMS responded directly to these concerns, as noted below.

Surgical Site Selection

"The decision regarding the most appropriate care setting for a given surgical procedure is a complex medical judgment made by the physician based on the beneficiary's individual clinical needs and preferences and on the general coverage rules requiring that any procedure be reasonable and necessary. We also reiterate our previous statement that the removal of any procedure from the IPO list does not require the procedure to be performed only on an outpatient basis…we believe that the surgeons, clinical staff, and medical specialty societies who perform outpatient TKA and possess specialized clinical knowledge and experience are most suited to create such guidelines. Therefore, we do not expect to create or endorse specific guidelines or content for the establishment of providers' patient selection protocols."

Recovery Audit Contractor (RAC) Review for Site-of-Service

317 Massachusetts Avenue NE
Suite 100
Washington, D.C. 20002-5701
PHONE 202.546.4430
www.aaos.org/dc

"We would also prohibit RAC review of patient status for TKA procedures performed in the inpatient setting for a period of 2 years to allow providers time to gain experience with these procedures in the outpatient setting."

Effect of Removal on Bundled Payment for Care Improvement (BPCI) and Comprehensive Care for Joint Replacement (CJR)

"We believe that there is a subset of less medically complex TKA cases that could be appropriately and safely performed on an outpatient basis. However, we do not expect a significant volume of TKA cases currently being performed in the hospital inpatient setting to shift to the hospital outpatient setting as a result of removing this procedure from the IPO list. At this time, we expect that a significant number of Medicare beneficiaries will continue to receive treatment as an inpatient for TKA procedures. We do not expect a significant shift in TKA cases from the hospital inpatient setting to the hospital outpatient setting between January 1, 2018 (the effective date for the removal of TKA from the IPO list) and the current end dates of the performance periods for the BPCI and CJR models, September 30, 2018 and December 31, 2020, respectively. Accordingly, we do not expect a substantial impact on the patient-mix for the BPCI and CJR models. We intend to monitor the overall volume and complexity of TKA cases performed in the hospital outpatient department to determine whether any future refinements to these models are warranted."

Delay in TKA addition to Ambulatory Surgery Center (ASC) covered procedures

"While we are finalizing our proposal to remove CPT code 27447 from the OPPS IPO list for CY 2018, we are not adding the procedures to the ASC covered surgical procedures list for CY 2018."

Additional Arthroplasty Procedures for Removal from IPO and Addition to ASC List

"For the remaining CPT codes requested to be removed from the IPO list that describe joint replacement procedures, because of the strong public interest and numerous comments that we have received from stakeholders regarding our proposals to remove other joint replacement procedures, namely the TKA procedure, from the IPO list, we are not removing these procedures from the IPO list at this time to allow for further discussion. We will take these requests into consideration and any proposed policy changes regarding these procedures will be announced in future rulemaking."

"We appreciate the feedback we received as to whether TKA, partial and total hip replacement procedures meet the criteria to be added to the ASC covered surgical procedures list. For CY 2018, we are not removing CPT codes 27125 and 27130 from the OPPS IPO list.

TABLE 77.—PROCEDURES REQUSTED BY COMMENTERS TO BE REMOVED FROM THE CY 2018 INPATIENT ONLY LIST

CY 2018 CPT Code	CY 2018 Long Descriptor

23470	Arthroplasty, glenohumeral joint; hemiarthroplasty
23472	Arthroplasty, glenohumeral joint; total shoulder (glenoid and proximal humeral replacement (eg, total shoulder))
27125	Hemiarthroplasty, hip, partial (eg, femoral stem prosthesis, bipolar arthroplasty)
27130	Arthroplasty, acetabular and proximal femoral prosthetic replacement (total hip arthroplasty), with or without autograft or allograft
27702	Arthroplasty, ankle; with implant (total ankle)
27703	Arthroplasty, ankle; revision, total ankle

Payment Changes for X-rays Taken Using Computed Radiography (CR) Technology

CMS did not resist the statutorily required payment decrease for CR use. It has finalized the 7% decrease for 2018, as well as the subsequent 10% cut for 2023.

Additions to ASC Covered List

CMS has finalized the additions of two disc arthroplasty procedures to ASC covered list.

TABLE 86.—ADDITIONS TO THE LIST OF ASC COVERED SURGICAL PROCEDURES FOR CY 2018

CY 2018 CPT Code	CY 2018 Long Descriptor	CY 2018 ASC Payment Indicator
22856	Total disc arthroplasty (artificial disc), anterior approach, including discectomy with end plate preparation (includes osteophytectomy for nerve root or spinal cord decompression and microdissection); single interspace, cervical	J8
22858	Total disc arthroplasty (artificial disc), anterior approach, including discectomy with end plate preparation (includes osteophytectomy for nerve root or spinal cord decompression and microdissection); second level, cervical (list separately in addition to code for primary procedure)	N1

HOPD Payment Rate

For CY 2018, CMS is increasing the payment rates under the OPPS by an Outpatient Department (OPD) fee schedule increase factor of 1.35 percent. This increase factor is based on the hospital inpatient market basket percentage increase of 2.7 percent for inpatient services paid under the

hospital inpatient prospective payment system (IPPS), minus the multifactor productivity (MFP) adjustment of 0.6 percentage point, and minus a 0.75 percentage point adjustment required by the Affordable Care Act. CMS will continue to implement the statutory 2.0 percentage point reduction in payments for hospitals failing to meet the hospital outpatient quality reporting requirements, by applying a reporting factor of 0.980 to the OPPS payments and copayments for all applicable services.

CMS is continuing the adjustment of 7.1 percent to the OPPS payments to certain rural SCHs, including essential access community hospitals (EACHs). This adjustment will apply to all services paid under the OPPS, excluding separately payable drugs and biologicals, devices paid under the pass-through payment policy, and items paid at charges reduced to cost.

Hospital Outpatient Quality Reporting (OQR) Program

CMS has finalized the removal of 6 measures from the OQR measure set for the CY 2020 payment determination and subsequent years. Those with significance for the AAOS membership include: OP-21: Median Time to Pain Management for Long Bone Fracture was removed due to concerns that it might create undue pressure for hospital staff to prescribe more opioids. OP-26: Hospital Outpatient Volume Data on Selected Outpatient Surgical Procedures because there is a lack of evidence to support this measure's link to improved clinical quality. OP-25: Safe Surgery Checklist Use has topped out.

CMS also finalized the proposal to delay implementation of the Outpatient and Ambulatory Surgery Consumer Assessment of Healthcare Providers and Systems (OAS CAHPS) Survey-based Measures (OP–37a–e) beginning with the CY 2020 payment determination (CY 2018 data collection) in order to collect more operational and implementation data.

ASC Payment Rates

CMS will continue to use the CPI–U update factor to update ASC rates for CY 2018. The final ASC conversion factor of $45.575, for ASCs that meet the quality reporting requirements, is the product of the CY 2017 conversion factor of $45.003 multiplied by the wage index budget neutrality adjustment of 1.0007 and the MFP-adjusted CPI–U payment update of 1.2 percent. The final ASC conversion factor of $44.663 for ASCs that do not meet the quality reporting requirements is the product of the CY 2017 conversion factor of $45.003 multiplied by the wage index budget neutrality adjustment of 1.0007 and the MFP-adjusted CPI–U payment update of -0.8 percent.

ASC Payment Reform

The vast majority of commenters were in favor of applying the hospital market basket to update annual ASC payment. CMS will consider this potential ASC payment reform issue under advisement and consideration for future policymaking.

CMS denied the requested device-intensive status for HCPCS codes 0275T (Percutaneous laminotomy/laminectomy (interlaminar approach) for decompression of neural elements, (with or without ligamentous resection, discectomy, facetectomy and/or foraminotomy), any method,

under indirect image guidance (eg, fluoroscopic, ct), single or multiple levels, unilateral or bilateral; lumbar); and 28297 (Correction, hallux valgus (bunionectomy), with sesamoidectomy, when performed; with first metatarsal and medial cuneiform joint arthrodesis, any method).

Ambulatory Surgical Center Quality Reporting (ASCQR) Program

CMS has finalized the proposal to adopt the ASC-17: Hospital Visits after Orthopedic Ambulatory Surgical Center Procedures measure in the ASCQR Program for the CY 2022 payment determination and subsequent years, as proposed. The measure is not currently NQF-endorsed. However, CMS intends to submit this measure for review and endorsement by NQF once an appropriate NQF project has a call for measures.

Additionally, CMS finalized removal of 3 measures from the ASCQR Program measure set. ASC-5: Prophylactic Intravenous (IV) Antibiotic Timing and ASC-6: Safe Surgery Checklist Use have topped out. ASC-7: Ambulatory Surgical Center Facility Volume Data on Selected Ambulatory Surgical Center Surgical Procedures was removed because there are better alternatives (i.e., ASC-17).

CMS also finalized the proposal to delay implementation of the Outpatient and Ambulatory Surgery Consumer Assessment of Healthcare Providers and Systems (OAS CAHPS) Survey-based Measures (OP–37a–e) beginning with the CY 2020 payment determination (CY 2018 data collection) in order to collect more operational and implementation data.

Recalibration of APC Relative Payment Weights

CMS finalized the proposal to extend the transition policy for 1 additional year and continue to remove claims from providers that use a cost allocation method of "square feet" to calculate CT and MRI CCRs for the CY 2018 OPPS.

Proposed Comprehensive APCs (C-APCs) Complexity Adjustments

Additional code combinations which may qualify for complexity adjustment inadvertently left out of proposed rule can now be found in Addendum J (https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Hospital-Outpatient-Regulations-and-Notices-Items/CMS-1678-FC.html). These include:

● CPT code 22510 (Percutaneous vertebroplasty (bone biopsy included when performed), 1 vertebral body, unilateral or bilateral injection, inclusive of all imaging guidance; cervicothoracic) and CPT code 22512 (Percutaneous vertebroplasty (bone biopsy included when performed), 1 vertebral body, unilateral or bilateral injection, inclusive of all imaging guidance; each additional cervicothoracic or lumbosacral vertebral body) for multi-level vertebroplasty in the cervicothoracic region);

● CPT code 22511 (Percutaneous vertebroplasty (bone biopsy included when performed), 1 vertebral body, unilateral or bilateral injection, inclusive of all imaging guidance; lumbosacral) and CPT code 22512 (Percutaneous vertebroplasty (bone biopsy included when performed), 1 vertebral body, unilateral or bilateral injection, inclusive of all imaging guidance; each additional cervicothoracic or lumbosacral vertebral body); and

● CPT code 22511 (Percutaneous vertebroplasty (bone biopsy included when performed), 1 vertebral body, unilateral or bilateral injection, inclusive of all imaging guidance; lumbosacral) and CPT code 20982 (Ablation therapy for reduction or eradication of 1 or more bone tumors (e.g., metastasis), including adjacent soft tissue when involved by tumor extension, percutaneous, including imaging guidance when performed; radiofrequency).

Diagnostic Bone Marrow Aspiration and Biopsy (C-APC 5072)

CMS finalized the deletion of HCPCS code G0364 (status indicator "D") and assigned revised CPT codes 38220 and 38221, as well as new CPT code 38222 (placeholder code 382X3) to C-APC 5072 (Level 2 Excision/Biopsy/Incision and Drainage), with a proposed payment rate of $1,268.53. Additionally, CMS finalized CY 2018 proposals, without modification, for the bone marrow aspiration and biopsy codes, specifically, CPT codes 20939, 38220, 38221, and 38222. CPT code 20939 (placeholder 2093X) was assigned a status indicator "N" (Packaged status because it is an add-on code. Table 30 below lists the final APC and status indicator assignments for CPT codes 20939, 38220, 38221, and 38222 for CY 2018.

TABLE 30.—FINAL CY 2018 STATUS INDICATOR (SI) AND APC ASSIGNMENT FOR THE BONE MARROW ASPIRATION AND BIOPSY CODES

HCPCS Code	CY 2018 OPPS/ASC Proposed Rule Placeholder Code	Short Descriptor	CY 2017 OPPS SI	CY 2017 OPPS APC	CY 2017 OPPS Payment Rate	CY 2018 OPPS SI	CY 2018 OPPS APC	CY 2018 OPPS Payment Rate
20939	2093X	Bone marrow aspir	N/A	N/A	N/A	N	N/A	N/A
38220	N/A	Dx bone marrow aspirations	J1	5072	$1,236.62	J1	5072	Refer to OPPS Addendum B
38221	N/A	Dx bone marrow biopsies	J1	5072	$1,236.62	J1	5072	Refer to OPPS Addendum B
38222	382X3	Dx bone marrow bx & aspir	N/A	N/A	N/A	J1	5072	Refer to OPPS Addendum B
G0364		Bone marrow aspirate	N	N/A	N/A	D	N/A	N/A

Musculoskeletal APCs (APC 5111 through 5116)

For CY 2018, CMS has finalized, without modification, the designation of CPT code 38222 as temporary office-based for CY 2018.

TABLE 85.—CY 2018 PAYMENT INDICATORS FOR NEW CY 2018 CPT CODES FOR ASC COVERED SURGICAL PROCEDURES DESIGNATED AS TEMPORARY OFFICE-BASED

CY 2017 OPPS/ASC Proposed Rule 5-digit CMS Placeholder Code	CY 2018 CPT Code	CY 2018 Long Descriptor	CY 2018 ASC Payment Indicator**
382X3	38222	Diagnostic bone marrow; biopsy(ies) and aspiration(s)	P3*

* If designation is temporary.

** Payment indicators are based on a comparison of the final rates according to the ASC standard ratesetting methodology and the MPFS final rates. Current law specifies a 0.5 percent update to the MPFS payment rates for CY 2018. For a discussion of the MPFS rates, we refer readers to the CY 2018 MPFS with comment period.

New HCPCS Codes for Which CMS is Soliciting Public Comments in this CY 2018 OPPS/ASC Final Rule with Comment Period

New Level II HCPCS Codes That Became Effective October 1, 2017 and New Level II HCPCS Codes That Will Be Effective January 1, 2018 codes are flagged with comment indicator "NI" in Addendum B to this OPPS/ASC final rule with comment period to indicate that CMS is assigning them an interim payment status which is subject to public comment. These will be finalized in the CY 2019 OPPS/ASC final rule with comment period.

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
E0953	W/c lateral thigh/knee sup	NI	Y					
E0954	Foot box, any type each foot	NI	Y					
G0516	Insert drug del implant, >4	NI	Q1	5735	4.1964	$329.99	.	$66.00
G0517	Remove drug implant	NI	Q1	5735	4.1964	$329.99	.	$66.00
G0518	Remove w insert drug implant	NI	Q1	5735	4.1964	$329.99	.	$66.00
G9942	Adtl spine proc on same date	NI	M					
G9948	Adtl spine proc on same date	NI	M					