*Transmittals-Items/R1833OTN.html?DLPage=1&DLEntries=10&DLFilter=9880&DLSort=1&DLSortDir=ascending*. However, we did rescind MLN Special Edition (SE) article 1607, partly because it referred to requiring weekly billing. We do not currently require PHPs to bill weekly, although PHPs may do so if they wish. Second, regarding the comment about limiting payment to a 3-service encounter, it was unclear if the commenter believed that PHP per diem payment was limited to that for 3 services. We note that the single-tier APCs for CMHCs and for hospital-based PHPs are based upon the geometric mean per diem costs for providing 3 *or more* PHP services per day. PHP APCs 5853 and 5863 do not limit PHP services to 3 per day.

Our goal is for PHP providers to continue to have flexibility in providing PHP services. However, we must ensure that Medicare beneficiaries enrolled in PHPs are legitimately eligible for PHP services and receive appropriately intensive treatment. As we seek to understand the usage of PHP services by Medicare beneficiaries, we also will continue to monitor the intensity of services provided on a weekly basis.

*C. Outlier Policy for CMHCs*

As discussed in the CY 2004 OPPS final rule with comment period (68 FR 63469 through 63470), after examining the costs, charges, and outlier payments for CMHCs, we concluded that establishing a separate OPPS outlier policy for CMHCs would be appropriate. Beginning in CY 2004, we created a separate outlier policy specific to the estimated costs and OPPS payments provided to CMHCs. We designated a portion of the estimated OPPS outlier threshold specifically for CMHCs, consistent with the percentage of projected payments to CMHCs under the OPPS each year, excluding outlier payments, and established a separate outlier threshold for CMHCs.

The separate outlier threshold for CMHCs resulted in $1.8 million in outlier payments to CMHCs in CY 2004, and $0.5 million in outlier payments to CMHCs in CY 2005. In contrast, in CY 2003, more than $30 million was paid to CMHCs in outlier payments. We note that, in the CY 2009 OPPS/ASC final rule with comment period, we also established an outlier reconciliation policy to address charging aberrations related to OPPS outlier payments (73 FR 68594 through 68599). In CY 2017, we implemented a CMHC outlier payment cap to be applied at the provider level, such that in any given year, an individual CMHC will receive no more than a set percentage of its CMHC total per diem payments in outlier payments (81 FR 79692 through 79695). This outlier payment cap only affects CMHCs, and does not affect other provider types. This outlier payment cap is in addition to and separate from the current outlier policy and reconciliation policy in effect. We finalized the CMHC outlier payment cap to be set at 8 percent of the CMHC's total per diem payments (81 FR 79694 through 79695).

In the CY 2018 OPPS/ASC proposed rule (82 FR 33642), we proposed to continue to designate a portion of the estimated 1.0 percent hospital outpatient outlier threshold specifically for CMHCs, consistent with the percentage of projected payments to CMHCs under the OPPS in CY 2018, excluding outlier payments. This policy results in CMHC outliers being paid under limited circumstances associated with costs from complex cases, rather than as a substitute for the standard PHP payment to CMHCs. In the CY 2018 OPPS/ASC proposed rule, we also noted that CMHCs are projected to receive 0.02 percent of total hospital outpatient payments in CY 2018, excluding outlier payments. Therefore, we proposed to designate approximately 0.0027 percent of the estimated 1.0 percent hospital outpatient outlier threshold for CMHCs. As we do for each rulemaking cycle, we have updated the CMHC CCRs and claims data used to model the PHP payments rates for this final rule with comment period.

Based on our simulations of CMHC payments for CY 2018, in the proposed rule, we proposed to continue to set the cutoff point for outlier payments for CY 2018 at 3.4 times the highest CMHC APC payment rate implemented for that calendar year, which for CY 2018 is the payment rate for CMHC APC 5853. In addition, we proposed to continue to apply the same outlier payment percentage that applies to hospitals. Therefore, for CY 2018, we proposed to continue to pay 50 percent of CMHC APC geometric mean per diem costs over the cutoff point. For example, for CY 2018, if a CMHC's cost for partial hospitalization services paid under CMHC APC 5853 exceeds 3.4 times the proposed payment rate for CMHC APC 5853, the outlier payment would be calculated as 50 percent of the amount by which the cost exceeds 3.4 times the payment rate for CMHC APC 5853.

In section II.G. of the proposed rule, for the hospital outpatient outlier payment policy, we proposed to set a fixed dollar threshold in addition to an APC multiplier threshold. APC 5853 is the only APC for which CMHCs may receive payment under the OPPS, and is for providing a defined set of services that are relatively low cost when compared to other OPPS services. As such, it is not necessary to also impose a fixed dollar threshold on CMHCs. Therefore, we did not propose to set a dollar threshold for CMHC outlier payments.

In summary, we proposed to continue to calculate our CMHC outlier threshold and CMHC outlier payments according to our established policies.

We did not receive any public comments on these proposals. Therefore, we are finalizing our proposals to continue to calculate CMHC outlier threshold and CMHC outlier payments according to our established policies. Using the updated data for this final rule with comment period, CMHCs are projected to receive 0.03 percent of total hospital outpatient payments in CY 2018, excluding outlier payments. Therefore, for CY 2018 we are designating approximately 0.02 percent of the estimated 1.0 percent hospital outpatient outlier threshold for CMHCs.

## IX. Procedures That Will Be Paid Only as Inpatient Procedures

*A. Background*

We refer readers to the CY 2012 OPPS/ASC final rule with comment period (76 FR 74352 through 74353) for a full historical discussion of our longstanding policies on how we identify procedures that are typically provided only in an inpatient setting (referred to as the inpatient only (IPO) list) and, therefore, will not be paid by Medicare under the OPPS, and on the criteria that we use to review the IPO list each year to determine whether or not any procedures should be removed from the list. The complete list of codes that will be paid by Medicare in CY 2018 as inpatient only procedures is included as Addendum E to this final rule with comment period (which is available via the Internet on the CMS Web site).

*B. Changes to the Inpatient Only (IPO) List*

1. Methodology for Identifying Appropriate Changes to IPO List

In the CY 2018 OPPS/ASC proposed rule (82 FR 33642 through 33645), for CY 2018, we proposed to use the same methodology (described in the November 15, 2004 final rule with comment period (69 FR 65834)) of reviewing the current list of procedures on the IPO list to identify any procedures that may be removed from the list. We have established five criteria that are part of this methodology. As

noted in the CY 2012 OPPS/ASC final rule with comment period (76 FR 74353), we utilize these criteria when reviewing procedures to determine whether or not they should be removed from the IPO list and assigned to an APC group for payment under the OPPS when provided in the hospital outpatient setting. We note that a procedure is not required to meet all of the established criteria to be removed from the IPO list. The criteria include the following:

1. Most outpatient departments are equipped to provide the services to the Medicare population.

2. The simplest procedure described by the code may be performed in most outpatient departments.

3. The procedure is related to codes that we have already removed from the IPO list.

4. A determination is made that the procedure is being performed in numerous hospitals on an outpatient basis.

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.

Using the above-listed criteria, in the CY 2018 OPPS/ASC proposed rule (82 FR 33643 and 33644), we identified the procedures described by the following codes that we proposed to remove from the IPO list for CY 2018: CPT code 27447 (Arthroplasty, knee, condyle and plateau; medical and lateral compartments with or without patella resurfacing (total knee arthroplasty)) and CPT code 55866 (Laparoscopy, surgical prostatectomy, retropubic radical, including nerve sparing, includes robotic assistance, when performed). The procedures that we proposed to remove from the IPO list for CY 2018 and subsequent years, including the HCPCS code, long descriptors, and the CY 2018 payment indicators, were displayed in Table 29 of the proposed rule.

We note that we address the public comments we received on removing the procedure described by CPT code 55866 from the IPO list under section IX.B.2. of this final rule with comment period. We address the public comments we received on removing CPT code 27447 from the IPO list under section IX.B.3. of this final rule with comment period.

2. Removal of Procedure Described by CPT Code 55866

In the CY 2018 OPPS/ASC proposed rule, we proposed to remove CPT code 55866 from the IPO list and to assign it to C–APC 5362 (Level 2 Laparoscopy & Related Services) with status indicator ''J1''. We stated in the proposed rule that after consulting with stakeholders and our clinical advisors regarding the procedure described by CPT code 55866, we believe that this procedure meets criteria 1 and 2. We sought comment on whether the public believes that these criteria are met and whether CPT code 55866 meets any other of the five criteria cited earlier.

*Comment:* Commenters, including cancer centers, physicians, and individual stakeholders, supported the proposal to remove CPT code 55866 from the IPO list. These commenters believed this procedure could be safely performed on hospital outpatients and noted that many hospital outpatient departments are equipped to do so.

*Response:* We appreciate the commenters' support.

*Comment:* One commenter opposed the removal of CPT code 55866 from the IPO list, stating that the procedure cannot be safely performed as an outpatient procedure for a majority of patients.

*Response:* We continue to believe that the procedure described by CPT code 55866 can be safely performed in the hospital outpatient setting on patients who are appropriate candidates to receive the procedure in that setting. Because the procedure meets several of the criteria for removal from the IPO list, we believe it is appropriate to remove it.

3. Removal of the Total Knee Arthroplasty (TKA) Procedure Described by CPT Code 27447

For a number of years, total knee arthroplasty (TKA) has been a topic of discussion for removal from the IPO list with both stakeholder support and opposition. Most recently, in the CY 2017 OPPS/ASC proposed rule (81 FR 45679 through 45681), we sought public comments on the removal of the TKA procedure from the IPO list from interested parties, including specifically: Medicare beneficiaries and advocate associations for Medicare beneficiaries; orthopedic surgeons and physician specialty societies that represent orthopedic surgeons who perform TKA procedures; hospitals and hospital trade associations; and any other interested stakeholders. In the CY 2017 proposed rule comment solicitation, we requested stakeholder input on whether the TKA procedure met the established criteria used to identify procedures to remove from the IPO list. We also requested input regarding how to modify current Medicare payment models that include TKA, such as the Bundled Payments for Care Improvement (BPCI) and the Comprehensive Care for Joint Replacement (CJR) initiatives, if the procedure was removed from the IPO list.

Below is a summary of the public comments we received in response to the comment solicitation in the CY 2017 OPPS/ASC proposed rule. These public comments were varied and nuanced.

- A number of commenters believed that continued refinements to the TKA surgical procedure allowed it to be performed safely on properly selected Medicare beneficiaries in the outpatient setting. A number of facilities indicated that they were currently performing TKA procedures on an outpatient basis in both the HOPD and ASC on non-Medicare patients. Commenters who supported removing the TKA procedure from the IPO list also noted recent peer-reviewed publications that reported on investigations of the feasibility of outpatient TKA with positive results; that is, TKA outpatients did not experience higher rates of complications or readmissions in comparison to TKA inpatients.
- A minority of commenters (including teaching hospital stakeholders and some professional organizations representing orthopedic surgeons) stated that the risk of postsurgical complications was too high for patients with the TKA procedure performed in the outpatient setting for the Medicare population and noted that patients appropriate for the TKA procedure performed on an outpatient basis tend to be younger, more active, have fewer complications, and have more at home support than most Medicare beneficiaries. These commenters also believed there was insufficient research on the TKA procedure performed on an outpatient basis to definitively claim that the procedure could be safely performed in the outpatient setting.
- Some commenters noted that if the TKA procedure was removed from the IPO list, inpatient TKA cases should not be subject to Recovery Audit Contractor (RAC) review for appropriate site-of-service. In addition, some commenters expressed concerns about the effect that removing the TKA procedure from the IPO list could have on the BPCI and CJR Medicare payment models. We stated in the CY 2017 OPPS/ASC final rule with comment period (81 FR 79699) that we would consider all public comments received in future policymaking.

In the CY 2018 OPPS/ASC proposed rule (82 FR 33643), we stated that we have reviewed the clinical characteristics of the TKA procedure and related evidence, including current

length-of-stay (LOS) data for inpatient TKA procedures and peer-reviewed literature related to outpatient TKA procedures. We also stated that we have considered input from the comment solicitation in the CY 2017 OPPS/ASC proposed rule (as summarized earlier) and the professional opinions of orthopedic surgeons and CMS clinical advisors. In addition, we stated that we have taken into account the recommendation from the summer 2016 meeting of the HOP Panel to remove the TKA procedure from the IPO list. Based on this information, we stated in the CY 2018 OPPS/ASC proposed rule that we have determined that the TKA procedure would be an appropriate candidate for removal from the IPO list. We stated that we expect providers to carefully develop evidence-based patient selection criteria to identify patients who are appropriate candidates for an outpatient TKA procedure as well as exclusionary criteria that would disqualify a patient from receiving an outpatient TKA procedure. We believe that the subset of Medicare beneficiaries who meet patient selection criteria for performance of the TKA procedure on an outpatient basis may have the procedure performed safely in the outpatient setting.

In the CY 2018 OPPS/ASC proposed rule, we stated that we believe that the TKA procedure described by CPT code 27447 meets a number of criteria for removal from the IPO list, including criteria 1, 2, and 4. We sought comments on whether the public believes that these criteria are met and whether the TKA procedure meets any other of the five criteria stated in the beginning of this section. In the proposed rule, we also proposed that CPT code 27447 would be assigned to C–APC 5115 (Level 5 Musculoskeletal Procedures) with status indicator ''J1''.

*Comment:* Numerous commenters, including individual stakeholders, orthopedic surgeons, clinical specialty societies, national and State-level hospital associations, hospital systems, device manufacturers, and private insurance providers responded to this proposal. Some commenters, including some orthopedic specialty societies and surgeons, private insurance providers, ambulatory surgical centers, hospital systems, and beneficiaries supported the proposal to remove CPT code 27447 from the IPO list. Many of these commenters believed that TKA met CMS' established criteria for removing a procedure from the IPO list and stated that appropriately selected patients who were in excellent health and with no or limited medical comorbidities and sufficient caregiver support could be successful candidates for outpatient TKA. Several commenters referenced their personal, positive experiences with outpatient TKA. Other commenters supported the proposal, but with certain caveats regarding patient safety, including requests that CMS develop, with input from stakeholders, patient selection criteria and risk stratification protocols for TKA to be performed in an outpatient setting. Two orthopedic specialty societies stated that their organization was in the process of developing these patient selection and protocol tools.

In addition, some commenters requested that CMS explicitly state that the surgeon is the final arbiter of the appropriate site for the surgical procedure, that CMS provide an incentive for outpatient and ambulatory settings performing TKA, PHA, and THA to be a part of a registry such as the American Joint Replacement Registry, and that CMS confirm that surgeons will continue to have the option to select the appropriate setting (inpatient or outpatient) for the procedure.

Some commenters expressed concerns that removal of TKA from the IPO list may lead commercial payers to implement coverage policies that would drive these surgeries from the inpatient setting to lower cost outpatient settings that may not be sufficiently prepared to handle the complexities or risks associated with some outpatient TKA procedures. Further, some commenters stated that removing TKA from the IPO list could drive TKA to specific facilities based on cost alone, which could result in significant further stresses in isolated rural care settings.

*Response:* We appreciate the commenters' support of our proposal. As previously stated in the discussion of the CY 2018 OPPS/ASC proposed rule, 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.

While we continue to expect providers who perform outpatient TKA 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 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. However, we remind commenters that the ''2-midnight'' rule continues to be in effect and was established to provide guidance on when an inpatient admission would be appropriate for payment under Medicare Part A (inpatient hospital services). In general, this guidance provides that if the physician expects the beneficiary to require hospital care that spans at least 2 midnights and admits the beneficiary based upon that expectation, the case is appropriate for payment under the IPPS (80 FR 70539). For stays for which the physician expects the patient to need less than 2 midnights of hospital care, an inpatient admission is payable under Medicare Part A on a case-by-case basis if the documentation in the medical record supports the admitting physician's determination that the patient requires inpatient hospital care. This documentation and the physician's admission decision are subject to medical review, which is discussed in greater detail below (80 FR 70541). The 2-midnight rule does not apply to procedures on the IPO list; that is, medically necessary procedures that are on the IPO list are appropriate for Medicare Part A payment without regard to the actual or expected length of stay (80 FR 70539).

With regard to the behavior of commercial insurance providers and site selection for outpatient TKA, while we believe that these comments are out of the scope of the proposed rule, we note that commercial providers are responsible for establishing their own rules governing payment for services.

*Comment:* Several commenters opposed the proposal to remove the TKA procedure from the IPO list, including national and State-level hospital associations, hospital systems, and individual stakeholders. Some of these commenters expressed concerns that TKA was not clinically appropriate for the outpatient setting. The commenters stated that the TKA procedure is invasive and Medicare beneficiaries are more likely to have comorbidities that could make pain more difficult to control. The commenters also stated that, because of these comorbidities, Medicare beneficiaries will face greater complications, recovery times, and rehabilitation needs than non-Medicare populations to recover from TKA procedures.

*Response:* We continue to believe that the TKA procedure meets a number of our established criteria for removal from the IPO list, including criteria 1, 2, and 4. We also continue to believe that there are a subset of Medicare beneficiaries with less medical complexity who are able to receive this procedure safely on a hospital outpatient basis and that providers should adopt evidence-based patient selection protocols to appropriately identify these patients. As previously noted, removal of a procedure from the IPO list does not require the procedure to be performed only on an outpatient basis. Rather, it allows payment to be made under the OPPS when the procedure is performed on a hospital outpatient. In addition, we expect that physicians will continue to exercise their complex medical judgment, based on a number of factors, including the patient's comorbidities, the expected length of stay in the hospital (in accordance with the 2-midnight rule), the patient's anticipated need for postoperative skilled nursing care, and other factors.

*Comment:* Several commenters stated their concerns regarding the ability of beneficiaries to access postacute care for a TKA procedure at an SNF. By statute, beneficiaries must have a prior inpatient hospital stay of no fewer than 3 consecutive days to be eligible for Medicare coverage of inpatient SNF care. The commenters stated that discharging outpatient TKA patients without a 3-day stay and access to adequate rehabilitation would increase the likelihood of further medical concerns that may result in readmissions, which will result in higher expenses for the beneficiary, the Medicare program, and the hospital. These commenters stated that if there is no commensurate waiver of the SNF 3-day stay requirement, all outpatient TKA patients would need to be appropriate for discharge to home or home health care. One commenter questioned beneficiaries' ability to access the SNF benefit if a beneficiary has outpatient TKA surgery and is then admitted as an inpatient after being discharged from the hospital outpatient department. Other commenters noted that the vast majority of beneficiaries who fit the criteria for an outpatient TKA or THA procedure would not need institutional postacute care services. Commenters also stated that a large percentage of TKA inpatients do not require a 3-day length of stay, and that removing TKAs from the IPO list would not preclude these patients from meeting the 3-day qualifying stay requirement when warranted.

*Response:* We reiterate that removal of the TKA procedure from the IPO list does not require the procedure to be performed only on an outpatient basis. Removal of the TKA procedure from the IPO list allows for payment of the procedure in either the inpatient setting or the outpatient setting. The commenter is correct that a prior inpatient hospital stay of at least 3 consecutive days is required by law under Medicare FFS as a prerequisite for SNF coverage. We note that Medicare Advantage plans may elect, pursuant to 42 CFR 409.30 and 422.101(c), to provide SNF coverage without imposing the SNF 3-day qualifying stay requirement and that 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.

We agree that the physician should take the beneficiaries' need for post-surgical services into account when selecting the site of care to perform the surgery. We would expect that Medicare beneficiaries who are selected for outpatient TKA would be less medically complex cases with few comorbidities and would not be expected to require SNF care following surgery. Instead, we expect that many of these beneficiaries would be appropriate for discharge to home (with outpatient therapy) or home health care. We believe that comprehensive patient selection protocols should be implemented to properly identify these beneficiaries. However, we do not believe that Medicare should establish such protocols and believe that physicians and providers should select an appropriate patient selection protocol.

*Comment:* Numerous commenters from stakeholders addressed the effect that removing TKA from the IPO list could potentially have on two Medicare payment models currently being administered by the Center for Medicare and Medicaid Innovation: BPCI and the CJR model. The commenters were concerned that the proposal to remove TKA from the IPO list could significantly alter the composition of BPCI and CJR participant hospitals' patient populations. Specifically, the commenters believed that younger and healthier patients would be more likely to receive outpatient TKAs and that a higher proportion of patients receiving inpatient TKAs would be high risk and/or more likely to require additional postacute care support. As a result, the commenters believed that a change in patient-mix could increase the average episode payment of the remaining inpatient TKA BPCI and CJR episodes when compared to current payment levels and affect a hospital's ability to fall below the established target price for the episode, thereby hindering the hospital's ability to generate savings under the BPCI or CJR model. The commenters presented several proposed refinements to the BPCI and CJR models to mitigate these effects, including adjusting the target price for BPCI and CJR episodes involving TKA to exclude procedures that could have been performed in the HOPD or allowing BPCI Model 2 and CJR episodes to be initiated by TKA performed in the hospital outpatient department.

*Response:* As mentioned earlier, 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. As providers' knowledge and experience in the delivery of hospital outpatient TKA treatment develops, there may be a greater migration of cases to the hospital outpatient setting. However, 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.

*Comment:* Some commenters asked CMS to reconsider the proposed assignment of CPT code 27447 to C–APC 5115 (Level 5 Musculoskeletal Procedures) with status indicator ''J1''. The commenters presented an analysis of OPPS claims data which indicated that approximately one-third of the TKA claims reported no joint implant HCPCS C-code on the claim. Some of these commenters asserted that the claims that did not include a joint implant had a geometric mean cost of approximately

$3,808 and the claims that did include a joint implant had a geometric mean cost of approximately $13,843, while the overall geometric mean cost for claims with CPT code 27447 was approximately $8,602. The commenters requested that CMS only use claims for ratesetting for CPT 27447 that include a joint implant and to assign the procedure to APC 5116 (Level 6 Musculoskeletal Procedures). One commenter also stated that CMS failed to provide the general public with an explanation of the source of the geometric mean cost of the TKA procedure, which was CMS' basis for assigning the TKA procedure to a C–APC.

*Response:* Since the assignment of CPT code 27447 to the IPO list, no payment for claim lines billing this procedure code were made. Based on clinical similarity with other musculoskeletal procedures, we continue to believe that C–APC 5115 is an appropriate APC assignment for CPT code 27447. Further, we note that the 50th percentile IPPS payment for TKA without major complications or comorbidities (MS–DRG 470) is roughly $11,760 for FY 2018. We note that the geometric mean cost for C–APC 5116 is over $15,000. As previously stated, we would expect that beneficiaries selected for outpatient TKA would generally be expected to be less complex and to not have major complications or comorbidities. Therefore, we do not believe that it would be appropriate for the OPPS payment rate to exceed the IPPS payment rate for TKA without major complications/comorbidities because IPPS cases would generally be expected to be more complicated and complex than those selected for performance in the hospital outpatient setting and because inpatient cases would include room and board as well as more time in the hospital.

With respect to the billing concern, we rely on hospitals to bill all HCPCS codes accurately in accordance with their code descriptors and CPT and CMS instructions, as applicable, and to report charges on claims and charges and costs on their Medicare hospital cost reports appropriately (77 FR 68324). As we do every year, we will review and evaluate the APC groupings based on the latest available data in the next rulemaking cycle.

After consideration of the public comments we received, we are finalizing our proposal to remove the TKA procedure described by CPT code 27447 from the IPO list beginning in CY 2018 and to assign the TKA procedure to C–APC 5115 with status indicator ''J1''.

4. Recovery Audit Contractor (RAC) Review of TKA Procedures

In the CY 2018 OPPS/ASC proposed rule (82 FR 33643 and 33644), we proposed that if we finalized our proposal to remove the TKA procedure described by CPT code 27447 from the IPO list, 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. We believe this approach will help ensure that hospitals can determine whether to perform the procedure on a hospital outpatient or hospital inpatient basis without taking into account the possibility of an inpatient TKA claim being denied upon a patient status review by a RAC. That is, given that this surgical procedure is newly eligible for payment under either the IPPS or the OPPS, we proposed that RAC patient status reviews of a hospital claim is prohibited for a period of 2 years. We note that RAC reviews of TKA procedures described by CPT code 27447 will continue to be permitted for issues other than patient status as an inpatient or outpatient, including those for underlying medical necessity.

*Comment:* Many commenters supported a prohibition on RAC review for patient status for TKA procedures performed in the inpatient setting for a period of 2 years. Some commenters suggested that CMS prohibit RAC review for a period of at least 36 months to allow consensus to develop around appropriate evidence-based patient selection criteria. One commenter requested that CMS impose a permanent moratorium on RAC reviews of patient status for TKA or confirm that after any moratorium is lifted, a RAC will only be permitted to undertake such a review upon a referral by a Quality Improvement Organization (''QIO''). One commenter also requested that CMS also clarify that its current 2-midnight policy will apply to the TKA procedure if it were to be removed from the IPO, as it does for other inpatient admissions.

*Response:* We continue to believe that a 2-year prohibition on RAC review for TKA procedures performed in the inpatient setting is an adequate amount of time to allow providers to gain experience with determining the most appropriate setting to perform these procedures and establishing patient selection criteria to assist in the determination. As stated in the CY 2016 OPPS/ASC final rule with comment period (80 FR 70538 through 70549), under the 2-midnight rule, an inpatient admission is generally appropriate for Medicare Part A payment if the physician (or other qualified practitioner) admits the patient as an inpatient based upon the expectation that the patient will need hospital care that crosses at least 2 midnights. However, Medicare Part A payment is allowed on a case-by-case basis for inpatient admissions that do not satisfy the 2-midnight benchmark, if the documentation in the medical record supports the admitting physician's determination that the patient requires inpatient hospital care despite an expected length of stay that is less than 2 midnights. The initial medical reviews of claims for short-stay inpatient admissions are conducted by QIOs, which may refer providers to the RACs due to exhibiting persistent noncompliance with Medicare payment policies, including, but not limited to: Having high denial rates and consistently failing to adhere to the 2-midnight rule, or failing to improve their performance after QIO educational intervention. The 2-midnight rule and this medical review policy do not apply to procedures that are included on the IPO list. However, these policies do apply to other inpatient admissions for procedures that are not included on the IPO list and would also generally apply to TKA procedures performed in the hospital inpatient setting. As mentioned previously, however, RAC patient status reviews for TKA procedures performed in the hospital inpatient setting is prohibited for a period of 2 years.

5. Public Requests for Additions to or Removal of Procedures on the IPO List

Commenters who responded to the CY 2018 OPPS/ASC proposed rule also requested that CMS remove several additional procedures from the IPO list. These additional procedures are listed in Table 77 below.

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

| CY 2018 PT 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. |
| 43282 | Laparoscopy, surgical, repair of paraesophageal hernia with implantation of mesh. |
| 43772 | Laparoscopy, surgical, gastric restrictive procedure; removal of adjustable gastric restrictive device component only. |
| 43773 | Laparoscopy, surgical, gastric restrictive procedure; removal and replacement of adjustable gastric restrictive device component only. |
| 43774 | Laparoscopy, surgical, gastric restrictive procedure; removal of adjustable gastric restrictive device and subcutaneous port components. |

After evaluating the above list of codes that commenters requested to be removed from the IPO list against our established criteria, we believe that CPT codes 43282, 43772, 43773, 43774 meet several criteria to be removed from the IPO list, including criteria 3. Accordingly, we are removing these four CPT codes from the IPO list for CY 2018 and assigning them to APCs in this final rule with comment period.

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. A further discussion of the comment solicitation of the possible removal of partial hip arthroplasty (PHA) and total hip arthroplasty (THA) procedures from the IPO list is included under section IX.C. of this final rule with comment period.

One commenter requested that CMS add the procedure described by CPT code 92941 (Percutaneous transluminal revascularization of acute total/subtotal occlusion during acute myocardial infarction, coronary artery or coronary artery bypass graft, any combination of intracoronary stent, artherectomy and angioplasty, including aspiration thrombectomy when performed, single vessel) to the IPO list because this procedure is performed emergently to treat acute myocardial infarction patients.

We evaluated the procedure described by CPT code 92941 against our criteria, and we agree with the commenter that CPT code 92941 should be added to the IPO list.

6. Summary of Changes to the IPO List for CY 218

After consideration of the public comments we received and for the reasons discuss previously, we are removing the following procedures from the IPO list for CY 2018: CPT codes 27447, 43282, 43772, 43773, 43774, and 55866. We also are adding CPT code 92941 to the IPO list for CY 2018. The specific procedures, including the CPT code, long descriptors, and the CY 2018 status indicators, are displayed in Table 78 below.

TABLE 78—CHANGES TO THE INPATIENT ONLY LIST FOR CY 2018

| CY 2018 CPT code | CY 2018 long descriptor | Status | CY 2018 OPPS APC assignment | CY 2018 OPPS Status indicator |
|---|---|---|---|---|
| 27447 | Arthroplasty, knee, condyle and plateau; medical and lateral compartments with or without patella resurfacing (total knee arthroplasty). | Removed | 5115 | J1 |
| 43282 | Laparoscopy, surgical, repair of paraesophageal hernia with implantation of mesh. | Removed | 5362 | J1 |
| 43772 | Laparoscopy, surgical, gastric restrictive procedure; removal of adjustable gastric restrictive device component only. | Removed | 5303 | J1 |
| 43773 | Laparoscopy, surgical, gastric restrictive procedure; removal and replacement of adjustable gastric restrictive device component only. | Removed | 5361 | J1 |
| 43774 | Laparoscopy, surgical, gastric restrictive procedure; removal of adjustable gastric restrictive device and subcutaneous port components. | Removed | 5303 | J1 |
| 55866 | Laparoscopy, surgical prostatectomy, retropubic radical, including nerve sparing, includes robotic assistance, when performed. | Removed | 5362 | J1 |
| 92941 | Percutaneous transluminal revascularization of acute total/subtotal occlusion during acute myocardial infarction, coronary artery or coronary artery bypass graft, any combination of intracoronary stent, artherectomy and angioplasty, including aspiration thrombectomy when performed, single vessel. | Added | N/A | C |

The complete list of codes (the IPO list) that will be paid by Medicare in CY 2018 as inpatient only procedures is included as Addendum E to this final rule with comment period (which is available via the Internet on the CMS Web site).