

MEDICARE COMPLIANCE

With Surgery Billing Status Less Clear, Hospitals Should Examine Pay, Compliance

Classifying the billing status of some high-dollar surgical procedures has become trickier as InterQual and Medicare criteria reflect changes in the use of technology and shift more outpatient vs. inpatient decision making to hospitals, some experts say. Left to fend for their own medical-necessity compliance while trying not to lose their shirt, hospitals should consider all the angles when dealing with procedures like automatic implantable cardio defibrillators (AICD) and percutaneous cardiac intervention (PCI).

"The classification of surgical procedures has become a real challenge," maintains Joe Zebrowitz, M.D., executive vice president and senior medical director of Executive Health Resources in Philadelphia. "It used to be that Medicare classification of surgery was pretty black and white." But circumstances have changed, he says.

For one thing, in recent years Medicare has taken a number of procedures off the "inpatient-only list," which includes the procedures Medicare pays for only when they are performed on an inpatient basis. AICD and PCI (which is cardiac stenting and angioplasty) are not on the Medicare list. Also, in 2007, InterQual — which has its own list of procedures that it considers appropriate for the inpatient setting — removed some significant procedures, Zebrowitz says. "They took off stents, angioplasties and AICD — three high-cost, high-reimbursement procedures — and hospitals are left with no guidance on them," he says. "If it's not on the Medicare list, and it's not on InterQual, then hospitals have to decide how to classify [the procedure]." There's an exception: AICDs and PCIs can be performed on an inpatient basis if there is an urgent or emergent need for any of these surgeries, or if they are done via thoracotomy.

Another development: In the 2008 proposed outpatient prospective payment system (OPPS) changes (*RMC 7/23/07, p. 1*), Medicare, as usual, listed code edits that signal it won't pay for certain devices unless they are provided in connection with particular diagnosis codes. But the specific OPPS code edits dealt with outpatient codes for AICDs — a sign that Medicare expects to see at least a percentage of AICDs and PCIs performed as outpatient surgeries, Zebrowitz says.

The forces at work are not necessarily good for a hospital's bottom line, Zebrowitz says. AICDs and PCIs involve costly devices, and OPPS reimbursement barely

covers their costs. "AICDs are complex devices that deliver electrical shocks to the heart in case of life-threatening heart rhythms. The device itself is very expensive. Under OPPS, the payment is such that it's hard for some hospitals to continue to provide the service from a purely economic point of view," he says.

Notwithstanding the push toward outpatient surgical settings and the absence of an inpatient mandate, certain AICD and PCI patients must receive their surgery in the hospital. Biventricular AICDs are always performed in the hospital. However, "50% or more of AICDs are single- or dual-chamber AICDs, and Medicare has made it pretty clear, and so has InterQual, that in the absence of documentation indicating otherwise, these procedures can be done in an outpatient setting," Zebrowitz says.

To stay on top of the distinctions, make sure relevant hospital staff has access to the full download of the Medicare inpatient-only list, he says. At first, only short descriptors appear, but they may give a misleading picture of which surgeries must be performed on an inpatient basis, he says. When the long descriptors are accessed, hospitals get a more accurate, fuller picture. The short descriptor implies that all AICDs must be done on an inpatient basis, but the long descriptor makes it clear that just AICD placement via thoracotomy is on the inpatient-only list. Similarly, just some types of appendectomies are on the inpatient-only list, but the short descriptors might make it seem like they all are, he says.

Hospitals Have Choice With AICD Patients

With single- or dual-chamber AICD patients, hospitals have a choice, he says: Either treat them all as outpatients (and potentially lose a lot of money on those patients who warrant admission), or "take a medically sophisticated look at patients who are receiving AICDs and risk-stratify them and apply evidence-based medicine." That way, the hospital can take a systematic approach to deciding which patients require inpatient care for the surgery.

For example, a patient who has a number of comorbid conditions, including diabetes, is scheduled for AICD. During the preoperative clearance phase, it's mentioned he will need an insulin drip to keep his blood sugar normal. "That active comorbidity makes this a more

complex patient, warranting an inpatient case," Zebrowitz says.

Or suppose the patient is classified by the American Society of Anesthesiologists as having an ASA score of four or five. "That suggests the perioperative morbidity or mortality is very high for that patient, and that may warrant inpatient admission," he says.

But few hospitals have mechanisms to screen these procedures to ensure they take place in the right setting, he says. The ideal thing to do would be to "screen and risk-

stratify the procedure to maintain compliance, revenue integrity and quality of earnings," which he described as assurance that revenue booked is compliant revenue.

"We used to leave [these decisions] up to luck and hope it was going OK, but you do this now at your own peril," Zebrowitz says. "Anyone who thinks high-dollar procedures aren't being audited for medical necessity is not looking at what's going on in the Medicare community right now."

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