

The Movement to Outpatient Coronary Interventions

By Nicole Furl

The movement of Percutaneous Coronary Interventions (PCI) from the inpatient to outpatient case type has become somewhat of a hot topic in recent months. Corazon works with many hospital clients across the United States to analyze and understand their specific markets; to date, hospital volume data that details inpatient and outpatient procedures and market data in states that accurately report and track outpatient data does not yet support a widespread shift of PCI volumes from the inpatient to outpatient setting. Market data often lags, and in most states, outpatient data is not reliably and consistently reported. However, as we look to the future with eyes on ‘the cutting edge of care,’ we believe this movement will soon be evident as the result of several technology and regulatory trends.

The first trend for coronary interventions has been a progressive one. Advancing technologies, such as improved closure devices and better anticoagulation management strategies, have resulted in increased safety overall and decreased time between post-procedure care and discharge, ultimately decreasing the length-of-stay for PCI patients. This information, coupled with an increased confidence of physicians and caregivers in understanding the typical post-procedure course of care for elective PCI patients, has allowed some facilities to move a number of PCI cases to “outpatient” status.

Studies suggest that elective “low-risk” coronary interventions are safe, even when completing and billing as an outpatient procedure. However, this terminology can be misleading, because the procedure is classified as “outpatient” from a billing perspective only, not from a setting-of-care perspective. In Corazon’s experience, only a relative few patients are actually being discharged directly (within two-four hours) after the procedure.

Most PCI patients that classify as outpatients actually move to observation status; therefore, many of these so-called “outpatients” are staying overnight, though are discharged within 24 hours. In some hospitals, these patients move to an Observation Unit where the staff is focused on their care and rapid movement to discharge. In other hospitals, these observation status patients continue on to the traditional nursing floors, utilizing the same level of services as the inpatient PCI population.

It is Corazon’s experience that an Observation Unit provides a more focused approach to control costs, while still providing the best care for the patient. Imbedding observation patients in the traditional nursing unit where caregivers cannot differentiate and modify their approach to care can cost an organization **real** dollars. A rigorous approach to modifying nurse-to-patient ratios and assuring a streamlined path to discharge for the observation patient on the traditional telemetry unit should be hardwired. Employing distinct processes for each patient type can assure that the resources expended for observation patients are not the same as the resources used for a PCI patient that qualifies for an inpatient stay.

The movement of PCI cases to outpatient status may result in an increase in the inpatient length-of-stay as the one-day stays convert to outpatient status skewing the inpatient average upward. Payers are scrutinizing all one-day stay inpatient cases, and day denials are on the increase.

This payor scrutiny has its roots in changes to the InterQual admission criteria (McKesson) that dropped elective PCI cases from a list of procedures that qualify or are deemed appropriate for an inpatient setting of care. A similar scenario has occurred with Pacemakers and Implantable Cardioverter Defibrillator (ICD) implants, which likewise have been under increased review and subject to day-denials.

The magnitude of these changes should not be overlooked as Medicare Fiscal Intermediaries (FIs) utilize InterQual criteria to justify the patient admission, and typically a high percentage (usually greater than 50%) of cardiovascular patients are Medicare. This trend has left many cardiovascular service line administrators and case management personnel conflicted about what setting of care is best for the PCI patient **and** the hospital’s bottom line.

As detailed in Figure 1, a Medicare PCI patient billed as an outpatient is generally reimbursed between 28 - 38% LESS than one billed as an inpatient. Based on this difference in setting-of-care, the resultant difference in payment, and in consideration of the current reimbursement climate, this and other such changes will no doubt greatly affect PCI programs—especially those already currently struggling financially or operationally.

Figure 1:

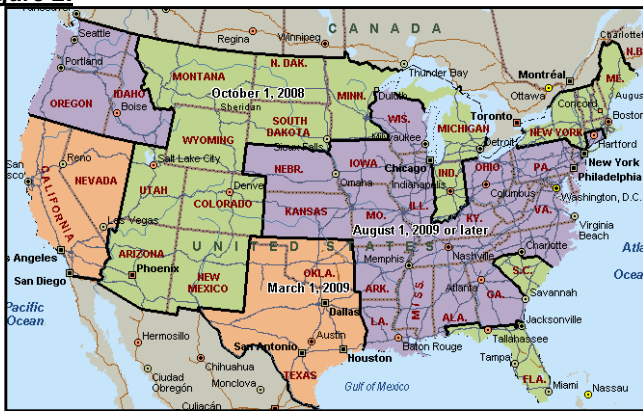
PCI with Drug Eluting Stent		PCI with Non-Drug Eluting Stent	
Inpatient (MS-DRG)		Inpatient (MS-DRG)	
247 PCI w/DES w/o MCC	\$10,620	249 PCI w/non-DES w/o MCC	\$9,104
Outpatient (APC)		Outpatient (APC)	
656 Coronary Angioplasty with DES	\$7,669	104 Coronary Angioplasty with Stent	\$5,638
Medicare Reimbursement Difference		Medicare Reimbursement Difference	
	-28%		-38%

The next trend affecting PCI care came with the creation and implementation of the Recovery Audit Contractors (RACs), which started as a demonstration project in six states (California, Florida, New York, Arizona, South Carolina, and Massachusetts). This now permanent program is expected to be implemented in all 50 states by 2010. RACs—outsourced agencies whose overarching goal is to safeguard the Medicare program—identify and investigate over- and under-payments to providers from Medicare. By identifying improper payments, these RACs are paid a contingency based on a percentage of total improper payments.

An easy means to identify so-called improper payments has been for the audit contractors to focus on and scrutinize one-day stays within a hospital. During audits, RACs may deem these as a medically unnecessary service or inappropriate care setting. Admission for one-day in-hospital stays are difficult for providers to justify, thus lessening the likelihood of successful appeal. This is a major issue for the cardiovascular service line because the majority of one-day stays are cardiac in nature. This scrutiny over one-day stays and the resultant focus on the cardiovascular service line has further pushed PCI to an outpatient setting.

In response to this trend, some organizations have taken a more reactive approach, moving to automatic outpatient billing of one-day stays for coronary interventions. A loss in revenue results from this type of classification, however, because the organization would otherwise have gained a higher payment for those cases that did qualify for the inpatient one-day stay.

Figure 2:



This map illustrates when the RAC roll-out is to occur across the nation. Green states will be audited after October 2008, orange states after March 2009, and purple states after August 2009.

So how do organizations find equilibrium between what to classify (and bill) as inpatient versus outpatient? How can an organization meet the challenges and overcome the barriers that accompany the changes in industry trends? Corazon advises taking a proactive approach, including some or all of the below recommendations:

1. Have full understanding of the Recovery Audit Contractor process and diligently prepare for future audits.
 - o Know the contractor assigned to your state
 - o Be alerted as to when your organization gets the audit notice
 - o Understand the timeframe of claims that can be reviewed
 - o Submit requested medical records 100% of the time
 - o Monitor the status of your claims online
 - o Know the different levels of appeals and develop a sound appeal process; Consider meeting with legal advisors around possible arguments to plead your case
2. Monitor and justify one-day stays
 - o Build reporting to assist with the monitoring of your department's one-day stays
 - o Develop organizational-specific admission criteria to justify one-day stays; use a multi-disciplinary team including key physician stakeholders that focuses on both patient severity and procedure type
 - o Build educational and documentation tools based on developed criteria
 - o Ensure case management's involvement in the patient status decision-making process
 - o Consider implementing a bill hold to ensure criteria is met prior to billing inpatient one-day stays
 - o Follow-up with relevant staff / physicians to ensure documentation exists to justify the episode of care
3. Continue to monitor and manage operational costs
 - o Develop reporting to monitor procedure duration, stent usage, stent costs, etc.
 - o Collect and analyze post-department / physician-specific benchmark data
 - o Ensure adequate cost benefit from the use of technology to decrease post-operative care time
 - o Investigate cost-saving initiatives such as an observation overnight unit to accommodate these patient types; Rooms should be smaller and utilize a lower nurse-to-patient ratio (when compared to an inpatient unit)

These strategies can assist your organization in being prepared for changes related to care-settings and patient-classifications for PCI procedures. As payors and national agencies further evaluate the impact of these recent decisions on the clinical, operational, and financial viability of PCI programs, Corazon believes that all organizations must make setting-of-care decisions that will provide best-practice care, regardless of the impact on reimbursement. Using sound criteria for one or the other classification will ensure that ALL PCI cases—both inpatient and outpatient—will receive the appropriate treatment with the best chance for success.



Nicole is a Consultant at Corazon, a recognized leader in strategic heart and vascular program development, assisting clients through the **full spectrum** of cardiovascular consulting and recruitment services from feasibility studies and business planning through clinical readiness and all facets of a successful implementation, including executive and physician search.

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