Documentation –Total Knee Anguish for Traditional Medicare.

New focus: 2 MN rule, 1st point of contact, Ortho surgeon & primary care documentation

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All Payers are auditing…

- Each payer has their own set of 'criteria' for coverage- Milliman/MCG, Interqual, medically necessary stay (?). (United, Blues, Part C Medicare, PEPPER/Traditional Medicare is targeting 1 day surgical, 2 day Surgical, same day medical, and same day surgery, etc.)
- Each payer has their own standards for appeals
- Each payer determines if the documentation supports the service that was billed.
- Documentation to tell a strong pt story – but be aware of the enhanced payer battles..

Why we LOVE the 2 MN Rule for Traditional Medicare?

- What is the difference between inpt and obs for Traditional Medicare?
- 2 MN presumption: the provider declaring the estimated need for 2 MN PLUS a plan that will take the 2 MN.
- 2 MN benchmark: the provider declaring the need for a 2nd medically appropriate MN after the 1st MN as an outpt PLUS a plan that will take a 2nd MN.
- EASY ---LOVE IT! (Other payers – not so much!)

Key elements of new Medicare inpt regulations – 2 methods

- **2midnight presumption**
- "Under the 2 midnight presumption, inpt hospital claims with lengths of stay greater than 2 midnights after formal admission following the order will be presumed generally appropriate for Part A payment and will not be the focus of medical review efforts absent evidence of systematic gaming, abuse or delays in the provision of care.

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- **Benchmark of 2 midnights**
- **The new Medicare Inpt**
- "the decision to admit the beneficiary should be based on the cumulative time spent at the hospital beginning with the initial outpt service. In other words, if the physician makes the decision to admit after the pt arrived at the hospital and began receiving services, he or she should consider the time already spent receiving those services in estimating the pt's total expected LOS.

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STILL largest lost revenue – 2 MN benchmark – converting after 1st MN

- After the 1st MN as an outpt – anywhere – or the first MN in another facility and transferred in –
- "The decision to admit becomes easier as the time approaches the 2nd MN, and the beneficaries in *necessary hospitalization* should NOT pass a 2nd MN prior to the admission order being written.' (IPPS Final rule, pg 50946)
- Never, ever, ever, ever have a 2nd medically appropriate MN in outpt..convert, discharge or free…

"Meeting Criteria" – means Traditional Medicare ?

- It never has and never will mean – "meeting clinical guidelines" (Interqual or Milliman)
- It has always meant – the physician's documentation to support inpt level of care in the admit order or admit note.
- SO –if UR says: Pt does not meet "Criteria"/Medical necessity not met – this means: Doctor cannot attest to a medically appropriate 2 midnight stay with a plan for 2 MN or additional 2nd MN after a 1st outpt MN– right?
- **11/1/2013 Section 3, E. Note: "It is not necessary for a beneficiary to meet an inpatient "level of care" by screening tool, in order for Part A payment to be appropriate"**
- **Hint: 1st test: Can provider attest/certify estimated LOS of 2 midnights? THEN check clinical guidelines to help clarify any medical qualifiers… but the physician's order with PLAN – trumps criteria.**

More on clinical guideline clarifications/CMS

- FAQ: Does the beneficiaries' hospital stay need to meet inpt level utilization review screening criteria to be considered reasonable and necessary for Part A Payment?
- A: if the beneficiary requires medically necessary hospital care that is expected to span 2 or more MN, then inpt admission if generally appropriate.. While UR committees may continue to use commercial screening tools to help evaluate the inpt admission decision, the **tools are not binding on the hospital** or CMS. (update 3-12-14)
- If it not necessary for a beneficiary to meet an inpt 'level of care' as may be defined by a commercial screening tool, in order for Part A payment to be appropriate. In addition, meeting an inpt LOC as may be defined by a commercial screening tool, does NOT make Part A payment appropriate in the absence of an expected LOS ..

Observation challenges

- Medicare – Can the provider declare the pt will need 2 MNs at the onset of care? No, but not safe to go home? Then place in obs with an action plan. Monitor closely. As the 2nd MN approaches, safe to go home? If not, does the pt need a 2nd MN? If yes, CONVERT to inpt. 1st outpt MN does NOT count toward 3 MN SNF.
- Non-Medicare – whatever the payer determines –with some 'help."

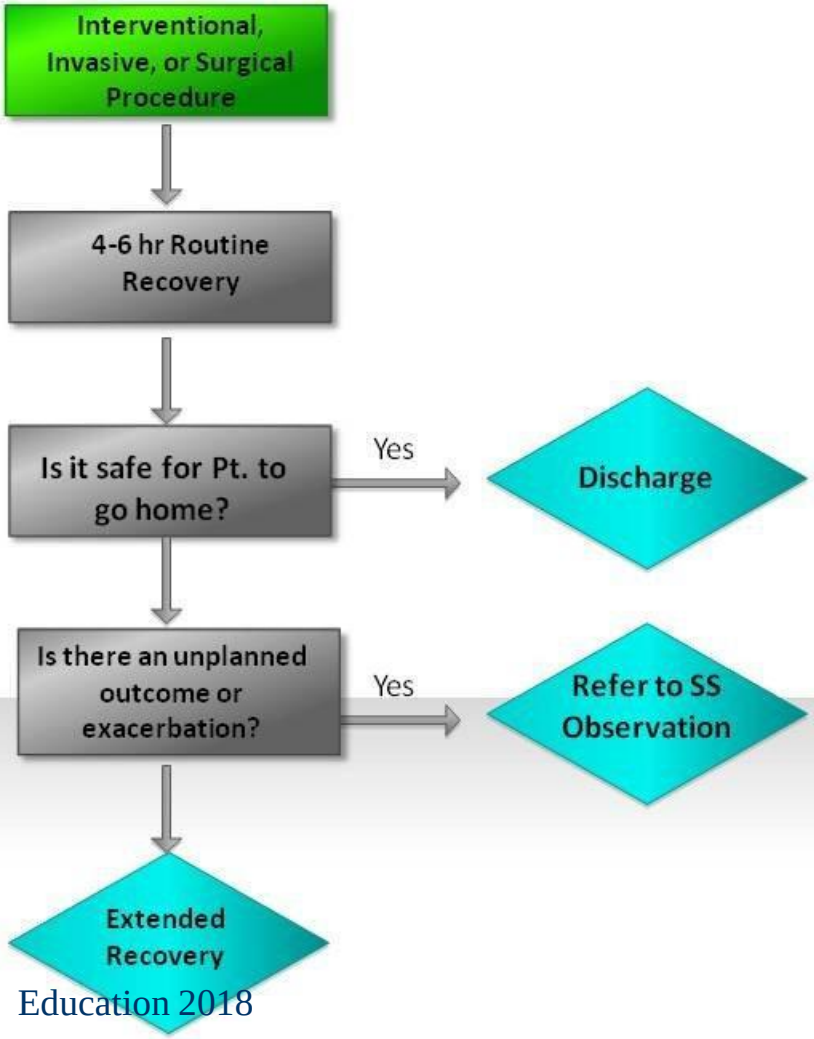
More 2006 Regulations

Observation status is commonly assigned to pts with **unexpectedly** prolonged recovery after surgery and to pts who present to the emergency dept and who then require a significant period of treatment or monitoring before a decision is made concerning their next placement. (Fed Reg, 11-10-05, pg 68688)

Recovery Guidance

- Services that are covered under Part A, such as a medically appropriate inpt admission or as part of another Part B service, such as postoperative monitoring during a standard recovery period (4-6 hrs) which should be billed as recovery room services. Similarly, in the case of pts who under diagnostic testing in a hospital outpt dept, routine preparation services furnished prior to the testing and recovery afterwards are included in the payment for those dx services. Obs should not be billed concurrently with therapeutic services such as chemotherapy. (Pub 100-02, Ch 6, Sec 70.4)

OBSERVATION DECISION TREE



Need an updated order

Payment issues- Outpt surgery

- **There is NO additional payment** for extended recovery or observation –pre or post outpt procedures.
- ALL costs are included in the CPT-driven payment/APC rates
- Ensure there is a clinical reason to be a bed beyond the up to 6 hrs routine recovery. Not just 'stay the night.'
- CAH – are paid for all hrs.

And now the removal of the Total Knee from the Inpt only list.

- Final OPPS 2018 regs: Removal of TKA from IPO list.
- CMS stated: "*The decision regarding the most appropriate care setting for a given surgical procedure is a complex medical judgement made by the physician." …that Medicare beneficiaries 'who are able to receive this procedure safely on an outpt basis are a subset…and CMS does not expect a significant shift in TKA cases from the hospital inpt setting to the hospital outpt setting."*
- *<u>Opinion</u>: American Association of Hip and Knee Surgeons. *Open door call, did not support**

Background:

- **TKA removed from the IP-only list-CY 2017 OPPS/ASC rule, effective 1-1-18. (81 FR 45679 through 45681). 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]).**

Medically necessary to have a total knee procedure

- **Reference "CMS Releases Major Joint Replacement Booklet" Medicare Learning Network ICN 909065 May 2017. CMS prohibited the RAC reviews for patient status for TKA procedures performed in the inpatient setting for a period 2 yrs to allow time and experience for these procedures under this setting." However, these procedures remain 'fair game' for review for medically necessity of the surgical procedure -regardless of patient status.**

- **MLN outlines the required documentation to support the surgical procedure -at all. …medical record supports the determination that major joint replacement surgery was reasonable and necessary for the pt.**
- **Elements to include: Pt history, physical exam/ROM, investigations/xray, pre-op studies, pre-operative findings, limitations with ADLs, contraindications to non-surgical treatments, failed non-surgical treatments, pain, safety issues, reasons for deviating from a stepped-care approach.**

Reference: www.cms.gov/outreach-and-education/Medicare-Learning-Network-MLN/MLNMattersArticlces/downloads/se1236.pdf.

Next steps= Start as an outpt?

- If the initial review/conversation with surgeon does not reveal any ‘at risk factors” to support the expectation of 2 MN – default to outpt.
- 2) Outpt surgery, routine recovery (up to 6hrs) and then assess extended recovery IF the pt needs more ‘routine’ time to recover.
- 3) Outpt surgery/above- but not recovery as expected. Explore observation and watch closely for the 2nd MN = benchmark. If clinical care is required for the 2nd MN = COVERT to inpt with a plan..

Decision process -TKR

- **Then make a decision : Inpatient or outpatient – at the time of scheduling.**
- **Outpatient**
- **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, many of these beneficiaries would be appropriate for discharge to home (with outpatient therapy) or home health care.**

- **Patient is expected to stay less than 24 hrs. *Routine recovery up to 6 hrs, then extended recovery until expected 'safe discharge' is met.***

- **Inpatient**

- **The 2 MN rule applies. There are two types of 2 MN rule- Presumption and Benchmark.**
- **Presumption: Ortho surgeon believes the pt will need an estimated 2 MN stay as part of the knee replacement.**
- **Benchmark: Ortho surgeon does not believe the patient needs 2 MN at the onset of surgery so starts the surgery as an outpt surgery. However, as the 2nd MN approaches, the pt is not progressing as anticipated, the surgeon converts to inpt to a plan for why the 2nd MN is necessary with a plan for the 2nd MN. (Assess post-operative risk and actual events)**
- **EXCEPTION GRANTED BY CMS: Even with the 2 traditional 2 MN options, in 2015, CMS created an exception to either of the 2 MN rules. There is an exception where the ortho surgeon documents that need for inpt pre-operatively to justify an inpt without the anticipation of a 2MN stay. Huge risk for audit but it is present as an option.**

- **Basic guidelines to support Inpatient for a TKA-must be documented to answer – 'Why an Inpt?" *If presumption, at the initial order for inpt surgery. *If benchmark, at the 2nd MN as an outpt with post-procedure issues included for the plan for the 2nd MN.**
- **• Document the medical necessity for performing the PROCEDURE *See MLN Matters SE1236***
- **• Next, document the medical justification for an INPATIENT admission . Include in the justification for 'why 2 MNs or the 2nd MN after the 1st outpt MN are required for this patient" or Why only 1 MN is necessary as an inpt when the 2 MN rule was not met/exception.**
- **• History and physical — assessment and plan**
  - **– Suspects**
  - **– Concerns**
  - **– Predictable risk**
- **Patient risk: comorbidities, medications, age, ASA, obesity, living conditions, stairs**

  Procedure risk: anticipated, other medical considerations
- **– Intent for treatment -needs post care of SNF/Inpt rehab, inability to meet benchmark 'safe for discharge criteria due to….**

Change in UM Work Flow

Change in work flow for Utilization Management:

- **At the point of scheduling ANY Traditional Medicare total knee – read the documentation to support the ordering of 'inpt.' Immediately do intervention with the ortho surgeon if any of the above items are not crystal clear. If 2 MN is expected, the above documentation should be present. If there is no 2 MN expectation/ EXCEPTION – carefully, closely review the 'why this pt needs to be an inpt and does not meet the 2 MN expectation."**
- **As the 2nd MN approaches after the 1st MN as an outpt, why is the patient not safe for discharge? Ortho surgeon & UM nurse discuss the discharge plan to determine if a 2nd MN is medically appropriate. If there is a medical reason to be 'in a hospital', then convert to inpt.**
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Financial Impacts of Change- Traditional Medicare

Critical Access Hospitals are paid differently

- <u>Facility Payment</u>
- Inpt DRG: 470

  Ave: $10,630 (JJ-Ga, AL, TN/34,777 cases JtoJ2017)

  Ave: $12,010 *

DRG is wage adjusted+teaching +++

- APC Payment for CPT 27447/APC 5115

  Ave: $10,122 *

APC is wage adjusted. Higher = higher payment; less than "1" wage factor = lower than base payment

- <u>Patient portion</u>
- Inpt every 60 –day deductible: $1340/2018
- APC frozen amt per CPT: $2024/20% of APC$ -but cannot exceed inpt deductible. So CMS pays the difference to the site.
- Amount due from pt: **Inpt Deductible**

SUMMARY:

Key to Total Knee – inpt or outpt

- Evaluate every pt, every time.
- First point of contact – point of scheduling.
- Use the 2 MN rule to justify an inpt: Presumption

Will the other medical factors support the need for an estimated 2 MN stay? Look at failure to improve after outpt treatments: rehab, weight loss, braces, other. PLUS other joint issues impacting ability to recover rapidly. PLUS ability to ambulate PLUS pain PLUS home situation including care giver, stairs, other medical complications

Going Forward

- Track and trend all 1 MN stays for TKAs.
- Is there risk that the pt should have begun as an outpt, watched for unplanned recovery events and/or 2nd outpt MN = convert to inpt then with a plan for the 2nd MN = **inpt/Benchmark.**
- Is there a justified inpt with the expectation of 2 MN well documented at the point of surgery with the pt having an unexpected early discharge? = **inpt /Presumption**
- **Resource: MLN 909065 Major Joint Replacement Booklet**

And more chaos on TKA

- Future – indicates moving more surgeries to Ambulatory Surgical Clinics/ASC –including all joint replacements, cardiac stents and ablations.
- Humana/Medicare Mgd/MA already thinks they can allow inpt only surgeries at ASCs on MA patients. (**Thanks, Dr Hirsch.* *www.racmonitor.com/news-alert-is-humana-putting-profits-before-patient-safety.)*
- *"10 key trends in ASCs and outpt surgery in the next 10 years." Laura Dyrda 4-2-18*

Questions and Answers

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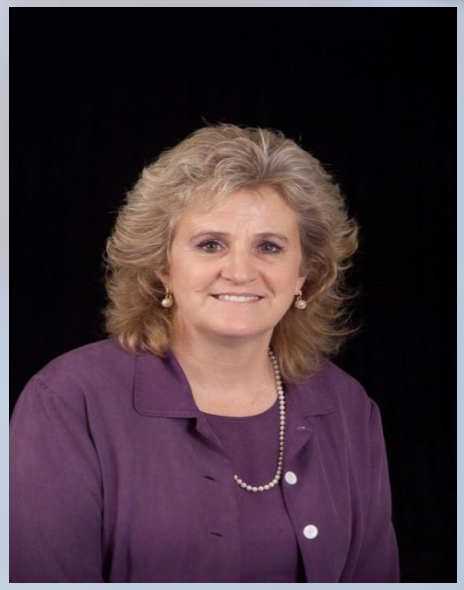

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