U.R. & Surgery Scheduling – Addressing Inpatient-Only Best Practices & U.R. w/Surgery Daily Activity

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Surgery U.R. Basics

- Vital to have U.R. presence in the peri-operative area;
- Ideally – U.R. R.N. should watch cases as they go in/out of surgery and ensure appropriate placement orders;
- R.N. should have exceptional communication skills and good understanding of payer requirements as well as knowledge of the Medicare Inpatient Only List and regulations – basic understanding of CPT codes.
- Must have broad knowledge of surgical procedures.

Surgery U.R. Basics

- Medicare has a Surgical Inpatient Only List – it can be found in the Outpatient Prospective Payment System Final Rule – Addendum E (also applicable to CAH).
- Beware that code descriptors used on the list are "short" – you must verify the full descriptor in the CPT Manual.
- IP order is required for these surgeries – they must be performed in the inpatient setting.

Updated IP Only Procedure Rule

- As of 4/1/15 – CMS will allow "inpatient-only" procedures that occur within the outpatient setting to be bundled with a related inpatient admission that occurs within three calendar days from the patient procedure.
- For critical access hospitals, the window is one-day prior to the date of admission.

Reference: https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3238CP.pdf

Best Practices - Medicare

- Ensure IP order present for known IP only cases prior to procedure – work with scheduling to schedule as IP;
- IF THESE CASES ARE NOT BILLED on IP claim – will not get paid – must be billed as IP to receive payment.
- NEVER SCHEDULE OBSERVATION – only Inpatient or Outpatient;
- Surgeon's office should provide CPT codes & schedulers should cross verify – when possible – collaborate with U.R. when needed;
- For cases that change intra-operatively, e.g. – planned laminectomy; surgeon removes synovial cyst – becomes IP only – watch as case comes out & obtain order immediately post-op.
- When unsure of how case will code – confer w/ Hospital Coding.

Best Practices – Commercial

- When case being scheduled – collaborate with prior authorization department to determine what status payer has (if) authorized.
- Ensure case gets scheduled in that status.
- U.R. should review regularly and early to determine that nothing egregious is being planned – e.g. patients that should be IP (3-4 day stays) are being authorized as OP – intervene/escalate when that happens.
- If case changes intra-operatively, U.R. should have process to notify payer immediately of change in procedure/status.

Surgery Outpatients in a Bed

- Does procedure not on Inpatient Only List have to be done as an outpatient? NO!
- However, physician needs to document clearly why patient needs to be admitted, e.g. 3 level laminectomy – high risks and expected LOS of 3-5 days.
- If provider can document that patient needs to be hospitalized for at least 2 midnights – then consider for inpatient.
- When surgeon "wants" to admit without clear reason – involve physician advisor.

Surgery Outpatients in a Bed

- What about outpatient surgeries than need to stay overnight?
- Example – parathyroidectomy – pt does well post op, but surgeon wants to monitor calcium level, swelling, etc.
- Do not automatically place this patient in observation – consider outpatient in a bed or extended recovery;
- Outpatients need standard recovery time, e.g., 4-6 hrs, before making decision on obs or admit.

Surgery - Observation

- Consider observation for outpatient surgery only after sufficient recovery time and observed, unexpected complication;
- Pain/nausea are expected after surgery – unless severe – do not place in observation;
- Consider obs for dyspnea, hyper/hypotensive, tachycardia - if severe/additional time/resources needed – then full upgrade to inpatient.

Pre-Bill Edit Process

- Important to establish process with Coding/Revenue Cycle to review any Medicare Inpatient Only procedure that was done in the outpatient setting.
- Bear in mind – you get no payment when this happens (can't even bill for ancillaries).
- Best thing to do is to review with Provider to ensure that coding is accurate.

Example – Pre Bill Edit Process:

Example:

During an outpaitent melanoma removal on the scalp, surgeon biopsies a section of the skull – coder coded the case to craniectomy (no exact code for this). Case referred to U.R. post coding and brought to surgeon and he verified that he did not do a craniectomy (he did a bone shaving) – changed to unlisted code.

Best Practices

- Physician Advisor needs to be aware of peri-op utilization review processes, requirements, and issues;
- Physician Advisor needs to intervene in inappropriate status decisions and possibly post-operative coding issues;
- Utilization Review team – needs expanded list of inpatient only codes and needs Coding contact to verify procedure codes;
- Utilization Review team – needs to be a resource to Schedulers and Pre-Auth team and needs access to information used by those areas.

Best Practices

- Utilization Review team – need to review O.R. list in advance, ensure appropriate orders and authorizations are in place – resolve issues prior to surgery;
- Have process in place to review inpatient only procedures done in the outpatient setting;
- Track all data related to losses and "saves" to demonstrate effectiveness of program.

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