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Total knee arthroplasty (27447) removed from Inpatient only list – causing confusion

I January's newsletter I provided the information and link to the final ruling that CMS did regarding total knees. This has caused ongoing confusion for both the surgeons and facilities. I have been hearing from offices around the States that hospitals are not allowing them to schedule total knee arthroplasty as inpatients. Further information has been supplied by AAHKS (American Academy of Hips and knees Society) that does an excellent job of clarify. Here is that link

http://www.aahks.org/aahks-position-statement-removal-of-tka-from-inpatient-only-list/

"The final rule was a response to emerging evidence in non-Medicare patients that there appears to be a healthy cohort suitable for TKA in an outpatient setting; it was also a concession to the expressed interest on the part of some orthopaedic surgeons of extending this option to Medicare beneficiaries. Historically, the Medicare program covered knee replacement surgery only if it was performed on an inpatient basis. Through the final rule, CMS took a measured step towards allowing Medicare coverage for outpatient TKA surgeries by only allowing the procedure in outpatient facilities associated with a hospital. CMS did not allow the procedure to be moved to the free standing ambulatory surgery setting, indicating a desire to move slowly,

presumably to ensure safety during this proposed transition. The final rule was clear in stating CMS's expectation was that the great majority of TKAs would continue to be provided in an inpatient setting.
Unfortunately, the unintended consequence of this change has been an unprecedented amount of confusion on the part of a variety of stakeholders regarding how to interpret this new rule. Hospitals, surgeons, and payers are interpreting the rule from different perspectives and as such are each coming to very different conclusions. Further, there is no observed consistency in interpretation among hospitals and surgeons, yielding uncertainty about the freedom they have to prescribe the most clinically appropriate location for a patient's surgery. Of additional concern is the fact that many are reporting that Medicare Advantage plans are directing their networks to drive the majority of TKAs to outpatient status, despite clear evidence that that was not CMS's intent. This may be creating unsafe conditions for patients. As such, AAHKS offers this guidance to its members."

If you are getting push back from hospitals when scheduling, please pass this information on to them.

Physical Therapy Exceptions
The wait is over, and the Government has continued the therapy caps for 2018 but has also provided future year information also.

You will be able to use the KX modifier up to a $3,700 threshold, then will be subject to targeted review for therapy claims above that. What was passed recently states that the threshold will be lowered gradually over 5 years to $3,000, while the cap is gradually increased from this year's $2,010. This means the number of claims they can report KX on will steadily shrink between now and 2023.

In addition to 'fixing' this therapy cap and threshold issues, the government took it one step further and requested that by 2022, Medicare will start paying therapy assistants at 85% of the Part B physician fee schedule amount. This is like the 'incident to' that currently already exists when NPPs work incident to the physician. However, the different is that CMS must come up with a modifier for this issue by 2019. Specialty society APTA, is not happy about this decrease in reimbursement that is scheduled and will be working to try to get changes to this. You will want to follow their actions on their website http://www.apta.org/. The have a great article

titled "The post therapy cap system – 5 things you need to know" that you will want to read.

Essentially Congress had made a permanent fix for the therapy cap situation which will eliminate the need to try to fix it year after year. The current cap of $2010 will continue to be adjusted annually so you will want to watch for that amount yearly. But as indicated the threshold will be decreasing from the current $3700 to $3000 through 2027.

CMS stated: "Starting January 25, 2018, CMS will immediately release for processing held therapy claims with the KX modifier with dates of receipt beginning from January 1-10, 2018. Then, starting January 31, 2018, CMS will release for processing the held claims one day at a time based on the date the claim was received, i.e., on a first-in, first-out basis. At the same time, CMS will hold all newly received therapy claims with the KX modifier and implement a "rolling hold" of 20 days of claims to help minimize the number of claims requiring reprocessing and minimize the impact on beneficiaries if legislation regarding therapy caps is enacted. For example, on January 31, 2018, CMS will hold all therapy claims with the KX modifier received that day and release for processing the held claims received on January 11. Similarly, on February 1, CMS will hold all therapy claims with the KX modifier received that day and release for processing the held claims received on January 12, and so on.

Under current law, CMS may not pay electronic claims sooner than 14 calendar days (29 days for paper claims) after the date of receipt, but generally pays clean claims within 30 days of receipt." https://www.cms.gov/Center/Provider-Type/All-Fee-For-Service-Providers-Center.html

Anthem changes reduction policy
"Anthem has dropped its plan to reduce by 25 percent payments for certain evaluation and management codes. The policy was to have gone into effect on March 1 across the company's commercial health insurance businesses. The insurer made the policy change in response to strong opposition from the American Medical Association and other physician groups, the AMA said on Friday, the same day it heard from Anthem." For full details check out - http://www.healthcarefinancenews.com/news/anthem-rescinds-evaluation-and-management-reimbursement-policy-cut-payments?utm_source=Anthem+Rescinds+Payment+Reduction+Policy+on+E%2FM+with+Modifier+25&utm_campaign=Modifier+25+-+Rescinded&utm_medium=email

Passing of a Colleague
Many of you may know Harry Goldsmith, DPM who presented many times with me for DecisionHealth at the Advanced Ortho Symposiums over the years. Unfortunately, he passed away the first part of February. He will truly be missed. https://www.calpma.org/news-events/enewsroom/news-1/2018-news/january-february-2018/harry-goldsmith-dpm-a-man-for-all-seasons

If you have issues or concerns that you would like further input on, please feel free to send emails to info@margievaught.com. If you would like to schedule any audios or live presentations, please feel free to contact me.

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Upcoming Audios and Workshops 2018

March 13th, 2018 – Audio – ICD-10 Coding for Fractures – Sponsored by www.audioeducator.com

March 27th, 2018 – Audio – Fracture coding are you documenting and coding correctly? – Sponsor Decisionhealth – www.codingbooks.com

April 10th, 2018 – National AAPC – Orlando Florida – Breakout sessions on Spine and shoulder – sponsored by www.aapc.com **-** http://www.healthcon.com/

April 11th, 2018 – Audio – Hands, wrist and fingers surgical procedures and coding – sponsored by www.audioeducator.com

April 14-17th, 2018 – Annual AAOE – Orlando Florida - http://s4.goeshow.com/aaoe/annual/2018/registration_information.cfm

April 19th, 2018 – AmSurg New Orleans sponsored by AmSurg contact mblock@amsurg.com

May 9th, 2018 – Audio – Ankle/feet/toes understanding the procedures and coding – sponsored by www.audioeducator.com

June 20th, 2018 – Audio – Understanding shoulder procedures and coding – sponsored by www.audioeducator.com

July 11th, 2018 – Audio – Coding and documenting hip and knee procedures – sponsored by www.audioeducator.com