What to Do When an Auditor Knocks

Joydip Roy, MD

Senior Director: Audit, Compliance and Education

AHA Solutions, Inc., a subsidiary of the American Hospital Association, is compensated for the use of the AHA marks and for its services in connection with certain products and services. By agreement, pricing of certain products and services may not be increased by the providers to reflect fees paid to the AHA.

*HFMA staff and volunteers determined that this publication meets the criteria developed under the HFMA Peer Review Process. HFMA does not endorse or guarantee the use of this product.

2008 ■ 2009 ■ 2010 ■ 2011 ■ 2012

Agenda

- Medicare Overview
- Program Integrity Efforts
- Medicare Auditors
- Auditor Target Areas
- Best Practices for Success
- Medicaid Recovery Audit Contractors
- **C**MS IPPS 2014 Final Rule

Auditors Target 'Gray' Area Cases

GRAY ZONE

Increasingly overlapping

Potential for Inpatient (review required):
- Acute MI
- Coronary Artery Bypass Graft
- Open Appendectomy
- Acute Intracranial Bleed
- Valve Transplant
- Respiratory Failure

Inpatient Care | **Outpatient Care**

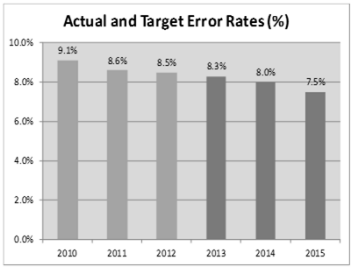
Potential for Outpatient/OBS (review required):
- Scheduled Transfusion
- Injection / Chemotherapy
- Lymph Node Biopsy
- Inner Ear Infection
- Dilation & Curettage

'Gray' Area – Cases that require individual assessment due to unclear Medical Necessity:
- Chest Pain
- Anemia
- Dehydration
- Syncope
- Back Pain
- Cardiac- Stent, PTCA, ICDs…
- Mastectomy
- Prostatectomy
- Laparoscopic Appendectomy

Improper Payment Report

* Estimated $31.2 billion in improper payments in 2013

"The primary causes of improper payments, as identified in the Medicare FFS Improper Payments reports, are insufficient documentation errors, medically unnecessary services, and to a lesser extent, incorrect coding."



*From the FY 2012 HHS Agency Financial Report (AFR)

Today's Audit Environment

- The regulations haven't changed
- The procedures haven't changed
- How can providers be wrong 90% of the time?
- It is about how the contractors interpret the regulations
- If providers don't challenge them, the new interpretations become the new rules

Screening Criteria are Not Dispositive

- CMS contractors are **not required to automatically deny a claim that does not meet the admission guidelines of a screening tool**
- CMS considers the use of **screening criteria as only one tool** that should be utilized by contractors to assist them in making an inpatient hospital claim determination
- For each case, the review staff will utilize the following when making a medical necessity determination
  - Admission criteria
  - Invasive procedure criteria
  - CMS coverage guidelines
  - Published CMS criteria
  - Other screens, criteria, and guidelines (e.g., **practice guidelines that are well accepted by the medical community**).

– Sources: Chapter 6 of the Medicare Program Integrity Manual; http://www.cms.gov/manuals/downloads/pim83c06.pdf
– Chapter 1, Section 10 of the Medicare Benefit Policy Manual; http://www.cms.gov/manuals/downloads/bp102c01.pdf

Governmental Audit and Fraud Fighting Entities and Initiatives

Who	What
OIG	Office of the Inspector General
DOJ	Department of Justice
MCR RAs	Medicare Recovery Auditors
MACs	Medicare Administrative Contractors
HEAT	Health Care Fraud Prevention and Enforcement Action Team
CERT	Comprehensive Error Rate Testing
MIP	Medicaid Integrity Plan
MIG	Medicaid Integrity Group
MICs	Medicaid Integrity Contractors
MIG	Medicaid Inspector General
MCD RAC	Medicaid Recovery Audit Contractors
PERM	Payment Error Rate Measurement
PSCs	Program Safeguard Contractors
ZPICs	Zone Program Integrity Contractors

Medicare Fraud Fighting Initiatives

- **DOJ**
  - Civil and criminal fraud investigations: False Claims Act/Health Care Fraud
- **OIG**
  - Audits: ZPIC and CERT referrals
  - Fraud investigations
  - Medicaid investigations
- **Recovery Auditors**
  - Contracts up for renewal
  - New duties for RA's
- **MAC**
  - Short-stay audits
  - DRG-specific prepayment denials
  - Introducing new interpretations of the regulations
- **CERT**
  - Specifying "error rate"
  - DRG-specific denials

Department of Justice (DOJ) Focus Areas

Current DOJ Activities

- Defibrillators (ICDs)
  - DOJ resolution model:

  http://www.cardiosource.org/News-Media/Publications/Cardiology-Magazine/~/media/Files/Advocacy/DOJ%20ICD%20selfresolution%20model.ashx
- NCDs
- Kyphoplasty
- Referrals from other government contractors
- Qui Tam cases

Areas of Compliance Risk Broadened

Example:

Hospital on the East Coast

- Agreed to pay $2.8 million to settle Federal claims that it failed to prevent a cardiologist from placing medically unnecessary stents in dozens of patients from 2003 through 2006
- Hospital admitted no liability and had already repaid nearly $1 million prior to the settlement
- Cardiologist was convicted of healthcare fraud and related charges for falsifying patient records. He made it appear that patients needed coronary stents, and then billed private and public insurers hundreds of thousands of dollars for the unwarranted procedures
- Cardiologist was sentenced to 8 years in prison

Compliance Under Scrutiny

- It is a real problem when Finance starts dictating level of care
  - "we need more IP and less OBS"
- Compliance being left out of meetings
  - if compliance officers do nothing about a violation, but remain at the organization, they may become the 'sacrificial lamb'

Report on Medicare Compliance, March 4, 2013

Office of Inspector General (OIG) Focus Areas

Current OIG Audit Activity

- Coding/complications
- Short-stay procedures
- Canceled surgery
- Readmissions
- High-cost cases
- Technical issues
- Patterns of fraud

2012 OIG Work Plan Targets

Targets Impacting Hospitals:

- Inpatient payments greater than $150,000
- Inpatient and outpatient claims paid greater than charges
- One-day stays at acute care
- Major complication/co-morbidity and complication/co-morbidity
- Payments for inpatient same-day discharges and readmissions
- Inpatient manufacturer credits for replacement of medical devices (defibrillators)
- Outpatient manufacturer credits for replacement of medical devices
- Post-acute transfers to SNF/HHA/another acute care/non-acute inpatient facility
- Outpatient claims billed with modifier 59 (unbundling)

2013 OIG Work Plan Targets *(con't)*

Targets Impacting Hospitals:

- Diagnosis-related group window
- Same-day readmissions
- Payments for canceled surgical procedures
- Inpatient and outpatient payments to acute care hospitals
- IRFs – transmission of patient assessment instruments
- IRFs – appropriateness of admissions and level of therapy
- LTCHs – OIG will examine the extent to which improper payments were made for interrupted stays in 2011

See Appendix

Additional OIG Activity

•Extrapolation began the 4th Quarter of 2012

•Physician-Hospital Billing Concordance

•2013 Work Plan

****Source: Review of Place-of-Service Coding for Physician Services Processed by Medicare Part B Contractors during Calendar Year 2009 (A-01-10-00516) http://go.usa.gov/0z6***

See Appendix

2013 OIG Looking at CMS Contractors

- Overview of CMS' contractor landscape
- MACs – CMS' monitoring and assessment of performance
- RAs – Identification and recoupment of improper and potentially fraudulent payments and CMS' oversight and response
- ZPICs – CMS' oversight of task order requirement

See Appendix

Recovery Auditors: Focus Areas

CMS Recovery Amounts

October 2009 – September 2010	FY2010	$	92.3
October 2010 – September 2011	FY2011	$	939.3
October 2011 – September 2012	FY2012	$	2,400.7
October 2012 – December 2012	Q1 FY2013	$	779.2
January 2013 – March 2013	Q2 FY2013	$	657.5

Total corrections to date equal $4.8 billion with $4.5 billion being overpayments

Source: http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Recovery-Audit-Program/Downloads/National-Program-Corrections-FY-2013-2nd-Qtr2013.pdf

CMS Recovery Amounts (Through Q1 FY2013)

Medicare Fee for Service
National Recovery Audit Program
Figures provided in millions
(January 1, 2013 – March 31, 2013)
Quarterly Newsletter

RECOVERY AUDITOR	OVER-PAYMENTS COLLECTED	UNDER-PAYMENTS RETURNED	TOTAL QUARTER CORRECTIONS	FY TO DATE CORRECTIONS
Region A: DCS (Diversified Collection Services)	$111.3	$11.4	$122.7	$299.2
Region B: CGI (CGI Federal)	$106.4	$1.2	$107.6	$229.0
Region C: Connolly	$190.6	$10.4	$201.0	$456.4
Region D: HDI (HealthData Insights)	$218.2	$8.0	$226.2	$452.1
Nationwide Totals	**$626.5**	**$31.0**	**$657.5**	**$1,436.7**

Source: http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Recovery-Audit-Program/Downloads/Medicare-FFS-Recovery-Audit-Program-2nd-Qtr2013.pdf

Top Issues By Recovery Auditor

Region	Overpayment Issues	Areas of Focus
Region A: Performant Recovery, Inc.	**Cardiovascular Procedures:** (Medical Necessity) Medicare pays for inpatient hospital services medically necessary for the setting billed. Medical documentation for patients undergoing cardiovascular procedures also needs to be complete and support all services provided in the setting billed. 6/11: Cancelled elective surgery: IP 7/8: Inpt Rehab (IRF) Admission	NY, PA
Region B: CGI, Inc.	6/7: Cancelled elective surgeries 6/10: Intensity-modulated radiation therapy 6/12: Post Acute Transfer – NGS* 6/21: Post Acute Transfer – WPS* ** Applies to all DRGs using code 02, 03, 05, 06, 62, 63, 65*	IL, MI, OH
Region C: Connolly, Inc.	6/5: IRF Case Mix Group Audit 6/6: DRGs 252, 253,254: Other Vascular Procedures… 6/10: Cancelled elective surgeries Blepharoplasty – eyelid lifts – IP Intensity-Modulated Radiation Therapy – IP	FL, LA, TX, NC
Region D: HealthData Insights	6/6: Prepayment review DRGs 252, 253, 254 6/10: Cancelled Elective Surgeries Intensity-Modulated Radiation Therapy Blepharoplasty – eyelid lifts – IP	CA, MO

Source: http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Recovery-Audit-Program/Downloads/Medicare-FFS-Recovery-Audit-Program-2nd-Qtr2013.pdf

Recovery Auditor (RA) Pre-Payment Project

- The Demonstration will take place between August 27, 2012 and August 26, 2015
- The 11 states included in this Demonstration are CA, FL, IL, LA, MI, MO, NC, NY, PA, OH, and TX
- Focus on claims with high improper payment rates
  - Begin with short inpatient stays (< 2 days)
  - Inpatient hospital stays only

Just like the Part A to Part B Rebilling Demo…look for this demo to end early…with more widespread application to all states

RA Pre-Payment Project *(con't)*

- Will NOT replace MAC pre-payment review
  - o "Contractors will coordinate review areas to not duplicate efforts"
- Selected claims will be off-limits from future post-payment reviews by a CMS contractor
- A hospital has 30 days to send documentation for review (if not, case will be denied)
- Will review for DRG validation and coding issues
- For now limits on pre-payment and post-payment reviews won't typically exceed current post-payment ADR limits

RA Pre-Payment Project *(con't)*

- **The Recovery Auditors (RAs) will target the originally published MS-DRGs; and they will be phased in throughout the first few months of the Demonstration. The following lists the first date of the approved issue by at least one of the RAs:**
  - Aug. 27: MS-DRG 312 SYNCOPE & COLLAPSE
  - Dec. 26: MS-DRG 069 TRANSIENT ISCHEMIA
  - March 14: MS-DRG 377 G.I. HEMORRHAGE W MCC
  - March 14: MS-DRG 378 G.I. HEMORRHAGE W CC
  - March 14: MS-DRG 379 G.I. HEMORRHAGE W/O CC/MCC
  - May 9: MS-DRG 637 DIABETES W MCC
  - May 9: MS-DRG 638 DIABETES W CC (pre-pay demonstration)
  - May 9: MS-DRG 639 DIABETES W/O CC/MCC
  - June 10: MS-DRG 252 OTHER VASCULAR PROCEDURES w MCC
  - June 10: MS-DRG 253 OTHER VASCULAR PROCEDURES w CC
  - June 10: MS-DRG 254 OTHER VASCULAR PROCEDURES w/o CC/MCC
- Percentage of claims to be reviewed is unknown at this time

 25

RA Pre-Payment Project: Q and A from CMS Open Door Forum

- Normal CMS appeals process
- Time is in calendar days and not business days
- Date is based on claim submission date (not date of service)
- RA receives same contingency fee payment
- No physician or Part B claims to be reviewed
  - (However, Connelly announced complex reviews of physician's E/M codes 99215)
- CAHs and PIPs CAN be included in program

 26

Changes with Next Round of RA's

- This will occur with the next round of 5-year contracts to be awarded this summer
  - There will be five – four regions as before and a national fifth one
- CMS cut in half — from 60 days to 30 days — the time a RAC has to complete a review after receiving the provider's medical records
  - If deadline missed, RA loses contingency fee
- RACs will be required to help CMS defend overpayment determinations
  - Even up to a federal court
  - Participate in at least 25% of ALJ hearings

Source:: Report on Medicare Compliance, May 6, 2013

 27

Chart Pull Limits

- The maximum request is now 'per campus,' which is different from 'provider based status.' 'Campus' = one or more facilities under the same Tax Identification Number (TIN), located in the same area and using the first 3 positions of the zip code
  - Provider A has TIN 123456789 and 2 locations in zip codes 12345 and 12356, counting as one 'campus unit'
  - Provider B has TIN 123456780 and is located in 12345 and 21345. Each location is counted separately and has its own limit
- Each limit is based on the provider's prior calendar year Medicare claims volume

 28

Chart Pull Limits *(con't)*

- The maximum number of request per 45 days is 400
  - Providers with over $100,000,000 in MS-DRG payments who were notified by CMS of an increased cap of 500 requests will **now have a cap of 600**
- Recovery Auditors may request up to 20 records per 45 days from providers whose calculated limit is 19 additional documentation requests or less
- CMS may give the RAs permission to exceed the limit, either from their own initiative or from the RA requesting permission. Providers will be notified in writing

Source: http://www.cms.gov/Recovery-Audit-Program/Downloads/Providers_ADR_Limit_Update-03-12.pdf

 29

CMS 'Highlights' for FY 2012

- In FY 2012, Medicare FFS Recovery Audit Program demanded approx. $2.6 billion and recovered $2.3 billion
- FY 2012 recoveries were 187% higher than 2011 recoveries
- CMS efforts in the Medicare Secondary Payer (MSP) area saved the Medicare trust funds approx. $7.17 billion in first 11 months of FY 2012
- Total recoveries by the MSPRC during first 11 months of FY 2012 were $548 million, which already exceeded the $526 recovered in all of FY 2011
- CMS' Consolidated Balance Sheet has reported assets of $424.8 billion, (with the bulk invested in U.S. Treasury Special Issues)
- CMS' total benefit payments were $796.9 billion for FY 2012. Administrative expenses were $3.7 billion, less than 1% of total net Program/Activity costs of $737.8 billion

Source: *CMS Financial Report FY 2012, pgs. 22-32.*

 30

Medicare Administrative Contractors (MACs) Focus Areas

MAC Activity

- Primary responsibility is processing claims
- Now auditing hospitals and physicians
  - Mobile audits
  - Prepayment reviews
  - Few claim/chart limits
  - Focusing on medical necessity
- Increased denial activity, especially during contract renewal periods
- Frequently, guidance provided appears to be inconsistent with statutes, regulations, and manuals

 32

Specific MAC Activity

MAC	Activity/Focus
Cahaba Government Benefit Administrators	Current Prepayment Medical Review Log for Part A (not an all inclusive list): DRGs 069, 189, 190, 191, 192, 226,227, 235, 242, 243, 244, 245, 247, 249, 251, 287, 312, 313, 392, 460, 470, 552, 641, 714, 981, 982, 983, Inpatient Rehabilitation Facility A0801-A0803 and A2001-A2004, and CMG's A0701, A0702, A0703. Full list: www.cahabagba.com/part-a/medical-review/j10-ab-mac-prepayment-medical-review-log-part-a/. *(updated Aug. 1, 2013)*
First Coast Service Options	Prepayment Review for DRGs 153, 328, 357, 455, 473, 517, 226, 227, 242, 243, 244, 245, 247, 251, 253, 254, 264, 287, 292, 313, 392, 458, 460, 470, 490, 552, 641 (updated July 2, 2013) plus identified hospitals who sustain low error rates for certain DRGs. They are exempt from prepayment editing for those specific DRGs.
Novitas Solutions, Inc.	Prepayment Review of DRGs 227, 243, 244, 251, 287, 292, 313, 392, 470, 673, 714, medical back problems w/ and w/out MCC with LOS< 3 days, Transurethral Prostatectomy w/out CC/MCC with LOS< 3 days (see Novitas website: www.novitas-solutions.com/parta/index.html)
National Government Services	Mobile Audit /Prepayment Review: *MAC transition dates for Jurisdiction K*: Part A/Part B : Phase 1 in CT, NY (cutover date 6/1/13); Part A – Phase 2: CT, ME, MA, NH, RI, VT (cutover date 10/18/13); Part B – Phase 3: ME, MA, NH, RI, VT (cutover date 10/25/13). 7/13/13 cutover for J6 in IL, WI for hospital services. skilled nursing, inpatient rehab.

Specific MAC Activity *(con't)*

MAC	Activity/Focus
NHIC, Corp.	MAC for ME, MA, NH, RI, VT, CT. Partnering with NGS to administer the Medicare program in JK.
Noridian Healthcare Solutions	Prepayment Review for DRGS 245, 247, 264, 287, 293, 308-310, 470, 490, 491, 714 and one-day stays (state-specific prepayment reviews. List of affected states can be found at: www.noridianmedicare.com/parta/coverage/service_specific_review.html#ipps.)
Palmetto Government Benefits Administrator	DRGs 039, 069, 190, 208, 227, 243, 244, 247, 260, 287, 291, 292, 309, 310, 377, 392, 460, 470, 491, 641, 683, 690, 812, 853, 945 – edits now being discontinued in J1 regions. J11 performing prepayment probe on short stays for 291, 292, 293 in NC, SC, VA, WVA : sampling 100 claims per DRG.
Wisconsin Physicians Service	Current prepay edits include 48 hr observation, high dollar claims, inpatient rehab facility, long-term acute care hospital, and short-term acute care hospital
CGS	J15 A Medical Review dept will perform a probe review on Cardiac Pacemaker Implant (DRG 243, 244) based on national CERT data. Will perform on 100 claims DRG 243, 244 in OH. **Also DRGs 177-179 for KY and OH; and 811-812 KY and OH.** 34

Zone Program Integrity Contractors (ZPICs) Audit Areas

ZPICs Overview

- **Formerly Program Safeguard Contractors (PSCs)**
- Perform the following functions:
  - Investigate potential fraud
  - Perform medical reviews
  - Perform data analysis
  - Refer cases to law enforcement
  - Conduct interviews and/or onsite visits
  - Identify the need for a prepayment or auto-denial edit and refer these edits to the MAC

 36

ZPICs Overview *(con't)*

- ZPICs do <u>NOT</u> perform the following functions:
  - Claims processing, including paying providers/suppliers
  - Provider outreach and education
  - Recouping monies lost to the Trust Fund
  - Medicare review not for benefit integrity purposes
  - Complaint screening
  - Claims appeals of ZPIC decisions
  - Claim payment determination
  - Claims pricing
  - Auditing provider cost reports

ZPICs - Extrapolation

- ZPICs may only use extrapolation as a means to determine overpayment amounts to be recouped if the Secretary determines that one of the following apply:
  - documented educational intervention failed to correct the payment error
  - there is a sustained or high level of payment error
  - the determination of a sustained or high degree of payment error is not appealable

The ZPICs and Their Zones

ZPIC	Zone	States in Zone
Safeguard Services (SGS)	1	California, Hawaii, Nevada, American Samoa, Guam, the Northern Mariana Islands, Palau, Marshall Islands, and the Federated States of Micronesia
NCI (previously AdvanceMed)	2	Washington, Oregon, Idaho, Utah, Arizona, Wyoming, Montana, North Dakota, South Dakota, Nebraska, Kansas, **Iowa**, Missouri, and Alaska
Cahaba Safeguard Administrators	3	Minnesota, Wisconsin, Illinois, Indiana, Michigan, Ohio, and Kentucky
Health Integrity	4	Colorado, New Mexico, Texas, and Oklahoma
NCI (previously AdvanceMed)	5	Arkansas, Louisiana, Mississippi, Tennessee, Alabama, Georgia, North Carolina, South Carolina, Virginia, and West Virginia
Under Protest	6	Pennsylvania, New York, Delaware, Maryland, D.C., New Jersey, Massachusetts, New Hampshire, Vermont, Maine, Rhode Island, and Connecticut
Safeguard Services (SGS)	7	Florida, Puerto Rico, U.S. Virgin Islands

ZPIC to "UPIC"

- The Centers for Medicare and Medicaid Services (CMS) are preparing a **unified program integrity contract** that would combine Zone Program Integrity Contractors (ZPIC), Medicaid Integrity Contractors (MIC) and Medicare-Medicaid data matching work. A draft of the new plan will be released on July 26. Any changes to the programs are expected to go through a long process.

  Last year the Office of Inspector General (OIG) and the Government Accountability Office (GAO) released reports regarding the MIC program that showed a significantly poor return on investments from the program. From June of 2007 through February of 2012, MIC contractors cost $102 million and returned less than $20 million. CMS also announced last year that it would not renew three of the five MIC contracts and would instead work more collaboratively with states.
- https://www.fbo.gov/?s=opportunity&mode=form&id=408e8137e17c76a2686ef7af0bb7204b&tab=core&_cview=1

Best Practices: Responding to Individual Audits

Today's Audit Environment

- If you are treating patients and submitting claims, you will likely be audited
- It is about how the contractors interpret the regulations:
  - The regulations haven't changed
  - The procedures haven't changed
- Providers must appeal or the contractors' interpretations become the new standard
  - Determinations based solely on screening criteria
  - Timing as sole determining factor (e.g., there is no 24-hour rule)
- The solution is NOT to make all prepayment reviewed cases observation
- Appeal cases that are inappropriately denied

Internal Audit Preparation

- **Communicate to all relevant parties quickly and engage them:**
  - Finance
  - Compliance
  - Legal
  - Medical Records
  - Clinical Leadership
  - Physician Advisor
- **Ask key questions internally:**
  - Who does this audit involve?
  - Do we want to review the charts?
  - Do we need legal representation?

 43

Communicate with the Auditor

- Gather information about the audit
  - Why are we being targeted with this audit?
  - What will the scheduling be?
  - Will it be onsite or off-site?
  - What is the time period?
  - Can we review audit results?
  - Will there be opportunities to discuss them prior to the appeals process?

 44

What Not to Do

- DO NOT wait until a few days before the auditors arrive to take action
- DO NOT refrain from asking for more information about the audit and audit selection process
- DO NOT simply accept the audit findings as accurate
- DO NOT cease filing appeals
- DO NOT begin self-denying or overusing observation in an attempt to avoid a future audit

 45

Best Practice Approach

- Demonstrate a consistently followed Utilization Review process for every patient
- Educate medical staff on documentation practices to avoid future technical issues
- Prove that the error rate within your hospital is not accurate by focusing on successfully appealing denials
- Hospitals need to be prepared to defend their decisions and advocate for their rights

 46

Best Practice for Medicare Appeals Success

PEER REVIEWED by HFMA

BEST PLACES TO WORK

2008 • 2009 • 2010 • 2011 • 2012

Handling Delays at the QIC

Delays at reconsideration are unlike delays at redetermination, where there is no procedural recourse should the contractor take more than 60 days to issue a decision. At reconsideration the Qualified Independent Contractor (QIC) is supposed to notify all parties if it is unable to render a decision in 60 days. Furthermore, that notice must inform the parties that there are two options available in proceeding:

- The first option is to take no action and allow the QIC to finish its review and issue a decision. Aside from the initial 60 days, there is no definitive timeframe for the QIC to issue a decision, and there is no way to estimate when the reconsideration decision will be issued. For providers that prevent recoupment, the overpayment will not be recouped until the QIC issues a decision.
- The second option is to inform the QIC that the appeal should be escalated to the Administrative Law Judge (ALJ). Within 5 days of receipt of the escalation request, the QIC must either render a decision or forward the case to the ALJ level of appeal, without a decision being rendered at the QIC level. **If a case is escalated to the ALJ, the timeframe for an ALJ to render a decision is extended from 90 days to 180 days**. Additionally, upon escalation, the overpayment amount will be recouped if the provider had prevented recoupment.

 48

3-Tiered Tactical Approach to RAC Appeals

- All appeals should be prepared to be presented to the ALJ
- Your argument must address three key components to have any likelihood of success:
  - **Clinical:** Strong medical necessity argument using evidence based literature
  - **Compliance:** Need to demonstrate a compliant process for certifying medical necessity was followed
  - **Regulatory:** Want to demonstrate, when applicable, that the RAC has not opined consistent with the Social Security ACT (SSA)

 49

Medical Necessity

- Documentation is the difference
  - Explicitly detail why the care provided was medically necessary in the inpatient setting
- The critical factor:
  - The judgment of the admitting physician with reference to the guidance of the Medicare Benefit Policy Manual and other CMS Manuals
- Citation to relevant medical literature and other materials
  - Utilization management criteria, local and national standards of medical care, published clinical guidelines, and local and national coverage determinations may be considered

 50

Focus on the ALJ

- Administrative Law Judges of the Office of Medicare Hearings and Appeals
  - Four field offices:
    - Southern (Florida)
    - Western (California)
    - Mid-West (Cleveland)
    - Mid-Atlantic (Virginia)
  - Central Docketing (Cleveland)
  - Answers to the Secretary of Health and Human Services, not to CMS
  - Hearings are usually conducted by telephone
  - No current plans to increase staff, despite volume

 51

ALJ Level of Appeal ♦ Our Experience

- EHR's experience in appeals from the permanent Recovery Auditor program:
  - Assisted hospitals in appealing 280,000+ recovery audit denials
  - Represented client hospitals in 12,000+ ALJ hearings
- Key observations
  - ALJ hearings are as varied as the ALJs themselves
- The axiom: ***When you have seen one ALJ hearing, you have seen one ALJ hearing***
  - Different ALJs have different styles, and, as a result, often place different demands on the appellant
  - Preparation and experience are of paramount importance
- **NEW: 80% of contractors are having a physician or attorney attend the hearing – Required under Statement of Work**

 52

ALJ Variability Examples

- Syncope and the ear exam
- Dictator approach
- Personal experiences
- Expert witness (Cardiologist)
- Personal criteria
- Hearing procedures (brief, noted page numbers, other)
- Waive hearing for outpatient payment

 53

The Bottom Line

- Medical Necessity is a complicated issue – but it is possible to achieve success
- Admission decisions must be based on clinical and regulatory evidence and best practices
- Consistent process must be paired with diligent oversight and data review
- Identify procedural failures
- Recognize that your hospital will receive inappropriate denials and be prepared to appeal
- Be prepared to advocate for your hospital

 54

The Medicaid RAC Program

Source Authorities

- Section 6411 of Affordable Care Act (ACA)
  - March 23, 2010 signed by President Obama
- Proposed Rule was published November 10, 2010
  - Federal Register, Vol. 75, No. 217 beginning pg. 69037
  - http://edocket.access.gpo.gov/2010/pdf/2010-28390.pdf
- Final Rule was published September 16, 2011
  - Federal Register, Vol. 76, No. 180 beginning pg. 57808
  - http://www.gpo.gov/fdsys/pkg/FR-2011-09-16/pdf/2011-23695.pdf
- Frequently asked questions Section 6411(a) of the Affordable Care Act December 2011
  - http://www.cms.gov/MedicaidIntegrityProgram/downloads/Scanned document 29-12-2011 13-20-42.pdf

Medicaid RAC Different from Medicare RA

- So many unknowns
- Statement of Work (SOW) less detailed
- States have far more latitude such as chart limits, appeals process, payments, other
- States may have fewer resources to implement properly
- Providers may be subject to multiple state rules
- All providers are at risk including inpatient and outpatient

Selected State Medicaid RACs

State	Current Status
Iowa	Optum Public Sector Solutions
Missouri	Cognosante
Minnesota	HMS
Illinois	Not reporting RAC data
Wisconsin	RAC in procurement

Comparison of Medicare vs. Medicaid

- Objective as stated by CMS:

  "We interpret the statutory language that States must establish a Medicaid RAC program 'in the same manner as the Secretary enters into contracts with' Medicare RACs to mean that some of the provisions of the ***Medicare RAC program, generally, should serve as a model for the proposed Medicaid RAC program,*** *not that Medicaid RACs should be structured identically to Medicare RACs."*

  (CMS-6034-F, p.9)

Comparison of Medicare vs. Medicaid *(con't)*

- Contingency Fees:
  - Medicare
    - 4 Medicare regional RACs operating. Those RACs are paid an average contingency fee rate of 10.86 percent by CMS, with the highest rate being 12.50 percent
  - Medicaid
    - Contingency fees to be negotiated by the State with the contractor but may not exceed maximum amount of Medicare contingency fees (Medicare currently 12.50 percent)

      (455.510(b)(3) and (b)(4)

Comparison of Medicare vs. Medicaid *(con't)*

- Contingency Fees:
  - Medicaid
    - State may only pay contingency fees from overpayments collected. If the state pays more than this, then it will come from state funds only
    - State will be mandated to refund Federal portion of overpayment, whether it was collected by State or not
- Management of Underpayments:
  - Medicare
    - Medicare contingency fees are based on the same fashion as the overpayments

 61

Comparison of Medicare vs. Medicaid *(con't)*

- Appeal Rights:
  - **Medicare:** 5 levels consistent throughout the country
  - **Medicaid:**
    - 2 proposed alternatives
      - State may use an existing appeals infrastructure to adjudicate Medicaid RAC appeals
      - State may elect to establish a separate appeals process for RAC determinations, which must also ensure providers adequate due process in pursuing an appeal

 62

Lessons Learned from the Medicare RA Program

- Medicare Demonstration Project showed lack of preparedness and flaws in RA contractor systems
  - Was a steep learning curve for RAC and providers
  - May be more problematic in Medicaid program with so many vendors and differing state rules
- Document problems for feedback to state and CMS
  - Provider feedback on Medicare RAC resulted in improvements for providers and changes in vendors
- Hold RA vendors accountable to follow your state rules

 63

Lessons Learned from the Medicare RA Program *(con't)*

- New Medicare Statement of Work for RAC released September 12, 2011
- Changed from RAC to simply Recovery Auditor (RA)
- After Medicare RACs failed to meet budgeted goals, CMS took a much more aggressive stance – including claims volume goals
- RAs rapidly adding issues, including complex reviews
- The situation is constantly evolving - as we expect Medicaid RAC to do, as well

 64

Lessons Learned from the Medicare RA Program *(con't)*

- Insist that you receive education from the state on the Medicaid RAC implementation and its rules
- Know your Medicaid Education Representative
  - Medicare RAs have not made education easily available
- Work through your state Hospital Association and use them as a resource (groups have a bigger voice)
- Develop links to the Medicaid RAC program for regular updates and searches
  - Much like checking the issues lists of your Medicare RA

 65

Key Points

- **Your Medicaid RAC appeal process will be different than the Medicare RAC appeal process**
  - Ensure that your process for Medicaid RAC appeals takes into consideration the following:
    - Levels and the process for appeal
    - Timely filing deadlines for appeal
    - Definitions of key terms – medical necessity, inpatient, outpatient, observation and readmissions

 66

Key Points *(con't)*

- Your hospital and designated staff should compile and comprehend the following:
  - Screening criteria employed by the contractor or state agency
  - Definitions from the state statute, administrative code, and Medicaid provider manuals
  - Contacts within the appropriate state agency
- Be prepared to add any Medicaid RAC-specific process changes into your overall plan

 67

Summary

- Understand your state's definitions and appeal process
- Many states have RAC-like entities or functional processes already in place
- Be aware of the Medicaid RAC chosen for your state as it may be performing the same function in another state. It is likely, as with Medicare RACs, that the Medicaid RACs will focus on similar issues, depending on their level of success

 68

Key Takeaways

- For Medicare and Medicaid reviews, you should focus on the front end process. If you are focusing on appeals, you've already lost
- Not all auditors are created equal; understand the differences and their potential impacts
- The best appeals address the clinical argument; reinforce your consistent process and follow the regulations

 69

Finally…

- It is no longer a matter of "IF" you are going to get audited, but "WHEN"
- You can win. You have to pay attention on the front end to provide documentation for audits

 70

CMS IPPS 2014 Final Rule

 71

Expectation/Certification

- Physician must document that they ***expect*** the beneficiary to require care spanning more than 2 midnights
- Certification (§424.13)
  - Begins with the order for inpatient admission
  - Must include the reasons for hospitalization for inpatient medical treatment
  - Must include diagnosis
  - Must include the estimated time the patient will need to remain in the hospital
  - Plans for posthospital care, if appropriate
  - May be entered on forms, notes, or records that the appropriate individual signs, or on a special separate form.
  - If information is in different places (i.e. progress notes, H+P) [certification] statement should indicate where it may be found
  - Must include services were provided in accordance with §412.3 of this chapter
  - Certification must be signed and documented in the medical record prior to the hospital discharge (if delayed – reason must be documented)
- Acknowledgment Statement must be on file at hospital

 72

Documentation

- "Order must be supported by objective medical information for the purposes of the Part A payment determinations."
- "Documentation is evaluated in conjunction with the order and certification."
- "While the physician order and the physician certification are required for all inpatient hospital admissions in order for payment to be made under Part A, the physician order and the physician certification are not considered by CMS to be conclusive evidence that an inpatient hospital admission or service was medically necessary. Rather, the physician order and physician certification are considered along with other documentation in the medical record."

Page 50940, IPPS

 73

Documentation - Efficiency

- For cases with > 2 midnights
  - Was the care provided in an efficient manner?
  - Was there a delay in service that resulted in prolonging the hospital stay?
    - i.e., why was the cardiac catheterization done on day 3 and not on day 2?
    - Weekend delay in stress test, initiation of services
    - Similar to some current commercial per diem reviews

 74

Documentation Improvement

Educate your physicians on documentation requirements*:

- Order requirements
- Certification requirements
- Expectation of 2 night stay
- Medical necessity rational each day to avoid question of delay in care

* EHR is available to assist you with your documentation training needs

 75

Review Considerations

- Review cases as close to time of admission as possible
- Cases that do not meet screening criteria should be sent to EHR
- Review should include:
  - Order in medical record
  - Certification in medical record
  - Expectation of 2 midnights
  - Documentation supporting medical necessity

 76

Impacts on process

- Medical cases or procedures with expected same day or next day discharge (hospital care not expected to span 2 midnights)
  - Procedures on the Medicare Inpatient Only List remain inpatient, require order pre-procedure and other documentation
  - Other cases will probably not meet threshold for inpatient consideration
- Medical cases or procedures with care expected to span 2 midnights
  - Need order, and usual medical necessity review approach
- Inpatient admissions expected to span 2 midnights but did not – may require additional review
- Outpatients whose LOS extends beyond 2 midnights may require additional review
- Some inpatients spanning 2 midnights may be pulled by contractors for efficiency review

 77

Summary

- Understand the new regulations
- No changes until October 1, 2013
- Maintain processes to ensure correct status at time of admission
- Establish process to ensure that required documentation is present on the medical record early in the hospital stay
- Continue to refer "grey zone" cases to EHR
- Stay tuned for CMS updates and subregulatory guidance
- Stay tuned for further EHR update on process implications

 78

Questions?

Joydip Roy, MD
Senior Director: Audit, Compliance and Education
jroy@ehrdocs.com

877-EHR-DOCS
www.ehrdocs.com
info@EHRDOCS.COM

 79

Appendix

 80

2013 OIG Work Plan Targets

Issues Impacting Hospitals:

- **Diagnosis-Related Group Window:** OIG will examine claims data to evaluate the possibility of saving money by expanding the DRG window from 3 days to 14 days. (p. 2)
- **Same-Day Readmissions:** OIG will examine trends in Medicare claims to evaluate effectiveness of combining same-day admissions into a single claim. (p. 2)
- **Payments for Cancelled Surgical Procedures:** OIG will examine inpatient admissions for cancelled surgical procedures (whether or not the procedure is rescheduled) and the possibility of precluding payment for the initial admission for the cancelled procedure. (p. 3)
- **Inpatient and Outpatient Payments to Acute Care Hospitals:** OIG will review claims for compliance with billing requirements. OIG will perform "focused review of claims" and review of compliance programs for hospitals at risk of overpayments. (p. 4)
- **IRFs – Transmission of Patient Assessment Instruments:** OIG will examine whether IRFs received reduced payments for transmitting PAIs to CMS more than 27 days following discharge. (p. 8)
- **IRFs – Appropriateness of Admissions and Level of Therapy:** OIG will examine appropriateness of IRF admissions and intensity of therapy required. (p. 8)
- **LTCHs** – OIG will examine the extent to which improper payments were made for interrupted stays in 2011. OIG will also look at readmission patterns. (p. 8)

 81

2013 OIG Also Looking at CMS Contractors

- **Overview of CMS' Contractor Landscape (New):** This review will determine the numbers, types, and dollar amounts of active CMS contracts, and will examine how CMS maintains all of its contract information. (p. 31)
- **MACs** – CMS' Monitoring and Assessment of Performance **(New)**: OIG will examine the extent to which CMS monitored MAC performance and identified performance deficiencies, as well as the extent to which MACs addressed these deficiencies. (p. 33)
- **RAs** – Identification and Recoupment of Improper and Potentially Fraudulent Payments and CMS' Oversight and Response: OIG will review RA-identified improper payments, vulnerabilities, and fraud referrals in 2010 and 2011 and CMS' response. (p. 34)
- **ZPICs** – CMS' Oversight of Task Order Requirements **(New):** OIG will review CMS oversight of fraud and abuse task order requirements for ZPICs. (p. 34)

 82

Additional OIG Activity

- Extrapolation began 4th quarter of 2012
  - The process that Medicare contractors use to estimate a total overpayment based on an audit of a smaller subset of claims
  - Statistical extrapolation can yield estimates of massive overpayments with minimal investment of contractor resources
- Physician-Hospital Billing Concordance
  - "…identify physician services at high risk for place-of-service miscoding and recover any identified overpayments."*

****Source: Review of Place-of-Service Coding for Physician Services Processed by Medicare Part B Contractors during Calendar Year 2009 (A-01-10-00516) http://go.usa.gov/0z6***

 83

OIG Now into Concordance

Review of Place-of-Service Coding for Physician Services Processed by Medicare Part B Contractors during Calendar Year 2009 (A-01-10-00516) http://go.usa.gov/0z6

We recommend that the Centers for Medicare & Medicaid Services (CMS) instruct its Medicare contractors to (1) recover approximately $3,000 in overpayments for the sampled services; (2) immediately reopen the claims associated with the non-sampled services, review our information on these claims (which have estimated overpayments of $9.5 million), and work with the physicians who provided the services to recover any overpayments; (3) continue to strengthen their education process and reemphasize to physicians and their billing agents the importance of correctly coding the place of service and the need for internal controls to prevent Medicare billings with incorrect place-of-service codes; and (4) **continue to work with program safeguard contractors and, if necessary to coordinate Part A and Part B data matches, with other Medicare contractors to develop a data match that will identify physician services at high risk for place-of-service miscoding and recover any identified overpayments.** CMS concurred with our recommendations and described the corrective actions that it was taking or planned to take.

 84

IPPS 2014 Final Rule: Table of Contents*

 85

IPPS 2014 Final Rule: Table of Contents*
(con't)

 86

Rebilling Evolution

	Prior to New Rulings	Interim 1455	CMS Final Rule
Self Auditing	Bill Part B Ancillaries only. Subject to limitations of CC 44	Allows providers to rebill only for claims denied by a Medicare contractor	Allows providers to rebill inpatient Part A claims denied as a result of a "self-audit"
Part B Rebilling	Only allowed if Judge determined appropriate. No regulations	Rebilling of covered Part B charges when the Part A claim is denied as not medically reasonable and necessary	Part B rebilling to claims for services rendered to beneficiaries enrolled in Medicare Part B
Timeliness for Rebilling	Only if within timely filing (one year) or Judge orders (no time limit)	Allows for rebilling 180 days from denial or lost appeal with date of service before Sept 30, 2013	Standard timely filing requirements (1 year from the date of service) on rebilled claims
Impact to Beneficiary	To be held harmless	Upon rebilling, requires hospital to adjust beneficiary billing	Upon rebilling, requires hospital to adjust beneficiary billing

 87

Get the Latest Industry News & Updates

EHR's Compliance Library
Register today at
www.ehrdocs.com

Follow EHR on Twitter!
@EHRdocs
http://www.twitter.com/EHRdocs

 88

About Executive Health Resources

AMA Solutions, Inc., a subsidiary of the American Hospital Association, is compensated for the use of the AMA marks and for its assistance in marketing endorsed products and services. By agreement, pricing of endorsed products and services may not be increased by the providers to reflect fees paid to the AMA.

EHR has been awarded the exclusive endorsement of the American Hospital Association for its leading suite of Clinical Denials Management and Medical Necessity Compliance Solutions Services.

PEER REVIEWED by HFMA

* HFMA staff and volunteers determined that this product has met specific criteria developed under the HFMA Peer Review Process. HFMA does not endorse or guarantee the use of this product.

EHR received the elite Peer Reviewed designation from the Healthcare Financial Management Association (HFMA) for its suite of medical necessity compliance solutions, including: Medicare and Medicaid Medical Necessity Compliance Management; Medicare and Medicaid DRG Coding and Medical Necessity Denials and Appeals Management; Managed Care/Commercial Payor Admission Review and Denials Management; and Expert Advisory Services.

BEST PLACES TO WORK
2008 ★ 2009 ★ 2010 ★ 2011 ★ 2012

EHR was recognized as one of the "Best Places to Work" in the Philadelphia region by Philadelphia Business Journal for the past five consecutive years. The award recognizes EHR's achievements in creating a positive work environment that attracts and retains employees through a combination of benefits, working conditions, and company culture.

 89

 90