

Mastering Utilization Review and Patient Status

a NAHRI virtual event 

Practical Solutions for Inpatient-Only Compliance

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Presented By



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Kimberly is the Director of Medicare and Compliance for HCPPro, Inc. She oversees HCPPro's Medicare Boot Camps® and is the lead instructor for HCPPro's Medicare Boot Camp® – Hospital Version and Utilization Review Version and an instructor for the Medicare Boot Camp® – Critical Access Hospital Version, Rural Health Clinic Version and Provider-Based Department Version. Kimberly serves as a Regulatory Specialist for HCPPro's Medicare Watchdog services, specializing in regulatory guidance on coverage, billing and reimbursement. She is a former hospital compliance officer and in-house legal counsel and has over 25 years of healthcare experience, including 15 years of experience teaching, speaking and writing about Medicare coverage, payment, and coding regulations. She is a frequent expert on HCPPro's webinars and has been a speaker at national conferences on patient status and observation.

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Learning Objectives

- At the completion of this educational activity, the learner will be able to:
 - Define the change from 2021 to 2022 in the CMS' policy for inpatient-only procedures
 - Describe two procedures that were removed from the inpatient (IPO) list in 2021 that remain off the list in 2022
 - Discuss two strategies for preparing for and complying with the annual changes to the IPO list

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Agenda

- Reversal of the IPO List
 - Coded left off the reinstated list
 - Criteria added for future removal of procedures
- CMS Audit Strategy
 - Procedure exempt from denial
 - Standards for review
- Implementation Strategies
 - What does CMS actually say about procedures removed from the IPO list
- Details of the IPO List (Supplemental)
 - Three exceptions to the IPO payment prohibition

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Inpatient-only List Reversal



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Inpatient Only List Reversal

The IPO list has been used for *two purposes*

- **Payment prohibition**, payment not allowed for procedures designated inpatient only if provided to outpatients
 - Procedures removed from the IPO list are payable under Part B/OPPS (if no inpatient order) OR under Part A/IPPS (if inpatient order and meets req's)
 - Revenue cycle saw elimination of the IPO list (2021 OPPS final rule) as a positive
- Safe harbor for appropriate **inpatient admission** and Part A payment
 - Procedures on the IPO list are payable under Part A/IPPS even if documentation is insufficient to support two midnight expectation or case-by-case admission
 - Utilization review saw the elimination of the IPO list as a negative, requiring more documentation and opening up cases for denial because they don't meet req's

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Inpatient Only List Reversal

- In the calendar year (CY) 2021 OPPS final rule, CMS finalized the elimination of the IPO list over the course of three years
 - 298 procedures were removed from the list for 2021
 - Proposed **266 musculoskeletal** procedures
 - Finalized additional **16 related anesthesia codes** and **16 additional procedures** recommended by the Hospital Outpatient Payment panel
 - Remaining procedures were to be removed in 2022 and 2023 – the list was to be fully eliminated by 2024

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Inpatient Only List Reversal

- In CY2021, CMS also made accompanying changes to the Ambulatory Surgical Center (ASC) list
 - CMS finalized adding 11 procedures to the ASC covered procedure list (CPL) using its normal process, including hip arthroplasty (Table 59 of the OPPS)
 - Procedures can't be on the IPO list to be added to the CPL
 - CMS finalized two additional approaches to add to the CPL:
 - Removed general criteria for exclusion and instead excluded procedures on the IPO list as of December 31, 2020
 - General criteria were move to section titled Physician Considerations beginning January 1, 2021
 - Process for stakeholders to request/notify CMS to add procedures meeting requirements to the CPL
- Resulted in additional 258 procedures added to the ASC CPL, as displayed in Table 60 of the final rule

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Inpatient Only List Reversal

- In CY 2022, CMS reversed the policy they finalized for CY 2021 due to feedback from commenters requesting the list be reinstated for the following reasons:
 - Patient safety
 - Increased burden during the PHE
 - Additional time needed to adjust to the changes
 - Unintended impact on Medicare Advantage and commercial payers that impose outpatient when procedure is not on IPO list despite clinician order or patient care concerns

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Inpatient Only List Reversal

In the CY 2022 OPPS final rule, CMS reversed their policy change from CY 2021

- No longer eliminating the IPO list over the next two years
- Reinstated 293 of the 298 procedures removed from the list in 2021
 - Procedures that continue to be outpatient (i.e., not reinstated on the IPO list)
 - Lumbar spine fusion (CPT® code 22630)
 - Reconstruct shoulder joint (23472)
 - w/ anesthesia for shoulder replacement (01638)
 - Reconstruct ankle joint (27702)
 - w/ anesthesia for ankle replacement (01486)

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Inpatient Only List Reversal

In the CY 2022 OPPS final rule, CMS reversed their policy change from CY 2021

- Codified criteria used on a sub-regulatory basis prior to CY 2021 to remove procedures from the inpatient only list:
 1. Most outpatient departments are equipped to provide the services to the Medicare population
 2. The **simplest procedure described by the code** may be furnished 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 furnished in numerous hospitals on an outpatient basis
 5. A determination is made that the procedure can be appropriately and safely furnished in an ASC and is on the list of approved ASC services or has been final by us for addition to the ASC list

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Inpatient Only List Reversal

In the CY 2022 OPPS final rule, CMS reversed their policy change from CY 2021

- Replaced regulatory provisions in place prior to 2021 containing long standing safety criteria historically used to add procedure to the ASC CPL
- Removed 255 procedures from the ASC CPL
 - Procedure added to the CPL in 2021 and remaining on the list:
 - 0499T – Cystourethroscopy w/ drug delivery for urethral stricture or stenosis
 - 54650 – Orchiopexy, abdominal approach for intra-abdominal testis
 - 60512 – Parathyroid autotransplantation, separate procedure

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CMS Audit Strategy



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Audit Strategy

Audit strategy adopted for CY 2021 for procedures removed from the IPO list

- Services removed from IPO list in 2020 (i.e., THA) - 42 *CFR* 412.3(d)(2)(i)
 - Exempt from denial (but not audit) for two years (CY2020 and CY2021)
- Services removed from IPO list in 2021 and later - 42 *CFR* 412.3(d)(2)(ii)
 - Exempt from denial (but not audit) for **an indefinite period** until data shows procedure is more commonly performed on an outpatient basis (i.e., more than 50% of the time)
 - Determination is based on Medicare claims data
 - **Evaluated on a yearly basis** and CMS will “revisit in rulemaking whether and when an exemption for a procedure should be ended” (CY 2021 OPPS Final Rule, 85 *Fed. Reg.* 86119)

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Audit Strategy

Audit strategy amended for CY 2022 based on reversal of the policy to eliminate the IPO list

- CMS amended 42 *CFR* 412.3 (d)(2)(i) to indicated services removed from the IPO list on or after January 1, 2020, would be exempt for two years
- CMS failed to amend 42 *CFR* 412.3(d)(2)(ii), adopted in 2021, and it still provides for an exemption for procedures removed on or after January 1, 2021, until the procedure is more commonly performed on an outpatient basis
 - This would seem to override the prior section r/t on or after January 1, 2020, even though CMS' stated intention in the CY 2022 OPPTS Final Rule in amending (d)(2)(i) was to implement a two-year exemption period

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Audit Strategy

During exemption period, contractors

- Will continue medical review of short stays for procedures removed from the IPO list
 - Medical necessity of the procedure; and
 - Medical necessity for the site of service
- Will not deny cases for the incorrect site of service (i.e., noncompliance with the 2-midnight rule)
 - Will provide education to the provider for the noncompliant claims
 - Will not be used for referral to RAC for non-compliance reviews
 - RAC will not conduct site of service reviews
- CMS reserved the right to conduct audits if there is evidence of fraud or abuse

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Audit Strategy

CMS regarding the exemption:

...Whether a procedure has an **exemption or not**, does not change what site-of-service is medically necessary or appropriate for an individual beneficiary. Providers are still expected to use their **complex medical judgment to determine the appropriate site of service** for each patient and to bill in compliance with the 2-Midnight rule. The exemption is not from the 2-Midnight rule but from certain medical review procedures and site-of-service claim denials. (CY 2022 OPPS Final Rule, 86 *Fed. Reg.* 63739)

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Audit Strategy

CMS regarding the exemption:

Old language:

...The **indefinite exemption** will help hospitals and clinicians become used to the **availability of payment** under both the hospital **inpatient and outpatient** setting for procedures removed from the IPO list. (CY 2021 OPPS Final Rule, 85 *Fed. Reg.* 86120)

New language:

...we explained that it was our belief that the **2-year exemption** from referrals to RACs, RAC patient status review, and claim denials would be sufficient to allow providers time to update their billing systems and gain experience with respect to newly removed procedures **eligible to be paid under either the IPPS or the OPPS**, while avoiding potential adverse site-of-service determinations. (CY 2022 OPPS Final Rule, 86 *Fed. Reg.* 63739)

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Audit Strategy

And don't forget about the 2-midnight presumption

...for services removed from the IPO list, **under the 2-Midnight presumption**, inpatient hospital claims with lengths of stay greater than **2 midnights after admission** will be **presumed to be appropriate** for Medicare Part A payment and would **not be the focus of medical review** efforts, absent evidence of systematic gaming, abuse, or delays in the provision of care in an attempt to qualify for the 2-Midnight presumption. (CY 2021 OPPS Final Rule, 85 *Fed. Reg.* 86115, CY 2022 OPPS Final Rule, 86 *Fed. Reg.* 63738)

Translation: inpatient lengths of stay of two days or greater are effectively exempt from CMS contractor audit (watch out for the OIG)

- This is independent of the list of procedures removed from the inpatient only list and exempt from denial, but not audit

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Audit Strategy: Standard of Review

After elimination of the IPO list, the standard of review for all procedures will be either:

- 2-midnight benchmark; or
- Case-by-case determination

...We believe...many inpatient admissions for procedures formerly on the IPO list **are likely to meet either the 2-midnight benchmark or the case-by-case exception** to that benchmark mitigates the concerns regarding denial of payment under Medicare Part A for procedures no longer included on the IPO list. (CY 2021 OPPS Final Rule, 85 *Fed. Reg.* 86088)

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Audit Strategy: Standard of Review

So what did CMS have to say about the 2-midnight rule?

...We believe that with the elimination of the IPO list, *the 2-Midnight benchmark will remain an important metric* to help guide when Part A payment for inpatient hospital admissions is appropriate. With more services available to be paid in the hospital outpatient setting, it will be *increasingly important for physicians to exercise their clinical judgment* in determining the generally appropriate clinical setting for their patient to receive a procedure... (CY 2021 OPPS Final Rule, 85 *Fed. Reg.* 86115)

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Audit Strategy: Standard of Review

And they reiterated the need to account for outpatient time in the two-midnight benchmark:

...With respect to the 2-Midnight *benchmark*, however, the *starting point* is when the beneficiary begins *receiving hospital care* either as a registered outpatient or after inpatient admission. That is...we consider the *physician's expectation* including the *total time spent receiving hospital care*—not only the expected duration of care after inpatient admission, but also any time the beneficiary has spent (before inpatient admission) receiving *outpatient* services, such as *observation* services, treatments in the *emergency department*, and *procedures* provided in the operating room or other treatment area (CY 2021 OPPS Final Rule, 85 *Fed. Reg.* 86114)

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Audit Strategy: Standard of Review

And what about case-by-case admission

...we allow for case-by-case exceptions to the 2-midnight benchmark, whereby Medicare Part A payment may be made for inpatient admissions where the admitting physician **does not expect** the patient to require hospital care spanning **2 midnights**, if the documentation in the medical record supports the physician's determination that the **patient nonetheless requires inpatient hospital care**. (CY 2021 OPPS Final Rule, 85 *Fed. Reg.* 86087-86088)

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Implementation Strategies

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What Does CMS Have to Say?

Comments from the rule

...It is **not CMS' policy to require** services that are removed from the IPO list to only be performed in the **outpatient** setting. Instead, we aim to offer providers enhanced **flexibility and choice** in determining the safest, most efficient setting of care for Medicare beneficiaries...(CY 2021 OPPS final rule, 85 *Fed. Reg.* 86087)

...It is a **misinterpretation** of CMS payment policy for providers to create policies or guidelines that establish the **outpatient setting as the baseline or default site of service** for a procedure based on...the elimination of the IPO list. (CY 2021 OPPS final rule, 85 *Fed. Reg.* 86087)

...In prior rulemaking, we have stated that regardless of how a procedure is classified for purposes of payment, we expect that in every case the **surgeon and the hospital will assess the risk** of a procedure or service to the individual patient, taking site of service into account, and will **act in that patient's best interests**. (CY 2021 OPPS final rule, 85 *Fed. Reg.* 86092-93)

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What Does CMS Have to Say?

Comments from the rule

...Similar to other services that have been removed from the IPO list in previous years, **we expect that the volume of services** currently being performed in the inpatient setting that can be appropriately performed in the outpatient setting **will gradually shift** as physicians and providers gain experience furnishing these services to the appropriate Medicare beneficiaries in the HOPD. (CY 2021 OPPS final rule, 85 *Fed. Reg.* 86089)

And what does *this* mean?

...and it is equally important to note that providers are **not required to perform services in the outpatient department** as services are eliminated from the IPO list **if they are not ready**. (CY 2021 OPPS final rule, 85 *Fed. Reg.* 86092)

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What Does CMS Have to Say?

And patients needing skilled nursing facility (SNF) care? Don't they need three nights as an inpatient?

... we would expect that Medicare beneficiaries who are identified as appropriate candidates to receive a surgical procedure in the **outpatient setting** instead of being admitted as an inpatient, **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**. (CY 2021 OPPS final rule, 85 *Fed. Reg.* 86089)

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IPO List Strategies

Don't apply an outpatient presumption to procedures removed from the inpatient only list

- Outpatient presumption:
 - Impacts the patient's ability to qualify for SNF care with three-night stay requirement
 - Impacts application of the two-midnight presumption
 - May affect reimbursement – and not always in the way you might think

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IPO List Strategies

- Payment varies significantly depending on where the services are provided

	Payment with WI =1 w/o adjustments	Payment in rural AL (w/ adjustments)	Payment in Bay Area CA (w/ adjustment)
APC 5115	\$12,593	\$9,936	\$19,309
DRG 470 (hip and knee)	\$12,531	\$11,505 (\$16,435)	\$19,923 (\$21,746)
DRG 469 (ankle)	\$20,349	\$18,683 (\$25,534)	\$32,353 (\$35,197)
DRG 483 (shoulder)	\$15,731	\$14,444 (\$20,160)	\$25,012 (\$27,253)

- Adjustments include adjustments for quality, sole community hospital (SCH), disproportionate share hospital (DSH)/ uncompensated care, medical education, low volume hospitals, Medicare Dependent Hospital (MDH)

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IPO List Strategies

Do apply 2-midnight benchmark for most cases and case-by-case admission option where appropriate for complex cases

- CMS has discussed two total knee clinical scenarios (discussed below)
- Work with physicians to develop criteria (score cards, risk assessments, etc.)
 - One of the reasons (advantages) CMS slowed down elimination of the list
- Remember CMS has provided some things to consider in determining inpatient and outpatient
 - The anticipated need for SNF care post procedure (CY 2018 and CY 2021 OPPI rules)
 - Low anesthesia risk, without significant comorbidities, family members to assist – likely good outpatient candidate (CY 2020 OPPI rule)
 - Revision of prior replacement, other complicating clinical conditions, including multiple comorbidities such as obesity, diabetes, heart disease “may not be strong candidates for outpatient THA” (CY 2020 OPPI rule)
 - Scheduled or emergent THA for hip fracture may be more appropriate inpatient (CY 2020)

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What Does CMS Have To Say About It?

SE19002 on removal of TKA from IPO list provided a two-midnight case study:

- Case 2: 65-year-old female, elective TKA procedure
 - History of arthritis, diabetes mellitus, arrhythmia, sleep apnea, chronic pain
 - POD 1 shaky/dizzy during A.M. therapy, hypoglycemic, P.M. therapy also shaky, hypoglycemic, diabetic medications adjusted,
 - POD 1 patient admitted for monitoring and glucose stabilization
 - Discharged POD 2 after tolerating therapy
- CMS: documentation of symptoms during PT and two episodes of hypoglycemia requiring adjustment of insulin and close blood sugar monitoring provides a reasonable expectation of a two midnight stay at the time of the inpatient order

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What Does CMS Have To Say About It?

SE19002 on removal of TKA from IPO list provided some case-by-case examples:

- Case 2: 73-year-old male, elective TKA procedure
 - History of coronary artery disease, atrial fibrillation, complete heart block w/pacemaker, diabetes, osteoarthritis, and hypertension
 - Developed post operative bradycardia resulting in urgent electro-physiology and correction of pacemaker malfunction
 - In addition to pain management and antibiotics, patient also had hydration, anti-emetics and anti-coagulants
 - One night stay
- CMS: "...due to the patient's extensive cardiac history **with decompensation** and need for urgent evaluation and treatment, it is reasonable to approve this case based on patient history and comorbidities and current medical needs, severity of signs and symptoms, and presence of risk factors for an adverse event."

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What Does CMS Have To Say About It?

Was risk enough or was development of a complication required?

- Prior version of SE19002 may shed some light?
 - SE19002 was originally published January 8, 2019, rescinded January 11, 2019, and reissued January 24 2019
- In the origin version, case 3 was exactly the same as reissued version case 2, except the patient did not develop any complications
 - CMS: record “supported case-by-case exemption” ... “due to the patient’s extensive cardiac history, it is reasonable to approve this case based upon presence of risk factors for an adverse event.”
- Reissued version had other changes, but this seems significant and seems to imply risk alone without development of a complication may not be enough for case-by-case admission, but unclear
 - And remember note to case 3 – no complication that supported inpatient status???

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What Does CMS Have To Say?

We might get some help from CMS:

...in the future, we **plan** to provide **information on appropriate site of service selection** to support physicians' decision-making. We note that these considerations will be for **informational or educational purposes only** and will not supersede physicians' medical judgment about whether a procedure should be performed in the inpatient or outpatient hospital setting. (CY 2021 OPPS final rule, 85 *Fed. Reg.* 86088)

Although 2022 seems less certain:

...In the future, we **may** provide additional **educational material** regarding considerations for the **selection of site-of-service** for a procedure to support physicians' decision making. We note that this additional information will be for **informational or educational purposes only** and will not be intended to prohibit payment of procedures that were previously included on the IPO list in the outpatient setting. (CY 2022 OPPS final rule, 86 *Fed. Reg.* 63740)

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Details of the IPO List



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Inpatient Only List

- Designated by CPT code in the OPPS payment Addendum E, or Addendum B w/ status indicator “C”
 - Available on the OPPS Regulations and Notices page of the CMS website:
<https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Hospital-Outpatient-Regulations-and-Notices>
- BUT hospitals bill inpatient cases with ICD-10-PCS codes not CPT codes—difficult for auditors to identify
- **No payment** for IPO procedures (or anything in the same encounter) if performed on an outpatient basis (i.e., no inpatient order)

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IPO List Exceptions

Exceptions to the rule

1. Three-day window exception
2. Emergency procedure exception
 - Patient expires
 - Patient survives
3. Separate procedure exception

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IPO List Exceptions

Exception 1: Three-Day Window

- IPO procedures are *included on a later inpatient claim* under the three-day window if they:
 - Occurred on the same day as the inpatient admission (i.e., inpatient order)
 - Occurred in the three days before the inpatient admission and are diagnostic
 - Occurred in the three days before inpatient admission and are clinically related

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IPO List Exceptions

Exception 2: Emergency Procedure

- Requires
 - Procedure was begun on an **emergency basis**
 - Does not apply to elective or scheduled procedures
 - Patient **expired** or was **transferred** before the inpatient order was written
 - Modifier “-CA” is reported on the IPO procedure
 - Bill on an outpatient bill type (0131) as covered
 - Use patent discharge status code 20 (patient expired)
- Payment is made under Comprehensive APC 5881
 - CY 2022 — \$12,366, up from \$8,744.90 in CY 2021
- Payment includes payment for all OPPS services provided on the same claim

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IPO Payment Prohibition Exceptions

Exception 3: Separate Procedure

- Separate Procedure Exception Criteria
 - Surgical procedure with status indicator = “T” or “J1”
 - AND
 - IPO procedure on “separate procedure list” (**add-on codes** normally added to inpatient only procedures)
 - Available on the OCE Quarterly Release Files
- What happens?
 - IPO procedure is “rejected” (instead of causing denial)
 - AND
 - Status indicator “T” or “J1” procedure is processed for payment according to usual payment rules

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