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Total Knee Arthroplasty (TKA) Removal from the Medicare Inpatient-Only (IPO) List and Application of the 2-Midnight Rule

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PROVIDER TYPE AFFECTED

This MLN Matters Special Edition Article is intended for hospital providers that submit hospital inpatient or outpatient claims for Total Knee Arthroplasty (TKA) procedures. This includes acute care inpatient hospitals, inpatient psychiatric facilities (IPFs) and long-term care hospitals (LTCHs). Inpatient rehabilitation facilities (IRFs) and critical access hospitals (CAHs) are excluded.

CMS recognizes that a MLN article on the 2-Midnight Rule has already been published and is available at the following link:

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM10080.pdf

This article is distinguished by its focus on TKA procedures and application of the 2-Midnight Rule now that this procedure has been removed from Medicare's inpatient-only (IPO) list.

*NOTE: Throughout this document the term "Provider" when used means "Hospital".

WHAT YOU NEED TO KNOW

The Centers for Medicare & Medicaid Services (CMS) removed the CPT code describing TKA procedures from Medicare's Inpatient-Only List (IPO) effective January 2018. This allows TKA procedures to be performed on an *inpatient* or *outpatient* basis. In other words, it allows Medicare payment to be made to the hospital for TKA procedures regardless of whether a beneficiary is admitted to the hospital as an inpatient or as an outpatient, assuming all other criteria are met. This does not have any impact on CMS' 2-midnight policy.

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CMS policy does not dictate a patient's hospital admission status and has no default determination on whether a TKA procedures should be done on an inpatient or outpatient basis. Rather, CMS continues its long-standing recognition that the decision to admit a patient as an inpatient is a complex medical decision, based on the physician's clinical expectation of how long hospital care is anticipated to be necessary, and should consider the individual beneficiary's unique clinical circumstances. CMS has not made any pre-determinations on specific percentages of the number of Medicare beneficiaries receiving TKA procedures that should be treated as an inpatient or outpatient.

The Beneficiary and Family-Centered Care Quality Improvement Organizations (BFCC-QIOs) are contracted by CMS to review a sample of Medicare fee-for-service (FFS) short-stay inpatient claims (claims with hospital stays lasting less than 2 midnights after formal inpatient admission) for compliance with the 2-Midnight Rule.

BACKGROUND

The 2-Midnight Rule

In August 2013 and effective October 1, 2013, CMS finalized the FY 2014 Inpatient Prospective Payment System (IPPS) which directed how claims are to be reviewed by Medicare review contractors to determine the appropriateness of Medicare Part A payment. The regulation established two distinct but related medical review policies, the two midnight **presumption** and the two-midnight **benchmark**.

> **2-Midnight Presumption (helps guide contractor selection of claims for medical review):** Hospital claims with lengths of stay greater than 2 midnights after the formal admission are presumed to be reasonable and necessary for Medicare Part A payment. Generally, BFCC-QIOs will not focus their medical review efforts on stays spanning 2 or more midnights after formal inpatient admission absent evidence of systematic gaming, abuse, or delays in the provision of care in an attempt to qualify for the Two-Midnight presumption.
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> **2-Midnight Benchmark (helps guide contractor reviews of short stay hospital claims for Part A payment)**: Hospital claims are generally payable under Medicare Part A if the admitting practitioner reasonably expects the beneficiary to require medically necessary hospital care spanning 2 or more midnights and such this expectation is supported by the medical record documentation. The time a beneficiary has spent receiving hospital care prior to inpatient admission will be considered when assessing whether this benchmark is met.

CMS revised the 2-Midnight Rule, effective January 2016 and pursuant to CMS-1633-F, to add the **Case-by-Case Exception**. The case-by-case exception states that for hospital stays that are expected to span less than 2 midnights, an inpatient admission may be payable under Medicare Part A on a case-by-case or individualized basis if; the medical record documentation supports the admitting physician/practitioner's judgment that the beneficiary required hospital

inpatient care despite lack of a 2-midnight expectation based on complex medical factors including but not limited to:

- Patient's history, co-morbidities, and current medical needs
- Severity of signs and/or symptoms
- Risk of Adverse Events

Beneficiary and Family-Centered Care Quality Improvement Organizations (BFCC-QIOs)

BFCC-QIOs are tasked by CMS to review a sample of Medicare fee-for-service short-stay inpatient claims for compliance with the 2-Midnight Rule. CMS began using BFCC-QIOs, rather than Medicare Administrative Contractors (MAC) or Recovery Audit Contractors (RACs), to conduct the initial medical reviews of providers who submit claims for short stay inpatient admissions on October 1, 2015.

The focus of these reviews is also for BFCC-QIOs to educate admitting physicians/practitioners and providers about the Part A payment policy for inpatient admissions.

CMS instructs BFCC-QIOs to conduct routine analysis of hospital billing and target for review hospitals with high or increasing numbers of short inpatient stays that are potentially inappropriate under the 2-midnight policy.

TKAs, like any other condition or procedure not on the IPO list, are subject to medical review by CMS contractors. The review is based on documentation in the medical record that supports either the 2-Midnight Benchmark or the Case-by-Case Exception. It is important to note that CMS does NOT target condition or disease-specific claims, such as TKA procedures, for BFCC-QIO review.

BFCC-QIO reviewers look for documentation in the medical record that supports:

- the admitting physician/practitioner's reasonable expectation that the beneficiary will require medically necessary hospital services spanning 2 midnights or longer and admits the patient to the hospital based on that expectation

OR:

- the admitting physician/practitioner's judgment that the beneficiary required hospital care on an inpatient basis despite lack of a 2-midnight expectation based on complex medical factors including but not limited to patient's history, co-morbidities and current medical needs; severity of signs and/or symptoms; risk of adverse events.

The BFCC-QIO reviews the entire medical record for supporting documentation.

What does Removing TKA from the IPO list mean?

1. This **allows** TKA procedures to be paid by Medicare FFS when performed in **either** the hospital inpatient or hospital outpatient setting, assuming all other criteria are met.
2. This **allows** TKA short-stay inpatient claims (if chosen in a sample of claims) to be reviewed by the BFCC-QIOs for compliance with the 2-Midnight Benchmark or Case-by-Case exception.

NOTE: The cost-sharing amount the beneficiary is responsible for will differ based on whether the surgery is performed on an inpatient or outpatient basis (and will vary based on other factors such as geographic location).

What does Removing TKA from the IPO list NOT mean?

1. It does **not** mean that all TKAs **must** be performed on a hospital outpatient/observation basis.
2. It does **not** mean that all TKAs **must** be billed as outpatient procedures for Medicare FFS beneficiaries.
3. It does **not** mean that TKA Short Stay inpatient claims are targeted for review by CMS.

CMS has not made any pre-determinations on specific percentages of patients receiving TKA procedures that should be treated as an inpatient or outpatient.

In the CY 2018 OPPS final rule, CMS also prohibited Recovery Audit Contractor (RAC) patient status reviews for TKA procedures performed in the hospital inpatient setting for a period of two (2) years (CY 2018-2019).

Examples of TKA Cases and Rationale for Payment Determinations:

Case #1: Meets 2-Midnight Presumption:

Dates of Service: 2/7/2018 − 2/9/2018 (greater than 2 midnights)

Case Summary: This 68-year-old female patient presented to the hospital on February 7, 2018, for an elective total left knee arthroplasty. The patient had a past medical history of left knee osteoarthritis with pain and swelling. There were no surgical complications or unstable comorbid conditions noted. The patient received a pre-procedural health assessment, radiology, and laboratory services and was started on IV fluids, IV Cefazolin 2 grams, Celebrex, Tylenol, and tranexamic acid pre-operatively. The patient was discharged to home on February 9, 2018.

Rationale for the Approval: The patient had one or more procedures that were not on the 2018 CMS IPO List (27447). However, the patient remained inpatient receiving hospital services for greater than 2 midnights.

The first midnight included arthroplasty pre- and post-surgical interventions and care for the left knee. The second midnight of hospital services included post-procedural pain and bowel management. The patient was started on Lovenox as well as sequential compression and TED stockings for prevention of deep vein thrombosis. The patient was managed for nausea and received incisional care. The patient became weight bearing after physical and occupational consultation, education, and activities of daily living safety assessment were completed on day 2. The patient was able to ambulate with minimal cues and the IV access device was discontinued. She was discharged to home with her spouse.

Case #2: Documentation Supports 2-Midnight Benchmark:

Dates of Service: On 3/6/18, patient was receiving hospital observation services; on 3/07/18, the physician order was written for inpatient admission; on 3/8/18, the patient was discharged home.

Case Summary: This 69-year-old female presented to the facility on March 6, 2018 for elective TKA surgery and was placed in observation that same day. She was converted to inpatient status on March 7, 2018. She had a medical history of arthritis, diabetes mellitus, arrhythmia, sleep apnea, and chronic pain. Medical management provided surgical repair, anesthesia administration, pre- and post-operative monitoring, and pain management. No intraoperative complications were noted. On March 8, 2017, she was discharged home.

Rationale for Approval:

The patient was admitted under observation for an elective TKA on 3/6/18.
The Physical Therapy (PT) progress notes on Post-op Day (POD) 1, indicated the patient complained of feeling shaky and dizzy and had limited mobility. Additional PT documentation on POD 1 indicated improvement, but patient became shaky and complained of feeling hot. The patient was admitted as an inpatient on 3/7/18. PT progress notes on the morning of POD 2 indicate significant improvement and the patient was able to be discharged 3/8/18. Symptoms during PT provide reasonable expectation of 2-Midnight stay.

Case #3: Medical Record Documentation Supports Case-by-Case Exemption

Dates of Service: 02/12/2018 - 02/13/2018 (one midnight)

Case Summary: This 82-year-old male presented for total left knee replacement elective surgery on February 12, 2018 and admitted to inpatient status the same day. He had a history of Coronary Artery Disease (CAD), atrial fibrillation (a-fib), complete heart block with pacemaker placement, obstructive sleep apnea, osteoarthritis, and hypertension. Medical management provided consisted of intravenous hydration, cardiac monitoring, laboratory testing, analgesics, antiemetics, anticoagulant, and IV antibiotic and home medications. On February 13, 2018 he was discharged to home.

Rationale for Approval:
This was an elective admission for a TKA. This procedure is no longer on the inpatient-only list and the status of the procedure is based on associated risk factors, comorbidities, and or

complications. The procedure was performed without complications, and the patient was quickly mobilized. His pain was controlled with oral pain medication soon after the procedure.

While this patient was previously physically active, due to the patient's extensive cardiac history, inclusive of chronically occluded right coronary artery and pacer, it is reasonable to approve this case based upon presence of risk factors for an adverse event

Case #4: Medical Record Documentation Did Not Support the 2-Midnight benchmark or the case by case exception:

Dates of Service: 03/6/18 - 03/07/18 (one midnight)

Case Summary: This 69 year-old female presented on March 6, 2018 for an elective TKA surgery and was admitted to inpatient status that same day. The patient had a past medical history of awareness under anesthesia and gastroesophageal reflux disease. Medical management provided consisted of the surgical procedure of left TKA, pre- and post-operative monitoring, imaging, laboratory studies. No intraoperative or post-operative complications were noted. Medications administered during this hospitalization included intravenous fluids, Cefazolin (IV) x 2, Oxycodone (po) x 5 and Toradol (IV) x 4. The patient was discharged to her home on March 7, 2018.

Rationale: 69 years old for elective left TKA. This procedure is no longer on the IPO list and the status of the procedure is based on associated risk factors, comorbidities, and/or complications. The procedure was performed without any intraoperative complications. Patient comorbidities were minor and no adverse concerns documented. The patient was monitored post operatively with good pain control, stable vital signs and was discharged the next day. The documentation did not support that hospital services were expected to span 2-midnights or more. There were no intra or post-operative complications documented in the medical record that supported inpatient status.

NOTE: The time a beneficiary spent as an outpatient before being admitted as an inpatient is considered during the medical review process for purposes of determining the appropriateness of Part A payment, but such time does not qualify as inpatient time. (See the Medicare Benefit Policy Manual, Chapter 1, Section 10, https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c01.pdf for additional information regarding the formal order for inpatient admission.)

FREQUENTLY ASKED QUESTIONS

Question 1: Will CMS target TKA procedures for patient status review now that they are not on Medicare FFS IPO list?

Response 1: No. Claim selection is not condition or disease-specific. Sampling is done at the hospital level not at the claim level. Accordingly, TKA procedures are not targeted for review by CMS. CMS instructs BFCC-QIOs to conduct routine analysis of a sample of hospital claims with

high or increasing numbers of inpatient stays less than 2-Midnights. When TKA or any type of claim is reviewed for Part A eligibility, BFCC-QIOs identify and educate the hospital on opportunities for improvement.

Question 2: Does removal of TKA from Medicare's FFS IPO list mean that this procedure should only be performed on a hospital outpatient basis?

Response 2: No. Removing a procedure from Medicare's FFS IPO list does not require the procedure to be performed on an outpatient basis. Rather, it allows the procedure to be performed in a hospital inpatient or hospital outpatient status.

Question 3: Who determines patient status as a hospital inpatient or outpatient?

Response 3: CMS policy does not dictate patient status. CMS continues its long-standing recognition that the decision to admit a patient as an inpatient is a complex medical decision, based on the physician's clinical expectation of how long hospital care is anticipated to be necessary, considering the individual beneficiary's unique clinical circumstances

Question 4: What do BFCC-QIOs look for when evaluating a TKA or other short-stay inpatient claim, for compliance with the 2-Midnight Rule?

Response 4: BFCC-QIOs look for:

- documentation in the medical record that supports a reasonable expectation of medically necessary hospital services for 2 midnights or longer including all outpatient/observation and inpatient care time

OR

- documentation in the medical record that supports the admitting physician's determination that the patient required inpatient care despite the lack of a 2-midnight expectation based upon complex medical factors including but not limited to:
  - Patient's history, co-morbidities and current medical needs
  - Risk of adverse events
  - Severity of signs and symptoms

Question 5: Are there plans to remove other orthopedic inpatient surgical procedures from Medicare's FFS IPO list?

Response 5: Any future plans to remove orthopedic procedures from Medicare's FFS IPO will be communicated through the rulemaking process. This allows for stakeholder comments to be submitted and reviewed prior to release of CMS final rules.

ADDITIONAL INFORMATION

MLN Matters Article, MM10417, January 2018 Update of the Hospital Outpatient Prospective Payment System (OPPS) Update with the removal of TKA from the IPO is available at

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM10417.pdf .

MLN Matters Article, MM10080, Clarifying Medical Review of Hospital Claims for Part A Payment, is available at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM10080.pdf for additional information of the 2-midnight rule.

CMS-1633 is available at https://www.gpo.gov/fdsys/pkg/FR-2015-11-13/pdf/2015-27943.pdf. A fact sheet on the Two-Midnight Rule Fact Sheet is available at https://www.cms.gov/newsroom/fact-sheets/fact-sheet-two-midnight-rule-0.

If you have questions, your MACs may have more information. Find their website at http://go.cms.gov/MAC-website-list.

DOCUMENT HISTORY

Date of Change	Description
November 20, 2018	Initial article released.