EHR Client Bulletin:

CMS Proposes Updates to Inpatient Admission and Medical Review Criteria

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On April 26, 2013, the Centers for Medicare & Medicaid Services (CMS) issued Proposed Rule CMS-1599-P, “Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Proposed Fiscal Year 2014 Rates; Quality Reporting Requirements for Specific Providers; Hospital Conditions of Participation.”

This Proposed Rule seeks to make numerous updates to the Inpatient Prospective Payment System (IPPS) for Fiscal Year 2014, including:

- A revision of the Medicare IPPS for operating and capital-related costs of acute care hospitals;
- The implementation of certain statutory provisions contained in the Patient Protection and Affordable Care Act and other legislation;
- Updates to the rate of increase limits for certain hospitals excluded from the IPPS;
- Updates to the payment policies and annual payment rates for the Medicare PPS for inpatient hospital services provided by long-term care hospitals;
- Changes relating to direct graduate medical education and indirect medical education payments;
- New or revised requirements for quality reporting by specific providers that are participating in Medicare;
- Updates to policies relating to the Hospital Value-Based Purchasing (VBP) Program and the Hospital Readmissions Reduction Program (HRRP);
- A revision of the Conditions of Participation (CoPs) for hospitals relating to the administration of vaccines by nursing staff, as well as the CoPs for critical access hospitals relating to the provision of acute care inpatient services; and
- An update to admission and medical review criteria for hospital inpatient services under Medicare Part A.

As your hospital’s medical necessity compliance partner, our team is focusing on how the proposed updates to admission and medical review criteria might impact the provider community and beneficiaries.

Overview of Proposed Updates to Admission and Medical Review Criteria

In a section entitled “Policy Proposal on Admission and Medical Review Criteria for Hospital Inpatient Services under Medicare Part A” (pages 657-681 of the Proposed Rule), CMS proposes certain clarifications of the requirements for reimbursement of inpatient hospital services under Medicare Part A.

Specifically, CMS proposes “a time-based presumption of medical necessity for hospital inpatient services based on the beneficiary’s length of stay, as part of our medical review criteria for payment of hospital inpatient services under Part A.” CMS cites the increasing utilization of outpatient observation services, the resultant effects on beneficiary liability, a purported high rate of improper payments for inpatient hospital short stays, and the call for clearer inpatient criteria from the provider community as the driving forces behind this potential shift.
The following provides a summary of the most substantial components of the proposed updates:

- **2-Midnight Threshold**: In the past, CMS has provided guidance that the expectation of a hospital stay of 24 hours or greater was one of the elements to consider when evaluating a potential admission. CMS now proposes changing the 24-hour benchmark to a 2-midnight threshold, under which “a physician or other practitioner should order admission if he or she expects that the beneficiary’s length of stay will exceed a 2-midnight threshold or if the beneficiary requires a procedure specified as inpatient-only under 42 CFR 419.22.”

CMS suggests that, for the purposes of this time-based standard, the inpatient admission would begin when the patient “is moved from any outpatient area to a bed in the hospital in which the additional hospital services will be provided.” CMS further proposes that an inpatient stay spanning at least 2 midnights would create a presumption, for the purpose of claim review, that inpatient care was medically necessary.

This represents a shift in Medicare direction, as the existing 24-hour benchmark creates no such presumption. In other respects, however, the proposed threshold is not a major departure from existing CMS guidance, which emphasizes the 24-48 hours after a patient arrives in the hospital as the critical period during which admission decisions will generally be made. The Proposed Rule does also acknowledge that there may well be valid exceptions to the length of stay-based presumption.

- **Physician Orders**: CMS proposes to clarify that a physician order for inpatient admission must be present in the medical record in order for the hospital to be reimbursed for inpatient services under Part A. CMS reiterates its position that while a patient is considered an inpatient upon issuance of an admission order by the treating physician, the order is to be given no presumptive weight. Rather, it is to be considered in the “context of the evidence in the medical record.”

- **Physician Documentation**: Although meeting the proposed 2-midnight threshold would create a presumption that inpatient care is medically necessary, CMS stresses that physician documentation must “clearly and completely” justify the decision to admit. The admitting physician must still weigh the totality of the patient’s circumstances, because “[i]t is the documentation of the reasonable basis for the expectation of a stay crossing 2 midnights that would justify the medical necessity of the inpatient admission, regardless of the actual duration of the hospital stay and whether it ultimately crosses 2 midnights.” Therefore, admission reviews should continue to play an important role in ensuring that hospitals remain compliant with CMS guidelines.

- **Medical Review Criteria**: Because the proposed threshold would create a presumption that inpatient care was warranted for admissions spanning at least 2 midnights, CMS proposes that Medicare contractors focus their medical reviews on those inpatient claims that fail to meet this threshold (i.e. inpatient stays that span 1 midnight or less).

This does not represent a significant shift in claims review strategy, as Medicare review contractors are already focusing much of their efforts on inpatient hospital short stays. However, under the Proposed Rule, reviews of such claims would consider whether the patient’s complex medical factors, such as past medical history and co-morbidities, “support a reasonable expectation of the needed duration of the stay relative to the 2-midnight threshold.” So for inpatient stays resulting in less than 2 midnights, the Proposed Rule states “if it was reasonable for the physician to expect the beneficiary to require a stay lasting 2 midnights, even though that did not transpire,
payment would be made under Medicare Part A if the documentation in the medical record reflected such complex medical factors (and the physician’s order and certification requirements also are met).” For inpatient stays of 2 midnights or longer, medical reviews “would focus on undue delays in the provision of care in an attempt to meet the 2-midnight threshold (that is, inpatient hospital admissions where medically necessary treatment was not provided on a continuous basis throughout the hospital stay and the services could have been furnished in a shorter timeframe). Beneficiaries should not be held in the hospital absent medically necessary care for the purpose of meeting the 2-midnight presumption.”

**Some Initial Considerations for Comment**

Providers have advocated for clearer guidance from CMS surrounding inpatient and outpatient observation, and it is clear that CMS is seeking to address this feedback through particular sections of the Proposed Rule. Upon our initial evaluation of these proposed changes, however, a few important issues arise. Taken together, these indicate that CMS is giving greater weight to easily defined technicalities (existence of an order, 2-midnight stay) rather than the factors which truly impact the quality of patient care (patient acuity and risk; complexity of care required and delivered). This focus on simplistic, technical parameters seems driven more by a desire to simplify a review process than to achieve the best outcome for beneficiaries and providers. Some specific areas of concern:

**Orders:**

Historically, the inclusion of a physician’s inpatient admission order in the medical record was considered a “best practice,” and the lack of such an order could be overcome in the claim review process by clear documentation of the physician’s intent that the patient be admitted and treated as an inpatient. However, CMS now proposes that an inpatient admission order be a condition for payment of a claim under Part A. In other words, even if the medical record fully documents the physician’s intention and it is clear that the patient required and received services that could only be provided in the inpatient setting, the hospital’s Medicare Administrative Contractor (MAC) could still issue a technical denial for lack of an inpatient order.

This proposed change is a significant departure from current Medicare policy and has the potential to cause a number of problems if implemented. Of primary concern is the possibility that an absolute requirement for an inpatient order for payment under Part A may encourage providers to essentially “default” their patients to inpatient status and issue inpatient admission orders inappropriately as a means of safeguarding against technical claim denials. However, such practices would be highly problematic and may very well constitute fraud. In any case it is unclear how requiring a physician order for inpatient admission furthers CMS’s stated goals of ensuring that patients receive necessary care in the appropriate setting.

**2-Midnight Threshold:**

While the “presumption” related to a 2-midnight threshold stay appears to give new emphasis to time, in fact it is an evolution of positions previously articulated by CMS. Medicare inpatient admission decision-making guidance has evolved from the expectation of an overnight stay using 24 hours as a benchmark period, to a 24 hour minimum period, now to drawing a line at two midnights. The proposed rule does appear to elevate time from being one of the factors, but not the sole factor in determining proper patient status, to being the most important factor. However, while the Medicare Benefit Policy Manual includes time as a criterion in determining when a patient should be formally admitted, it expressly states that admissions “are not covered or non-covered solely on the basis of the length of time the patient actually spends in the hospital.”
CMS has good reasons for requiring consideration of multiple factors in the admission decision. Even if the “2-midnight” presumption were to suggest a “bright line” interpretation, CMS has already acknowledged several exceptions. Patients who die within the initial days of their stays may still be considered inpatients, as well as those who require transfer to another facility. We would suggest that patients who are discharged “against medical advice” also be added to this list. The last exception granted in the proposed language includes patients undergoing procedures on the CMS “inpatient only procedures list”.

Each year CMS publishes the “inpatient only procedures list” to define a group of procedures that on the basis of quality and safety considerations may only be performed in an inpatient setting. Some of the procedures on the list have very short lengths of stay. For example, carotid stents remain on this list, and therefore due to quality and safety considerations may only be performed in an inpatient setting, yet the geometric mean length of stay for these procedures is approximately one day. Although it is appropriate for CMS to continue to recognize procedures on this list to be inpatients, even if they do not remain in the hospital for two midnights, it would be inappropriate for CMS to consider this list to be exhaustive. Many procedures are similar in risk for many or most Medicare beneficiaries, but not for all Medicare beneficiaries. Treatments and procedures for these patients would not be on the list, but at the same time it should not be considered safe or high quality care delivery to provide these services to beneficiaries in an outpatient setting, simply on the basis of “time” or length of stay.

Superficially, 1599-P appears to establish a bright-line for determining when a patient is appropriate or inappropriate for admission; in practice, however, CMS continues to emphasize that providers must demonstrate, and scrupulously document in the medical record, that the patient adhered to all the admission factors currently outlined in the Medicare Benefit Policy Manual. We believe this re-emphasis on all of the factors indicates that CMS understands that a simplistic use of time to define appropriate admissions is ineffective and impractical.

Error Rates:
In the Proposed Rule, CMS asserts a high error rate for short stay cases. The EHR white paper on Program Integrity, submitted to the Senate Finance Committee in June 2012, pointed out the many methodological concerns regarding the CERT error rate calculations (insufficient sample size, no consideration of denied cases which are overturned on appeal, lack of a clear standard for definition of an error) which call into significant question the accuracy of the error rate calculations. We continue to maintain that these factors lead CMS to overstate the error rates on these cases. EHR’s high level of success overturning denials on appeal further supports the validity of providers’ positions on these cases.

Potential Impact on Providers and Beneficiaries

Clearly, CMS’s proposed changes to its inpatient admission criteria have the potential to significantly impact Medicare-participating hospitals. The 2-midnight threshold for inpatient hospital stays will have the effect of inflating the average length of stay for inpatient DRGs, because most inpatient stays of less than two midnights will no longer be captured by the DRG. Rather than acknowledge and adjust for this, 1599-P does the opposite; it lowers the DRG payment rate to reflect an actuarial assumption of an increase in inpatient stays. EHR is concerned that the CMS actuarial analysis may underestimate the negative financial impact on providers. As such, EHR is performing a data analysis to evaluate the potential impact on hospitals and we encourage our hospital clients to do the same. Even if the CMS assumptions prove to be accurate (which is difficult to assess given the lack of detail provided in the Rule), this change essentially amounts to a unilateral renegotiation of DRG payments by CMS, as current DRG payments do not account for the hospital’s increased costs in caring for patients over greater periods of time.
Furthermore, the Proposed Rule, while purportedly seeking to streamline the process of making patient status determinations, is unlikely to have any mitigating effect on the current atmosphere of redundant audits and rampant inappropriate denials. Because the proposed inpatient admission criteria would simply shift the emphasis from an expectation of a 24-hour hospital stay to an expectation of a 2-midnight stay—rather than give appropriate weight to clinical complexity and physician judgment—we expect current audit and denial rates to continue unabated.

Importantly, in addition to the significant impacts that the Proposed Rule will have on hospitals, the proposed changes have the potential to greatly impact Medicare beneficiaries, as well. As discussed above, application of a bright-line, time-based rule introduces the potential risk of negatively impacting the setting and delivery of appropriate patient care. In addition, because beneficiaries pay a single Part A deductible when admitted as inpatients, as opposed to a copayment for each outpatient service under Part B, they generally face lesser financial liability when treated as inpatients. However, by shifting the threshold for an inpatient admission from 24 hours to 2-midnights (which could amount to as much as 71 hours), beneficiaries may find themselves being treated as outpatients more often and therefore shouldering greater out-of-pocket costs.

**Next Steps For Hospital Providers**

While CMS-1599-P remains a proposal, providers should continue to follow existing CMS procedures and guidance regarding inpatient admission decision-making and billing. Furthermore, the Proposed Rule does not appear to alter the existing requirements for Utilization Review under the Conditions of Participation for hospitals (located at 42 CFR §482.30). Therefore, whether the Proposed Rule is finalized in its current form or not, it remains incumbent upon hospitals to take the necessary steps to ensure that they “get it right” in real-time when making patient status determinations.

The required 60-day comment period related to Proposed Rule CMS-1599-P will expire at 5:00 p.m. EDT on Tuesday, June 25, 2013. EHR plans to submit comments focused on some of the outstanding questions related to the Proposed Rule, and we strongly encourage our clients to share their comments on the Proposed Rule with CMS, as well. Our team will continue to share updates and recommendations related to this Rule with all of our hospital clients. If you have questions related to the Proposed Rule, please contact your Director of Strategic Accounts.