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The New World of Total Knee Replacements

Announcer:
You're listening to Conference Coverage on ReachMD, captured on location at the Physician Advisor and Medical Director Summit in Orlando, Florida. Your host is Dr. Prathima Setty, obstetrician, gynecologist, and a fellow of the American College of Obstetrics and Gynecology.

Dr. Setty:
Hello, this is Dr. Prathima Setty with ReachMD, and I'm here at the Physician Advisor and Medical Director Summit in Orlando, Florida. I'm here with Dr. Simon Ahtaridis, the National Clinical Advisor, Chief Medical Officer, and Chief Medical Officer of Advisory Services of Sound Physicians, and he's here to discuss the new world of total knee replacements.

Thank you for joining us, Dr. Ahtaridis.

Dr. Ahtaridis:
Thank you for having me.

Dr. Setty:
So, Dr. Ahtaridis, what happened to total knee replacements and the inpatient-only list? Can you briefly explain?

Dr. Ahtaridis:
Sure. CMS provided guidance as of January 1, 2018, total knee replacements will no longer be on the inpatient-only list. And the inpatient-only list is a list of procedures that, regardless of length of stay, regardless of the traditional metrics of medical necessity, are considered inpatient-only procedures; that is, the patient is admitted, they receive the procedure, and they are on inpatient status. Medicare Part A is billed regardless of how long the patient is in the hospital or what other medical needs they might have. CMS continually evaluates this list and determines whether a procedure should remain on the inpatient-only list. And total knee replacements are something that have seen tremendous advances, both in the perioperative care and also in the ORs, where length of stay has dropped off tremendously, and we've gotten very good at providing this procedure efficiently, decreasing complications.

CMS has certain metrics they use to evaluate whether a procedure can come off the inpatient-only list. There are 5 traditional categories. Interestingly, knee replacements didn't meet all 5 of these categories. They are, arguably, procedures that can be handled by outpatient department, but it is the only CPT code in its class that has been removed from the inpatient-only list, and it is not being routinely performed in ambulatory surgical centers; but regardless, CMS did elect to remove it from the inpatient-only list. What this means is that when this procedure is done in hospitals, it will no longer automatically count as a DRG, and it might be billed out as an outpatient procedure.

Dr. Setty:
So, Dr. Ahtaridis, what is the impact of this for providers, for patients, for hospitals? What is your opinion on that?

Dr. Ahtaridis:
So it's interesting. It will have tremendous impact, and the magnitude of that impact is unclear. First, with respect to hospitals, the DRG payments for knee replacements are significantly higher than what we call APC payments for outpatient procedures for knee replacements. The hit to hospitals will be anywhere from 2– to potentially as much as 15–, $20,000 in decreased reimbursement. And we also consider the Bundled Payment Program. Some of the healthier patients that might be part of Bundled Payment Program will now be removed from the denominator, and there may be some reconciliation for that. For surgeons, what it will mean is that they will have to help guide the decision of whether a patient is an observation patient or an inpatient and help to justify the appropriate status of

that patient. And for patients, what it will mean is, if they undergo this procedure, they may be billed as an outpatient and may be subject to additional copayments and additional costs, and they might also lose some traditional benefits that they would have under inpatient status, such as having a SNF coverage benefit if they require 3 midnights of hospitalization. The big question though is how many of these patients will remain on inpatient status and how many will be converted to an outpatient status, and that's where there is a lot of debate. And also, what rules will be used to determine whether a patient is inpatient or outpatient, that also has been an area of intense debate.

Dr. Setty:
So, Dr. Ahtaridis, that is good to know, that not all TKAs are automatically considered outpatient. How does one determine if a TKA will remain inpatient or if it is, in fact, outpatient?

Dr. Ahtaridis:
So, when a procedure comes off the inpatient-only list, all that means is that the least restrictive setting is not the inpatient status. It doesn't mean that the procedure cannot be done in the inpatient status. And again, CMS in their guidance indicated that they do not expect a significant number of these procedures to go to the outpatient status. They didn't give any specifics about that. In terms of what guidance do we have and how do we determine whether someone is inpatient or outpatient, CMS continually pointed to the Two Midnight Rule in their guidance, and the interpretation that we're hearing from multiple groups is that if a patient is expected to require 2 midnights of hospitalization after their procedure, that they will qualify for inpatient status, and there's not a lot of debate on that. If I have a reasonable suspicion that this patient in this facility is going to have a 2-midnight stay, it's appropriate to designate that patient as an inpatient. Where there is a lot of debate and discussion is around case-by-case exception. CMS says, for patients that require less than 2 midnights of hospitalization, on a case-by-case basis, those patients can be evaluated for consideration for inpatient status. And when we consider some very high-performing joint center programs, they actually send a disproportionate share of their patients home after a single midnight and are particularly susceptible to seeing a tremendous drift in their volume to outpatient status. And what is less clear is how do we justify a case-by-case exception to the Two-Midnight Rule. There are criteria that would make a case inpatient regardless of a 2-midnight stay in some traditional metrics. However, a lot of the guidance around those case-by-case exceptions dealt with acutely outpatients that had life-threatening conditions. That is not the population that we're talking about. A total knee replacement is always an elective procedure in an otherwise medically stable patient. Extrapolating prior guidance on case-by-case exceptions is a tremendous challenge with total knee replacements. And likewise, the different stakeholders have had very different opinions about how to apply it. Some professional societies have advocated that it is the onus of the provider to justify why the patient is safe to be outpatient, and on the other end of the spectrum, some compliance agencies have advocated that there should only be a strict application of the Two-Midnight Rule with no case-by-case exceptions; that is, all patients are outpatient unless the patient is anticipated to have a 2-midnight stay based on their comorbidities.

Dr. Setty:
In your opinion, what further guidance is needed from CMS?

Dr. Ahtaridis:
There's not a lot of debate about what happens if a patient stays for 2 midnights. Where there is tremendous debate is, if I am in a center that provides high-quality, efficient care and I am sending most of my patients home after 1 midnight, can I apply the case-by-case exception, and if so, by what criteria? Again, this is a bit of untested waters. We haven't really had prior precedent here for applying a case-by-case exception to a non-acutely ill patient. What we're hoping to see from CMS or the QIOs, the Quality Improvement Organizations that help administer the Medicare plan, is guidance on what would qualify as a case-by-case exception to the Two-Midnight Rule in the area of hip replacements, and I think that that guidance is going to be particularly important; or again, we might see a significant drift of patients from the inpatient setting to the outpatient setting, particularly at centers that do perform this procedure in high volume and with very good outcomes.

Dr. Setty:
So, Dr. Ahtaridis, what advice do you have for providers? It seems like this is going to be a change, especially for those providers who perform these procedures quite a bit?

Dr. Ahtaridis:
So one of the critical things is going to be good documentation. When a patient is on the inpatient-only list—again, regardless of what we document the traditional merits of case—they are inpatient. Now we're going to be judging whether a patient will require inpatient status based on the documentation of the provider. And the 2 components that really must be present is: What is the expectation of the patient's stay? Do we expect this patient is going to stay for 2 midnights or more, and why do we expect that that patient is going to stay for 2 midnights or more? So we're also going to have to articulate what comorbidities does this patient have that might warrant a 2-midnight stay as opposed to a healthier, younger patient. So, clear documentation of medical comorbidities, clear documentation of

anesthesia risk, documentation of any other conditions that make this case more challenging—everything from having competent caregivers at home, having support at home, preexisting gait functional issues—all this is going to be critically important to document in the chart to give the patient an appropriate status.

Dr. Setty:
So documentation is key. That's good to know. Do you have any final thoughts on this subject?

Dr. Ahtaridis:
Well, one of the things I think hospitals are going to need to do, and soon, is really understand their own internal performance and really reach out to providers and make sure that they understand the implications of this, and this really will require a multidisciplinary effort. It's going to require efforts from the OR staff, the orthopedic surgeons, the medical providers that provide pre-op clearances for the patients, and the anesthesiologists to accurately portray the patient and make sure that the patient is presented in the most valid and accurate fashion. And again, I think it is important for systems to take a look at this. It could be a big financial hit to some institutions. They should understand what this means for them. And also, in terms of what to expect next from CMS, it certainly looks like other joint replacement procedures may soon follow similar guidance. One last thought that I have is just in terms of the type of change that we saw. The Federal Register provided about 5,000 words of guidance when it removed total knee replacements from the inpatient-only list. What I hope is that this isn't a sign of what's to come. Traditionally, when procedures have been removed from the inpatient-only list, it's been a lot simpler, a lot cleaner. If we do have multiple changes like this with a great deal of nuance and great deal of complexity in terms of understanding whether they should be inpatient or outpatient, it is going to make the healthcare landscape much more confusing for both patients, providers and for systems, and I expect that we'll see a great deal of disagreement and conflict over what proper assignments are. And what we hope is that we'll have cleaner, more specific guidance from the Federal Register and the QIOs.

Dr. Setty:
Well, thank you for explaining that new change in total knee replacements, Dr. Ahtaridis. Thank you for joining us.

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