Dear Colleagues,

Many of you who are hospitalists, and some of you in other fields, have probably received calls from Executive Health Resources over the years about whether your patient should be in observation status or inpatient status. I can share some details about the company, their current predicament, and some tips for advocating on behalf of your patient when you take these calls.

Executive Health Resources (EHR) was formed in the 1990's as a side business of a eastern Pennsylvania hospitalist group that provided second level reviews of medical necessity for hospital services. You have probably encountered utilization review nurses or case managers who tell you from time to time that a particular patient doesn't "meet criteria" for some hospital service. The set of criteria to which they refer are either the InterQual or Milliman guidelines, which are proprietary decision support tools, that now have an enormous misclassification rate in assigning patients to inpatient, observation, or other categories of hospital-based care. The misclassification rate in these systems led to the need for second-level reviews to amend the recommendations of the first level software. In-house physician reviewers, Accretive, and EHR all work to provide these second level reviews using their own internal guidelines.

EHR grew over the years since inception into a company valued at a billion dollars when it was acquired by United Health Group about three years ago. Beyond concurrent reviews of hospital stays, it has moved into services lines addressing insurance denials, appeals, and post-discharge reviews. The company has its own legal team to stand behind its hospital stay classification recommendations in cases appealing RAC recovery attempts before an administrative law judge and the outcomes of those contests were used, along with medical literature of varying degrees of quality, to create clinical guidelines used by EHR Physician Advisors (the company physicians who call you) in arguing for an assignment to inpatient, observation, outpatient, or other level of care classifications.

What difference does it make when a patient is assigned to observation versus inpatient status? Well, the reimbursement to the hospital is roughly triple for patients receiving the same services depending on whether they receive these services as observation patients or inpatients. Moreover, the patient responsibility charges to Medicare patients treated in the observation classification are much higher, pharmacy charges in the hospital are not covered, and access to SNF's or swing beds after discharge are not covered by CMS.

So far, so good. EHR has a business model that looks to have the foundations for sustainability and growth. The more contests before administrative law judges, the more informed its recommendations became, and the value of its "business intelligence" increased. EHR developed a system of recommendations to greatly reduce the likelihood that RAC's (an enforcement contractor of CMS, incentivized like bounty hunters) would be able to take back hospital billing receipts under CMS's "pay and chase" strategy. However, since the basis for the recommendations was proprietary, front-line clinicians were no longer able to discern whether inpatient status or observation status was more appropriate. Both CMS payment enforcement actions and defense of these actions became the province of private contractors, using their own rules that were not transparent.

There were some bumps in the road. An enormous backlog of RAC audit appeals developed and the time to get a hearing before an ALJ jumped to about 200 days. Interestingly, the arguments used by RAC's in seeking to deny improper payments on medical necessity grounds were not about whether a service may or may not have been needed or appropriate but whether it might have been provided on an outpatient basis. There was a disproportionate impact on smaller hospitals that may not be able to muster the financial means to pursue lengthy appeals and that may also have more limitations in the spectrum of outpatient service offerings.

There was some backlash from CMS beneficiaries who began to realize that assignment to observation status greatly reduced their Medicare hospitalization benefits especially as they had no standing to challenge the assignment to observation or inpatient status which had substantial financial impact on the Medicare population. The decision logic was secret and could not be challenged.

A business cataclysm in the second level review industry occurred in May 2013 when CMS announced the FY2014 Inpatient Prospective Payment System (IPPS) guidelines. The guidelines introduced the now-famous "two-midnight" rule. Briefly, the rule can be summarized as follows: Inpatient services are generally appropriate for CMS beneficiaries if they have a need for a service that can only be reasonably and immediately provided in a hospital setting for a period of time from start of service to discharge that spans 2 consecutive midnights or is a surgical service that is mentioned on the CMS Inpatient Only list irrespective of time spent in hospital. The good faith estimate of the admitting physician that a course of care from start of service (e.g. ER triage time) to discharge would more probably than not span 2 midnights was grounds for classifying a patient as an inpatient. Considerations such as the patient's history and the course of similarly-situated patients at that institution were all fair bases for such an estimate. This rule was disruptive for EHR because the decision to assign patients to inpatient or observation status was no longer the sole province of proprietary expert system guidelines but was now within the grasp of ordinary well-intentioned physicians using a simple rule of thumb. The acuity of the patient or the rate of hospital resource consumption were not the primary determinants of correct classification of level of care. The market foundations for the first level and second level review systems were now much shakier. Since the implementation of the CMS two-midnight rule, the demand for EHR services has contracted greatly, its workforce in concurrent reviews is down about 40-50%, executive leadership has undergone a change, and the company is literally asking for suggestions as to how it might revive its concurrent second-level review system. Large hospital chains, such as Columbia/HCA have dropped their EHR contracts and some hospitals have stopped doing first and second level necessity reviews altogether.

Besides EHR, who comprises the other losers and winners under the two-midnight rule? Since expected duration of care rather than intensity of care is now the benchmark for classifying a hospital stay as inpatient or observation, high-intensity, short duration hospital stays (for example, scheduled cardiac ablations) were now classified as outpatient services. Depending on the hospital, such admissions may account for a large or small number of total hospital admissions (ranging from 10-70%) and there was a much bigger impact on larger hospitals that provided many of these short duration, high-intensity services. This was also a "have's" vs. "have-not's" disparity in the effect of this rule, but this time, more well-heeled institutions bore the most adverse impact. Predictably, the American Hospital Association

has been joined by others in filing a lawsuit against CMS challenging the two-midnight rule. Overall, hospital admissions of CMS beneficiaries classified as inpatient declined about 15% since the two-midnight rule was implemented on October 1, 2013. However, some patients may stand to benefit from the rule. Fragile geriatric patients with a variety of painful or disabling conditions at presentation who were previously assigned to in-hospital observation level of care classifications for periods exceeding a week on average for some diagnostic groups might now receive these services as inpatients if the good faith estimate of the duration of need for in-hospital services was 2 midnights or more at the time of admission.

How did EHR respond to this challenge? One way was to shed labor costs as quickly as possible. Another was to specifically instruct its physician advisors to refrain from using level of care classifications based on the two-midnight logic (except if there was documentation of an expected length of stay less than 2 midnights) or the Inpatient only list but rather to rely on its proprietary decision tools. So, while EHR will admit that it can do little to upgrade to inpatient classification short stay, higher-acuity services, it will continue to say that longer duration, lower intensity hospital stays are still classified as observation or not appropriate for in-hospital services. EHR has continued to give these recommendations since October 1, 2013 even though it has not participated in a single appeal since the 2 midnight rule implementation. EHR will still claim expertise in correct assignment of level of care even though the regulatory foundations for this claim have changed fundamentally.

So, what if EHR calls you about a patient's level of care? My recommendation is to stand your ground and to defend your patient's best interests. The playing field for level of care classification has been levelled. You know your patient. You are in a position to estimate how long this patient will likely be in the hospital, or for the surgeons, you know which HPHCS code applies to the services you provide. The EHR physician advisors have never seen your patient and their recommendations rely on proprietary guidelines that have not been subjected to public scrutiny. EHR's interests and that of their clients have now diverged. EHR is desperately trying to preserve the value of their intellectual capital even if their clients suffer. Moreover, while CMS may enjoy immunity from beneficiary lawsuits, EHR and United Health Group who continue to recommend level of care classifications at variance with the two-midnight rule since October 1, 2013 have no such protections.

Thomas M. Horiagon, MD MOccH