The release of the 2018 Final Rule for the Outpatient Prospective Payment System (OPPS) in November 2017 has created quite a stir across the orthopedic healthcare community. In what has been deemed a questionable decision, the Centers for Medicare and Medicaid Services (CMS) decided to remove Total Knee Arthroplasty (TKA) from the inpatient-only surgical list beginning January 1, 2018.

Many hospital executives are asking, "How does this affect our bottom line regarding the inpatient orthopedic surgery program?" The problem is that the answer may take some time to decipher. One thing we do know is that facility reimbursement will be affected. The average Medicare payment for inpatient TKA's is $12,384 whereas the outpatient average for 2018 is $10,122 and is estimated to result in a $311M worth of savings for Medicare. But is this the best decision for the patient and are facilities at risk?

The most significant question that has derived from the TKA change is how to determine the correct status for patients. Currently, the decision to assign the patient to outpatient status is based on factors such as the patient's age, health status, and the complexity of the procedure. However, the new rule may require a more comprehensive evaluation of risks associated with outpatient surgery.

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decision to assign the patient to outpatient status is left up to the clinical judgment of the surgeon, which will likely change in the future once more specific, clinical criteria is developed. Other questions such as "what to do if a patient is cleared for outpatient by surgeon consult, but during pre-operative evaluations a significant comorbidity is discovered, can the status then be changed to inpatient?" The answer lies within the documentation, which clearly indicates the medical necessity of the inpatient status. If the patient should be inpatient due to a significant comorbidity then the answer is clear, regardless of when the criteria was discovered. Per a study by The Advisory Board Company, 48% of TKA’s are performed on patients who are eligible for outpatient surgery.

In an effort to provide facilities the time to implement these changes and develop a protocol for determining accurate patient status, CMS has mandated that Recovery Audit Contractors will not review TKA procedures for "patient status" for a period of 2 years.

Inpatient TKA’s are reported with 2 DRG’s, 469, Major joint replacement or reattachment of lower extremity with a major complication and/or comorbidity and 470 Major joint replacement or reattachment of lower extremity without out a major complication and/or comorbidity. Based on CMS’s MEDPAR data for 2016, there were a total of 482,891 combined joint replacements or reattachments of lower extremities. However, it's important to understand that this total also includes partial knee replacements and hip replacements. Upon further review, it was determined that TKA’s were approximately 281,000 of the total major joint replacement or reattachment of lower extremity cases.

TKA’s with no complications and/or comorbidities made up 57% of the 2016 Medicare total, and TKA’s with a complication or comorbidity resulted in approximately 25% of the total DRG set. Given that information, the most common question is why not assign all the cases with major complication and comorbidities to inpatient, and move the rest to outpatient? It's not that simple due to the number of patients who have multiple comorbidities which require a multispecialty approach to their care, as demonstrated by the

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approach to their care, as demonstrated by the 2.7 length of stay average for DRG 470 across the country.

To understand the true reimbursement impact, a facility must calculate their specific utilization to determine how many cases could be impacted, given the estimated 18% reduction derived from moving qualified patients from inpatient to outpatient status.

Medicare still has some cleaning up to do on their side. For instance, according to HOPPS Addenda Table B, CPT 01405, Anesthesia for open or surgical arthroscopic procedures on knee joint; total knee arthroplasty, is categorized with Status "C" meaning it is an inpatient only procedure. This snafu will likely be corrected with the next round of edits but clearly indicates there are a lot of moving parts to manage with this significant change. Not to mention the fact that shoulder and hip replacements were on last year’s proposed rule but did not make it through the cut but will likely be moved to outpatient in the near future.

A summary of what we do know at this point:

- The two-midnight rule applies
- Final decision is left up to the physician/surgeon
- RAC assessments for place of service for TKA will be frozen for two years
- TKA’s have not been approved for ASC’s; only hospital outpatient departments
- A large shift of TKA’s to outpatient status would reduce qualifying volumes for bundling programs such as BPSI and CJR

In summary, the best way to defend your facility is to gather data and closely watch the Emergency Department visits and Readmissions for TKA outpatients. Therefore, each facility will need to create a TKA outpatient tracking mechanism to capture those occurrences since the original surgery is performed as an outpatient and won’t get captured with the typical readmission process.

Furthermore, ongoing coding audits are critical for both the inpatient (DRG) and outpatient (APC) cases to assure all comorbidities and procedures are captured. This is a critical step of the process which is necessary to identify

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and report all resource consumption regarding TKA’s and provide education to clinical and coding staff.

This Week’s Audit Tip Written By:

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Upcoming Webinar Sessions

NAMAS is proud to offer the following webinars in May:

Overpayments, Clawbacks, Identified Billing Errors & Voluntary Refunds
(Compliance Webinar Series)
May 15, 2018
2pm EST
Speaker: David Glaser, JD

Hands On: Orthopedic Surgery
(Hands on Webinar Series)
May 22, 2018
2pm EST
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