ACP American College of Physicians
INTERNAL MEDICINE | *Doctors for Adults*

June 24, 2013

Marilyn B. Tavenner
Administrator
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
Hubert H. Humphrey Building, Room 445-G
200 Independence Avenue, SW
Washington, DC 20201

Re: 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 (CMS-1599-P)

Dear Administrator Tavenner:

The American College of Physicians (ACP) appreciates this opportunity to comment on the above referenced Hospital Inpatient proposed rule--our comments only focus on section V. N of the rule pertaining to "Policy Proposal on Admission and Medical Review Criteria for Hospital Inpatient Services under Medicare Part A." The ACP is the largest medical specialty society and second largest physician membership organization in the United States, representing 133,000 internal medicine physicians who specialize in primary and comprehensive care of adolescents and adults and medical students who are considering a career in internal medicine.

The College commends CMS for its recent and current efforts to address the problematic increased frequency of beneficiaries in hospital settings being categorized as outpatients receiving observation services rather than regular inpatient admissions, and to address the related issue of providing improved clarification in criteria used in determining the appropriateness of an inpatient admission. We believe that CMS' recent administrative ruling and related proposed rule [1] (once finalized) regarding "Part B Inpatient Billing" will lessen the need for hospitals to inappropriately use observation status to protect themselves from potential inpatient denials. The above referenced current proposed rule goes one step further; it provides significant clarification for hospitals --- and particularly the admitting physician --- regarding when CMS contracted auditors will presume a short term inpatient admission to be reasonable and necessary.

It is our understanding that under this propose rule, an inpatient admission would be justified that includes: an admission order by a physician (or other authorized licensed practitioner granted such privileges by the state); appropriate medical documentation required under longstanding hospital conditions of participation (COP) requirements, and the inclusion of documentation for a reasonable basis for the expectation of a stay of at least one Medicare utilization day (a stay that crosses two midnights). Furthermore, under this proposed rule, Medicare external contractors conducting hospital inpatient admission audits would "presume"

[1] Medicare Program; Part B Inpatient Billing in Hospitals; Proposed Rule (CMS-1455-P)

that hospital inpatient admissions are reasonable and necessary for beneficiaries who require more than one Medicare utilization day within the inpatient setting. This presumption would only be disregarded if the hospital is found to be systematically delaying the provision of care to pass this utilization requirement.

As mentioned above, the College believes that this clarification is helpful and will have the effect of decreasing the need of inpatient hospital facilities to inappropriately use the observation status category. The College furthermore offers the following additional recommendations regarding the issues of observation status and inpatient admission criteria:

- The College agrees with the statement in the Medicare Benefit Policy Manual "that the decision to admit a patient is a complex medical judgment which can be made only after the physician has considered a number of factors." [2] The further guidance offered in rather vague terms (e.g., the patient's history and current medical needs; the severity of signs and symptoms exhibited; the medical predictability of something adverse happening) with minimal operational reference, which makes it difficult for the physician to be assured that the admission meets clinical Medicare reasonable and necessary criteria. While the addition of a "length of time" benchmark certainly helps to clarify inpatient admission criteria, we further recommend **continued efforts to provide increased clarity to the clinical factors (criteria) that support a reasonable and necessary inpatient admission.** One way to accomplish this would be to use the large number of evidence based guidelines covering a variety of conditions frequently encountered in the hospitalization decision-making process (e.g., chest pain, heart failure, chronic obstructive pulmonary disease) offered through the Agency for Healthcare Research and Quality (AHRQ) National Guidelines Clearinghouse (http://guideline.gov/browse/by-topic.aspx) and other sources (e.g., the various medical specialty societies). It is essential that CMS be clear and transparent in their admission coverage criteria. The process of incorporating these guidelines within the admission criteria, and any other efforts to clarify these criteria, should include participation of the medical community.
- The proposed rule highlights the importance of the physician's judgment (or other authorized licensed practitioner granted such privileges by the state) in making the "complex" decision regarding the need for inpatient care. Despite this recognition, denials of such admissions are made by the Medicare external auditors based on reviews by non-physicians. It is the College's position that these reviewers do not have the clinical "real life" experience to make an accurate assessment to support a denial. Thus, **the College recommends that prior to any denial of admission by a Medicare contractor, the denial be reviewed and confirmed by a physician.**
- The one Medicare utilization day length of stay criterion may be sufficient to address the problems associated with payment for short-term inpatient admissions. Nonetheless, the College suggests that CMS consider an alternative approach to be used either in place of or to complement this length of stay approach. **More specifically, the College suggests consideration of the creation of new short term inpatient DRG code that would cover a**

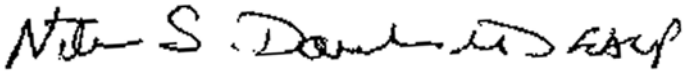
[2]Centers for Medicare and Medicaid Service. Medicare Benefit Policy Manuel; Chapter 1 (Page 7). Available at: http://www.google.com/url?sa=t&rct=j&q=medicare%20benefit%20policy%20manual&source=web&cd=3&ved=0CFUQFjAC&url=http%3A%2F%2Fwww.cms.gov%2FRegulations-and-Guidance%2FGuidance%2FManuals%2Fdownloads%2Fbp102c01.pdf&ei=PXcyUNv2Mo6E8QSA2IHICA&usg=AFQjCNFpkVMAsLWOQV9sULAghkevQuI2Wg

short term inpatient stay where the physician believes that the close observation by skilled nursing and advanced life-saving technology available within the inpatient setting are necessary. This would help ensure reasonable reimbursement to the treatment facility that covers the additional labor and technology resource costs associated with inpatient care.

- The proposed rule does not fully address the on-going problem of inadequate beneficiary protections from significant, unexpected financial liability resulting from a denial of an inpatient stay. This liability is accrued through the increased cost of Part B deductibles and coinsurance as compared to their costs under a Part A billing, and the need to meet a three-day inpatient requirement for Medicare payment of any subsequent skilled nursing facility (SNF) care. Ideally, the proposed length of stay benchmark will eliminate lengthy hospital stays under observation status and the resulting problematic high costs to the beneficiary. The rule does not address situations when relatively long inpatient stays are denied. . **The College encourages CMS to include additional beneficiary protections in the final rule, which will negate or significantly limit these adverse financial consequences to beneficiaries. The following additional protections are offered for your consideration:**
    - **The beneficiary's financial liability be limited to the smaller of payments that would be required if the stay was billed by the inpatient facility under Part A or Part B in situations when an inpatient admission is denied,**
    - **Removal of the three day inpatient requirement for Medicare payment of a subsequent SNF admission. At a minimum, any beneficiary who has stayed in the inpatient facility under inpatient or observation status for at least 3 days should be considered as fulfilling the three-day SNF coverage requirement.**
- **The College recommends that CMS continue to closely monitor inpatient use of observation status and the frequency of denials regarding short-term hospital stays** to help determine whether the related regulatory changes currently going through the rule making process have their intended effect once implemented.

Please contact Neil Kirschner, Ph.D. on our staff at nkirschner@acponline.org or 202 261-4535 if you have any questions regarding these comments and recommendations.

Respectfully,



Natin S. Damle
Chair, Medical Practice and Quality Committee