- The simplest procedure described by the code may be performed in most outpatient departments.
- The procedure is related to codes that we have already removed from the IPO list.
- A determination is made that the procedure is being performed in numerous hospitals on an outpatient basis.
- A determination is made that the procedure can be appropriately and safely performed in an ASC and is on the list of approved ASC procedures or has been proposed by us for addition to the ASC list.

2. Procedures Proposed for Removal from the IPO List

Using the listed criteria, for the CY 2020 OPPS/ASC proposed rule, we identified one procedure described by CPT code 27130 (Arthroplasty, acetabular and proximal femoral prosthetic replacement (total hip arthroplasty) with or without autograft or allograft) that met the criteria for proposed removal from the IPO list. The procedure that we proposed to remove from the IPO list for CY 2020 and subsequent years, including the CPT/HCPCS code, long descriptor, and the proposed CY 2020 payment indicator was displayed in Table 23 of the proposed rule.

For a number of years, total hip arthroplasty (THA) has been a topic of discussion for removal from the IPO list with both stakeholder support and opposition. Most recently, in the CY 2018 OPPS/ASC proposed rule (82 FR 33644 and 33645), we sought public comment on the possible removal of partial hip arthroplasty (PHA), CPT code 27125 (Hemiarthroplasty, hip, partial (for example, femoral stem prosthesis, bipolar arthroplasty)), and total hip arthroplasty (THA) or total hip replacement, CPT code 27130 (Arthroplasty, acetabular and proximal femoral prosthetic replacement (total hip

arthroplasty), with or without autograft or allograft from the IPO list. Both THA and PHA were placed on the original IPO list in the CY 2001 OPPS/ASC final rule with comment period (65 FR 18780).

Among those commenters expressing support in response to the CY 2018 OPPS/ASC proposed rule (which we summarized and responded to in the CY 2018 OPPS/ASC final rule with comment period (82 FR 52527 through 52528)) for removal of THA from the IPO list were several surgeons and other stakeholders who believed that, given thorough preoperative screening by medical teams with significant experience and expertise involving hip replacement procedures, the THA procedure could be provided on an outpatient basis for some Medicare beneficiaries. These commenters noted significant success involving same day discharge for patients who met the screening criteria and whose experienced medical teams were able to perform the procedure early enough in the day for the patients to achieve postoperative goals, allowing home discharge by the end of the day. The commenters believed that the benefits of providing the THA procedure on an outpatient basis include significant enhancements in patient well-being, improved efficiency, and cost savings to the Medicare program, including shorter hospital stays resulting in fewer medical complications, improved results, and enhanced patient satisfaction.

We stated in the CY 2018 OPPS/ASC proposed rule that, like most surgical procedures, both PHA and THA need to be tailored to the individual patient's needs. Patients with a relatively low anesthesia risk and without significant comorbidities who have family members at home who can assist them may likely be good candidates for an outpatient PHA or THA procedure. These patients may also be able to tolerate outpatient

rehabilitation in either an outpatient facility or at home postsurgery. On the other hand, patients with multiple medical comorbidities, aside from their osteoarthritis, would more likely require inpatient hospitalization and possibly postacute care in a skilled nursing facility or other facility. Surgeons who discussed outpatient PHA and THA procedures in public comments in response to our CY 2017 OPPS/ASC proposed rule (81 FR 45679) comment solicitation (which we summarized and responded to in the CY 2017 OPPS/ASC final rule with comment period (81 FR 79696)) on the TKA procedure emphasized the importance of careful patient selection and strict protocols to optimize outpatient hip replacement outcomes. These protocols typically manage all aspects of the patient's care, including the at-home preoperative and postoperative environment, anesthesia, pain management, and rehabilitation to maximize rapid recovery, ambulation, and performance of activities of daily living.

Numerous commenters representing a variety of stakeholders, including physicians and other care providers, individual stakeholders, specialty societies, hospital associations, hospital systems, ASCs, device manufacturers, and beneficiaries, responded to our solicitation of comments regarding the removal of PHA and THA from the IPO list (which we summarized and responded to in CY 2018 OPPS/ASC final rule with comment period (82 FR 52527 through 52528)). The comments were diverse and some were similar to the comments we received on our proposal to remove TKA from the IPO list. Some commenters, including hospital systems and associations, as well as specialty societies and physicians, stated that it would not be clinically appropriate to remove PHA and THA from the IPO list, indicating that the patient safety profile of outpatient THA and PHA in the non-Medicare population is not well-established. Commenters

representing orthopedic surgeons also stated that patients requiring a hemiarthroplasty (PHA) for fragility fractures are, by nature, a higher risk, suffer more extensive comorbidities, and require closer monitoring and preoperative optimization; therefore, it would not be medically appropriate to remove the PHA procedure from the IPO list.

Other commenters, including ambulatory surgery centers (ASCs), physicians, and beneficiaries, supported the removal of PHA and THA from the IPO list. These commenters stated that the procedures were appropriate for certain Medicare beneficiaries and most outpatient departments are equipped to provide THA to some Medicare beneficiaries. They also referenced their own personal successful experiences with outpatient THA.

a. Removal of Total Hip Arthroplasty from the Inpatient Only List

After reviewing the clinical characteristics of the procedure described by CPT code 27130, considering the public comments described earlier from past rules, additional feedback from stakeholders, and with further consultation with our clinical advisors regarding this procedure, in the CY 2020 OPPS/ASC proposed rule (84 FR 39524), we stated our belief that this procedure meets criterion 2 (the simplest procedure described by the code may be performed in most outpatient departments) and criterion 3 (the procedure is related to codes that we have already removed from the IPO list). As such, we believe that appropriately selected patients could have this procedure performed on an outpatient basis. Therefore, we proposed to remove THA from the IPO list and to assign the THA procedure (CPT code 27130) to C-APC 5115 with status indicator "J1". We sought public comments on our conclusion that the procedure described by CPT code 27130 meets criteria 2 and 3 and our proposal to assign the procedure to C-APC 5115

with status indicator "J1". We did not propose to remove PHA from the IPO list because we continue to believe that it does not meet the criteria for removal.

Comment: In response to our proposal to remove CPT code 27130 from the IPO list, we received many of the same type of comments that we received in response to our CY 2018 proposed rule comment solicitation for removing THA. Many commenters, including health care providers and medical associations, supported the proposal. The commenters recognized that with careful, appropriate selection, THA could be performed in the outpatient setting with few to no complications. One commenter, an orthopaedic specialty society, agreed with the patient selection characteristics that were noted in the proposed rule—namely, that good candidates for outpatient THA have relatively low anesthesia risk, do not have significant comorbidities, have in-home support, and are able to tolerate post-surgical outpatient rehabilitation in either an outpatient facility or in the home.

One commenter suggested that a patient that requires a revision of a prior hip replacement, and/or has other complicating clinical conditions, including multiple co-morbidities such as obesity, diabetes, heart disease, is not a strong candidate for outpatient THA and should be scheduled for an inpatient stay. Furthermore, another commenter stated that the following social factors should be considered when analyzing the implications of outpatient THA: living alone, pain, prior hospitalization, depression, functional status, high-risk medication, and health literacy. Additionally, both supporters and opponents requested that CMS provide detailed guidance on what those selection criteria should look like.

Some commenters did not support the proposal, citing both clinical and operational concerns based on their experience with the removal of TKA from the IPO in 2018. Those commenters believe that it would be hasty to remove THA without waiting for providers and MACs to have a better handle on performing TKA in the outpatient setting and developing better skill at performing appropriate patient selection. One commenter suggested delaying the removal of THA from the IPO list for a year, until CMS could provide greater evidence, specifically, a rigorous medical literature review, that THA could be performed safely in the outpatient or ASC setting, especially for beneficiaries with multiple co-morbidities.

Some commenters, including two major orthopaedic associations, raised concerns about whether the THA procedure meets the criteria required to be removed from the IPO list. One commenter, an orthopaedic surgery specialty society for hips and knees, shared that they do not believe THA meets criterion 2 (the simplest procedure described by the code may be performed in most outpatient departments) — they argued that there is no such thing as a simple THA and that all procedures described by CPT code 27130 have moderate risks for complications. The commenter further argues that criterion 3 (the procedure is related to codes that we have already removed from the IPO list) is also not met since they do not believe that THA and TKA are similar, except for the risks associated with each in moving the site of surgery. The commenter expressed additional concerns regarding criterion 4 (a determination is made that the procedure is being performed in numerous hospitals on an outpatient basis) and the lack of peer-reviewed literature that would provide supportive data. Finally, the commenter expressed concerns regarding criterion 5 (a determination is made that the procedure can be appropriately and

safely performed in an ASC and is on the list of approved ASC procedures or has been proposed by us for addition to the ASC list), stating that there is a lack of peer-reviewed literature and the ability to guarantee excellent patient selection and education, tailored anesthetic techniques, well-done surgery, good medical care, and exceptional post-operative care coordination in the ASC setting. The commenter conceded that performance of THA in the outpatient setting is possible, but does not believe that data and guidance on appropriate patient selection and education, patient-specific anesthetic techniques, and post-operative care coordination are well demonstrated in peer-reviewed literature. This commenter did note that appropriate patient selection for outpatient THA candidates could mitigate some of its concerns.

Another orthopaedic surgery specialty society called the removal of THA from the IPO list "rash," and expressed extensive concern that CMS would remove a procedure from the IPO list based on only two of the five criteria used to determine appropriate removals for the IPO list. The commenter further expressed concern that the rationale behind removing THA from the IPO list – specifically that CMS believes it meets criteria 2 and 3—fails to consider whether or not outpatient facilities are equipped and appropriate for outpatient THA, and whether or not THA is performed safely in outpatient settings a majority of the time.

Response: We thank commenters for providing public comments on the appropriateness of removing THA from the IPO list and providing it in outpatient settings. We appreciate the support for the proposal. We also recognize concerns for ensuring patient health and quality care. As we have stated numerous times, like most surgical procedures, the appropriate site of service for THA should be based on the

physician's assessment of the patient and tailored to the individual patient's needs. As we stated in the proposed rule (84 FR 39524), patients with a relatively low anesthesia risk and without significant comorbidities who have family members at home who can assist them may likely be good candidates for an outpatient THA procedure. On one hand, it may be determined that these patients will also be able to tolerate outpatient rehabilitation either in an outpatient facility or at home postsurgery. On the other hand, patients that require a revision of a prior hip replacement, and/or have other complicating clinical conditions, including multiple co-morbidities such as obesity, diabetes, heart disease, may not be strong candidates for outpatient THA. We also recognize that elective THA, necessitated, for example, by osteoarthritis, for a generally healthy patient with at-home support is different than THA for a hip fracture that is performed on either an emergent or scheduled basis. While the former may be appropriate for outpatient THA if the physician believes that the patient may be safely discharged on the same or next day, the latter may be more appropriate for hospital inpatient admission.

As previously stated in the discussion of the CY 2018 OPPS/ASC final rule (82 FR 59383), we continue to believe that 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. That is, when a procedure is removed from the IPO, it simply means that Medicare will pay for it in either the hospital inpatient or outpatient setting; it does not mean that the procedure must

be performed on an outpatient basis. The 2-midnight rule, which is discussed in section X.B. of this final rule with comment period, provides general guidance on when payment under Medicare Part A (that is, hospital inpatient) may be appropriate. However, the 2-midnight rule also recognizes the importance of the attending physician's clinical judgment regarding the appropriate setting of care for a procedure to be performed.

While we continue to expect providers who perform outpatient THA on Medicare beneficiaries to use comprehensive patient selection criteria to identify appropriate candidates for the procedure, we believe that the surgeons, clinical staff, and medical specialty societies who perform outpatient THA 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.

With respect to certain criteria not being met, we remind commenters that not all criteria must be met for a service to be removed from the IPO. We continue to believe that THA meets criteria 2 and 3.

Comment: Several commenters stated concerns regarding the impact of removing THA from the IPO list in light of the 2-midnight rule and subsequent RAC review. Because of past concerns with the removal of TKA from the IPO list and fear of RAC review, commenters also suggested that if THA is removed from the IPO list, that CMS should provide a two-year exemption from site-of service denials and Recovery Audit Contractor (RAC) referrals. Commenters further stated that in addition to the exemption, CMS should also educate providers that CMS policy allows for case-by-case exceptions

to the 2-midnight rule in consideration of patient history, co-morbidities, and risk of adverse events.

Response: We thank the commenters for their feedback. We will again refer readers to the more extensive discussion of an exemption from site-of service denials and RAC referrals in section X.B. of this final rule with comment period. The case-by-case exception under the 2-midnight rule continues to allow for Part A payment to be made, on a case-by-case basis, where the physician does not expect the patient to remain in the hospital for at least two midnights but nonetheless determines that inpatient admission is necessary based on the clinical characteristics of the patient and that determination is supported by the medical record.

Comment: Several commenters opposed the removal of THA due to potential detrimental impacts on hospitals participating in the Comprehensive Care for Joint Replacement (CJR) Program and the Bundled Payments for Care Initiative (BCPI). Some commenters supported the proposal, but requested that payment for THA in the context of alternative payment models be adjusted.

Response: We again refer readers to the CY 2017 OPPS/ACS final rule with comment period (81 FR 79698 through 79699) in which we originally proposed the removal of TKA procedural codes from the IPO list and sought comments on how to modify the CJR and BPCI programs to reflect the shift of some Medicare beneficiaries from an inpatient TKA procedure to an outpatient TKA procedure in the BPCI and CJR model pricing methodologies, including target price calculations and reconciliation processes, as we also believe it to be applicable to THA. As in the case of the policy change to move THAs from the IPO list, the CMS Innovation Center may consider

making future changes to the CJR and BPCI Models to address the removal of THAs from the IPO list and the performance of THA procedures in the OPPS setting.

Additionally, CMS notes the concerns about appropriate patient selection raised by commenters and agrees that it is imperative that physicians and hospitals are mindful of factors that affect whether a patient would be a good candidate for outpatient THA or should instead be admitted as a hospital inpatient; however, for the reasons cited in the CY 2020 OPPS/ASC proposed rule, we continue to believe that it is appropriate to remove THA as described by CPT code 27130 from the IPO list. After consideration of the public comments we received, we are finalizing the removal of CPT code 27130, and assigning the procedure to C-APC 5115 (Level 5 Musculoskeletal Procedures) with status indicator "J1". In addition, we are removing anesthesia code 01214, (anesthesia for open procedures involving hip joint; total hip arthroplasty) as a conforming change.

As stated above, 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. Further, the removal of any procedure from the IPO list, including THA, does not require the procedure to be performed only on an outpatient basis. That is, when a procedure is removed from the IPO, it simply means that Medicare will pay for it in either the hospital inpatient or outpatient setting; it does not mean that the procedure must be performed on an outpatient basis. The decision to admit as an inpatient admission or to perform the procedure on a hospital outpatient basis is subject to the complex medical judgment of the physician. While we have not established patient selection criteria for THA or any other procedure,

we reiterate our finding that patients with a relatively low anesthesia risk and without significant comorbidities who have family members at home who can assist them may likely be (but are not necessarily) good candidates for an outpatient THA procedure. These patients may be determined to be able to tolerate outpatient rehabilitation either in an outpatient facility or at home postsurgery. While on the other hand, patients that require a revision of a prior hip replacement, and/or has other complicating clinical conditions, including multiple co-morbidities such as obesity, diabetes, heart disease, may not be strong candidates for outpatient THA. As stated previously, we also recognize that elective THA, necessitated, for example, by osteoarthritis, for a generally healthy patient with at-home support is different than THA for a hip fracture that is performed on either an emergent or scheduled basis. While the former may be appropriate for outpatient THA if the physician believes that the patient may be safely discharged on the same or next day, the latter may be more appropriate for hospital inpatient admission.

3. Solicitation of Public Comments on the Potential Removal of Procedures Described by CPT Codes 22633, 22634, 63265, 63266, 63267, and 63268 from the IPO List

Throughout the years, we have received several public comments on additional CPT codes that stakeholders believe fit our criteria and should be removed from the IPO list. In the CY 2020 OPPS/ASC proposed rule, we sought public comment on the removal of the following procedures from the IPO list in Table 47.

TABLE 47.—IPO List CPT Codes Included in Comment Solicitation to be Potentially Removed from the IPO List

CPT Code	Long Descriptor

CPT Code	Long Descriptor
22633	Arthrodesis, combined posterior or posterolateral technique with posterior interbody technique including laminectomy and/ or discectomy sufficient to prepare interspace (other than for decompression), single interspace and segment; lumbar;
22634	Arthrodesis, combined posterior or posterolateral technique with posterior interbody technique including laminectomy and/ or discectomy sufficient to prepare interspace (other than for decompression), single interspace and segment; lumbar;| each additional interspace and segment
63265	Laminectomy for excision or evacuation of intraspinal lesion other than neoplasm, extradural; cervical
63266	Laminectomy for excision or evacuation of intraspinal lesion other than neoplasm, extradural; thoracic
63267	Laminectomy for excision or evacuation of intraspinal lesion other than neoplasm, extradural; lumbar
63268	Laminectomy for excision or evacuation of intraspinal lesion other than neoplasm, extradural; sacral

We reviewed the clinical characteristics of CPT codes 22633 and 22634 and stated that we believe they are related to codes that we have already removed from the IPO list. Specifically, stakeholders have suggested that CPT codes 22633 and 22634 are related to CPT code 22551 (Arthrodesis, anterior interbody, including disc space preparation, discectomy, osteophytectomy and decompression of spinal cord and/or nerve roots; cervical below c2), which is currently performed in the outpatient hospital setting. During the proposed rule, we sought public comments that would provide additional information on the safety of performing CPT codes 22633 and 22634 in the outpatient hospital setting.

In addition, we reviewed CPT codes 63265, 63266, 63267, and 63268. Over the years, stakeholders indicated that this series of CPT codes should be considered minimally invasive, arguing that CPT codes 63265, 63266, 63267, and 63268 meet criteria 1 and 2 for removal from the IPO list: most outpatient departments are equipped to provide the services to the Medicare population and the simplest procedure described by the code may be performed in most outpatient departments. We sought public comment on whether CPT codes 63265 through 63268 meet criteria to be removed from the IPO list, including information from commenters to demonstrate that the codes meet these criteria.

Comment: We received a few comments in support of the removal of the services described by CPT codes 22633, 22634, 63265, 63266, 63267, and 63268. Commenters agreed that these procedures were both related to codes that were previously removed from the IPO list and are performed safely in numerous hospitals on an outpatient basis. Commenters largely provided anecdotal experience in support of removing these services from the IPO list. One commenter provided a March 2019 published retrospective cohort study of lumbar interbody fusion to treat spinal pathology using the American College of Surgeons National Surgical Quality Improvement Program database. The commenter believed that this study provided additional insight into the perioperative safety profile and operative efficiency and efficacy of performing transforaminal lumbar interbody fusions (TLIF) at an outpatient facility.

Commenters in support of the proposal argued that physicians perform the cases regardless of the IPO list – evaluating each patient carefully to determine the best fit clinically for that patient. Several ASCs commented that they often perform all listed

procedures with few to no complications in that setting. This commenter supported not only removing all six procedures from the IPO list, but also adding them to the ASC-CPL list.

Commenters further stated that although their current patient volume does not constitute a large percentage of Medicare beneficiaries, they would expect to see similar results with Medicare patients that are active, have a relatively low anesthesia risk, do not have significant comorbidities and that also have a support system at home that can assist them post-procedure. The commenters specifically supported the removal of the six procedures based on the development of less invasive techniques, improved perioperative pain management, and expedited rehabilitation protocols.

Specifically for the services described by CPT codes 22633 and 22634, commenters agreed that related procedures and similar codes such as 22551 (Arthrodesis, anterior interbody, including disc space preparation, discectomy, osteophytectomy and decompression of spinal cord and/or nerve roots; cervical below c2); 22612 (Arthrodesis, posterior or posterolateral technique, single level; lumbar (with lateral transverse technique, when performed); and 22614 (Arthrodesis, posterior or posterolateral technique, single level; each additional vertebral segment) were previously removed from the IPO list. One commenter specifically pointed out that performance of CPT codes 22612, 22614, and 22551 are all allowed in the ASC setting, and that their safety was reconfirmed in the review of procedures added to the ASC covered procedures list in the CY 2019 OPPS/ASC final rule (83 FR 59057).

In reference to the laminectomy codes, commenters specifically supported their removal from the IPO list based on their perceived safe and effective performance in the outpatient setting, in accordance with criterion 2.

We also received a few general comments in opposition to the prospect of removing the codes. Specifically, those who opposed removing the procedures expressed concern that all six procedures in this comment solicitation are complex procedures and that very few Medicare beneficiaries are likely to be good candidates to receive the procedures in the outpatient setting because of their complexity. The commenters further stated that removing these procedures from the IPO list and providing them in the outpatient setting may impact patient safety and outcomes, which they believe should be the primary considerations when determining which procedures can be removed from the IPO list.

Response: After reviewing clinical evidence and the public comments, including input from multiple spinal specialty societies and ASCs we have determined that the services described by CPT codes 22633, 22634, 63265, 63266, 63267, and 63268 are appropriate candidates for removal from the IPO list. CMS notes the overall support and for the reasons cited in the proposed rule, we believe that it is appropriate to remove CPT codes 22633 and 22634 from IPO list because they meet criteria one and two: most outpatient departments are equipped to provide the services to the Medicare population and the simplest procedure described by the code may be performed in most outpatient departments. We also believe that it is appropriate to remove CPT codes 63265, 63266, 63267, and 63268 from the inpatient only list, based on criterion one; most outpatient departments are equipped to provide the services to the Medicare population. Therefore,

we are finalizing the removal of CPT codes 22633, 22634, 63265, 63266, 63267, and 63268, and assigning the procedures as follows. The APC and status indicator assignments are reflected in Table 48 below.

Additional Requests for Changes to the IPO List:

Comment: CMS received two additional comments recommending the removal of several procedures not originally proposed for removal from the IPO list for CY 2020. These recommended procedures related to other procedures that were recently removed from the IPO. Specifically, the commenters referenced the following anesthesia codes for removal:

Table 48—APC and Status Indicator Assignments

CPT Code	Long Descriptor	Rationale
00670	Anesthesia for extensive spine and spinal cord procedures (for example, spinal instrumentation or vascular procedures)	Associated with surgical CPT codes 22551, 22552, 22845, 22633, 22634, 63265, 63266, 63267
00802	Anesthesia for procedures on lower anterior abdominal wall; panniculectomy	The only anesthesia code associated with CPT code 15830 Excision, excessive skin and subcutaneous tissue (includes lipectomy); abdomen, infraumbilical panniculectomy.
00865	Anesthesia for extraperitoneal procedures in lower abdomen, including urinary tract; radical prostatectomy (suprapubic, retropubic)	Associated with surgical CPT code 55866, which is not on the IPO list.
00944	Anesthesia for vaginal procedures (including biopsy of labia, vagina, cervix or endometrium); vaginal hysterectomy	Associated with surgical CPT codes 58262, 58260, 58270, 58290, 58552, 58553 and 58554, which are not on the IPO list.

CPT Code	Long Descriptor	Rationale
01214	Anesthesia for open procedures involving hip joint; total hip arthroplasty	Associated with surgical CPT code 27130.

Response: We thank the commenters for their feedback. After consideration of the public comments, we agree that the recommended anesthesia CPT codes should be removed from the IPO list, as they meet criterion 3; the procedure is related to codes that we have already removed from the IPO list. Notably, these removed anesthesia codes will be assigned a status indicator of "N".

Comment: Finally, we also received a comment from a provider organization that suggested that CMS eliminate the IPO list. Specifically, the commenter argued that the IPO list should to be eliminated to allow patient status to be determined by the physician based on the individual patient's clinical condition.

Response: We thank the commenters for their feedback and will consider this feedback for future rulemaking.

Table 49 contains the final changes that we are making to the IPO list for CY 2020.

TABLE 49.—CHANGE TO THE INPATIENT ONLY (IPO) LIST FOR CY 2020

CY 2020 CPT Code	CY 2019 Long Descriptor	Final Action	CY 2020 OPPS APC Assignment	CY 2020 OPPS Status Indicator
27130	Arthroplasty, acetabular and proximal femoral prosthetic replacement (total hip arthroplasty) with or without autograft or allograft	Remove from the IPO	5115	J1

CY 2020 CPT Code	CY 2019 Long Descriptor	Final Action	CY 2020 OPPS APC Assignment	CY 2020 OPPS Status Indicator
22633	Arthrodesis, combined posterior or posterolateral technique with posterior interbody technique including laminectomy and/ or discectomy sufficient to prepare interspace (other than for decompression), single interspace and segment; lumbar;	Remove from the IPO	5115	J1
22634	Arthrodesis, combined posterior or posterolateral technique with posterior interbody technique including laminectomy and/ or discectomy sufficient to prepare interspace (other than for decompression), single interspace and segment; lumbar;| each additional interspace and segment	Remove for the IPO	N/A	N
63265	Laminectomy for excision or evacuation of intraspinal lesion other than neoplasm, extradural; cervical	Remove from the IPO	5114	J1
63266	Laminectomy for excision or evacuation of intraspinal lesion other than neoplasm, extradural; thoracic	Remove from the IPO	5114	J1
63267	Laminectomy for excision or evacuation of intraspinal lesion other than neoplasm, extradural; lumbar	Remove from the IPO	5114	J1
63268	Laminectomy for excision or evacuation of intraspinal lesion other than neoplasm, extradural; sacral	Remove from the IPO	5114	J1
00670	Anesthesia for extensive spine and spinal cord procedures (for example, spinal instrumentation or vascular procedures)	Remove from the IPO	N/A	N
00802	Anesthesia for procedures on lower anterior abdominal wall; panniculectomy	Remove from the IPO	N/A	N
00865	Anesthesia for extraperitoneal procedures in lower abdomen, including urinary tract; radical prostatectomy (suprapubic, retropubic)	Remove from the IPO	N/A	N
00944	Anesthesia for vaginal procedures (including biopsy of labia, vagina, cervix or endometrium); vaginal hysterectomy	Remove from the IPO	N/A	N
01214	Anesthesia for open procedures involving hip joint; total hip arthroplasty	Remove from the IPO	N/A	N

X. Nonrecurring Policy Changes