

2018 Total Knee Arthroplasty FAQs (Updated 3/1/18)

Until recently, total knee arthroplasty (TKA) was included on the Medicare inpatient-only (IPO) list. In light of the removal of TKA from the IPO, we are providing answers to some frequently asked questions. It will be updated continually, as questions arise. Please find the most up to date information on the AAOS website, [here](#). For additional questions, please contact Dena McDonough, Manager of Payment Policy at mcdonough@aaos.org.

Q1: What does removal from the IPO mean?

A1: 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.

Q2: What is the effect on TKAs by removal from the IPO?

A2: 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 be required to document the reason for inpatient status, as required by the 2-midnight rule. **There is no need to justify why a procedure is not being performed as an outpatient**.

We have heard of some issues surrounding preauthorization for Medicare Advantage (MA) patients. There seems to be a forceful push to default TKAs to the outpatient setting, assuming many cases will, ultimately, be converted to inpatients. Unfortunately, CMS allows MA discretion in coverage determination. We will continue to push for CMS intervention on minimum coverage standards.

Q3: How will the removal of TKA from the IPO impact the BPCI and CJR models?

A3: 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**.

Q4: Will CMS create guidelines or protocols for patient selection?

A4: 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, **CMS does 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.

Q5: Will the “two-midnight” rule continue to be in effect?

A5: 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. While the need for an inpatient stay must be documented, it is not necessary to justify why it is not being done as an outpatient.

Q6: How will this change affect reimbursement for physicians?

A6: The IPO list status of a procedure has no effect on the MPFS (Medicare Physician Fee Schedule) professional payment for the procedure. Physicians will continue to be paid the same regardless of the site of service. For 2018, the unadjusted payment rate for CPT 27447 is \$1408.30. It is important to point out that, as more TKAs are performed in the outpatient setting, CMS could choose to revalue the code resulting in decreased payment in future years. We will continue to monitor this issue and advocate for fair payment for all codes.

Q7: How will this change affect reimbursement for hospitals?

A7: 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 carry different facility payments. **The facility payment under the OPSS will be lower than under the DRG system.** Again, this decrease will only apply to those cases done outpatient, for which provision of care has significantly lower cost. To reiterate, CMS expects the number of outpatient cases to be very low and have minimal effect on reimbursement.

Procedures are paid either under the inpatient payment system (IPPS), by Medicare severity-diagnosis related group (MS-DRG), or under the outpatient payment system (OPSS), by ambulatory payment classification (APC). The TKA procedure, described by CPT code 27447, is assigned to MS-DRG 469 or 470 when performed inpatient and comprehensive APC 5115 when performed outpatient. Hospital Part B services will also be paid through the C-APC.

The 50th percentile IPPS payment for TKA without major complications or comorbidities (MS-DRG 470) is roughly \$11,760 for FY 2018. The unadjusted payment for C-APC 5115 (Level 5 Musculoskeletal Procedures) is \$10,122.92 for 2018.

Q8: What happens when an outpatient is admitted?

A8: On occasion, patients brought in as outpatients may require inpatient hospitalization. Once the physician makes this determination, **the admission order and supporting two-midnight documentation will convert the entire episode to the IPPS and corresponding MS-DRG payment.** This includes services provided prior to the formal admission order. Because episodes covered by DRG payments begin 72 hours prior to admission, the APC is superseded. The case will then trigger CJR or BPCI if applicable.

Q9: What happens when an inpatient is discharged before satisfying the “two-midnight” rule?

A9: As long as the expected need for an inpatient stay (i.e., defined as a need for two-midnights) is well documented on admission, **early discharged is not penalized.** CMS does not discount inpatient DRG payments for patients who leave on postoperative day 1.

Q10: Will TKA be subject to RAC audits?

A10: **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. Of note, RACs may occasionally question early discharge for patients, but this can and should be appealed. Again, as long as the inpatient admission is properly documented, the expected need for inpatient status is what is the deciding factor.

Q11: How will this affect patient’s ability to go into a skilled nursing facility for rehab?

A11: **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.

Q12: When did this go into effect?

A12: January 01, 2018

Q13: Are there other procedures that are being considered for removal from the IPO?

A13: 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)