Cath Lab Digest
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A Product, News and Clinical Update for the Cardiac Catheterization Laboratory Specialist

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Coping With the Reimbursement Challenges of a Cath Lab

In this month's article, we welcome back Nicole Knight, Director of Revenue Cycle Solutions at MedAxiom. Nicole's expertise and experience regarding coding and billing are important in today's healthcare climate, as hospitals are faced with so many challenges and the uncertainty of what gets paid and under what conditions. We have posed questions to Nicole that are common in our discussions with cardiac cath lab programs and hope that this information will help shed a little more light on some of the challenges in the PCI setting.

— *Gary Clifton, Vice President, Terumo Business Edge*

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Nicole Knight

For the patient who is admitted as an outpatient (OP) for an elective percutaneous coronary intervention (PCI), does the hospital receive any additional reimbursement for the patient staying overnight? Many hospitals believe that they are placing the patient in observation for the balance of the OP stay (<24 hours) and that there is an associated reimbursement. Can you explain?

This is a great question and probably one of the more misunderstood aspects of managing the billing for OP PCI procedures. The elective patient who is admitted as an outpatient and undergoes a PCI is billed as a comprehensive APC (Medicare's Ambulatory Payment Classification), which basically means all costs associated with that procedure are billed and reimbursed under one APC. CPT (Current Procedural Terminology) code 92928 Elective Single Stent is paid out under APC 5193 at an estimated $9752.

It is important to note that an elective stent procedure is considered a minor surgical procedure. So when patients with known diagnoses enter a hospital for a specific minor surgical procedure or other treatment that is expected to keep them in the hospital for only a few hours (<24h), they are considered outpatients for coverage purposes, regardless of the hour they came to the hospital, whether they used a bed, and whether they remained in the hospital past midnight. Observation is considered not medically necessary or reasonable for standing orders for observation following an outpatient procedure. The patient would have to have a medically necessary reason or condition to support observation. The vast majority of elective PCIs will be reimbursed as an outpatient. Physicians need to decide whether to keep individual patients longer than 6 to 8 hours when there is genuine concern for their well being, but at a financial cost to the health system (the hospital expends resources to care for the patient but receives no additional reimbursement). If hospitals are routinely admitting outpatients overnight for elective procedures and subsequently billing them as inpatients, they may be exposed to RAC (Recovery Audit Contractor) audits.

It is important to note that the hospital may well be billing for "observation" when they keep their OP PCI patients overnight, but they are more than likely not receiving additional reimbursement.

What, if anything, is the hospital reimbursed if a patient who is an OP undergoes treatment for a vascular access complication and is required to spend extra time in the hospital?

It really does depend on the complication, comorbidities, and overall risk/condition of the patient. It may well support admission to observation or inpatient, based on the physician's decision. As we discussed in the previous question, outpatient procedures include a 4- to 6-hour recovery period that is not separately reimbursed. If, however, the outpatient procedure recovery exceeds 6 hours and does not meet inpatient or office-based surgery (OBS) requirements, the facility is not reimbursed for additional time or resources expended to care for the patient.

So, as it relates to this particular situation, it really does depend on which APC is being applied to the procedure, and whether or not the particular diagnostic or intervention is being utilized to assess and treat the complication. CMS defines a comprehensive APC to reimburse observation services for the provision of a primary service and all adjunct services provided to support the delivery of the primary service. The comprehensive APC would treat all individually reported codes as representing components of the comprehensive service, resulting in a single, prospective payment based on the cost of all individually reported codes on the claim that represent the delivery of a primary service, as well as all adjunct services provided to support that delivery. Centers for Medicare and Medicaid Services (CMS) further defines "adjunctive services" as any service that is integral, ancillary, supportive, and/or dependent to the primary service. Therefore, depending on what adjunctive service was necessary to diagnose or treat the complication, this determines whether the service is partially or fully reimbursed, or possibly not reimbursed at all.

If a patient has a vascular access complication and is discharged, and then is asked to come back to the physician's office the next day, is this reimbursed (can the physician bill for it)?

Vascular and PCI procedures have a 1 calendar day global reimbursement. If a patient is seen the next day, the physician would bill their professional services with the applicable E&M (evaluation and management) visit code and any diagnostics that may be performed. These services would be reimbursed.

How is an acute myocardial infarction (MI) reimbursed if the patient is admitted to the hospital at 4am today and is discharged the following afternoon or early evening (considering this is only 1-night stay)?

For 2018, an acute MI would be considered an inpatient-only procedure; therefore, the patient must be admitted as an inpatient and meet the requirements.

If a vascular surgeon is consulted on a vascular access complication that occurs as part of a cardiac catheterization, does he receive a consultation fee? What if he is employed by the hospital? Does the Medicare patient have a co-pay?

In this case, the vascular surgeon would bill for his E&M service and should be reimbursed. Medicare no longer recognizes/reimburses consult codes, so this would be billed with the appropriate E&M visit code, based on the place of service. Because the vascular surgeon is a different designated specialty, regardless of employment, he can bill for his service.

As to the patient's financial responsibility, if the patient has Medicare only and no secondary insurance, they could be subject to 20% coinsurance out of pocket.

How is patient satisfaction tracked for Medicare patients who receive OP procedures?

This is done through the hospital survey process — methods vary, but it is generally done electronically via the patient portal to meet quality and HCAPS (Hospital Consumer Assessment of Healthcare Providers and Systems) requirements.

Complications resulting from an endovascular procedure, e.g., a vascular access site complication that is realized while the patient is recovering outside of the procedure room (short stay, telemetry, ward, etc.) should be assigned back to the area where the procedure is performed or where the patient is recovering?

There are no specific billing guidelines as to site of recovery for the patient undergoing an outpatient procedure. If the patient has a complication and is not admitted, reimbursement would fall under the APC for the PCI procedure. In the case of a PCI, the APC is billed as having been done in the cath lab. However, if a patient has a complication that would require surgery and/or blood transfusion that may meet the inpatient requirements, the patient would be admitted as an inpatient and the facility would then be reimbursed under a diagnosis-related group (DRG). So, all services would be lumped into the highest acuity DRG. It is likely that if the complication requires a surgical intervention, then the appropriate DRG for the surgery will be the higher acuity payment and thus would

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override the APC that would have been utilized by the cath lab for the original PCI procedure. In this case, the cath lab would not receive the APC.

A patient is discharged home from an OP status after receiving a PCI, and subsequently experiences a vascular access site complication (bleeding, hematoma, pseudoaneurysm, etc.), and presents to the emergency department (ED) for treatment. Can the hospital be reimbursed for any treatment rendered? Does the situation change if the patient has originally been an inpatient?

For an outpatient, any treatment/testing in the ED would be billed and more than likely reimbursed.

If the patient was an inpatient and is readmitted, the facility may be subject to a readmission penalty. For inpatients, a hospital readmission happens when a patient is admitted to a hospital within a specified time after being discharged from an earlier initial hospitalization. For Medicare, this time is 30 days, and includes readmissions to any hospital, not just where the patient was originally hospitalized, and for any reason.

Conclusion

Gary Clifton, Vice President, Terumo Business Edge

We want to thank Nicole for sharing her expertise on these questions. Coding and billing questions are just one of the many areas that we can focus on with the help of our partner, MedAxiom Consulting. Together we have a wide range of experience and expertise to the common challenges facing cath lab programs. We are all about helping you optimize your operation, uncovering cost reduction opportunities and streamlining your care pathways. ■

Source

1. Medicare Claims Processing manual. Chapter 4 - Part B Hospital (Including Inpatient Hospital Part B and OPPS). Available online at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c04.pdf. Accessed November 15, 2017.