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CMS Plans to End IPO List, Increase Prior Auth; Buck Would Stop with Two-Midnight Rule

By Nina Youngstrom

In an unexpected confluence of events, CMS is planning to terminate the inpatient-only (IPO) list, which guarantees Medicare payment for procedures only when they're performed on inpatients, while expanding prior authorization for outpatient procedures, according to the proposed 2021 outpatient prospective payment system (OPPS) regulation[1] that was published in the Aug. 12 *Federal Register*. If finalized, the changes will underscore CMS's emphasis on medical necessity and the primacy of the two-midnight rule, experts say. But they also are sparking concern that coverage decisions and payment are becoming indistinguishable. Hospitals should prepare to staff up utilization management, because checking the compliance boxes for IPO procedures is far less labor intensive than evaluating whether surgeries should be performed on inpatients versus outpatients.

The IPO procedure list, with 1,740 services, will be phased out in three years, starting with 266 musculoskeletal services next year. CMS test drove the idea when it recently moved total knee arthroplasty (TKA) and total hip arthroplasty (THA) off the IPO list and into the realm of the two-midnight rule. The proposed OPPS rule includes a table with the musculoskeletal codes and the comprehensive ambulatory surgical classifications (C-APCs) they will fall into if the procedure is performed on an outpatient.[2]

"All bets are off now, and there's no guaranteed status on any [surgical] cases," said Alvin Gore, M.D., physician advisor and director of utilization management at St. Joseph Health System in Santa Rosa, California. Once again, compliance officers and physician advisors will have to ask physicians to do a 180 for reimbursement purposes. "It will be on the physicians' shoulders to put in the documentation" why they admitted the patients. It's a departure from IPO claims, which "are very fast because they are a shoo-in. Finance likes them because they are quick and foolproof. Now they will be removed and will have to be relied on for the two-midnight obligation, so it's a subjective opinion," Gore said. The question is, how much more work will that be? That analysis is already underway at St. Joseph's.

Looking at the big picture, phasing out the IPO list is consistent with "the holistic process of lowering the cost of health care," he said. It represents CMS "finally realizing the only difference between inpatient and outpatient surgery is payment, and it makes no sense to deny payment because the doctor forgot to write an order" for an inpatient-only procedure, said Ronald Hirsch, M.D., vice president of R1 RCM.

But in one fell swoop, hospitals and physicians will face far more decision-making about which patients are expected to stay two midnights and who qualifies for a case-by-case exception to the two-midnight rule that, after a two-year moratorium, may be second-guessed by auditors, he said. And hospitals will take a financial hit. Some procedures that always generated MS-DRG payments will convert to C-APCs, which are usually a lower amount.

CMS 'Is Conflating Payment and Coverage'

Meanwhile, CMS proposed to add cervical fusion with disc removal and implanted spinal neurostimulators to the

five surgeries that have required prior authorization since the new process started July 1. The existing procedures are more cosmetic than the two being added, effective July 1, 2021.

"The global message is that medical necessity for procedures is being scrutinized much more than ever before," Hirsch said. His advice: Hospitals shouldn't schedule any procedures unless confident they meet medical necessity guidelines—a national coverage determination, local coverage determination or specialty society guidelines.

The juxtaposition of these developments is troublesome, said attorney Andy Ruskin, with K&L Gates in Washington, D.C. "On the one hand, CMS is saying, 'We're not going to babysit you any longer,' with respect to inpatient-only procedures, but on the other hand, they are putting in new prior authorization requirements for the two procedures," he said. The rationale CMS gives for killing the IPO list is that physicians should be allowed to use their own judgment. "But then why add these procedures to the prior authorization list? It seems completely inconsistent not to trust their judgment here but to entirely rely on their judgment regarding IPO-list procedures," Ruskin said.

He sees this expansion of prior authorization requirements as proof of CMS "conflating payment and coverage, and that's just wrong." CMS could have just as easily issued a national coverage determination for hospitals to follow, which is how it traditionally guides providers on medical necessity. Hospitals should expect more of this because of the July 17 decision[3] from the U.S. Court of Appeals for the District of Columbia upholding CMS's site-neutral payment policy. "CMS likely now believes that it has unlimited adjustment authority," Ruskin said.

He also sees the elimination of the IPO list as a step toward CMS expanding Medicare coverage of procedures at ambulatory surgery centers, which will result in lower reimbursement for these procedures and more competition for hospitals. In fact, the proposed rule adds 11 procedures, including THA, to the list that Medicare will pay for at ambulatory surgery centers in 2021.

Crystal Ball: More Utilization Reviews

In the proposed OPPS rule, CMS acknowledged the concerns for patient safety with phasing out the IPO list. But it contends that "the evolving nature of the practice of medicine, which has allowed more procedures to be performed on an outpatient basis with a shorter recovery time, in addition to physician judgment, state and local licensure requirements, accreditation requirements, hospital conditions of participation (CoPs), medical malpractice laws, and CMS quality and monitoring initiatives and programs will continue to ensure the safety of beneficiaries in both the inpatient and outpatient settings, even in the absence of the IPO list."

The IPO list would be history by Jan. 1, 2024. CMS asked for comments on whether three years is an appropriate amount of time for the transition, whether to include other services in 2021, and what "clinical families" should be removed next.

As soon as the OPPS rule was proposed, Gore started pondering how the elimination of the IPO list would affect staffing and workflow. "The IPO list is about five minutes' work," he said. "You just need to verify a few things." For example, has the physician placed an inpatient order? In the case of an orthopedic procedure, has the surgeon exhausted conservative strategies (e.g., physical therapy) before resorting to a joint replacement? Does presurgical documentation conform to medical necessity? If all is right with the world, claims are released from billing without additional review, Gore said.

That won't be the case in a few months, if CMS sticks to its plan. With 1,740 additional services eventually falling under the two-midnight rule, hospitals are looking at more internal and external reviews. Gore is trimming the IPO list to the procedures most frequently performed at St. Joseph to get a better feel for the impact of moving

them all off the list, starting with musculoskeletal procedures. "Our UR [utilization review] manager told me off the cuff about a 30% increase in staff is needed, but it's just a guestimate," he said. "If it all goes through the two-midnight rule, there will be an initial screening that's evidence based, and the ones that don't pass through the first level will have to go through a second review."

Gore anticipates some documentation challenges. For example, even though CMS left total joint revisions on the IPO list when TKA was moved off it, "now they have to be justified." As with all documentation, the magic word is "because," as in, "because of intra-operative difficulties with intubation, patient would require additional respiratory support that would extend the care beyond 2 midnights."

Initially, hospitals will be spared external audits. In the proposed OPPS rule, CMS said for the two years after procedures are taken off the IPO list, they will be exempt from claim denials under the two-midnight rule, as was the case with TKA and THA. But claims would still be denied if the quality improvement organization determines the procedures weren't medically necessary, and they may be audited for patient status for education purposes.

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1 Medicare Program: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs; New Categories for Hospital Outpatient Department Prior Authorization Process; Clinical Laboratory Fee Schedule: Laboratory Date of Service Policy; Overall Hospital Quality Star Rating Methodology; and Physician-Owned Hospitals, 85 Fed. Reg. 48,772 (August 12, 2020) , https://bit.ly/33Wywnu.
2 Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs, 85 Fed. Reg. 48,772, 48,912 (August 12, 2020) .
3 Nina Youngstrom, "Court Restores Site-Neutral Payments; Lawyer: More Trouble May Be Ahead," *Report on Medicare Compliance* 29, no. 27 (July 27, 2020), https://bit.ly/2XW1VdP.