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Current Hospital Issues in the Medicare Program

America's Essential Hospitals appreciates the opportunity to submit comments to the House Committee on Ways and Means regarding hospital issues in the Medicare Program, particularly concerns around the Centers for Medicare & Medicaid Services (CMS) two-midnight policy/short inpatient stays, auditing, and appeals.

America's Essential Hospitals is the leading association and champion for hospitals and health systems dedicated to high-quality care for all, including the most vulnerable. Since 1981, America's Essential Hospitals has initiated, advanced, and preserved programs and policies that help these hospitals ensure access to care. It supports members with advocacy, policy development, research, and education.

Our more than 200 essential hospital members are vital to their communities, providing primary care through trauma care, disaster response, health professionals training, research, public health programs, and other services. They innovate and adapt to lead the broader health care community toward more effective and efficient care.

Two-Midnight Policy

America's Essential Hospitals is deeply concerned about the impact of the two-midnight policy on our member hospitals. Last November, we urged CMS to delay enforcement of the revised inpatient admission guidelines and medical review criteria until at least October 1, 2014. Since that time, enacted legislation has extended an enforcement ban by an additional six months, until April 1, 2015. This extension indicate congressional recognition that the agency, hospitals, and other stakeholders are not prepared to implement the two-midnight policy, which will require thorough hospital and staff training and will subject hospitals to review contractor audits of short inpatient stays.

Due to the clinical complexity of the patients treated at essential hospitals, it is of utmost important that physicians be allowed to make determinations on the appropriateness of care for a given patient based on the patient's specific needs and comorbidities instead of being bound by a rigid assessment of the projected length of stay. We believe CMS should continue to work with stakeholders to revise the two-midnight policy so

physicians' judgment of the most appropriate level of care for a patient is preserved and not overturned by the retrospective evaluation of review auditors. =

Since the association's November letter, we have solicited additional feedback from our members on examples of these short stays. The clinicians at our member hospitals tell us that certain services are best provided in the inpatient setting and should be added as exceptions to the two-midnight policy (see attached). We are not suggesting these services be added to the inpatient-only list, but rather that they be added only to the list of services considered exceptions to the two-midnight policy.

These exceptions are especially important in our member hospitals, where the type of high-acuity care provided to complex and vulnerable patient populations often necessitates short-term inpatient stays. The complexity observed in our hospitals' patient populations results from multiple factors, including patient comorbidities and social factors. For example, our hospitals treat a racially and ethnically diverse mix of patients. This diversity may predispose patients to specific conditions, such as sickle cell anemia and thalassemia, which expose them to greater risk when receiving certain procedures. Because these diseases may complicate a patient's care, physicians often will determine that a procedure is most appropriately performed in an inpatient setting to manage these complexities. Patients with underlying conditions or complications will frequently require the resources available only in the hospital inpatient setting, even if those patients ultimately require only a short stay that does not cross the two-midnight threshold.

Except in rare and unusual circumstances, the revised inpatient admission guidelines would not allow Medicare Part A reimbursement to providers for short stays such as these—even when the services provided are best administered in an inpatient setting. Previously, many of these procedures were reimbursed when performed as inpatient procedures. The revised policy will force practitioners to re-evaluate their long-standing practice of basing admission decisions on clinical judgment and instead force them to base such decisions on administrative criteria. This has the potential to adversely affect patient care. Because of the potential negative impact of the two-midnight policy on the physician-patient relationship, it is important that the types of short-stay procedures listed in this letter be added as exceptions to the two-midnight policy. This will ensure physicians can continue to provide the type of appropriate care their patients need without payment being overturned by a review contractor making a decision at a later stage, removed from the clinical considerations that warranted an admission order by the physician.

Observation Status

In our fiscal year 2014 Hospital Inpatient Prospective Payment System comment letter, America's Essential Hospitals encouraged CMS to deem patients in outpatient observation status to have been admitted after 72 hours of observation services and pay hospitals a diagnosis-related group (DRG) payment for these deemed-admitted patients.

Hospitals provide observational services to patients based on a physician's clinical judgment that it is the most appropriate setting for the patient. In certain cases, a physician may decide that a patient's condition requires further treatment. To provide further clarity on the blurred line between payment for inpatient and outpatient services, we believe CMS should consider a patient who has been receiving observation services for 72 hours as "deemed admitted" for payment purposes. Cases involving extended observational services are more akin to an inpatient admission in terms of the complexity and level of care required to treat the patient.

To ensure the hospital is being reimbursed appropriately for these cases, CMS would bundle the outpatient services provided during the 72 hours into the DRG payment. Then, through separate rulemaking, CMS should modify its requirement for skilled nursing facility coverage so the period of observation care is counted toward meeting the three-day requirement for patients who are subsequently admitted to the hospital, including these deemed-admitted patients.

Medicare Auditing and Appeals

We greatly appreciate the committee's interest in Medicare auditing and review contractors. We previously recommended that CMS allow Medicare review contractors to review inpatient admissions that last for more than one Medicare utilization day only in limited instances when there is a clear indication of fraud or abuse. Under CMS' proposed policy, a review contractor would presume that a stay that was ordered by a physician and surpasses two midnights was medically necessary and therefore qualifies for Medicare inpatient reimbursement. Although there is a presumption that the inpatient admission is reasonable and necessary when it spans at least two midnights, the contractor still maintains the authority to review the entire medical record in a case and reverse a physician's judgment, even where there is a physician order and certification. Specifically, CMS notes that review contractors still should evaluate all inpatient admission decisions to identify any stays that were inappropriately prolonged to meet the two-midnight requirement. Also, a physician's order would hold no presumptive weight regarding the medical necessity of an inpatient admission and would be evaluated in conjunction with the evidence in the medical record.

While the proposed policy provides more clarity by adding the length of stay element to the criteria for an inpatient admission, the Medicare review contractor still retains excessive authority to make decisions that contradict the clinical judgment of a licensed physician who issued a physician order. These decisions by review contractors, which are frequently erroneous and reversed on appeal, can result in inappropriate reimbursement for inpatient admissions in cases where the physician's initial judgment was correct. For essential hospitals already stretched thin, these inappropriate and inaccurate reviews are truly detrimental. Therefore, in cases where there is no indication of fraud or abuse, CMS should remove this excessive review authority and consider stays lasting more than one

Medicare utilization day (i.e., crossing two midnights) reasonable and necessary inpatient admissions.

We appreciate the opportunity the Ways and Means Committee has afforded us to share the impact these Medicare policies have had on our more than 200 members nationwide. We are concerned that excessive auditing and faulty policies will burden essential hospitals committed to providing high-quality care to all, including the most vulnerable. If the committee or any other interested party wishes to learn more about how these policies impact essential hospitals nationwide, please contact Shawn Gremminger, director of legislative affairs, at 202-585-0112 or sgremminger@essentialhospitals.org.

ATTACHMENT 1

This is the list of services recommended for exclusion to the two-midnight policy and, when available, their current procedural terminology (CPT) codes:

- General procedures:
  - insertion of non-tunnel central venous catheter (CPT code 36556)
  - prostate surgeries, including transurethral resection of the prostate and prostatectomy (CPT code 52601)
  - tube thoracostomy (CPT code 32551)
  - incarcerated hernia (CPT code 49561)
  - modified radical mastectomy (CPT code 19307)
  - partial thyroidectomy (CPT codes 60210 and 60212)
  - total thyroidectomy (CPT code 60240)
  - drainage of hematoma/fluid (CPT code 10140)
  - laryngoscopy with tumor excision and scope (CPT code 31541)
  - laparoscopy appendectomy (CPT code 44970)
  - laparoscopic cholecystectomy (CPT code 47562)
- Cardiac procedures:
  - pacemaker, automatic implantable cardioverter defibrillators, and other implantable defibrillator placement/replacement/repositioning/removal, including removal of implantable cardioverter defibrillator (CPT code 33244) and biventricular cardiac defibrillator placement[1]
  - insert intracoronary stent (CPT code 92980)
  - left heart artery/ventricle angiography (CPT code 93458)
  - percutaneous aortic valvuloplasty (CPT code 92986)
  - percutaneous mitral valvuloplasty (CPT code 92987)
  - pericardiocentesis (CPT code 33010)
- Neurological procedures:
  - one-level cervical spine fusion (CPT 22554)[2]
- Oncological procedures:
  - hepatic transcatheter arterial chemoembolization[3]
  - elective chemotherapy cases for patients that have adverse effects
  - radioactive thyroid treatment, after which certain patients must be isolated due to high radiation levels
  - biopsy/removal of lymph nodes (CPT code 38525)
- Gynecological procedures:

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[1]Biventricular cardiac defibrillator placement requires an inpatient stay overnight to monitor complications, such as internal bleeding.

[2]Other comparable spine fusion procedures are on the inpatient-only list (e.g., CPT code 22585), and the one-level procedure requires care and treatment similar to these inpatient-only procedures.

[3]An inpatient stay is required to monitor when the tumor breaks down. There is a risk for kidney failure, and this is best treated in an inpatient setting.

- closure of vagina (CPT code 57120)
- myomectomy vaginal method (CPT code 58145)
- vaginal hysterectomy (CPT code 58260)
- vaginal hysterectomy, including tube(s) and/or ovary(ies) (CPT code 58262)
- laparoscopy, surgical, with total hysterectomy, with tube(s) and ovary(ies) 250 g or less (CPT code 58571)