

2018 Total Knee Arthroplasty FAQs (Updated 1/29/18)

Until recently, total knee arthroplasty (TKA) was included on the Medicare inpatient-only (IPO) list. The removal of TKA from the IPO has raised multiple questions. Because of the significant amount of confusion surrounding this issue, we are providing this list of frequently asked questions as an easily accessible resource.

Q: **What does removal from the IPO mean?**

A: Medicare classifies a procedure as “inpatient-only” based, in part, on the expectation that a stay of at least two midnights would be medically necessary. CMS uses established criteria to review the IPO list on an annual basis for determining whether any procedures should be removed from the list. Medicare explicitly states that **removal of a procedure from the IPO list does not require the procedure to be performed only on an outpatient basis**. It simply allows for the possibility in appropriate instances. The removal from the IPO allows for both hospital outpatient and inpatient care. The procedure is still not approved for ambulatory surgery centers (ASC). Addition to the ASC-approved list is a separate decision that Medicare may revisit in the future.

Q: **What is the effect on TKAs by removal from the IPO?**

A: Removal of the TKA procedure from the IPO list allows for payment in either the inpatient setting or the hospital outpatient setting. **Medicare still expects most TKAs to be performed on an inpatient basis**. There is a small subset of patients that could appropriately receive outpatient TKAs. It is for this minority of patients that Medicare is removing the requirement of inpatient surgery. Providers will continue to be required to document the reason for inpatient status, but that documentation need not be any different from what has been required for the past few years. **There is no need to justify why a procedure is not being performed as an outpatient**.

Q: **How will the removal of TKA from the IPO impact the BPCI and CJR models?**

A: The BPCI program will end on September 30, 2018 and BPCI Advanced will begin on October 1, 2018. The CJR program will continue through 2020. CMS states that it will monitor the effects of outpatient total knees on these programs. However, because it does not expect a significant volume of TKA cases to move from the hospital inpatient setting, CMS does not anticipate a substantial impact on the patient-mix for the BPCI and CJR models.

Q: Will CMS create guidelines or protocols for patient selection?

A: CMS acknowledges the importance of deferring to patients and providers to decide the appropriate site of service for a particular patient. While CMS believes that some less medically complex TKA cases could be appropriately and safely performed on an outpatient basis, they do not expect to create or endorse specific guidelines or content for the establishment of providers' patient selection protocols. The appropriateness of outpatient surgery for a patient depends on both medical and social factors. It should be determined on a case by case basis between the individual surgeon and the particular patient.

Q: Will TKA be subject to RAC audits?

A: **The RAC will not begin to audit these cases for site of service until 2020 and it will not be retroactive.** The delay in RAC for a period of two years will allow providers sufficient time to gain experience with performing these procedures in the outpatient setting.

Q: How will this change affect reimbursement?

A: The IPO list status of a procedure has no effect on the MPFS (Medicare Physician Fee Schedule) professional payment for the procedure. Hospitals do have lower costs for outpatient procedures, as compared to caring for patients who stay two or more nights. For this reason, the outpatient and inpatient procedures do carry different facility payments and the facility payment under the OPFS will be lower than under the DRG system. Again, this only affects those cases done outpatient, which should be very, very few.

Procedures are paid either under the inpatient payment system (IPPS) or outpatient payment system (OPFS). The TKA procedure, described by CPT code 27447, is assigned to MS-DRG 469 and 470 when performed inpatient. The 50th percentile IPPS payment for TKA without major complications or comorbidities (MS-DRG 470) is roughly \$11,760 for FY 2018. When performed outpatient, TKA will be assigned to comprehensive APC C-APC 5115 (Level 5 Musculoskeletal Procedures) with status indicator "J1" (hospital Part B services paid through a C-APC). The unadjusted payment for outpatient total knees is \$10,122.92 for 2018.

Q: Will the "two-midnight" rule continue to be in effect?

A: The Medicare policy regarding the "two-midnight" rule is unchanged. This policy applies to inpatient hospital admissions where the patient is reasonably expected to stay at least two midnights. Providers must assure that documentation in the medical record supports that an inpatient admission is necessary. This includes stays in which the physician's expectation is

supported, but the length of the actual stay was less than two midnights due to unforeseen circumstances such as unexpected patient death, transfer, clinical improvement or departure against medical advice. This justification remains independent of any decision for whether to do the procedure as an outpatient.

Q: How will this affect patient's ability to go into a skilled nursing facility for rehab?

A: There have been no changes to policies regarding skilled nursing facility (SNF) coverage. A prior inpatient hospital stay of at least 3 consecutive days is required by law under Medicare fee-for-service as a prerequisite for SNF. Moreover, CMS expects that the need for postsurgical services will be taken into account when choosing whether outpatient surgery is appropriate. Medicare Advantage plans may elect, to provide SNF coverage without imposing the SNF 3-day qualifying stay requirement and CMS has issued conditional waivers of the 3-day qualifying stay requirement as necessary to carry out the Medicare Shared Savings Program and to test certain Innovation Center payment models, including the Next Generation ACO Model.

Q: When did this go into effect?

A: January 01, 2018

Q: Are there other procedures that are being considered for removal from the IPO?

A: CMS plans to remove additional procedures from the IPO in future years. Moreover, there is interest in procedures appropriate for addition to the Ambulatory Surgery Center (ASC)-approved procedure list. CMS stated it will consider the following arthroplasty procedures to be both removed from the IPO and added to the ASC in future rules.

- Total hip arthroplasty (CPT Code 27130)
- Hip hemiarthroplasty (CPT Code 27125)
- Total shoulder arthroplasty (CPT Code 23472)
- Shoulder hemiarthroplasty (CPT Code 23470)
- Total ankle arthroplasty (CPT Code 27702)
- Revision total ankle (CPT Code 27703)

If you have additional questions, please contact Dena McDonough, Manager of Payment Policy at mcdonough@aaos.org.