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AAHKS AMERICAN ASSOCIATION OF HIP AND KNEE SURGEONS

MEMORANDUM

To: AAHKS **From:** Epstein Becker & Green, P.C.

Date: July 9, 2026

Re: Summary of the Proposed 2027 Medicare Payment Rules: Outpatient Prospective Payment System; and Ambulatory Surgical Centers

The Centers for Medicare & Medicaid Services (CMS) recently released the CY 2027 Medicare Hospital Outpatient Prospective Payment System and Ambulatory Surgical Center Payment System (OPPS & ASC) proposed rule. Comments on the proposed rule are due August 31, 2026. The following is a summary of policies in the proposed rule that may affect AAHKS members.

I. Arthroplasty Rates

CMS is proposing a 2.4% increase to payment rates under the OPPS and ASC payment systems. This update is based on the projected hospital market basket percentage increase of 3.2%, reduced by a productivity adjustment of 0.8 percentage points.

- 2027 OPPS rates:

CPT	2026	2027 (proposed)	Change
27130 & 27447	$13,116	$14,628	+10.2%
27487	$17,913	$20,224	+12.8%

- 2027 ASC rates:

CPT	2026	2027 (proposed)	Change
27130	$9,614	$10,108	+0.5%
27447	$9,393	$9,787	+0.4%
27487	$13,964	$14,655	+5%

When CPT 27487 (Revision of total knee arthroplasty, with or without allograft; femoral or entire tibial component) was coming off the Medicare inpatient only (IPO) list for 2026 and needed a new outpatient payment value, CMS initially proposed to payment level of $13,254. AAHKS commented to CMS at the time that $13,254 was well below the cost of short-stay procedures in terms of hospital resources and device cost. In response to AAHKS input, CMS

increased the final 2026 payment levels for 27487 in the hospital outpatient and ASC setting. CMS proposes further increases for this procedure in these settings for 2027.

II. Eliminating the IPO List

In 2026, CMS began a 3-year transition period to eliminate the Inpatient Only (IPO) list. CMS established the IPO list in 2000 to identify services reimbursable by Medicare only if furnished in the inpatient hospital setting due to the services' invasive nature or the need for additional recovery time for safe discharge. Over that time, stakeholders' challenges to the included services or even to the need for an IPO list led CMS to first propose removal of musculoskeletal procedures from the IPO list in 2021.[1]

CMS began by removing 285 musculoskeletal procedures from the IPO list in 2026, encompassing all procedures in the CPT code 27000 series. CMS now proposes to remove 638 services from the following clinical families in 2027: auditory, digestive, endocrine, female genital, hemic and lymphatic systems, integumentary, male genital, maternity care and delivery, mediastinum and diaphragm, respiratory, and urinary. CMS believes that the evolving nature of medical practice allows more procedures to be performed on an outpatient basis with a shorter recovery time, when determined to be clinically appropriate. CMS intends this to give patients more choices in site of care and lower out-of-pocket costs.

III. Method to Control Unnecessary Increases in the Volume of Outpatient Services Furnished in Excepted Off-Campus Provider-Based Departments (PBDs)

To contain "unnecessary" growth of covered outpatient department (OPD) services, in 2019 CMS instituted a policy to pay physician-equivalent rate for clinic visits (G0463) performed in "non-excepted off-campus PBDs", that is departments that began billing OPPS after October 2015.[2] CMS now believes this policy, while a positive step towards site-neutral payment, remains insufficient because "there is evidence of continued growth in the volume of OPD services driven by site of service payment differentials."[3]

In 2026, CMS build on its 2019 policy by lowering OPPS payments for drug administration services to PFS-equivalent rates at *excepted* PBDs, off-campus PBDs that were in operation prior to October of 2015. For 2027, CMS proposes to expand site-neutral payments to include imaging services without contrast furnished by excepted off-campus provider-based outpatient departments, with an exception for rural sole community hospitals (SCHs).

[1] This proposal was never implemented.
[2] PDBs that were operational prior to the passage of the Bipartisan Budget Act of 2015 ("exempted PBDs") continued to be reimbursed at higher OPPS rates.
[3] 90 FR 33685.

IV. Prior Authorization for Certain Outpatient Department Procedures

CMS is proposing to require prior authorization in 2027 for 8 new botulinum toxin injection codes due to recent unexplained increases in utilization. Recall, CMS already requires prior authorization under Original Medicare for the following outpatient hospital procedures:

- Blepharoplasty
- Botulinum toxin injections
- Panniculectomy
- Rhinoplasty
- Vein ablation
- Implanted Spinal Neurostimulators
- Cervical Fusion with Disc Removal
- Facet Joint Interventions

To date, CMS has instituted prior authorization for procedures it considers to be of questionable clinical value or where an exponential increase in utilization is observed.

V. Quality Reporting Programs

CMS's proposed updates to the outpatient and ASC quality reporting programs include removal of a cross-program measure on colonoscopies.

VI. "Pass-Through" Status for New Orthopedic Surgical Devices

a. Overview of Transitional Device Pass-Through Payment

CMS seeks public comment on the public applications received for Medicare's "transitional device pass-through payment" pathway. Generally, CMS uses a transitional pass-through payment framework to provide additional payment for a period of at least two years but not more than three years for new devices, drugs, and biologicals used by providers in the delivery of services that are too new to have adequate cost data and that meet certain eligibility criteria. Granting additional pass-through payments is intended to allow patient access to innovative technologies while CMS gathers additional cost data to set an appropriate, updated OPPS payment rate for the underlying procedure. Pass-through status is a facility-specific payment that has no direct impact on physician reimbursement.

If status is approved, the formula to calculate pass-through reimbursement is the hospital's charge for the device, adjusted to the actual cost for the device, minus the amount included in the APC payment amount for the device. Devices approved for pass-through payments are eligible for such payments for a period of at least two but not more than three years. Once the pass-through payment period expires, payment for the device is packaged into the OPPS payment rate for the associated procedures.

Medical devices must meet certain eligibility criteria and be described by a category of devices established by CMS regulations to qualify for transitional pass-through payment. CMS accepts applications for pass-through status on an ongoing basis and makes preliminary, subregulatory determinations on a quarterly basis. CMS outlines its analysis and solicits public comment for applications not preliminarily approved during the quarterly process during the next annual notice-and-comment rulemaking cycle. There following new pass-through applications are related to orthopedic surgery.

b. New Applications

- **RemeOs™ Screw LAG Solid (Biotec, Inc.)**
  - According to the applicant, the RemeOs™ Screw LAG Solid is an absorbable, magnesium-based alloy screw intended for the use in traumatic and orthopedic surgery for the fixation of bone fractures and for fixation after osteotomies, such as for the correction of deformities or malalignments. The absorbable implant provides temporary fixation and stabilization through osteosynthesis of bone fractures and osteotomies until bony fusion has occurred.
  - Device cost: $2,999
  - Associated with CPT 27766; 2025 payment rate - $7,143

- **TIDAL™ Fusion Cage System (Ossera™ AFX)**
  - According to the applicant, the TIDAL™ Fusion Cage is a single, continuous, porous piece of titanium alloy containing a circular window for an intramedullary nail used during salvage procedures to restore bone length due to bone void, absent bone or surgical resection. The TIDAL™ Fusion Cage System is composed of the TIDAL™ Fusion Cage and a Disposable Instrument Kit, which includes size trials, cannulated reamers, and inserters. The applicant stated that the TIDAL™ Fusion System is not for standalone use and is intended for use as an accessory to the DynaNail® TTC Fusion System and with an autograft and/or allogenic bone graft.
  - Device cost: $32,995
  - Associated with CPT 27871; 2025 payment rate - $13,116

- **LINK™ External Fixator (Metric Medical Devices, Inc.)**
  - According to the applicant, the LINK™ External Fixator is a dynamic percutaneous bone external fixator that provides continuous compression during the healing of bony fractures, fusions, and osteotomies. The applicant stated that the LINK™ External Fixator is composed of the (1) LINK™, a stainless steel box-shaped spring that applies forces to wires or pins inserted in the bone to either actively pull together and compress or distract the bones; (2) LINK™ Cover, a silicone cap that covers the bone pins or wire; and (3) LINK™ Bone Pins, which are inserted in a patient's bones and to which the LINKÔ attaches.
  - Device cost: $4,800
  - Associated with CPT 28899; 2025 payment rate - $239

c. Status Expiring

As noted above, pass through device status expires after 2-3 years. There are 21 current pass-through device categories approaching their expiration date, some of which may be of particular interest to AAHKS:

- ***C1602****: Orthopedic/device/drug/matrix/absorbable bone void filler, antimicrobial-eluting (implantable).* Expiring 12/31/2026

- ***C1737:*** *Joint fusion and fixation device(s), sacroiliac and pelvis, including all system components (implantable).* Expiring 12/31/2027

- ***C1741:*** *Anchor/screw for bone fixation, absorbable (implantable).* Expiring 9/30/2028

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