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Total Knee Replacements: Sample Policy for Making Admission vs. Outpatient Determinations (Patient Status)

I. SCOPE

This policy applies to patients at St. Elsewhere Health System with traditional health insurance provided by Medicare, also known as fee-for-service Medicare, who are not enrolled in a Medicare Advantage plan, and who are undergoing an elective total knee replacement (TKR).

II. PURPOSE

The purpose of this policy is to provide guidance to clinical staff and other personnel on the proper procedures and requirements for all patients to receive services for the appropriate patient status based on regulations issued by the Centers for Medicare & Medicaid Services (CMS). Per CMS, the clinical staff are most suited to create such guidelines (82 FR 59383).

III. POLICY

The patient status of every patient undergoing TKR will be determined prior to surgery by the performing surgeon after review of this policy. The patient status must be recorded in writing prior to the date of surgery, with the order dated and signed by the surgeon, or another physician or practitioner who will be involved in the care of the patient and has admitting privileges at the hospital. If inpatient admission is ordered, the inpatient admission formally begins when the patient enters the operating suite. If the surgery is canceled prior to the patient entering the operating suite, the inpatient admission will have not started, and any services provided to the patient in the pre-operative preparation area may be billed as outpatient services.

CMS has designated TKR to be a surgery that is not required to be performed only as an inpatient as of January 1, 2018. The fact that TKR is not designated as inpatient only does not mean that it must be performed as outpatient (82 FR 59383). When determining if a TKR should be performed as inpatient or outpatient, the physician should consider the following factors:

1. Clinical need for rehabilitation after surgery at a skilled nursing facility (82 FR 59384)
    a. If the surgeon determines that a patient's current living situation, support systems, or ability to safely reside at home after surgery is inadequate, those factors should be specifically documented in the medical record and inpatient admission ordered.
        i. Examples would include living alone; living with caregiver who is unable to assist patient with activities of daily living; inability to access living, bathing, and dining areas of home due to layout.
    b. Access to a skilled nursing facility for rehabilitation post-inpatient admission requires an inpatient admission of three or more days unless the hospital has been granted a waiver by CMS. Patients admitted as inpatient because of the need for rehabilitation at a skilled nursing facility after TKR

may be maintained as inpatient in order to meet the qualifying stay requirements.

2. Complexity of the surgery (80 FR 70541)
    a. If the surgeon determines that there are anatomic or technical considerations that would deem the surgery to be more technically challenging, these factors should be documented and inpatient admission ordered.
        i. Examples would include bilateral knee replacement, extensive vascular calcification, and severe joint deformity beyond that seen with osteoarthritis of the knee. The technical challenges should also be discussed in the operative report prepared after surgery to support that determination.
3. Need for over two midnights of in-hospital care (82 FR 59384)
    a. If the surgeon determines there are patient-specific factors that are likely to result in the patient being unable to be discharged on the day of surgery or on post-operative day 1, these factors should be documented and inpatient admission ordered.
        i. Examples would include severe gait abnormality pre-operatively that requires at least 48 hours of therapy in-hospital under close supervision of the surgeon, and baseline abnormal mental status where the surgeon determines the patient will need close supervision for at least the first 48 hours of therapy that cannot be adequately provided at home or in a skilled nursing facility.
4. Medical Comorbid Conditions (82 FR 59384)
    a. If any treating physician determines that there are medical comorbid conditions that would increase the risk of the surgery or the medical predictability of something adverse happening to the patient, these factors should be documented and inpatient admission ordered.
        i. American Society of Anesthesiologist (ASA) Class: An ASA classification of III or higher, with the comorbid conditions and supporting documentation that led to that classification, warrants inpatient admission.
        ii. Other comorbid conditions: Other conditions not listed in the examples provided by the ASA classification system, such as chronic kidney disease and chronic anemia. Extreme age may also be used as justification for inpatient admission. The finding and the perioperative risks imposed by that abnormality should be documented.
5. Patients whose surgery is performed as outpatient
    a. If it is determined that a patient meets no qualifications for inpatient admission for TKR, the surgery should be performed as outpatient.
    b. Outpatients whose surgery was performed as outpatient will be assessed by case management staff in the afternoon of surgery once the patient has been seen by physical therapy for their first session.
        i. If the patient was unable to participate in their therapy evaluation or has developed other unexpected complications, such as difficulty awakening from anesthesia, pain which is unable to be controlled with ordered post-operative analgesia, confusion or agitation, or exacerbation of a pre-existing medical condition, such as COPD, the physician should be

contacted.

1. If it is felt that the issue is minor and will resolve and not delay the patient's recovery, an order for observation services should be placed.

2. If the physician feels that the issue will delay the patient's recovery and they will likely require a second midnight in the hospital, either for treatment of the complication or additional in-hospital therapy, an inpatient order should be obtained.

c. Outpatients whose treatment has progressed as expected and are now on post-operative day 1 should be assessed for discharge readiness.

    i. If the patient is determined unable to be discharged, either due to requirement for additional in-hospital physical therapy, as determined by the physician and documented in the record, or due to delayed recovery or a complication, as documented in the record, an inpatient order should be obtained.

d. Patients requiring transfer to a SNF must be assessed for qualification for Part A coverage.

e. If the patient was admitted as inpatient post-operatively and has three inpatient days, not counting the day of discharge, the patient may be transferred to a SNF under their Part A benefit.

f. If the hospital is a participant in either BPCI or CJR, the patient was admitted as inpatient after surgery, and the patient is to be transferred to a SNF prior to three inpatient days, the record must be reviewed to ensure the patient's admission will fall into DRG 469 or 470. If the DRG does not fall into DRG 469 or 470, the three-day waiver is not applicabl,e and the patient may not be transferred under the waiver.

NOTICE: This sample policy was prepared independently by Ronald Hirsch, MD, FACP, CHCQM, and has not been reviewed or endorsed by any hospital organization, federal or state agency, or R1 RCM Inc. legal or compliance departments. It is not an official document, and the use of the policy as a template or guide does not carry with it any warranties, expressed or implied. In fact, Dr. Hirsch admits he has never written a policy before so remember that as you read this.