Prepare now for more stringent joint replacement documentation requirements

Medicare administrative contractors (MACs) in several states recently ratcheted up their documentation requirements for joint replacement surgery and other orthopedic procedures. For hospital ORs, these changes represent the tip of an iceberg that calls for careful navigation.

Enhanced medical necessity documentation requirements were launched in Florida in 2011. The state’s MACs spelled out detailed coverage requirements for major joint replacement, including demonstration of advanced joint disease and failure of conservative therapy.

In 2013 and 2014, similar requirements were adopted by MACs serving Virginia, North Carolina, and other states. Given the trajectory of this change and the dollars at stake, it is probable that more stringent requirements will soon be established in other administrative regions. Ultimately, the Centers for Medicare & Medicaid Services (CMS) will likely adopt the new standards on a national basis.

Although hospitals in many locales are not yet required to meet these new documentation requirements, preparing now makes sense. Meeting the more stringent requirements will help protect important service line revenue while enhancing your OR’s quality of care.

Higher bar
Medicare coverage determinations specify the clinical conditions under which services are considered reasonable and necessary. CMS sets nationwide coverage policy through national coverage determinations (NCDs).

However, regional MACs have the authority to issue local coverage determinations (LCDs) for issues on which a national policy has not been established. In fact, the majority of coverage determinations are local. While Medicare has established about 300 NCDs to date, regional MACs maintain approximately 1,800 active LCDs.

You can use the Medicare coverage database to determine whether new joint arthroplasty LCDs have been issued for your state (sidebar, p 22). In general, new joint replacement LCDs require more detailed information to demonstrate medical necessity. Four areas are key:

Demonstration of advanced joint disease. New coverage indicators emphasize the need to substantiate the presence of end-stage joint disease. For example, under L32971 issued by Cahaba Government Benefit Administrators, the MAC for Alabama, Georgia, and Tennessee, documentation for total knee replacement surgery must include one or more of the following:

• Arthritis of the knee, supported by x-ray or MRI imaging that demonstrates subchondral cysts, subchondral sclerosis, periartricular osteophytes, joint subluxation, joint space narrowing, avascular necrosis, or bone-on-bone articulations.
• Patient pain and functional disability caused by the knee joint. (In a 2012 issue of MLN Matters, CMS clarified that documentation of pain can include “onset, duration, character, aggravating, and relieving factors.”)

What are your state’s documentation requirements?

• Use the “Quick Search” function at the right side of the home page.
• Search by document type (NCD, LCD or both).
• Use the drop-down menu to select your state, territory, or region.
• Specify key words (such as “joint replacement” or “joint arthroplasty”) or specific CPT/HCPCS codes.
• On the Search Results page, be sure to scroll all the way to the bottom to view all pertinent documents.
A history of unsuccessful conservative treatment, such as anti-inflammatory medications or analgesics, flexibility and muscle-strengthening exercises, supervised physical therapy, assistive device use, weight reduction, or therapeutic injections.

**Distinct structural abnormalities.** New LCDs also specify the structural abnormalities that justify knee replacement surgery. According to L32971, surgery candidates must have distal femur fracture; proximal tibia fracture; malignancy of the distal femur, proximal tibia, knee joint, or adjacent soft tissues; or avascular necrosis of the knee.

**Necessity of a revision procedure.** The new coverage indicators also spell out the clinical situations that make a revision joint replacement reasonable and necessary. L32971 lists six conditions:
- loosening, fracture, and mechanical failure of one or more components
- failure of previous knee surgery (eg, unicompartmental knee replacement, previous osteotomy)
- infection
- periprosthetic fracture or bone loss of distal femur, proximal tibia, or patella
- implant or knee malalignment
- tibiofemoral or extensor mechanism instability.

Specific documentation requirements differ for different MACs. For example, according to L32081 from First Coast Service Options, “When infection is the reason for revision TKA [total knee arthroplasty] or THA [total hip arthroplasty] surgery, laboratory and/or pathology reports must be in the medical record, and all documentation regarding treatment of the infection and a physician note indicating that it is appropriate to proceed with surgery should be in the medical record as well.” This LCD also says conservative, nonsurgical therapy should usually be done for at least 3 months.

**Risks and benefits.** Some LCDs also require providers to document surgery risks and benefits. According to L32081, “For patients with significant conditions or comorbidities, the risk/benefit of noncardiac surgery, such as TKA [total knee arthroplasty] or THA [total hip arthroplasty], should be appropriately addressed in the medical record.”

In addition, recent LCDs establish enhanced medical necessity and documentation requirements for spinal fusion.

In general, the documentation of coverage criteria must be contained in the patient’s medical record. All documentation must be made available to the Medicare administrator upon request.
Hospital risks

In jurisdictions where new joint replacement LCDs apply, failure to meet the appropriate documentation requirements carries substantial risks for hospitals.

Foremost is the potential for a denial of coverage from Medicare. Most hospital ORs rely on their joint replacement service line to drive revenue, so even limited problems with joint surgery payment could have a significant impact. And billing patients for denied services is not an option—if a hospital has not adequately communicated to a patient that a service will likely be denied, the hospital is financially liable.

In addition, if a recovery audit contractor identifies claims for joint replacement procedures that were inadequately documented, the hospital could be found liable for overpayments.

What is the scope of this issue? As noted above, although only some MACs have issued enhanced coverage indicators, the trend is heading in the direction of higher standards nationwide. And Medicare payment is not the only issue. Some private insurers have already put similar documentation requirements in place. Any change in national Medicare policy would likely drive further spread to the private payer market.

What to do

More stringent joint replacement documentation requirements represent a challenge for hospital ORs. Barbara McClenathan, MBA, MHA, BSN, RN, CNOR, a consultant with Surgical Directions, recommends that hospitals focus on incorporating new documentation requirements into preadmission testing (PAT) processes. “OR leaders should establish the policy that all the coverage indicators must be fulfilled and documented before the case can be put on the schedule,” she says.

PAT nurses should work closely with surgeons and surgeons’ office staff to ensure full documentation. “Making sure surgeons have completely documented medical necessity under these emerging guidelines can be difficult,” McClenathan said. “Depending on the jurisdiction, surgeons now need to be very specific about things like patient pain and functional disability.”

One hurdle is that the new requirements may run counter to a physician’s practice philosophy. “Some surgeons don’t think that all their patients need to go through interventions like physical therapy and weight loss,” McClenathan said.

For hospital ORs that are transitioning to more stringent joint replacement documentation standards, step one should be communication. Send a letter to orthopedic surgeons explaining your state’s regulatory situation and detailing new documentation standards. In addition, explain the OR’s policy of not scheduling cases without full preoperative documentation of medical necessity.

This can be a good opportunity to remind surgeons of CMS signature requirements. Compliance in this area is becoming increasingly important as the government looks for ways to cut improper Medicare payments.

McClenathan also recommends providing surgeons with tools to help them meet the new requirements. “At a Florida hospital, we developed a ‘tip sheet’ for surgeons to use when documenting knee and hip replacement patients,” she said. A well-designed worksheet (sidebar) can help guide clinical decision making and simplify the documentation process for surgeons.

Upside for ORs

One potential upside of the new joint replacement LCDs is that they offer hospital ORs the opportunity to improve care quality.
“The new documentation requirements are based on solid clinical evidence about how best to care for joint replacement patients,” McClenathan said. “For many ORs, these coverage indicators can serve as a starting point for creating stronger evidence-based care pathways for this patient population.”

This column is written by the perioperative services experts at Surgical Directions (www.surgicaldirections.com) to offer advice on how to grow revenue, control costs, and increase department profitability.

References


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