AMA
AMERICAN MEDICAL ASSOCIATION

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Marilyn B. Tavenner
Acting 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

Dear Acting Administrator Tavenner:

On behalf of the physician and medical student members of the American Medical Association (AMA), I am writing to request that the Centers for Medicare and Medicaid Services (CMS) review and develop new policy concerning Medicare's three-day stay requirement to qualify for post-hospital extended care services. This policy is of great concern to the physician community because it has created significant confusion and tremendous, unanticipated financial burden for Medicare patients. The AMA supports rescinding the three-day stay policy, as well as counting observation care toward the three-day inpatient stay requirement for as long as this requirement remains in place.

The Medicare statute requires that a Medicare beneficiary spend at least three days, or 72 hours, as a hospital inpatient in order to qualify for Medicare coverage in a skilled nursing facility (SNF). In a growing number of cases, however, Medicare patients have had their SNF stays denied by Medicare because their hospital stays were classified (sometimes retroactively) as observation care instead of an inpatient admission. Moreover, even though Medicare manuals state that beneficiaries may not remain in observation status for more than 24 or 48 hours, some beneficiaries have had stays as long as 14 days billed as observation care.

The problem stems from Medicare's increasing reliance on a variety of federal contractors (such as Recovery Audit and Medicare Administrative Contractors, or RACs and MACs) to identify and deny or recoup payments for "inappropriate admission." To avoid such denials, many hospitals have started relying on "black box" screening criteria found in proprietary databases, such as Interqual, to assist them in identifying such "inappropriate admissions" based on whether an individual's condition is severe enough, or the services provided are intense enough, to be admitted.

These determinations by hospitals, without the admitting physician's or the patient's knowledge or consent, are inappropriate and can have serious negative consequences. For patients, a reclassification as "observation" rather than "admitted" can result in unanticipated costs and co-payments. Those who need SNF care face a coverage denial that triggers a substantial and unanticipated financial burden that may force them to forego the SNF stay and places them at high risk for re-hospitalization. In a further complication, a retroactive change to observation status forces beneficiaries to pay for their prescription drugs and other hospital services as if they were outpatients rather than inpatients. Even for patients with Part D coverage, because the drugs they are administered while hospitalized are likely to be selected without regard to their Part D plan's formulary or cost-sharing requirements, the patient's out-of-pocket drugs costs during the time in observation care could be high.

Retroactive status changes by hospitals have also generated tremendous confusion for physicians billing for services to hospital inpatients, such as initial, subsequent, and discharge day hospital visits, as there is no inpatient admission on record once the change has been made. This means that physician claims can be denied and/or subject to future audits because their Part B place of service does not match that claimed by the hospital (and where the hospital opts not to bill Medicare at all, there is simply no link with any Part A service). These difficulties for patients and physicians will only get worse as Medicare policy penalizing hospitals for inappropriate readmissions is implemented, and MACs and RACs increase their scrutiny of admission criteria in order to prevent hospitals from classifying patients as observation care in order to avoid readmission penalties.

The AMA also has identified significant problems with the accuracy, validity, and transparency of proprietary databases, such as Interqual, including their use of appropriateness standards that are not accepted by the relevant physician specialties. In the correct coding initiative (CCI) Medicare uses to review Medicare physician services, potential claims edits are made public for physician comment in advance of their use. This transparency allows problems with edits to be identified, but is not possible with proprietary products. In addition, the proprietary products often do not follow Medicare payment policy and have proved in the past to be far less cost-effective than the CCI edits. As a result, the Medicare Payment Advisory Commission recommended in its March 2000 report (see pg. 92) that the program use only open and transparent edits, and has maintained that position in more recent reports. The AMA fully supports this conclusion and believes that Medicare contractors should be held to the same standards as Medicare Quality Improvement Organizations regarding the requirements for physician review prior to payment denials based on a claims edit. Hospitals should also be required to submit claims based on the admitting physician's medical judgment, rather than asking another physician employed by the hospital to switch the claim from inpatient to outpatient status.

While the AMA has long supported repeal of Medicare's three-day stay requirement, we recognize that this may require a statutory change. If so, we would urge the Administration to submit legislation that would repeal the requirement. In the interim, CMS could and

should take other steps, including counting observation care days toward the three-day stay requirement for SNF coverage.

In light of the critical and complex issues surrounding the Medicare three-day stay requirement, the AMA urges CMS to address this issue in the rulemaking process for next year's hospital and physician payment rules through a multi-pronged approach:

- Hospitals should always be required to obtain the approval of the admitting physician prior to making any changes to a patient's inpatient admission status.

- Medicare-participating hospitals and Medicare contractors must also be required to use open and transparent claims edits, and not "black box" edits, in evaluating the appropriateness of admissions. These edits must also be made public for physician comment in advance of their use.

- Prior to making claims denials or recovery demands based on claims edits, Medicare should require concurrence of a practicing physician in the same specialty as the admitting physician.

- CMS should establish a Task Force to review the Medicare three-day stay policy and make recommendations for a new policy. The Task Force should hold stakeholder workshops to receive input from all stakeholders, including at least the physician community, hospitals and patients.

- Medicare RACs should not be permitted to review whether inpatient hospital services are medically necessary for the setting billed until Task Force recommendations are adopted by CMS as new policy addressing the three-day stay requirement. Further, these audits should not proceed until CMS has conducted a comprehensive education and outreach campaign on the new policies for hospitals and physicians.

We appreciate CMS' consideration of this important matter, and we look forward to working with the agency to resolve the difficult issues and unintended consequences resulting from the current Medicare three-day stay policy.

Sincerely,

James L. Madara, MD