REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 1-I-14

Subject: Hospital Admissions and Patient Management Contractors

Presented by: Jack McIntyre, MD, Chair

Referred to: Reference Committee J
(Melissa J. Garretson, MD, Chair)

At the 2013 Interim Meeting, the House of Delegates adopted Policy D-320.989, "Inappropriate Interference with Hospital Admissions by Patient Management Contractors," which states:

> That our American Medical Association (AMA) will study whether contracted patient management personnel are inappropriately making medical management decisions about hospital admissions outside of an established physician-patient relationship and without being duly licensed and privileged to do so, and make recommendations for new policy to address this issue.

This report provides background on Medicare hospital admissions policy and utilization review of inpatient admissions; discusses AMA advocacy on these issues; summarizes relevant AMA policy; and presents policy recommendations.

BACKGROUND

Resolution Policy D-320.989 responds to reports of out-of-state utilization management (UM) firms changing the admissions status of hospital patients and, in so doing, overriding the medical judgment and decision-making authority of treating physicians. The testimony specifically addresses UM-employed physician and non-physician reviewers who overrule direct referrals for inpatient care by assigning these patients to observation status. The testimony also noted that admissions reviewers employed by out-of-state UM firms are typically not licensed to practice medicine in states where they are making medical necessity determinations.

While the distinction between admissions classified as inpatient and observation is not always clear-cut, it greatly impacts Medicare patients' coverage and cost-sharing. Hospital inpatients receiving Part A benefits are also entitled to post-hospital skilled nursing facility (SNF) coverage after three consecutive hospital inpatient days. Patients assigned to observation status receive Part B benefits, which generally pay less and generate higher cost-sharing while providing no coverage for subsequent SNF care.

Hospital admission decisions are complex medical judgments made "only after the physician has considered a number of factors, including the patient's medical history and current medical needs, the types of facilities available to inpatients and to outpatients, the hospital's bylaws and admissions policies and the relative appropriateness of treatment in each setting."[1] The severity of patients' conditions and the likelihood of adverse events also influence the admissions determinations of physicians. The Medicare Benefit Policy Manual states unequivocally that "the

physician or other practitioner responsible for a patient's care at the hospital is also responsible for deciding whether the patient should be admitted as an inpatient."[2]

INPATIENT VERSUS OBSERVATION STATUS

An inpatient is defined in the Medicare Benefit Policy Manual as:

> …a person who has been admitted to a hospital for bed occupancy for purposes of receiving inpatient hospital services. Generally, a patient is considered an inpatient if formally admitted as inpatient with the expectation that he or she will remain at least overnight and occupy a bed even though it later develops that the patient can be discharged or transferred to another hospital and not actually use a hospital bed overnight.[3]

Observation care is described as:

> …a well-defined set of specific, clinically appropriate services, which include ongoing short term treatment, assessment, and reassessment before a decision can be made regarding whether patients will require further treatment as hospital inpatients or if they are able to be discharged from the hospital. Observation services are commonly ordered for patients who present to the emergency department and who then require a significant period of treatment or monitoring in order to make a decision concerning their admission or discharge.[4]

In 2013, the Centers for Medicare & Medicaid Services (CMS) issued the so-called "two-midnight rule" which instructed recovery audit contractors (RACs) to "presume that hospital inpatient admissions are reasonable and necessary for patients who require more than one Medicare utilization day (defined by encounters spanning two midnights) in the hospital receiving medically necessary services after inpatient admission."[5] Stays spanning less than two midnights will generally be considered outpatient and therefore paid for by Medicare Part B.[6] As part of the two-midnight rule, CMS issued guidance on the requirements for physician certification as well as documentation in the medical record that is needed to substantiate reasonable, necessary and appropriate inpatient services.

MEDICAL NECESSITY REVIEWS

In 2005, CMS began implementing the RAC program to identify improper Medicare payments to physicians, hospitals and other providers. Because they operate under contingency fee compensation arrangements, the RACs benefit financially by carrying out aggressive audits. When RACs purport to uncover improper inpatient admissions, CMS recoups Medicare Part A payments for patients' hospital care and the RACs earn a percentage of each recoupment. Reclassifying hospital inpatients to observation status has been lucrative for the RACs aggressively pursuing denials of medical necessity claims for short inpatient stays. Consequently, hospital UM staff stepped up in-house monitoring of inpatient admissions to avoid being penalized for inappropriate admissions.

Under hospital Conditions of Participation, a hospital's utilization review (UR) committee can conduct medical necessity reviews before, at the time of or after hospital admissions. Hospitals must follow requirements outlined in the Medicare Claims Processing Manual, which states that UR determinations of improper inpatient admissions should occur infrequently, such as late at night on weekends when case managers are not available to offer guidance.[7] CMS' State Operations Manual prohibits non-physicians from making final determinations about the medical necessity of a patient's stay; however, hospitals are expected to use case managers "to facilitate the

application of hospital admission protocols and criteria, to facilitate communication between practitioners and the UR committee or Quality Improvement Organization, and to assist the UR committee in the decision-making process."[8]

Many hospitals have in-house UR/UM departments; however, outside firms are frequently hired to implement UR plans and help screen patients for inpatient admissions. These contractors typically employ the same automated screening tools as the RACs and are adept at using proprietary criteria to flag questionable inpatient admissions. Many also employ physicians from a variety of specialties to conduct second tier admission reviews. Unless the firm is local or contracts with physicians in that state, UR/UM physician reviewers are typically not licensed in the states where the firm provides services.

RELEVANT AMA POLICY

Council on Medical Service 4-A-14 specifically addressed observation status and directed the AMA to continue advocating that CMS explore payment solutions to reduce the inappropriate use of hospital observation status (Policy D-280.989[2]). AMA policy maintains that it is the physician's responsibility to determine the medical necessity for hospital inpatient admissions (Policies H-225.997[9] and H-285.954). Level of care guidelines must also allow for appropriate physician autonomy to make responsible medical decisions (Policy H-285.920). Policy H-320.965 states that admissions should be made only by an MD or DO licensed in the same jurisdiction as the treating physician.

"Screening" and "medical necessity" are defined in Policy H-320.953, while emerging trends and physician leadership in UM programs are addressed in Policies H-320.958 and H-320.993. Constituent medical associations are urged by Policy H-320.973 to seek legislation requiring that UR be conducted by physicians licensed by the state in which they are doing the review, and that UR contractors be registered with the appropriate state regulatory agency and have an appropriately staffed office in the state.

Guidelines for preadmission reviews are laid out in Policy H-320.982. Retrospective denials of payments for medical services are addressed by Policies D-320.995, D-330.921 and H-320.948. Policies D-330.943, D-330.921 and D-320.991 also focus on RAC reviews.

AMA ADVOCACY

The AMA has articulated its concerns about payment denials based on medical necessity as well as retroactive patient status changes. In conversations with administration officials and in numerous letters to CMS, the AMA has repeatedly requested that CMS develop hospital admissions policy that addresses these issues and our concerns regarding the increased use of observation care. The AMA has repeatedly proposed that CMS convene affected stakeholders, including physicians, patients and hospitals, and come up with comprehensive solutions. In addition, the AMA has asked CMS to:

- Revise its policy regarding changes to a patient's admission status to require the concurrence of the admitting or treating physician;
- Preclude Medicare contract recoupment from physicians where there are admission status discrepancies between hospital and physician claims;
- Preclude hospital changes to patients' admission status as well as claim denials that do not

have the concurrence of a practicing physician in the same specialty as the admitting or treating physician; and

- Require meaningful physician input into the development of claims edit software.

The AMA also submitted comments to CMS outlining our many concerns with the two-midnight rule, and its onerous requirements for documenting the medical necessity of inpatient admissions. Although this rule has not been repealed, its enforcement has been delayed until at least March 2015 (PL 113-93). In the interim, RAC post-payment reviews of hospital admission claims have been suspended.

The AMA opposes the RAC program's contingency fee structure and has advocated for numerous changes that would reduce the program's burden on physicians. As a result of ongoing AMA advocacy, CMS recently announced improvements to the new RAC contracts, including withholding contingency payments to RACs until second level appeals are exhausted.

AMA model legislation ("Appropriate Use of Preauthorization Act") recommends that UR entities ensure that all adverse determinations are made by physicians who are licensed by the state and also board certified or eligible to practice in the same specialty as the treating physician. Federal legislation (HR 1250; S 1012) intended to rein in the RACs would also require physician review of payment denials based on medical necessity that were made by contractor employees who are not physicians. Earlier this year, the AMA filed an amicus brief in the appeal of *Bagnall v. Sebelius*, a case seeking redress on behalf of Medicare patients who did not meet the requirements for post-hospital SNF care because they were assigned to observation care while hospitalized.

DISCUSSION

The Council shares the concerns raised in Policy D-320.989 regarding out-of-state UM contractors overruling physician-initiated hospital admissions by changing the status of patients from inpatient to observation. The Council also recognizes that UM firms are hired to protect hospitals from financial risk associated with adverse RAC decisions. The Council, therefore, recommends that our AMA continue working with state medical associations to monitor UM policy to ensure that hospital admissions are reviewed by appropriately qualified physicians.

As the health care environment has evolved, many UR/UM firms have grown into sizeable entities whose operations span multiple states. Ideally, physicians employed or under contract with UR/UM firms would be licensed to practice medicine in each state where they provide services. The Council understands that this expectation may be perceived as burdensome for some contracting firms. The Council believes that individuals employed by or under contract to provide UR/UM patient status reviews are engaged in the practice of medicine and, as such, should maintain a license to practice medicine. Accordingly, the Council recommends reaffirmation of Policies H-320.973, H-320.965, D-330.921 and H-320.982. The Council also recommends rescinding Policy D-320.989, which calls for the study accomplished with this report

RECOMMENDATIONS

The Council recommends that the following be adopted, and that the remainder of the report be filed:

1. That our American Medical Association (AMA) continue to work with state medical associations to monitor utilization management policy to ensure that hospital admissions are

reviewed by appropriately qualified physicians and promote related AMA model legislation. (Directive to Take Action)

2. That our AMA reaffirm Policy H-320.973, which urges states to seek legislation requiring that utilization review for insurers be conducted by physicians licensed by the state in which they are doing the review, and also require utilization review organizations to have appropriately staffed offices and be registered with state health regulatory agencies in states where they are providing services. (Reaffirm HOD Policy)

3. That our AMA reaffirm Policy H-320.965, which maintains that the determination of the medical necessity for hospital admission should be made only by a doctor of medicine or a doctor of osteopathy licensed in the same jurisdiction as the treating physician. (Reaffirm HOD Policy)

4. That our AMA reaffirm Policy D-330.921, which directs the AMA to work with the Centers for Medicare & Medicaid Services and other stakeholders to address reclassifications of hospital admissions and make sure a process is in place allowing physicians to substitute their medical judgment for that of software screening programs. (Reaffirm HOD Policy)

5. That our AMA reaffirm Policy H-320.982, which upholds principles for preadmission reviews of hospital admissions, including that reviews should be performed by physicians or under close supervision of physicians; adverse decisions concerning hospital admissions should be finalized only by physician reviewers; and preadmission review programs should provide for immediate hospitalization of any patient whose treating physician determines the admission is an emergency. (Reaffirm HOD Policy)

6. That our AMA rescind Policy D-320.989. (Rescind HOD Policy)

Fiscal Note: Less than $500.

REFERENCES

[1] U.S. Department of Health and Human Services: Centers for Medicare & Medicaid Services. Medicare Benefit Policy Manual: Chapter 6–Hospital Services Covered Under Part B. Revised March 21, 2014.
[2] Ibid.
[3] U.S. Department of Health and Human Services: Centers for Medicare & Medicaid Services. Medicare Benefit Policy Manual: Chapter 1–Inpatient Hospital Services Covered Under Part A. Revised January 14, 2014.
[4] U.S. Department of Health and Human Services: Centers for Medicare & Medicaid Services. Medicare Benefit Policy Manual: Chapter 6–Hospital Services Covered Under Part B. Revised March 21, 2014.
[5] U.S. Department of Health and Human Services: Centers for Medicare and Medicaid Services. Medicare Program: Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Fiscal Year 2014 Rates; Quality Reporting Requirements for Specific Providers; Hospital Conditions of Participation; Payment Policies Related to Patient Status. Federal Register 2013; 78:160:50746.
[6] Ibid.
[7] U.S. Department of Health and Human Services: Centers for Medicare & Medicaid Services. Medicare Claims Processing Manual, Chapter 1–General Billing Requirements. Revised February 7, 2014.
[8] U.S. Department of Health and Human Services: Centers for Medicare & Medicaid Services. State Operations Manual Appendix A–Survey Protocol, Regulations and Interpretive Guidelines for Hospitals. Revised March 21, 2014.