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Inpatient-Only List Under Review; Medical Necessity vs. Setting May Muddy the Water

Trouble is brewing again with inpatient-only procedures, which have proven resistant to compliance antidotes.

Medicare auditors are reviewing and sometimes denying claims for procedures on the inpatient-only list even though they are supposed to be a shoo-in for Part A payment assuming the procedures are medically necessary, says Sharon Easterling, president of Recovery Analytics LLC in Charlotte, N.C. Hospitals have faced scrutiny for assorted inpatient-only procedures, include laparoscopic removal of an adjustable gastric restrictive device, hip and knee replacements, ventricular shunt, excision of spinal epidural mass and major joint and limb reattachment, she says. They may face more denials, now that CMS added four procedures to the inpatient-only list for 2014 without dropping any.

At the same time, some hospitals mistakenly assume a procedure's presence on the inpatient-only list — Addendum E of the outpatient prospective payment system — guarantees the medical necessity of the procedure, she says. The fact is, hospitals must document the procedure's medical necessity according to local or national coverage determinations (depending on the procedure) before they perform it and have a physician order before it begins or the denial is all but guaranteed — apart from validating the setting where it's performed, she says.

"There is a disconnect," Easterling says. "I don't think when the contractors send it back to the provider, they explain it is not about the level of care. It is the fact the service was not medically necessary."

Hospitals may spin their wheels appealing denials for status when they should possibly be gathering documentation to support the procedure, she says. For example, hip replacements are on the inpatient-only list and therefore must be covered by Medicare as an inpatient admission assuming they're medically necessary. If the MAC or RAC denies the claim, the hospital may get in a huff. But the MAC or RAC actually may be seeking documentation proving pain or functional disability, radiographic evidence, and showing the physician exhausted all conservative treatments (e.g., steroids, physical therapy, analgesics, weight, etc.), Easterling says.

The 2014 inpatient prospective payment system rule will bring more focus to inpatient-only procedures because they often entail short stays, which means they face contractor scrutiny, she says. "The provider may have to justify the patient being on the list and then validate the need for the procedure in cases in which a policy exists" (e.g., Cahaba, a MAC, has Part A and B LCDs for major joint replacements), she says. "Executing a thorough process to fulfill all aspects of inpatient-only procedures will be even more crucial to prevent denials."

Many other things sabotage compliance in this area, including problems with scheduling, physician orders and coding definitions.

"Where most hospitals fall down is [having] an administrative person in operating room scheduling who doesn't know" the patient is having a procedure on the inpatient-only list, says Ralph Wuebker, M.D., chief medical officer for Executive Health Resources in Newtown Square, Pa. "Their job isn't to understand what procedures are on the list. Their job is to schedule them."

Inpatient-Only Denials Have Two Causes

Harriet Kinney, organizational integrity manager for CHE Trinity Health in Livonia, Mich., says there are two causes of inpatient-only claim denials: (1) physicians write an outpatient status/admission order for a planned procedure on the inpatient-only list because Addendum E is not on their summer reading list; and (2) physicians start an outpatient procedure but they switch gears to an inpatient-only procedure midway for clinical reasons, and the order is never changed or it's changed too far after the fact. Obviously surgeons wouldn't interrupt a procedure to write a new order, but Kinney says claims have been denied because there was no inpatient order before the procedure started and they had to appeal to get reimbursed.

Scheduling also is a source of glitches, Kinney says. There are unplanned procedures, and case managers in the CHE Trinity emergency rooms are now more aware of the inpatient-only list and educate ordering physicians about the appropriate order and documentation of medical necessity. Planned procedures are scheduled by pre-

admission registrars or OR scheduling staff, but "these two groups of people are nowhere near each other," she says. "They may not even be on the same campus." If the person takes a call from the doctor's office about a procedure, he or she may not think to check the inpatient-only list.

Schedulers and case managers may be on top of things, but trying to nail down the specific type of procedure with the physician office staff can be tough, Kinney says. "Physicians are responsible for knowing the inpatient-only list, but they have no ownership," she says.

The coding quirks of the inpatient-only procedure list hamper compliance. Addendum E is an Excel spreadsheet with four columns. One has the CPT codes representing procedures that must be performed on an inpatient basis to get paid by Medicare, and a second column has short descriptors of the codes — "short" being a relative term. But hospitals have to code inpatient-only procedures in ICD-9 form, Easterling says. Coders with inpatient expertise may have trouble translating the CPT codes, and coders with CPT expertise may struggle with the ICD-9 conversion. Also, the Appendix E terminology isn't user friendly, Kinney says. When the physician calls the OR to schedule Mrs. Jones for a kidney biopsy, the scheduler may not find it because it's called renal biopsy.

To reduce claim denials and improve processes around the inpatient-only procedure list, hospitals should have a biller, coder, case manager or someone knowledgeable look at all Medicare fee-for-service surgical cases at the time they are scheduled, Wuebker says. When physician offices call the hospital to say they have a patient who needs open-heart surgery, "you need someone that can identify if the procedure is on the inpatient-only list and to get an inpatient order in the medical record before the procedure is started," he says.

Easterling notes that CMS added four laparoscopic surgeries to the inpatient-only list this year (HCPCS codes 44206, 44207, 44208 and 44213).

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