AMERICAN COLLEGE OF PHYSICIAN ADVISORS

IP Authorization for Cases No Longer on the MIO/IPO List

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Disclosures

Nothing to Disclose

Abbreviations Used in This Presentation

Abbreviations	Long Description	Abbreviations	Long Description
FFS MC	Fee For Service Medicare	OBS	Observation
IOP	Inpt Only Procedures	SEC	Surgical Evaluation Center
IPO	Inpt Procedures Only	PA	Prior Authorization
IP	Inpatient	TM	Traditional Medicare
MA	Medicare Advantage	TJR	Total Joint Replacement
MIO	Medicare Inpt Only		

A Favorite Quote

- *I never gave anyone hell. I just told them the truth, and they thought it was hell.*
  - *Harry Truman*
- The truth is that many elderly, frail patients with certain comorbidities and inadequate support systems post-op need to be IP for numerous reasons - to be further discussed.
- This requires planning and careful documentation – especially when a surgical procedure has been removed from the IPO list as technology and surgical techniques have improved

Insurance Realities

- Traditional Medicare members are embracing Medicare Advantage Plans
  - 2022 – 48% of Medicare recipients are enrolled in MA plans (varies by region)
    - In the future there will be more Medicare Advantage members with fewer FFS Medicare (TM)
    - CMS has lists of procedures that are so significant (high risk for adverse event) the patient must be IP for Medicare to pay for the services – the list changes year-to-year
  - Government plans include Tricare, which covers military and their families (ages 20's to 50's) and may be more fit than most of us listening to this presentation!
  - If IPO list was to protect frail, elderly or debilitated patients, how does the IPO list make any sense as applied to Tricare?

Why Try to Get IP approval?

- Recent headlines
  - Kaiser loses - $961 million in one quarter
  - Cleveland Clinic loses $787 million in one quarter – operations only
  - Ascension loses $1.8 billion in FY 2022 (ended June 30)
- Health plans report “record profits”
  - UHC 10.14.2022 Becker’s – 16.2% increase in net profits $11.4 billion (MA growth)
  - Optum – owned by UHC – 17.7% increase to $10.1 billion
  - Elevance (formerly Anthem) third quarter - $1.6 billion of profits

MCG Guidance on Total Joint Replacement

- Ambulatory: Selected patients undergoing a primary unilateral elective procedure who are without active or unstable comorbidities that significantly increase risk or require prolonged postoperative monitoring, and who receive appropriate perioperative clinical care and support (e.g., use of specific clinical perioperative care pathway)
- Inpatient: Patients undergoing nonelective, bilateral or revision procedures, patients with comorbidities who require more prolonged postoperative treatment or monitoring.

*** Clinical risk and documentation prior to the surgery needs to be clearly stated for correct status assignment and pre-authorizations.

Traditional Medicare (TM)

- Getting past the 2 MN IP rule for traditional Medicare
  - Could increase audit risks as “1 MN stays for services not on the IPO list” are a focus
  - No Prior Auth needed for Traditional Medicare, but audits have resumed and are ramping up
- Need to understand whether QIO’s, or others are pulling 1 MN stays for review and if hip and knee replacements are being denied with 1 MN stay
  - None found in our system as of Jan 2023
- Early reports have indicated at least some QIOs are going strictly by 1 MN / 2 MN

Medicare Advantage and Commercial Payers

- Prior Authorization (PA) for any cases where IP is appropriate should be obtained from the plan/ payor prior to admission
- Build the case via SEC exam and risk evaluation – and document well
- Involve surgical offices in getting PA from health plans that require prior auth for IP
  - Schedulers are NOT clinical – so they need clinical support to get the IP prior auth
  - Post-op – very unlikely to move from OBS to IP unless significant complications or prolonged stay
- **Discharge plans for SNF etc. set up prior to admission** – auth delays by the health plan post op will prolong stays

Medicare Advantage and Commercial Payers

- Each system must find the best way to accomplish the goal of the prior auth

- Prior auth process can be done in many ways (7-10 days prior to surgery)
  - SEC
  - Joint Class prior to surgery
  - Collaboration with Surgeon’s office

Specific Conditions that May Support Inpatient

- Different health systems have developed slightly different lists of reasons to make an OP surgery IP

- See ADDENDUM at end of presentation - 3 slides

Building the Process

- Administration buy-in and support
- One champion / physician leader – or more to include schedulers, nursing, Nurse Practitioners, Physician Assistants etc.
- Resources – Surgery Evaluation Center (SEC) or another pre-op process
- Partnership with Ortho or Surgeons' offices
  - Independent groups vs employed groups
- Thorough pre-op exam 2 weeks or more prior to surgery

Magnitude of the Problem

- Initial Focus on Hips and Knees
- Volumes – primary unilateral knees and hips
  - 1400
- Number of cases OP vs IP – prior to new approach
  - Per Traditional Medicare and MA plans – NONE were IP
  - TM – not on IPO list; MA plans push for OBS
- Pay difference for IP vs OP TJR
  - $1800+
- System impact in Indiana in $2.52 million

Success Story

- 90 % # of MA and TM (Traditional Medicare) cases converted from OBS to IP when appropriate – 870 (not all cases were Traditional Medicare or Medicare Advantage)
- Some cases appropriate for OBS or even OP surgery (D/C same day)
- $1.57 million added revenue
- This was for ONE hospital – largest volume facility in IN
  - Three other IN (Indiana) facilities do TJR
  - Another 800 or so cases

Surgery and Surgeon Buy In

- Since most IPO cases, and those removed from the MIO / IPO list are surgeries, that was the first focus
- For surgeons – pre-op checklists are a way of life for patient safety
  - Correct patient
  - Correct surgery
  - Correct side/ site
  - Time out
- Status is not relevant for surgeon payment – a hospital issue that is complex and can be debatable – but checklists may help move to IP

A Second System Example

- A large system (just like many across the country) felt the impact when hip and knee replacements fell off the IPO List
  - increase in long OBS or extended stays
- Hospitals saw many surgeries shift to Ambulatory Surgical Centers (ASC)
- Higher-risk complex patients needed more care than could be provided at the ASC
  - Hospitals usually see mostly high-risk cases

A Coalition of the Willing

- **Physician Advisors** – essential to every hospital - were consulted to help the system.
- Champions from certain depts were brought together
  - Surgeons and their office schedulers
  - Precertification/ Preauthorization department at the hospital
  - Allied clinical teams, Physician Assistants, Nurse Practitioners, etc.
  - Utilization review staff – case management staff if separate
  - Physician Advisors
  - Orthopedic Surgeons

Metrics Created and Analyzed

- Checklists created to document high risk patients
- 7-10 days prior to the procedure all cases are reviewed
- Preauthorization for IP sought when appropriate
- 80% approval rates for those cases deemed IP appropriate
- Signed and held order placed for day of surgery
- Reduction of day of surgery admission order confusion

Advantages of Correct Status Determination

- ✓ Patient Satisfaction Improved
- ✓ Surgeon satisfaction improved
- ✓ Hospital Staff satisfaction improved
  - ✓ Increased productivity
  - ✓ Decreased rework
- ✓ Hospital Metrics improved
  - ✓ CMI and LOS
  - ✓ Market share
  - ✓ Clean claim rate increased
  - ✓ Decrease in Denials
  - ✓ Financial bottom lines improved

Considerations in Starting a Program – Dr. Maigur

- Administrative support
- Performing stakeholder analysis
- Leveraging EMR tools
- Personnel assessment and allocation
- Medical staff education

Cautions and Caveats

- Each system must redeploy assets already in place, or may need to add assets or delete / add steps in the process as described
  - Cost considerations
  - Pre-op exam; educational meeting for patient and family (especially for joint replacement surgery); setting and agreeing on expectations post-op
- No two systems are likely to implement identical processes – what works for you?

Caveat 2 - Walk the Walk After Talking the Talk

- Appropriate monitoring post-op consistent with “risks”
  - If COPD or OSA are concerns, the continuous O2 monitoring is a MUST
    - Prolonged O2 post-op is a sign of need
  - Poorly controlled diabetes cannot be the case if there are no blood sugars scheduled on a regular basis
  - Bleeding concerns without HGB monitoring is illogical
  - Do patients with concerns for arrythmias require Telemetry? Probably.
  - Patients with prior CVA need to have residual deficits documented by PT or MD

Process for Success - Summary

- PROCESS : Establish a good process with all stakeholders, review claims from start to finish. From scheduling to the doctor's office to the closed claim.
  - Strong processes will be scalable and sustainable
  - Reports and metrics are key to strong process improvements
- PRODUCT: Use technology to ensure consistency and audit often.
  - EMR for best results and use for appeals/ audits.
- PEOPLE: Use a champion, celebrate success and educate often.

Addendum slides

Specific Conditions That May Support Inpatient

- Morbid Obesity or Obesity with other Comorbid Conditions
- Heart disease – CAD, CHF, AF, CMO especially if on Anticoagulants that need monitoring
- COPD – on meds or O2, moderate or severe
- DM – poorly controlled as measured by A1c, or tight insulin management (# doses /day)
- HTN – multiple meds, pre-op BP still higher than desired
- Prior issues with anesthesia – Nausea / vomiting, or other adverse reactions

Specific Conditions (continued)

- Obstructive Sleep Apnea – especially on CPAP
- Social determinants of health – use of frailty index
  - Will need rehab placement to get to PLOF
  - Lives alone or no adult caregiver
  - Patient that will require SNF for recovery should be IP from the start
  - Pts living in rural areas , with no immediate medical support within 25 miles
- On anticoagulants that need to be managed perioperatively
- Hemophilia or other coagulation disorders – Factor V Leiden deficiency as one example
- Poorly controlled seizures – breakthroughs despite adequate treatment

Specific Conditions - Example Template

Default?	Choice
☐	Osteoporosis or Osteopenia
☐	Uncontrolled Diabetes Mellitus HgbA1c >7
☐	Hypertension poorly controlled or requiring 3 or more medications
☐	Hypertension uncontrolled
☐	COPD Rx with ***
☐	Chronic resp failure on home oxygen
☐	Chronic resp failure with Hypercapnia
☐	VTE in the last 12 months of recurrent during lifetime
☐	Active Cancer - pt received Rx within last Six months
☐	Patient is under hospice care
☐	OSA screening total score equal or greater than 5 (STOP BANG)
☐	OSA untreated
☐	Poor wound healing or active infection issue
☐	Previous surgery - recovery period
☐	Cirrhosis of liver
☐	Hx of Opioid dependence
☐	Pain management issues in the past
☐	Renal impairment (Creatinine >2) or currently on HD
☐	Recent Myocardial Infarction or cardiac event (less than six month).
☐	AAA
☐	Hx of arrhythmia e.g., uncontrolled Afib, PPM etc.,
☐	Hx of CVA
☐	Stairs at home
☐	Location of home beyond 25 miles from primary treating hospital
☐	Social situation - support at home for post operative care.

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Thank you. Questions?

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