

MEDICARE COMPLIANCE

Hospitals Face Admission Denials for Stents, but May Prove Medical Necessity

Claim denials for cardiac stent insertions have been alarmingly high in some states, which should be a wake-up call for hospitals everywhere, medical-necessity experts say.

As more Medicare administrative contractors (MACs) begin to intensify their review of these cases — and recovery audit contractors (RACs) generally rev up their audit engines — there may be a rush to recoup payments for inpatient stent insertions that purportedly could have been done on an outpatient basis.

And things could get worse because CMS may soon drop the subset of carotid stents from Medicare's inpatient-only list, which would open the door to more denials over admissions that may or may not be medically necessary. But it's possible some MAC overpayment determinations won't hold up because they could fail to account for the varying circumstances of the procedures and patients in each case, according to physicians Thomas McCarter and Michael Taylor. These physicians say they have already successfully challenged many stent claims denials on appeal by proving the admissions met Medicare guidelines for a medically necessary inpatient admission.

A cardiac stent is a device used to prop open a blocked artery. After cardiologists identify a blockage through cardiac catheterization, they often perform an angioplasty and insert stents (or drug-eluting stents) so blood can pass to damaged or at-risk heart muscle. For most of the 1990s, stent placement was performed on an inpatient basis, with backup from a cardiac bypass team in case complications were to occur. When CMS implemented the outpatient prospective payment system in 2000, policymakers determined that cardiac stent insertion could be performed on an inpatient or outpatient basis depending on the circumstances. Now hospitals and physicians must make a convincing medical-necessity case for admissions; otherwise, payers probably consider outpatient the default setting.

Recently, a number of MACs have blown hospital DRGs for stents out of the water. For example, Trailblazer Health Enterprises, the MAC for Jurisdiction 4 (which includes Colorado, New Mexico, Oklahoma and Texas), audited 250 inpatient cardiac stents. *The result:*

TrailBlazer reports "an astounding" 98.8% payment error rate, says McCarter, chief clinical officer at Executive Health Resources, a Philadelphia-based firm that works with hospitals on medical-necessity compliance. But there's a potentially serious flaw with these and other MAC audits, McCarter and Taylor contend. Many of the overpayments may be identified by nurses or other non-physicians using admission screening criteria (e.g., InterQual or Milliman) — the first level of medical-necessity review — without any appropriate second-level physician review, they say.

Admission Hinges on Procedure, Patient

In many cases, whether a stent procedure should be performed on an inpatient or outpatient basis requires a more sophisticated assessment than a screening tool can provide, because Medicare patients often have complicating medical conditions, says Taylor, senior medical director for government appeals and regulatory affairs at Executive Health Resources. In fact, Medicare manuals do not declare InterQual, Milliman or other admission screening tools to be "dispositive" regarding the issue of medical necessity, he says. Instead, the Medicare Benefit Policy Manual states that admitting an inpatient is a "complex medical decision" that only the physician can make after considering these factors: medical history; current medical needs; facilities available to meet these needs (inpatient and outpatient); hospital bylaws and admission policies; severity of signs and symptoms; predictability of adverse happening; and findings of diagnostic studies that could assist in decision making.

In other words, admissions decisions depend on both the nature of the procedure and the circumstances of the patient, Taylor and McCarter say. Is the stent being placed in a left main artery, which is riskier, or a smaller vessel? Is the patient a relatively healthy 65-year-old, or a 75-year-old with kidney trouble and liver disease? "The procedure alone doesn't determine the setting," McCarter asserts.

Their position is gaining traction. "Of the stent denials that we appealed on behalf of hospitals, we have overturned a significant number," Taylor says.

A study by Masspro, the Medicare quality improvement organization (QIO) for Massachusetts, also lends credence to the importance of considering all the evidence before determining whether the stent should be inserted on an inpatient or outpatient basis. The QIO conducted an audit of one-day stays for insertion of drug-eluting coronary artery stents and initially declared a very high error rate based on screening criteria; it said 95% of the 300 cases reviewed “met neither the criteria for severity of illness nor those for intensity of service,” according to a report on the study. Because the error rate was so high, Masspro took a closer look, which included input from cardiologists. Ultimately, the QIO determined that site of service hinges on a variety of factors. “Masspro determined that it would not instruct or recommend that hospitals routinely bill elective [percutaneous coronary interventions] with coronary artery stent insertion to the OPs. Inpatient cases selected randomly during the regular course of Masspro’s Medicare case review, however, would be determined based on the documentation presented in the medical record as well as the circumstances of the admission,” the QIO stated.

There’s no question this area needs more attention from hospitals, McCarter and Taylor contend. “Stents haven’t gotten enough attention from case managers because traditionally stents have been viewed as procedures that have been appropriately done in an inpatient setting,” Taylor says. “Hospitals may be in the habit of letting their doctors admit a high number of stents. But now that MACs are getting more aggressive and RACs are here, hospitals can’t just certify what the doctors order” without more scrutiny.

Hospitals should follow Medicare guidelines on utilization review and implement appropriate UR processes, which involve case managers and physician reviewers, Taylor and McCarter say. “Some of these

stents should be done in inpatient settings, and some should be done in outpatient settings, and the only way to assign appropriate status is through a second-level physician review for medical necessity,” Taylor says.

Ensure Documentation With Stent Transfers

Documentation obviously is pivotal in establishing medical necessity for the appropriate site of service of any procedure. An underestimation of risk associated with stents might occur if there’s a failure to document the seriousness of the patient’s condition when he or she is transferred from another hospital for stent insertion, McCarter says. Patients having a heart attack might present at a hospital that doesn’t perform stent insertion. So the patient, who is obviously very sick, is transferred to a second hospital for the procedure and admitted as an inpatient. However, if the second hospital neglects to secure documentation from the first hospital on the extent of the patient’s illness (e.g., suffered heart attack) and the risk of adverse outcomes if he or she is sent home, Medicare auditors may assume the stent insertion was an elective, low-risk procedure, McCarter says.

Hospitals now have clarity when it comes to carotid stents, which are on the inpatient-only list. That means Medicare won’t pay for carotid stents unless they are performed on an inpatient basis. But sometime in the near future that procedure may fall off the inpatient-only list, McCarter says. That means case managers and physician reviewers may soon have to determine whether patients undergoing carotid stents should be considered inpatients or outpatients.

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