

Hospitalists, Too, Seek to Change Medicare's 3-Day Rule

BY MARY ELLEN SCHNEIDER

Fed up with the uncertainty and confusion surrounding Medicare's rules for when a patient should be admitted to the hospital or classified as under observation status, hospitalist leaders are urging Congress to address one key piece of the issue: the 3-day inpatient hospitalization requirement for coverage of a skilled nursing facility stay.

Earlier this year, a small group of lawmakers introduced bills in both the House and Senate to alter the requirement that Medicare beneficiaries must be hospital inpatients for at least 3 days in a row to qualify for Medicare coverage of their stay in a skilled nursing facility (SNF). Under the proposals, time spent in observation status at the hospital, which Medicare considers to be "out-patient" treatment, would be counted toward Medicare's 3-day requirement.

Dr. Ron Greeno, chief medical officer at Cogent HMG and chairman of the Society of Hospital Medicine's (SHM) Public Policy Committee, said there are a number of reasons why he's optimistic that the bills (H.R. 1179 and S. 569) will move faster than some other health care issues currently before Congress. For starters, the bills have at least some bipartisan support. Another is that the issue is easy to understand and will help seniors, a key voting demographic.

"It's very hard for legislators at this point to say that they aren't going to correct this really clear inequity in the system," Dr. Greeno said.

The biggest impact of the current 3-day requirement falls on Medicare patients who are facing either a significant cost burden or potentially less than ideal care. Patients who don't meet the 3-day inpatient requirement must pay out of pocket for their SNF stay or come up with a less comprehensive plan of care at home.

"We try to piecemeal a plan together that may not be entirely safe for them," said Dr. Ann M. Sheehy, head of the division of hospital medicine at the University of Wisconsin and a member of SHM's Public Policy Committee. "I certainly think that we end up sending patients home that are more likely to be readmitted."

But the legislation could hit a snag in Congress due to cost.

"It will increase the number of patients who qualify to have their SNF care covered by Medicare and so there's a cost," Dr. Greeno said. "I don't think there would be any resistance to either of these bills if it didn't come with a pretty hefty bill. That's where the push-back will come."

That leaves lawmakers to agree on a way to offset the cost, something that has already stalled progress on other issues with bipartisan support, such as repealing Medicare's Sustainable Growth Rate (SGR) formula.

If the 3-day rule legislation passes this year, it will be a "huge victory" and send the signal that Congress is serious

about reforming observation status, said Dr. Sheehy. But it will still leave hospitalists and other admitting physicians with a set of dysfunctional rules on when to employ observation status, she said.

The problem, Dr. Sheehy said, is that observation status has expanded dramatically in recent years as Medicare auditors have returned hundreds of millions of dollars to the Medicare program by deeming many inpatient admissions as inappropriate. Perhaps as a result of the aggressive auditing by Medicare, the number of Medicare beneficiaries classified as receiving observation services for more than 48 hours has grown from about 3% in 2006 to about 8% in 2011, according to the Centers for Medicare & Medicaid Services (CMS).

"Observation status right now is so dysfunctional because it has expanded greatly under audits to include so many patients that it's almost hard to envision a way that it can become functional again," Dr. Sheehy said. "It's so far from where it was intended to be that I don't know how it could be fixed."

In May, CMS proposed to simplify the current observation rules by creating a "time-based presumption" of medical necessity for hospital inpatient services based on the patient's length of stay. The plan was floated as part of the 2014 Hospital Inpatient Prospective Payment System proposed rule.

Under the rule, Medicare's external review contractors would presume that inpatient admissions were necessary for patients who require more than one Medicare utilization day (or two "midnights" in the hospital). The policy would also assume that hospital stays of less than two midnights should be classified as observation status.

Dr. Sheehy said it's a positive that Medicare wants to move away from the status quo. "But it's hard to know how

the rule change might play out," she added. "Only time will tell if these rules are going to be beneficial or not."

Dr. Greeno predicted that the issue isn't going to fade away. The Center for Medicare Advocacy, a consumer group, has filed a class action lawsuit against CMS on behalf of 14 Medicare beneficiaries seeking to remove the observation status designation. In *Bagnall v. Sebelius*, filed in November 2011, the Center for Medicare Advocacy states that the use of observation status violates federal law and beneficiaries' constitutional right to due process.

In the meantime, hospitalists will continue to struggle with how to abide by Medicare rules, while still looking out for the best interests of patients.

"People feel terrible because they know when they're writing that order that they are inflicting a significant

financial burden on that patient and their family," Dr. Greeno said.

Dr. Sheehy said that patients will sometimes ask if they can be admitted as inpatients when they find out that they are in observation status and will be paying more out of pocket. "The honest answer is, we can't," she said.

Physicians can insist on admitting patients that the hospital's case manager says don't meet Medicare criteria, Dr. Greeno said, but the likelihood is that the hospital will later be denied payment by Medicare.

"So what it does is it puts the doctor between the patient and the hospital," Dr. Greeno said. "That's a bad position to be in for a hospitalist. You're trying to do right by both and you can't."

MARY ELLEN SCHNEIDER is with the New York bureau of IMNG Medical News.

CDC Eyes New Coronavirus

BY MARK LESNEY

The Centers for Disease Control and Prevention has joined the World Health Organization (WHO) to closely follow the spread of a new and deadly coronavirus that emerged in the Middle East last fall and could threaten people with compromised immune systems.

Widely referred to as the "novel coronavirus" (NCoV) and the Middle East Respiratory Syndrome coronavirus (MERS-CoV), the new agent is similar to the severe acute respiratory syndrome-associated coronavirus. By Aug. 20, the new virus had been identified in 96 patients worldwide – in Saudi Arabia, Jordan, France, Italy, Tunisia, the United Kingdom, the United Arab Emirates, and Qatar – causing 47 deaths. Those

numbers are up from 36 cases and 20 deaths in May. No case had yet been reported in the United States.

"Clinicians are reminded that NCoV infection should be considered even with atypical signs and symptoms in patients who are significantly immune compromised," WHO said.

In its latest online post, the CDC advised U.S. health care professionals to "evaluate patients for MERS-CoV infection if they have had close contact with a symptomatic recent traveler from [the Middle East] who has fever and acute respiratory illness." Such patients should also be evaluated for common causes of community-acquired pneumonia, according to CDC.

MARK LESNEY is a senior editor with IMNG Medical News.