Issue Paper

Utilization in Respiratory Care

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As the AARC continues to pursue Medicare/Medicaid coverage of respiratory therapy outside of the hospital, questions are raised by policymakers concerning the utilization safeguards, which will insure that only appropriate RT will be provided. The comparison is made between fairly strict hospital utilization requirements versus the much less stringent utilization requirement in the alternate site.

This document is a comparison between the hospital utilization review (UR) and those in the alternate care sites. To summarize: (1) hospitals have been under scrutiny much longer than other alternate care sites; (2) alternate care sites are relatively a "new growth area". Overall, the majority of patients are found in the hospital, not in the alternate care site. While this is changing, UR focus is still on the most costly, most "used" site which is still the hospital. (3) hospital care sites are far more controllable than the more open-ended, nonhospital care sites; and (4) the complex system, which has been in place for the hospital, is very expensive. As nonhospital facilities look to save money, it is in the UR area where cutbacks are made. A more detailed explanation follows.

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Hospitals

To be approved as providers of services, hospitals are required, as a Medicare Condition of Participation (HCOP), to have in effect a plan for UR which applies to the inpatient services furnished to Medicare patients. The requirement may also apply to providers furnishing benefits to Medicaid patients.

A utilization review plan must provide review on a sample or other basis of (1) admissions; (2) duration of stays; (3) professional services furnished, including biologicals and drugs; and (4) all cases of continuous extended duration. UR review of hospital admissions may be performed before, at, or after hospital admissions. With the exception of extended stay review, reviews may be conducted on a sample basis. Utilization review plan requirement does not apply to hospitals where a peer review organization (PRO*) has assumed binding review. If a hospital chooses to be Joint Commission-accredited, it must contract with a PRO which will review a statistical sampling of claims or look at patterns of care. While most PRO contracts have standard language, they can be targeted to a particular state or area of care (i.e., there is a noticeable increase in C-sections performed in New England states. PROs in those states target their review in this one particular area.) PROs emphasize patterns of care and focus less on a case-by-case basis. PROs encourage hospitals to extend the review to all patients, not just Medicare/Medicaid patients, but it is the hospital's option to extend review to all patients.

Federal laws require hospitals which accept Medicare/Medicaid patients to have an in-house quality assurance committee regardless of whether they operate under Joint Commission or HCOP. As soon as one moves outside of the hospital, UR requirements (even under the MC/MC programs) decrease appreciably. Here's a breakdown of care sites as provided by HCFA staff and the MC/MC manual.

SNF Care

SNFs used to be under the same requirements as hospitals in regards to UR or PRO requirements. But with the Nursing Home Reform Act, this mandatory requirement was removed. It was thought that the requirements were too process-oriented and not on patient outcomes. There now is a focus on scrutinizing the "front loading' of SNF patients, which is why all SNF patients undergo an initial comprehensive patient assessment survey to determine what services are required. A SNF may choose to set up its own UR process and follow similar requirements as hospitals do.

If they choose to do this, the Medicare program will reimburse the UR efforts as a part of the facility's administrative costs. Many SNFs, however, simply do not choose to take this option, and apportion the administrative costs in other ways. All MC/MC nursing homes must establish a Quality Assessment and Assurance Committee, which as the HCFA staff indicated, is not well defined. The Medicare intermediary has the authority to come in and scrutinize certain claims.

Home Care Under the Home Health Agency

There are very little utilization review requirements. In fact, there is less than those required from SNFs. You must rely on the vigilance of the Medicare intermediary and how closely they choose to scrutinize a claim. As I said in the introduction, when costs must be cut in Medicare budgets, it is the administrative costs of the intermediary which gets the ax, and that translates into an effect on UR functions. HCFA staff indicated that it is easier to cut these administrative costs rather than cut benefits or monies to providers; representatives of these two different groups are quite vocal in these matters. An intermediary may look for "aberrant" behavior by an HHA. To scrutinize any facility or particular procedure, the intermediary must have justification. It cannot indiscriminately go prying into any and all submitted claims without just cause. Only 4% of all HHA claims are reviewed.

Comprehensive Outpatient Rehabilitation Facilities

CORFs must have in effect a written utilization review plan that is implemented at least quarterly to assess the necessity of services and promote the most efficient use of services provided by the facility. There must be a written procedure for evaluating (1) admissions, continued care, and discharges; (2) the applicability of the plan of treatment to establish goals; and (3) the adequacy of clinical records with regard to assessing the quality of services provided.

DME There are few requirements under the DME benefit. The need for DME services must be documented by a CMN. The general catchall phrase of "medically necessary services" is basically all that is available under the DME benefit.

I hope this information is useful. I expect that health reform will require a strict UR process for services rendered outside the hospital. Please remember that many groups benefit from the status quo. UR can be made to look like health care rationing and that will make it more difficult to sell.

CAB/jr

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*History of Peer Review - Shortcomings were believed to exist in the utilization review process; therefore in 1972, Congress created professional service review organizations (PSROs) which were to provide review mechanisms under which practicing physicians could eventually assume full responsibility for reviewing the utilization of services under Medicare and Medicaid. These provisions were amended several times, and since their inception, the PSRO program has been the center of controversy regarding its cost-effectiveness, as well as its effectiveness in meeting the goals of assuring the quality and ethicality of health care.

In 1982, Congress revamped the PSRO program and replaced it with a program called the PRO program. Under the new program, utilization of quality control peer review organizations also consisted of substantial numbers of practicing physicians in local areas.

Contracts of PROs – The peer review law requires the Secretary to enter into a contract with a utilization and quality control PRO for an initial period of three years, renewable every three years, to review services provided under the Medicare program. The organizations that are eligible to contract as PROs must show that they are either physician-sponsored or physicianaccess organization. A physician-sponsored organization, which has priority, is one which is composed of a substantial number of licensed doctors of medicine or osteopathy practicing medicine or surgery in their respective review areas. A physician-access organization is one that has available to it, by arrangement, the services of a sufficient number of licensed doctors of medicine or osteopathy practicing medicine or surgery in the review area to assure adequate peer review of the services furnished by the various medical specialties and subspecialties. In addition, the PRO must have one individual who is a consumer. Initial determinations denying payment for care and services provided by a physician may be made only by another qualified physician. Furthermore, decisions about procedural and diagnostic information must be made by a physician. Technical coding issues, however, must be reviewed by individuals with training and experience in that area.

Physicians must also be involved in quality review in the sanctions process, in developing criteria, and in making determinations on issues referred to the PRO. Additionally, the PRO must use board certified or board-eligible physicians or dentists in the appropriate specialty to make reconsideration determinations.