AAOS
American Association of Orthopaedic Surgeons

August 31, 2026

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Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1850-P
P.O. Box 8010
Baltimore, MD 21244-8010

On behalf of the more than 39,000 orthopaedic surgeons and residents represented by the American Association of Orthopaedic Surgeons (AAOS), I write to share our feedback on the Calendar Year (CY) 2027 Medicare Hospital Outpatient Prospective Payment System (OPPS) proposed rule (CMS-1850-P). The Centers for Medicare & Medicaid Services (CMS) proposes several revisions to the OPPS and the Ambulatory Surgical Center (ASC) payment systems and updates to requirements for the Hospital Outpatient Quality Reporting (OQR) Program and the ASC Quality Reporting (ASCQR) Program. In response to these proposals, AAOS recommends:

- **Site Neutral Payment for Non-Contrast Imaging:** AAOS appreciates that CMS recognizes the value of creating parity in non-contrast imaging payment rates across physician office and off-campus provider-based department (PBD) settings. By creating this equilibrium, we believe it will act as an enabling step toward preventing further consolidation and price inflation caused by large healthcare systems absorbing their independent physician competitors' sources of revenue. However, we urge caution against unintended consequences, including limiting access to critically important, low-cost diagnostic tools.

- **Device Pass Through Payments:** AAOS supports transitional device pass through payments for new technologies supported by adequate evidence demonstrating their safety, efficacy, and effectiveness in Medicare beneficiaries. In general, AAOS supports CMS's efforts to facilitate beneficiary access to innovative technologies and appreciates the agency's collaboration with the U.S. Food and Drug Administration (FDA), including through the Breakthrough Devices Program to encourage the development and adoption of clinically meaningful technologies that improve musculoskeletal care.

- **Complexity Adjustments:** We continue to support CMS permitting certain add-on codes (those that had previously been assigned to Device-dependent APCs) to qualify for the complexity adjustment. We encourage CMS to continue expanding eligibility for code pairs, including those that include procedure and select HCPCS device codes, possibly through modifications to the current cost threshold that determines code pair eligibility. We encourage CMS to reevaluate use of the two-times rule for higher-level MSK APCs to ensure hospitals can continue to provide patients with access to innovative technologies, and ask that CMS consider creating additional stability within the payment system by allowing established codes to maintain the complexity adjustment for three calendar years before they are required to undergo eligibility review.

- **ASC Weight Scalar:** AAOS urges CMS to remove the ASC weight scalar. While we appreciate the continued use of the hospital market basket methodology to update ASC payment rates, we remain concerned that the weight scalar constrains ASC payment updates and, in turn, limits opportunities for innovation in patient care and expanded access to surgical services across settings.

- **APC Code Updates:** Despite AAOS' longstanding concerns regarding the elimination of the IPO list, CMS has now finalized that policy. As CMS continues implementation of this policy through the CY 2027 OPPS/ASC Proposed Rule, it is critical that procedures paid under the OPPS are assigned to APCs that appropriately reflect hospital resource utilization and clinical complexity to ensure patients continue to have access to the highest quality care. AAOS respectfully requests that CMS continue evaluating the procedures identified in Appendix A as it develops the CY 2027 Final Rule.

We provide additional details on these recommendations and additional topics below.

Payment
CMS proposes that hospitals that meet their outpatient quality reporting requirements will receive a 2027 payment increase of 2.4%. CMS estimates that total payments to OPPS providers will increase by $9.5 billion over 2026, after accounting for changes in enrollment, utilization, and case mix. Likewise, ASCs will receive a 2.4% increase in payments and will see an increase in total payments of $520 million over 2026.

CMS has used the hospital market basket to update ASC payments since CY 2019 as it continues to evaluate whether applying the hospital market basket update has an effect on the migration of services from the hospital to ASC setting. CMS proposes to extend the use of the hospital market basket update in setting ASC payments for CY 2027. AAOS remains supportive of the proposal to extend the use of the hospital market basket methodology for ASCs and urges CMS to adopt this methodology on a permanent basis to better reflect the costs associated with providing surgical services in the ASC setting.

Site Neutral Payment for Non-Contrast Imaging
AAOS appreciates that CMS recognizes the value of creating parity in non-contrast imaging payment rates across physician office and off-campus provider-based department (PBD) settings. The proposal to apply the Physician Fee Schedule equivalent rate for any Healthcare Common Procedure Coding System (HCPCS) codes assigned to the imaging without contrast APCs when provided at an off-campus PBD is aimed at controlling the "unnecessary volume of imaging without contrast services." By creating this equilibrium, we believe it will act as an enabling step toward preventing further consolidation and price inflation caused by large healthcare systems absorbing their independent physician competitors' sources of revenue. However, we urge caution against unintended consequences, including limiting access to critically important, low-cost diagnostic tools.

AAOS broadly supports reform initiatives that minimize payment differentials for identical services that can be safely and effectively performed across two or more settings including a hospital outpatient department, ASC or physician office. We believe such reforms can curb inefficiencies and promote patient and physician choice. However, site-neutrality should not simply mean reducing payment across settings to the lowest rate without regard for the actual costs of safely and sustainably furnishing care. Doing so could further strain physician practices and ultimately reduce patient access to services. These changes must be implemented thoughtfully

and in tandem with broader reforms to stabilize the Medicare physician payment system, otherwise they risk undermining the very physicians and practices they aim to support.

Device Pass Through Payments

AAOS supports transitional device pass through payments for new technologies supported by adequate evidence demonstrating their safety, efficacy, and effectiveness in Medicare beneficiaries. In general, AAOS supports CMS's efforts to facilitate beneficiary access to innovative technologies and appreciates the agency's collaboration with the U.S. Food and Drug Administration (FDA), including through the Breakthrough Devices Program to encourage the development and adoption of clinically meaningful technologies that improve musculoskeletal care.

TOPS™ System

In the CY 2027 OPPS/ASC Proposed Rule, CMS proposes to finalize transitional device pass-through payment status for the TOPS™ System. Following review by AAOS physician advisors, AAOS agrees that the TOPS™ System meets all applicable criteria. Given that a Category I CPT code is not anticipated to be approved until later in CY 2026, AAOS supports CMS's proposal to finalize device pass-through payment status for the TOPS™ System for CY 2027.

TOUCH® CMC 1 Prosthesis

AAOS is also supportive of the application submitted by Medartis for the TOUCH® CMC 1 Prosthesis. Based on our physician advisors' review, AAOS believes the device meets eligibility criteria and supports CMS's proposal to approve transitional device-pass-through payment status for CY 2027.

Complexity Adjustments

We continue to support CMS permitting certain add-on codes (those that had previously been assigned to Device-dependent APCs) to qualify for the complexity adjustment. For those primary service and add-on code combinations that are determined to be sufficiently frequent and sufficiently costly, CMS believes that a payment adjustment is warranted.

Yet, we encourage CMS to continue expanding eligibility for code pairs, including those that include procedure and select HCPCS device codes, possibly through modifications to the current cost threshold that determines code pair eligibility. Although the two-times rule cost threshold works well for lower-cost APCs, it does not work well for higher-cost APCs and those with wider cost bands because two-times the higher baseline creates extremely high thresholds that are impossible to meet. Further, CMS more frequently than not provides exceptions even when the two times rule is violated making complexity adjustment eligibility even more critical. We encourage CMS to reevaluate use of the two-times rule for higher-level MSK APCs to ensure hospitals can continue to provide patients with access to innovative technologies.

Furthermore, we ask that CMS consider creating additional stability within the payment system by allowing established codes to maintain the complexity adjustment for three calendar years before they are required to undergo eligibility review. Likewise, for a family of related codes, we ask that CMS consider allowing the adjustment that applies to combinations involving one secondary procedure code to be applicable to combinations involved in all clinically similar primary procedures within that family.

Finally, we ask that CMS consider implementing the concept on which it requested comment last year to apply the complexity adjustment methodology not just to code pairs but also to code clusters, which we believe will more appropriately reimburse for higher than normal resource use which cannot always be identified by reviewing only code pairs.

ASC Weight Scalar

AAOS urges CMS to remove the ASC weight scalar. While we appreciate the continued use of the hospital market basket methodology to update ASC payment rates, we remain concerned that the weight scalar constrains ASC payment updates and, in turn, limits opportunities for innovation in patient care and expanded access to surgical services across settings. Continuing to apply the ASC weight scalar effectively imposes a second layer of budget neutrality, resulting in artificially lower payments to ASCs and undermining the adequacy of reimbursement for care delivered in this setting.

The statutory requirement for a budget neutrality adjustment applied only to the first year that CMS implemented the revised ASC payment system. However, CMS has continued to apply the weight scalar in subsequent years pursuant to its own administrative authority rather than an identified statutory mandate. Accordingly, CMS has the authority and discretion to discontinue use of the ASC weight scalar. AAOS urges CMS to exercise this authority and adopt a payment approach that better supports patient access, innovation, and continued viability of care delivered in the ASC setting.

CMS also solicits comments on whether the device portion of certain procedures should continue to be excluded from application of the ASC weight scalar or instead be treated as a scalable expenditure. AAOS does not support modifying the scalar methodology. Expanding the scope of the scalar would further compound our underlying concerns with its continued use. Rather than broadening its application, AAOS strongly urges CMS to eliminate the ASC weight scalar altogether while it continues to evaluate broader reforms that appropriately recognize the value, efficiency, and evolving role of care in ASCs.

APC Code Updates

AAOS appreciates CMS's ongoing work implementing the transition of procedures from the Inpatient Only (IPO) list to the OPPS Ambulatory Payment Classification (APC) categories. Despite AAOS' longstanding concerns regarding the elimination of the IPO list, CMS has now finalized that policy. As CMS continues implementation of this policy through the CY 2027 OPPS/ASC Proposed Rule, it is critical that procedures paid under the OPPS are assigned to APCs that appropriately reflect hospital resource utilization and clinical complexity to ensure patients continue to have access to the highest quality care.

AAOS appreciates CMS's continued refinement of Comprehensive APC assignments in the CY 2027 OPPS/ASC Proposed Rule. While CMS proposes no new Comprehensive APCs and relatively few changes to musculoskeletal APC assignments, AAOS appreciates the opportunity to provide additional feedback and believes several previously identified placement concerns remain unresolved. Accordingly, AAOS respectfully requests that CMS continue evaluating the procedures identified in Appendix A as it develops the CY 2027 Final Rule.

Following review of the CY 2027 OPPS/ASC Proposed Rule, AAOS physician reviewers continue to have concerns in three primary areas:

- Procedures that have traditionally been on the IPO List but are now placed into outpatient APCs, where current APC assignments may not fully reflect the hospital resource utilization required to perform these services in the outpatient settings;
- Procedures grouped within the same APC that appear substantially more or less resource intensive than other procedures assigned to that APC, including highly resource-intensive procedures assigned alongside lower-intensity procedures; and
- Related procedures whose APC placement appears inconsistent relative to one another based on expected hospital resource utilization or surgical approach, including percutaneous versus open procedures and revision versus primary procedures.

Across these categories, reviewers emphasized that the primary concern is not operative difficulty alone, but whether APC assignments appropriately reflect expected facility resource utilization, including implant costs, labor inputs, operative time, and overall facility resources. AAOS remains concerned that for many procedures newly transitioned from the IPO List, existing hospital outpatient cost data may not yet fully reflect resource utilization in the ambulatory setting. For lower-volume procedures in the Medicare population, it may take several years for sufficient outpatient data to accumulate to inform stable geometric mean cost calculations. In the interim, consideration of relative source intensity and comparison to clinically similar outpatient procedures may support appropriate APC re-alignment.

The procedures identified by AAOS physician reviewers, along with supporting rationale, are provided in **Appendix A**. AAOS respectfully requests that CMS continue to review these APC assignments and consider whether reassignment or additional evaluation is appropriate during development of the CY 2027 Final Rule.

Non-opioid Policies for Pain Relief Under OPPS and ASC Payment System

AAOS supports CMS' proposal to continue its policy, as finalized in CY 2025, to provide temporary additional payments for certain non-opioid treatments for pain relief in the hospital outpatient and ASC settings. As we have stated previously, AAOS is supportive of the utilization of non-opioid pain management where appropriate and commends CMS for taking steps to improve access to these treatments. Additionally, we reiterate our support for incentivizing payment for alternative chronic pain management treatments such as acupuncture, chiropractic services, osteopathic manipulation, cognitive behavioral therapy, and physical therapy, as appropriate in outpatient settings of care.

AAOS appreciates that CMS has proposed to include cyroneurolysis (e.g., Iovera) and the ON-Q Pump as qualifying for separate payment in CY2027. AAOS had previously recommended that CMS apply separate payment for these commonly used orthopedic non-opioid pain relief treatments. AAOS encourages CMS to consider a wide range of non-opioid treatments, including but not limited to intravenous acetaminophen, transcutaneous stimulators, and topical analgesics.

Non-opioid treatments are available throughout the Medicare program, including under Medicare Part D, and beneficiaries should be able to access these clinically appropriate medicines regardless of the coverage pathway. It is especially important that patients who receive non-opioid treatments during their surgery in an

ASC Or HOPD be able to continue to manage their pain with non-opioid treatments during their recovery. We therefore urge CMS to continue advancing policies and educational initiatives that increase awareness of and access to non-opioid medicines across Medicare. Expanding access through a coordinated, program-wide strategy is essential to ensuring beneficiaries can benefit from safe, effective alternatives to opioids for pain management.

Price Transparency RFI

AAOS appreciates the efforts of the agencies to foster a system of clear prices for health services. Both physicians and patients benefit when health care decision-making is built on a mutual understanding of all aspects of treatment, including cost. A lack of clarity surrounding the costs of care can lead to undue stress for patients. Developing a system where the prices for services are not a secret until the explanation of benefits statement arrives in the mail is critical to addressing this source of stress and improving the well-being of Americans. Toward that end, AAOS supports efforts to provide patients with easily understandable cost and quality information to encourage the use of high-value care options.

Allowing healthcare consumers to search for medical providers based on both measures of price and quality will increase patient empowerment when making serious decisions about medical treatment. AAOS has supported similar efforts, including the "Procedure Price Lookup Tool" which allows patients to compare average national prices for procedures in both ambulatory surgery center and hospital outpatient department settings.

Quality Reporting Request for Information

AAOS supports the implementation of measures aimed at elevating the quality of treatment and outcomes for musculoskeletal patients. CMS seeks comment on potentially including an Advance Care Planning electronic clinical quality measure (eCQM) in the Hospital Outpatient Quality Reporting Program through future rulemaking. This measure has the potential to help patients clarify their wishes and ensure that their care contingency plans are aligned with their goals. We agree that this measure may be appropriate for surgeons, but caution against unintended burden associated with the collection of its required data. Moreover, since this is a hospital-based measure, it is imperative that there is an appropriate on-ramp for integration into EHRs so that collecting this essential information does not result in an artificially punitive score.

AAOS appreciates that CMS is examining the data from the All-Cause Transfer/Admission measure and considering the incorporation of a phase of care stratification within the ASC Quality Reporting Program. We support this granular level of data collection and the subsequent impact it will have on optimizing care in ASCs for the most appropriate patients scheduled for care in this minimally acute setting.

Thank you for your attention to our comments. We appreciate your consideration of our feedback regarding CMS-1850-P. Should you have any questions or if the AAOS can further serve as a resource to you, please contact Lori Shoaf, JD, MA, AAOS Office of Government Relations at shoaf@aaos.org.

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Sincerely,

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This letter has received sign-on from the following orthopaedic societies:

American Orthopaedic Foot & Ankle Society
American Orthopaedic Society for Sports Medicine
American Shoulder and Elbow Surgeons
American Society for Surgery of the Hand
Arthroscopy Association of North America
Limb Lengthening and Reconstruction Society: ASAMI-North America
Musculoskeletal Tumor Society
Orthopaedic Trauma Association
Pediatric Orthopaedic Society of North America
Ruth Jackson Orthopaedic Society

Alabama Orthopaedic Society
Arkansas Orthopaedic Society
Connecticut Orthopaedic Society
Delaware Society of Orthopaedic Surgeons
Illinois Association of Orthopaedic Surgeons
Maryland Orthopaedic Association
Massachusetts Orthopaedic Association
Michigan Orthopaedic Society
Nebraska Orthopaedic Society
New Hampshire Orthopaedic Society
North Carolina Orthopaedic Association
North Dakota Orthopaedic Society
Ohio Orthopaedic Society
Pennsylvania Orthopaedic Society

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Sociedad Puertorriqueña de Ortopedia y Traumatología
South Dakota State Orthopaedic Society
Tennessee Orthopaedic Society
Texas Orthopaedic Association
West Virginia Orthopaedic Society

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Appendix A-Musculoskeletal Procedures Identified for CMS Review

APC	CPT	Descriptor	IPO Removal	Concern	Direction of Assignment Concern	Reviewers Notes
5111	27222	Treat hip socket fracture	Yes	Newly Outpatient Procedures	Under	Requires more manipulation, increasing required facility time relative to other 5111 assigned procedures
5111	29999	Unlisted px arthroscopy	N/A	Not Comparable Within APC	Under	New procedure that always requires repair
5112	20816	Replantation digit complete	Yes	Newly Outpatient Procedures	Under	Resource intense, complex procedure
5112	20822	Replantation digit complete	No	Not Comparable Within APC	Under	Resource intense, complex procedure
5112	20824	Replantation thumb complete	Yes	Newly Outpatient Procedures	Under	Resource intense, complex procedure
5112	20827	Replantation thumb complete	Yes	Newly Outpatient Procedures	Under	Resource intense, complex procedure
5112	23520	Cltx strnclav dislc w/o mnpj	No	Not Comparable Within APC	Over	N/A
5112	25259	Manipulate wrist w/anesthes	No	Not Comparable Within APC	Over	Level of hospital resource intensity should be reevaluated
5112	20661	Application halo cranial	Yes	Newly Outpatient Procedures	Over	Generally considered less resource intensive than 20664 which is assigned to APC 5112
5113	20650	Insert and remove bone pin	No	Not Comparable Within APC	Over	Level of hospital resource intensity should be reevaluated
5113	21720	Revision of neck muscle	No	Not Comparable Within APC	Over	Level of hospital resource intensity should be reevaluated
5113	23125	Claviculectomy total	No	Not Comparable Within APC	Under	A tumor case requiring complete resection
5113	24357	Repair elbow perc	No	Not Comparable Within APC	Over	Level of hospital resource intensity should be reevaluated
APC	**CPT**	**Descriptor**	**IPO Removal**	**Concern**	**Direction of**	**Reviewers Notes**

					Assignment Concern	
5113	27175	Treat slipped epiphysis	Yes	Newly Outpatient Procedures	Over	Treatment by traction likely valued less
5113	27176	Treat slipped epiphysis	Yes	Newly Outpatient Procedures	Over	Percutaneous treatment likely valued less than open treatment
5113	27185	Revision of femur epiphysis	Yes	Newly Outpatient Procedures	Over	Overvalued relative to preceding open treatment
5113	27258	Treat hip dislocation	Yes	Newly Outpatient Procedures	Under	Major hip reconstruction, significant risk
5113	27259	Treat hip dislocation	Yes	Newly Outpatient Procedures	Under	Major hip reconstruction, significant risk
5113	27365	Resect femur/knee tumor	Yes	Newly Outpatient Procedures	Under	Major surgery with neurovascular risk
5113	27590	Amputate leg at thigh	Yes	Newly Outpatient Procedures	Under	Patient generally with moderate risk factors
5113	27591	Amputate leg at thigh	Yes	Newly Outpatient Procedures	Under	Patient generally with moderate risk factors
5113	27592	Amputate leg at thigh	Yes	Newly Outpatient Procedures	Under	Patient generally with moderate risk factors
5113	27598	Amputate lower leg at knee	Yes	Newly Outpatient Procedures	Under	Patient generally with moderate risk factors
5113	27645	Resect tibia tumor	Yes	Newly Outpatient Procedures	Under	Major surgery with neurovascular risk
5113	27646	Resect fibula tumor	Yes	Newly Outpatient Procedures	Under	Major surgery with neurovascular risk
5113	27685	Revision of lower leg tendon	No	Not Comparable Within APC	Over	Level of hospital resource intensity should be reevaluated
5113	27686	Revise lower leg tendons	No	Not Comparable Within APC	Over	Level of hospital resource intensity should be reevaluated
5113	27687	Revision of calf tendon	No	Not Comparable Within APC	Over	Level of hospital resource intensity should be reevaluated
5113	27881	Amputation of lower leg	Yes	Newly Outpatient Procedures	Under	Patient generally with moderate risk factors
5113	27882	Amputation of lower leg	Yes	Newly Outpatient Procedures	Under	Patient generally with moderate risk factors

APC	CPT	Descriptor	IPO Removal	Concern	Direction of Assignment Concern	Reviewers Notes
5114	20955	Fibula bone graft microvasc	Yes	Newly Outpatient Procedures	Under	Extremely time and resource intensive
5114	20956	Iliac bone graft microvasc	Yes	Newly Outpatient Procedures	Under	Extremely time and resource intensive
5114	20957	Mt bone graft microvasc	Yes	Newly Outpatient Procedures	Under	Extremely time and resource intensive
5114	20962	Other bone graft microvasc	Yes	Newly Outpatient Procedures	Under	Extremely time and resource intensive
5114	20969	Bone/skin graft microvasc	Yes	Newly Outpatient Procedures	Under	Extremely time and resource intensive
5114	20970	Bone/skin graft iliac crest	Yes	Newly Outpatient Procedures	Under	Extremely time and resource intensive
5114	20972	Bone/skin graft metatarsal	No	Not Comparable Within APC	Under	Extremely time and resource intensive
5114	20973	Bone/skin graft great toe	No	Not Comparable Within APC	Under	Extremely time and resource intensive
5114	20983	Ablate bone tumor(s) perq	No	Relative Placement Among Similar Procedures	Over	Less intense service than most others in this APC level
5114	22212	Incis 1 vertebral seg thorac	Yes	Newly Outpatient Procedures	Under	Complex spine surgery, risk of spinal injury
5114	22214	Incis 1 vertebral seg lumbar	Yes	Newly Outpatient Procedures	Under	Complex spine surgery, risk of spinal injury
5114	23335	Shoulder prosthesis removal	Yes	Newly Outpatient Procedures	Under	Routinely complex
5114	26551	Great toe-hand transfer	Yes	Newly Outpatient Procedures	Under	Complex microvascular case, should be with other major free flaps
5114	26553	Single transfer toe-hand	Yes	Newly Outpatient Procedures	Under	Complex microvascular case, should be with other major free flaps
5114	26554	Double transfer toe-hand	Yes	Newly Outpatient Procedures	Under	Complex microvascular case, should be with other major free flaps
5114	26556	Toe joint transfer	Yes	Newly Outpatient Procedures	Under	Complex microvascular case, should be with other major free flaps

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APC	CPT	Descriptor	IPO Removal	Concern	Direction of Assignment Concern	Reviewers Notes
5115	23474	Revis reconst shoulder joint	Yes	Newly Outpatient Procedures	Under	Complex case with high risk of neurovascular injury and infection and more resource intensive
5115	23900	Interthoracoscplr amputation	Yes	Newly Outpatient Procedures	Under	Complex case with high risk of neurovascular injury
5115	23920	Disarticulation shoulder	Yes	Newly Outpatient Procedures	Under	Complex case with high risk of neurovascular injury
5115	27580	Fusion of knee	Yes	Newly Outpatient Procedures	Under	Complex case with high risk of meurovascular injury
5116	0656T	Ant lmbr vrt bdy teth <7 seg	Yes	Newly Outpatient Procedures	Under	Complex spine surgery requiring open retroperitoneal approach, risk of spinal injury
5116	0657T	Ant lmbr vrt bdy teth 8+ seg	Yes	Newly Outpatient Procedures	Under	Complex spine surgery requiring open retroperitoneal approach, risk of spinal injury
5116	0790T	Revj rplcmt/rmvl vrt tethrg	Yes	Newly Outpatient Procedures	Under	Complex spine surgery requiring open retroperitoneal approach, risk of spinal injury
5116	22800	Arthrd pst dfrm<6 vrt sgm	Yes	Newly Outpatient Procedures	Under	Complex spine surgery, risk of spinal injury
5116	22802	Arthrd pst dfrm 7-12 vrt sgm	Yes	Newly Outpatient Procedures	Under	Complex spine surgery, risk of spinal injury
5116	22804	Arthrd pst dfrm 13+ vrt sgm	Yes	Newly Outpatient Procedures	Under	Complex spine surgery, risk of spinal injury
5116	22808	Arthrd ant dfrm 2-3 vrt sgm	Yes	Newly Outpatient Procedures	Under	Complex spine surgery, risk of spinal injury
5116	22810	Arthrd ant dfrm 4-7 vrt sgm	Yes	Newly Outpatient Procedures	Under	Complex spine surgery, risk of spinal injury
5116	22812	Arthrd ant dfrm 8+ vrt sgm	Yes	Newly Outpatient Procedures	Under	Complex spine surgery, risk of spinal injury
5116	22818	Kyphectomy 1-2 segments	Yes	Newly Outpatient Procedures	Under	Complex spine surgery, risk of spinal injury
APC	**CPT**	**Descriptor**	**IPO Removal**	**Concern**	**Direction of**	**Reviewers Notes**

					Assignment Concern	
5116	22819	Kyphectomy 3 or more	Yes	Newly Outpatient Procedures	Under	Complex spine surgery, risk of spinal injury
5116	22836	Ant thrc vrt body tethrg <7	Yes	Newly Outpatient Procedures	Under	Complex spine surgery requiring thoracoscopic or open approach, risk of spinal injury
5116	22837	Ant thrc vrt body tethrg 8+	Yes	Newly Outpatient Procedures	Under	Complex spine surgery requiring thoracoscopic or open approach, risk of spinal injury
5116	22838	Rev rplc/rmv thrc vrt tethrg	Yes	Newly Outpatient Procedures	Under	Complex spine surgery requiring thoracoscopic or open approach, risk of spinal injury
5117	27702	Reconstruct ankle joint	No	Not Comparable Within APC	Over	Unidentifiable justification for this being placed above similar joints (wrist, elbow, shoulder)