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PROPRIETARY & CONFIDENTIAL

Disclaimer

- This material is designed and provided to communicate information about clinical documentation, coding, and compliance in an educational format and manner.
- The author is not providing or offering legal advice but, rather, practical and useful information and tools to achieve compliant results in the area of clinical documentation, data quality, and coding.
- Every reasonable effort has been taken to ensure that the educational information provided is accurate and useful.
- Applying best practice solutions and achieving results will vary in each hospital/facility and clinical situation.

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Agenda

- Overview of the Government's hold on healthcare today and getting to know the various agencies involved
- Benefit Integrity Programs and using your claims data to prepare
- Updates to the OIG Work Plan
- The appeals process
- Following the rules: Official Coding Guidelines, Medicare Manuals, Medicaid Guidelines
- Takeaway strategies

CHANGE HEALTHCARE

Medicare Parts A & B

- Medicare Part A covers certain inpatient services in hospitals and skilled nursing facilities (SNFs) and some home health services. Medicare Part B covers designated practitioners' services; outpatient care; and certain other medical services, equipment, supplies, and drugs that Part A does not cover. Centers for Medicare & Medicaid Services (CMS) uses Medicare Administrative Contractors to administer Medicare Part A and Medicare Part B and to process claims for both parts.
- Under current law, national health spending is projected to grow at an average rate of 5.5 percent per year for 2017-26 and to reach $5.7 trillion by 2026. While this projected average annual growth rate is more modest than that of 7.3 percent observed over the longer-term history prior to the recession (1990-2007), it is more rapid than has been experienced 2008-16 (4.2 percent).
- Health spending is projected to grow 1.0 percentage point faster than Gross Domestic Product (GDP) per year over the 2017-26 period; as a result, the health share of GDP is expected to rise from 17.9 percent in 2016 to 19.7 percent by 2026.
- OIG has focused its Medicare oversight reports on identifying and offering recommendations to reduce improper payments, prevent and deter fraud, and foster economical payment policies.

Source: The U.S. Centers for Medicare & Medicaid:
https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/nationalhealthexpenddata/nhe-fact-sheet.html

CHANGE HEALTHCARE

Let's Start with the MAC

- A Medicare Administrative Contractor (MAC) is a private health care insurer that has been awarded a geographic jurisdiction to process Medicare Part A and Part B (A/B) medical claims or Durable Medical Equipment (DME) claims for Medicare Fee-For-Service (FFS) beneficiaries.
- CMS relies on a network of MACs to serve as the primary operational contact between the Medicare FFS program and the health care providers enrolled in the program.
- MACs are multi-state, regional contractors responsible for administering both Medicare Part A and Medicare Part B claims. MACs perform many activities including:
  - Process Medicare FFS claims
  - Make and account for Medicare FFS payments
  - Enroll providers in the Medicare FFS program
  - Handle provider reimbursement services and audit institutional provider cost reports
  - Handle redetermination requests (1st stage appeals process)
  - Respond to provider inquiries
  - Educate providers about Medicare FFS billing requirements
  - Establish local coverage determinations (LCD's)
  - Review medical records for selected claims
  - Coordinate with CMS and other FFS contractors

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A/B Jurisdiction Map:10/17

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Home Health & Hospice MACs:10/17

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DME MACs: 10/17

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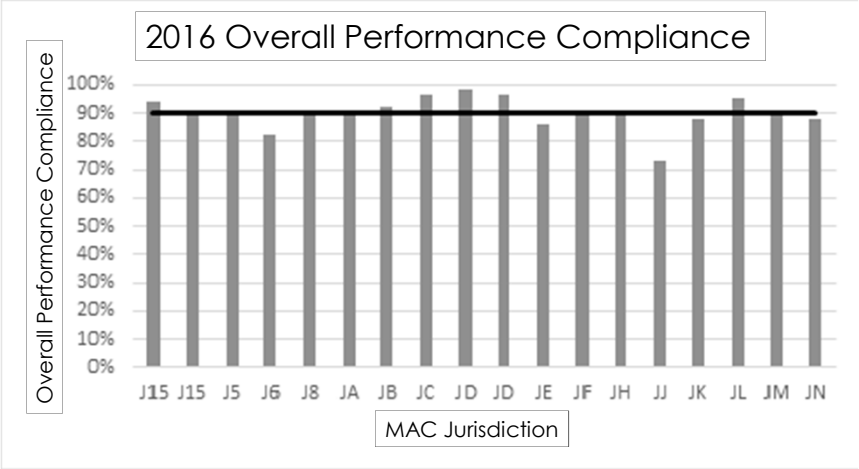
MB3

FY 2016 Overall MAC Performance Compliance



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On to the RACs

- RACs are CMS's Recovery Audit Contractors
- Section 302 of the Tax Relief and Health Care Act of 2006 made the RAC permanent and required the secretary to expand to all 50 states no later than 2010
- The mission of the Recovery Audit Program is to identify and correct Medicare and Medicaid improper payments through the efficient detection and collection of overpayments made on claims for health care services provided to Medicare and Medicaid beneficiaries, to identify underpayments to providers, and to provide information that allows CMS to implement actions that will prevent future improper payments.
- CMS oversees several different Recovery Audit Programs, such as those for Medicare FFS, Part C, and Part D. States oversee their own Medicaid Recovery Audit Programs in accordance with federal guidelines set by CMS.

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Slide 9

MB3 Cite source of data
McGhee, Brenda, 3/7/2018

Recovery Audit Program — It's Back!

- CMS awarded new FFS RAC contracts on October 31, 2016 to:
  - Region 1 – Performant Recovery, Inc.
  - Region 2 – Cotiviti, LLC
  - Region 3 – Cotiviti, LLC
  - Region 4 – HMS Federal Solutions
  - Region 5 – Performant Recovery, Inc.
- The RACs in Regions 1-4 will perform post-payment review to identify and correct Medicare claims that contain improper payments (overpayments or underpayments) that were made under Part A and Part B, for all provider types other than Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) and Home Health/Hospice.
- The Region 5 RAC will be dedicated to the post-payment review of DMEPOS and Home Health/Hospice claims nationally.
- RACs were approved to start the next round of audits in March 2017.

Source: The U.S. Centers for Medicare & Medicaid:
https://www.cms.gov/research-statistics-data-and-systems/monitoring-programs/medicare-ffs-compliance-programs/recovery-audit-program/recent_updates.html

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What Do the RACs Do?

- Identify improper payments from Medicare Part A and Part B claims
- Analyze claims and review those most likely to contain improper payments, which include:
  - Payments for items or services that do not meet Medicare's coverage and medical necessity criteria
  - Payment for items that are incorrectly coded
  - Payment for services where the documentation submitted did not support the services ordered
- Request and analyze provider claim documentation to ensure services provided were both reasonable AND medically necessary

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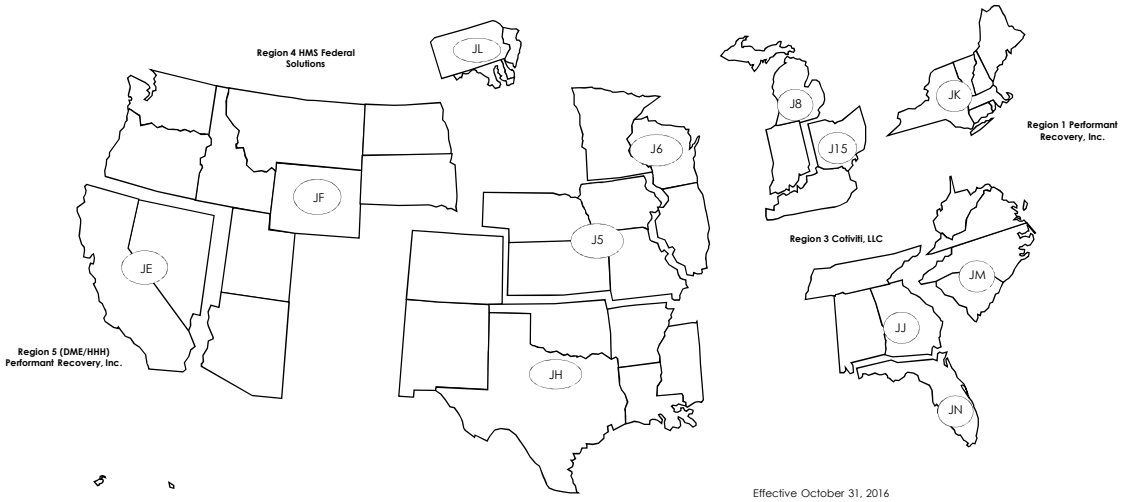
Current RAC Part A/B Jurisdictions



Effective October 31, 2016

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Total Corrections by Fiscal Year

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Medicare Fee-for-Service Recovery Audit Program

Total Corrections* - by Fiscal Year (FY)**

	FY 2010 (in Millions)	FY 2011 (in Millions)	FY 2012 (in Millions)	FY 2013 (in Millions)	FY 2014 (in Millions)	FY 2015^ (in Millions)	*National Program (in Billions)*
Overpayments Collected	$75.4	$797.4	$2,291.4	$3,650.9	$2,394.8	$359.7	*$9.3696*
Underpayments Returned	$16.9	$141.9	$109.4	$102.4	$173.1	$81.0	*$0.6247*
Total Corrections	$92.3	$939.3	$2,400.8	$3,753.3	$2,567.9	$440.7	*$10.2006*

* Amounts as reported in the Recovery Audit Program's Report To Congress for the respective Fiscal Year
**Fiscal Years run from October 1 of the previous calendar year, to September 30 of the next. For example, FY 2010 was from October 1, 2009 through September 30, 2010.
^ Amounts for FY2015 were reported in the FY2015 Agency Financial Report (AFR) released in November 2015

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RAC Statistics-Q3 2016

*Figures rounded to nearest hundredth; Nationwide figures rounded based on actual collections. Figures provided in millions. All correction data current through June 30, 2016

	Overpayment Collected	Underpayments Returned	Total Quarter Corrections	FY to Date Corrections
Region A: Performant	$13.41	$3.45	$16.86	$54.30
Region B: CGI	$10.50	$1.12	$11.62	$37.00
Region C: Cotiviti	$23.04	$9.34	$32.37	$166.42
Region D: HDI	$28.28	$10.38	$38.66	$176.80
Nationwide Total	$75.22	$24.29	$99.52	$434.52

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Top Issues Per Region-3Q 2016

Region A	**(Issue # A000382009)** (complex review) **MS-DRG Coding Validation: Severe Sepsis** MS-DRG Validation requires that diagnostic and procedural information and the discharge status of the beneficiary, as coded and reported by the hospital on its claim, matches both the attending physician description and the information contained in the beneficiary's medical record. Reviewers will validate for MS DRGs 177, 189, 193, 291, 438, 441, 592, 602, 682, 691, 693; principal diagnosis, secondary diagnosis, and procedures affecting or potentially affecting the MS-DRG.
Region B	**(Issue # B001012013)** (complex review) **Outpatient Therapy Claims above $3,700 Threshold – Skilled Nursing Facility** Targeted post-payment review of outpatient therapy claims paid in 2014 that reached the $3,700 threshold for PT and SLP services combined and/or $3,700 for OT services. When one or more lines of a claim have reached a therapy threshold, all lines of therapy services on that claim are subject to review.
Region C	**(Issue # C002492013)** (complex review) **Outpatient Therapy Claims above $3,700 Threshold – Outpatient Hospital** CMS determines an annual per beneficiary therapy cap amount for each calendar year. Exceptions to the therapy cap are allowed for reasonable and necessary therapy services. Per beneficiary, services about $3,700 for PT and SLP services combined and/or $3,700 for OT services are subject to manual medical review.
Region D	**(Issue # D001712010)** (complex review) **MS-DRG Coding Validation: Infections** DRG validation requires that diagnostic and procedural information and the discharge status of the beneficiary, as coded and reported by the hospital on its claim, matches both the attending physician description and the information contained in the beneficiary's medical record. Reviewers will validate for MSDRGs 094, 095, 096, 853, 855, 867, 868, 869, principal diagnosis, secondary diagnosis, and procedures affecting or potentially affecting the DRGs. (At this time, Medical Necessity excluded from review)

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New RAC Enhancements

- A major change to the RAC program is that CMS is requiring recovery auditors to support the agency throughout the entire appeals process, including at the administrative law judge (ALJ) level.
- The time frame for completing claims reviews is cut in half, from 60 to 30 days, and the new program gives CMS more teeth to stop work with a contractor that does not follow guidelines.
- RAC's must wait 30 days to allow for a discussion before sending the claim to the MAC for adjustment, and must provide receipt of a request within 3 business days.

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New RAC Enhancements

- CMS will work with Recovery Auditors to enhance their provider portals, including more uniformity and consistency in the claim status section, as well as display reason statement identifiers where available.
- CMS will require the RAC to broaden their review topics to include ALL claim/provider types and will be required to review certain topics based on a referral, such as an OIG report.
- RACs will not receive a contingency fee until **after** the second level of appeal is exhausted.
  - This delay in payment helps assure providers that the decision made by the Recovery Auditor was correct based on Medicare's statutes, coverage determinations, regulations and manuals.

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New RAC Enhancements

- RACs are required to maintain an overturn rate of less than 10% at the first level of appeal, excluding claims that were denied due to no or insufficient documentation or claims that were corrected during the appeal process. If the RACs overturn rate is less than 10%, the contingency fee they receive will increase.
- RACs are required to maintain an accuracy rate of at least 95%. Failure to maintain an accuracy rate of 95% will result in a progressive reduction in ADR limits.
- RACs are required to have a Contractor Medical Director and are encouraged to have a panel of specialists available for consultation. In addition, physicians are afforded the opportunity to discuss the improper payment identification with the Contractor Medical Director, who is a physician.
- CMS requires the RACs to provide consistent and more detailed review information concerning new issues to their websites as well as broaden their review topics to include all claim/provider types, and will be required to review certain topics based on a referral, such as an OIG report.
- CMS instructed the RACs to incrementally apply the additional documentation request (ADR) limits to new providers under review and revised the ADR limits for facility claims. The limits are diversified across all claim types of a facility (e.g., inpatient, outpatient).
- RACs will have 30 days to complete complex reviews and notify providers of their findings.
- RACs must wait 30 days to allow for a discussion request before sending the claim to the MAC for adjustment.

CHANGE HEALTHCARE

Process for Approval of New Issues

- To ensure that the RAC is making accurate claim determinations all reviews must receive CMS approval prior to proceeding with widespread reviews.
- RAC compiles required information supporting improper payment concepts to CMS for review and approval.
- "New Issue" packets are reviewed by CMS to verify audit concepts and ensure all supporting documentation is relevant and accurate prior to approving. Incomplete or incorrect new issue submissions are returned for correction or outright rejected.
- Information submitted may include and is not limited to the following elements.
  - ***Issue description***
    - ***Provider type***
    - ***Error type***
    - ***CMS policy references o Codes for review***
  - ***Edit parameters***
    - ***Dates and states requested for review o Good cause for claim reopening***
    - ***Improper payment rationale***
    - ***Claim samples***
- RAC identifies an issue to pursue or revise
- RAC submits New Issue package to CMS for approval
- RAC reviews comments from CMS to either improve the issue or not pursue. Then resubmit through same process
- Approved New Issues are posted to RACs Provider Portal as well as CMS.gov.

CHANGE HEALTHCARE

Additional Topics Proposed for Review: 2/14/18

Lab Services Rendered During an Inpatient Stay

- Description:
  - Laboratory services are covered under Part A, excluding anatomic pathology services and certain clinical pathology services, therefore if billed separately should be denied as unbundled services.
  - State(s)/MAC regions where reviews will occur:
  - All states
- Review type:
  - Automated review
- Provider type:
  - Lab
- Affected code(s):
  - HCPCS codes for:
    - Organ or Disease-Oriented Panels: CPT Code Range 80048-80076
    - Therapeutic Drug Assays: CPT Code Range 80150-80203
    - Evocative/Suppression Testing: CPT Code Range 80400-80439
    - Urinalysis: CPT Code Range 81000- 81050
    - Chemistry: CPT Code Range 82009-84830
    - Hematology and Coagulation: CPT Code Range 85002- 85810
    - Immunology: CPT Code Range 86602- 86804
    - Microbiology: CPT Code Range 87003-87905
  - Applicable policy references:
    - CMS IOM 100-04 Chapter 3, section 10.4
    - CPT Coding Book

CHANGE HEALTHCARE

Additional Topics Proposed for Review: 2/14/18

Cataract Removal – Excessive Units by Physician (Partial Denial)

- Description:
  - Cataract removal cannot be performed more than once on the same eye on the same date of service. Providers billing for more than one unit of cataract removal for the same eye, on the same claim line, will be denied. The New Issue indicates the finding is billed on the same claim line with units greater than 1 (for the same eye). The provider is entitled to payment for one eye and only a partial payment will be recovered.
- State(s)/MAC regions where reviews will occur:
  - All
- Review type:
  - Automated
- Provider type:
  - Physician/Non-Physician Practitioner
- Affected code(s):
  - CPT 66830, 66840, 66850, 66852, 66920, 66930, 66940, 66982, 66983, 66984
- Applicable policy references:
  - Title XVIII of the Social Security Act: Section 1833(e)
  - Title XVIII of the Social Security Act: Section 1862(a)(1)(A)

CHANGE HEALTHCARE

Additional Topics Proposed for Review: 2/14/18

Cataract Removal – Excessive Units by Physician (Full Denial)

- Description:
  - Cataract removal cannot be performed more than once on the same eye on the same date of service. Providers billing for more than one unit of cataract removal for the same eye will be denied. This new issue indicates that findings are across claims, for the same eye, and the finding claim line is a Full recovery.
- State(s)/MAC regions where reviews will occur:
  - All
- Review type:
  - Automated
- Provider type:
  - Physician/Non-Physician Practitioner
- Affected code(s):
  - CPT 66830, 66840, 66850, 66852, 66920, 66930, 66940, 66982, 66983, 66984
- Applicable policy references:
  - Title XVIII of the Social Security Act: Section 1833(e)
  - Title XVIII of the Social Security Act: Section 1862(a)(1)(A)
  - National Correct Coding Initiative (NCCI) Policy Manual (Chapter 8, Section D)

CHANGE HEALTHCARE

Additional Topics Proposed for Review: 2/14/18

Ancillary Services Billed without an Approved Surgical Procedure

- Description:
  - Select covered ancillary items and services are not payable if there is no approved ambulatory surgery center (ASC) surgical procedure on the same claim or in history for the same date of service and same provider.
- State(s)/MAC regions where reviews will occur:
  - All
- Review type:
  - Automated
- Provider type:
  - Ambulatory Surgery Center
- Affected code(s):
  - HCPCS/CPT Codes identified on the ASC Fee Schedule
- Applicable policy references:
  - Title XVIII of the Social Security Act: Section 1833(e)
  - Medicare Claims Processing Manual: CMS Publication 100-04; Chapter 14, § 40

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Additional Topics Proposed for Review: 2/14/18

CSW (Clinical Social Workers) during Inpatient Stay

- Description:
  - Services of Clinical Social Workers (CSW) rendered during inpatient hospital stay are included in the facility's PPS payment and are not separately payable under Part B. CSW providers are expected to seek reimbursement from the facility.
- State(s)/MAC regions where reviews will occur:
  - All
- Review type:
  - Automated
- Provider type:
  - Clinical Social Workers
- Affected code(s):
  - Psychiatry HCPCS/CPT Codes 90801-90899
- Applicable policy references:
  - Title XVIII of the Social Security Act: Section 1833(e)
  - Medicare Benefit Policy Manual: CMS Publication 100-02; Chapter 15, § 170
  - Medicare Claims Processing Manual: CMS Publication 100-04; Chapter 3, § 10.4

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Additional Topics Proposed for Review: 2/14/18

Technical Component of Lab/Pathology for Outpatient Hospitals

- Description:
  - The technical component (TC) of lab/pathology services to patients in an outpatient hospital setting are not separately payable. Findings are limited to claim lines billed with TC/PC indicator "3" for the TC component only.
- State(s)/MAC regions where reviews will occur:
  - All states
- Review type:
  - Automated review
- Provider type:
  - Physician/ Non-Physician Practitioner
- Affected code(s):
  - All Lab/Pathology CPT/HCPCS codes with TC/PC indicator 3 and/or CPT/HCPCS modifier TC
- Applicable policy references:
  - Title XVIII of the Social Security Act: Section 1833(e)
  - Medicare Claims Processing Manual: CMS Publication 100-04; Chapter 23; File Layout

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Additional Topics Proposed for Review: 2/14/18

Labs Subject to Part B Consolidated Billing by Clinical Lab – End Stage Renal Disease (ESRD)

- Description:
  - Certain laboratory services and limited drugs and supplies will be subject to Part B consolidated billing and will no longer be separately payable when provided for ESRD beneficiaries by providers other than the renal dialysis facility. Claims will be recouped for Labs subject to ESRD Consolidated Billing that are bundled into the facility payment.
- State(s)/MAC regions where reviews will occur:
  - All states
- Review type:
  - Automated review
- Provider type:
  - Professional Services (Physician/Non-Physician Practitioner)
- Affected code(s):
  - "Labs subject to ESRD Consolidated Billing" for CY 2014-2017 found on www.cms.gov/Medicare/Medicare-Fee-for-ServicePayment/ESRDpayment/Consolidated_Billing.html
- Applicable policy references:
  - Title XVIII of the Social Security Act, Section 1833. [42 U.S.C. 1395l] (e)
  - Medicare Claims Processing Manual 100-04; Chapter 8, Section 60.1 (effective 4/01/2015)
  - ESRD PPS Consolidated Billing from www.cms.gov/Medicare/Medicare-Fee-for-ServicePayment/ESRDpayment/Consolidated_Billing.html

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Additional Topics Proposed for Review: 2/14/18

Observation Evaluation & Management (E&M) Services Billed Same Day as Inpatient Admission

- Description:
  - Inpatient hospital E&M codes can't be billed on the same day as an E&M observation code for the same patient on the same date of service for the same provider.
- State(s)/MAC regions where reviews will occur:
  - All states
- Review type:
  - Automated review
- Provider type:
  - Professional Services (Physician/Non-Physician Practitioner)
- Affected code(s):
  - 99217, 99218, 99219, 99220, 99224, 99225, 99226
- Applicable policy references:
  - Title XVIII of the Social Security Act: Section 1833(e)
  - Medicare Claims Processing Manual: Publication 100-04; Chapter 12, § 30.6.8 (D)

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Additional Topics Proposed for Review: 2/14/18

Ventilators Subject to ACA Requirements Prior to January 1, 2016

- Description:
  - Identify claims for Ventilators that do not meet the indications of coverage and/or medical necessity.
- State(s)/MAC regions where reviews will occur:
  - All
- Review type:
  - Complex
- Provider type:
  - DME Supplier and DME by Physician
- Affected code(s):
  - E0450, E0460, E0461, E0463, E0464
- Applicable policy references:
  - Code of Federal Regulations, 42 CFR sections 405.980 (b) & (c) and section 405.986
  - Code of Federal Regulations, 42 CFR; section 410.38(g)(3)
  - Code of Federal Regulations, 42 CFR; section 410.38(g)(4)
  - Code of Federal Regulations, 42 CFR; section 424.57 (a)(12)
  - Title XVIII, Social Security, §1833(e)
  - Title XVIII, Social Security, §1862(a)(1)(A)
  - CMS, IOM Publication 100-02, Medicare Benefit Policy Manual, Chapter 15, Sections 110
  - CMS, IOM Publication 100-08, Medicare Program Integrity Manual, Chapter 4, Section 4.26
  - CMS, IOM Publication 100-08, Medicare Program Integrity Manual, Chapter 5, Section 5.2.4 – 5.2.8, 5.7, 5.8, and 5.9
  - CMS, IOM Publication 100-04, Medicare Claims Processing Manual Chapter 20
  - CMS, IOM Publication 100-03, Medicare National Coverage Determination Manual, Chapter 1, Part 4, §280.1

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Medical Record Request (ADR) Limits for Institutional Providers

- **Additional Documentation Limits for Institutional Providers can be found at:**
  - https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare- FFS-Compliance-Programs/Recovery-Audit-Program/Downloads/Institutional-Provider- Facilities-ADR-Limits-May-2016.pdf
- CMS will calculate each provider's ADR limit and will provide the limits to the RAC's. Examples of how the ADR limits are calculated can be found in the link above.
- The annual ADR Limit will be **one-half of one percent** (0.5%) of the provider's total number of paid Medicare claims from the previous year. The number of paid claims is determined by the 6-digit **CMS Certification Number (CNN)** and the provider's **National Provider Identifier (NPI)** number.
- For Institutional claims, ADR limits will be diversified across all claim types based on type of bill (TOB) and limited to no more than a 3-year look-back period from claim paid date based on using the .5% non adjusted baseline criteria.
- ADR letters are sent on a 45-day cycle. The annual ADR Limit will be divided by 8 to establish the ADR cycle limit, which is the maximum number of claims that can be included in a single 45-day period. Although the Recovery Auditors may go more than 45 days between record requests, in no case shall they make requests more frequently than every 45 days.

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ADR Limits for Physician/Non-Physician Providers (effective 1/1/16)

- A baseline annual ADR limit is established for each provider based on the number of Medicare claims paid in a previous 12-month period that are associated with the provider's 6-digit **CMS Certification Number (CCN)** and the provider's **National Provider Identifier (NPI)** number.
- Using the baseline annual ADR limit, an ADR cycle limit is also established. After three (3) 45-day ADR cycles, CMS will calculate (or recalculate) a provider's Denial Rate, which will then be used to identify a provider's corresponding "Adjusted" ADR Limit.
- Recovery Audit Contractors may choose to either conduct reviews of a provider based on their Adjusted ADR Limit (with a shorter look-back period) or their baseline annual ADR limit (with a longer look-back period).

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ADR Limits for Physician/Non-Physician Providers

- The baseline annual ADR Limit is **one-half of one percent** (0.5%) of the provider's total number of paid Medicare claims from a previous 12-month period.
- ADR letters are sent on a 45-day cycle. The baseline annual ADR Limit is divided by eight (8) to establish the ADR cycle limit, which is the maximum number of claims that can be included in a single 45-day period.
- Although the Recovery Audit Contractors may go more than 45 days between record requests, in no case shall they make requests more frequently than every 45 days.

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Examples of ADR:

- **Provider A** billed and was paid for 22,530 Medicare claims in 2014. The provider's baseline annual ADR limit would be 22,530 x 0.005, which is 112.65. The ADR cycle limit would be 112.65/ 8, which is 14.08, and would be rounded to **14** additional documentation requests per 45 days.
- **Provider B** billed and was paid for 255,000 Medicare claims in 2014. The provider's baseline annual ADR limit would be 255,000 x 0.005, which is 1,276. The ADR cycle limit would be 1,276/ 8, which is 159.375, and would be rounded to **159** additional documentation requests per 45 days.
- ADR limits must be diversified across all claim types of a facility, based on the Types of Bill (TOB) that the provider was paid for in the previous year.

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Risk-Based, Adjusted ADR Limits (updated 1/29/18)

- After three (3) 45-day ADR cycles, CMS will calculate (or recalculate) a provider's Denial Rate, which reflects their compliance with Medicare rules.
- The **Denial Rate** will be calculated using the number of claims containing improper payments that resulted in overpayments (less any determinations that are fully overturned during appeal) divided by the total number of reviewed claims, expressed as a percentage, on a cumulative basis.
- The Denial Rate will then be used to identify a provider's corresponding "Adjusted" ADR Limit, based on **Table 1**, on the next slide. The **Adjusted ADR Limit** will be used for the next three (3) 45-day ADR cycles.

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Risk-Based, Adjusted ADR Limits (updated 1/29/18)

- Table 1-per CMS website provider resources page

Denial Rate (Range)	Adjusted ADR Limit (% of Total Paid Claims)
91 – 100%	5.0%
71 – 90%	4.0%
51 – 70%	3.0%
36 – 50%	1.5%
21 -35%	1.0%
10 – 20%	0.5%
4 – 9%	0.25%
0 – 3%	No reviews for 3 (45-day) review cycles

Source: The U.S. Centers for Medicare & Medicaid:
January 29, 2018 - Institutional Provider (Facilities) ADR Limits [PDF, 75KB]

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Risk-Based, Adjusted ADR Limits (updated 1/29/18)

Example:

- After three (3) 45-day review cycles, **Provider A** had 20 claims containing improper payments (10 overpayments and 10 underpayments), out of a total of 42 reviewed claims. The Denial Rate would be 10 ÷ 42, which is 23.8% (rounded to 24%). Using Table 1, the Adjusted ADR limit would be 1.0% (two (2) times the baseline of 0.5%).
- In other words, Provider A previously had an ADR cycle limit of 14, and the Adjusted ADR Limit would be 2 x 14, which is 28.
- This Adjusted ADR limit would then apply to the next three (3) review cycles, after which their Denial Rate would be recalculated.

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ADR Look-back Period

Look-back Period

- Recovery Auditors who choose to review a provider using their Adjusted ADR limit must review under a 6-month look-back period, based on the claim paid date.
- Recovery Auditors who choose to review a provider using their 0.5% baseline annual ADR limit may review under a 3-year look-back period, per CMS approval.

CHANGE HEALTHCARE

PROPRIETARY & CONFIDENTIAL

ADR: Use of Extrapolation

- CMS will consider allowing Recovery Auditors to use extrapolation to estimate overpayment amounts for:
  - Providers who maintain a high denial rate for an extended time period
  - Providers who have excessively high denial rates for a shorter time period
  - Providers with a moderate denial rate, whose improper payments equal a significantly high overpayment dollar amount
- CMS reserves the right to establish a different record limit when directing the Recovery Audit Contractors to conduct reviews of specific topics or providers.

CHANGE HEALTHCARE

PROPRIETARY & CONFIDENTIAL

Provider Options: RAC Overpayment Determination

	Discussion Period	Rebuttal	Redetermination
Which option should I use?	The discussion period offers the opportunity for the provider to provide additional information to the RAC to indicate why recoupment should not be initiated. It also offers the opportunity for the RAC to explain the rationale for the overpayment decision. After reviewing the additional documentation submitted the RAC could decide to reverse their decision. A letter will go to the provider detailing the outcome of the discussion period.	The rebuttal process allows the provider the opportunity to provide a statement and accompanying evidence indicating why the overpayment action will cause a financial hardship and should not take place. A rebuttal is not intended to review supporting medical documentation nor disagreement with the overpayment decision. A rebuttal should not duplicate the redetermination process. (See 42 CFR 405.374-375)	A redetermination is the first level of appeal. A provider may request a redetermination when they are dissatisfied with the overpayment decision. A redetermination must be submitted within 30 days to prevent offset on day 41.
Who do I contact?	Recovery Audit Contractor (RAC)	Claim Processing Contractor	Claim Processing Contractor
Timeframe	Day 1-30	Day 1-15	Day 1-120 Must be submitted within 120 days of receipt of demand letter. To prevent offset of day 41 the Redetermination must be filed within 30 days.
Timeframe Begins	Automated Review: Upon receipt of the Initial Findings Letter (IFL) Complex Review: Upon receipt of Review Results Letter	Date of Demand Letter	Upon receipt of Demand Letter
Timeframe Ends	Day 30 (offset begins on day 41)	Day 15	Day 120

CHANGE HEALTHCARE

PROPRIETARY & CONFIDENTIAL 39

Additional Documentation Request (ADR) Letter

Send requested documentation to support review of claim(s)

- RAC will request both specific items and the complete record for review. To avoid unnecessary delays and potentially incorrect findings submit ALL documentation to support the billing and coding of the claims under review.
- You may submit records via esMD, CD/DVD, or paper. It is important that providers **send one, complete submission** of records as the audit timeframe begins upon receipt of any record related to the review. Do not send multiple submission of records.
- To avoid unnecessary delays, if there are questions or problems with locating the complete record set please contact your RACs Customer Service department for assistance.

CHANGE HEALTHCARE

PROPRIETARY & CONFIDENTIAL 40

Medical Record Submissions

You may submit requested documentation via:

- **Electronic submission (esMD),** or
- **Postal mail**
  - Either as images on CD/DVD, or
  - On paper

CHANGE HEALTHCARE

Electronic Submission (esMD)

CMS offers Providers an automated mechanism for submitting medical documentation via an Health Information Handler (HIH)

- The esMD system allows providers and HIHs to electronically send their responses to Additional Documentation Request (ADR) letters to review contractors during the claims review process.
- One of the benefits of using esMD is that it can help mitigate late submissions and potential technical denials.
- The RAC cannot recommend a HIH, however there are seventeen HIH's available to offer esMD gateway services to Providers.
  - They can be found at: https://www.cms.gov/Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/ESMD/

CHANGE HEALTHCARE

Medical Record Payment

The RAC is required to reimburse providers for the submission of medical records in accordance with the current guidelines prescribed in the PIM section 3.2.3.6.

- The current per page rate reimbursement for medical records submission costs is:
  - 0.12 cents per page, plus first class postage, for reproduction of PPS provider records
  - 0.15 cents per page, plus first class postage, for reproduction of non-PPS institutions and practitioner records
  - Providers (such as critical access hospitals) under a Medicare reimbursement system receive no photocopy reimbursement
  - An additional $2 is added for esMD submissions per case in lieu of postage
  - **The maximum payment to a provider per medical record shall not exceed $25.**
- The RAC will track record submissions and issue a check within 45 days of the record submission. There is no requirement to invoice.

CHANGE HEALTHCARE

PROPRIETARY & CONFIDENTIAL 43

RAC Audit Guidelines

- The RAC shall comply with all NCDs, national coverage/coding articles, LCDs, local coverage/coding articles, and provisions in Internet Only Manuals, such as the Claims Processing Manual and the PIM. NCDs, LCDs, and coverage/coding articles can be found in the Medicare Coverage Database at http://www.cms.gov/medicare-coverage-database/
- Internet Only Manuals can be found at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs.html
  - In addition, the RAC shall comply with all applicable change requests and Technical Direction Letters forwarded to the RAC by the CMS COR.
- The RAC shall not apply any policy retroactively to claims processed prior to the effective date of the policy. The RAC shall ensure that policies utilized in making a review determination are applicable at the time the service was rendered.
- The RAC shall clearly document the rationale for the review determination. This rationale shall include a detailed description of the Medicare policy or rule that was violated and a statement as to whether the violation resulted in an improper payment. The RAC shall ensure they are identifying pertinent facts contained in the medical record/documentation to support the review determination. Each rationale shall be specific to the individual claim under review and shall be included in the review results letter sent to the provider.

CHANGE HEALTHCARE

PROPRIETARY & CONFIDENTIAL 44

RAC Automated Workflow (Example from Performant)

RAC Selection	Generate Initial Finding Letter	30 Day Hold	Discussion Period Review
• Identify Claims for Selection • Report to RAC DW to remove exclusions, suppression, bankruptcies	• Print and mail letters	• All findings held for 30 days • Allows provider to file a discussion period within 30 days • If no discussion period received, claims are sent to MAC on day 31	• Dedicated stuff to review discussions within 30 days

Customer Service	MAC	Print and Mail Discussion Result Letters
• Answers questions • Performs courtesy calls and additional record requests • Provides record receipt extensions • Validates medical record payments	• Issues demand letter for findings submitted by the RAC with appeal rights • Initiates recoupment day 41 • Handles Level 1 Appeals	• Discussion period result letters sent • Overturned claims are closed. No further action will be taken. • Upholds are sent to the MAC

Operations

Audit

CHANGE HEALTHCARE

PROPRIETARY & CONFIDENTIAL 45

RAC Complex Workflow (Example from Performant)

RAC Selection	Generate Medical Record Requests	Records Received	Distribute Records and Perform Audits	Quality Assurance
• Identify Claims for Selection • Report to RAC DW to remove exclusions, suppression, bankruptcies	• Print and mail letters • Provider has 45 to send records	• Via CD, paper, or esMD, scanned into system	• Distribution of records to Nurses and Coders audit staff • Follow CMS Guidelines, MR, LCD, NDC, InterQual, Coding guidelines • Customized rationale • Complete review within 30 days	• 100% for new auditors and new concepts; monthly random selection thereafter • All findings are reviewed • CMD oversight

Customer Service	MAC	Discussion Period Review	30 Day Hold	Print and Mail Review Results Letters
• Answers questions • Performs courtesy calls and additional record requests • Provides record receipt extensions • Validates medical record payments	• Issues demand letter for findings submitted by the RAC with appeal rights • Initiates recoupment day 41 • Handles Level 1 Appeals	• Dedicated staff to review Discussions within 30 days • Discussion period result letters sent • Overturned claims are closed. No further action will be taken. • Upholds are sent to the MAC	• All findings held for 30 days • Allows provider to file a discussion period within 30 days • If no discussion period received, claims are sent to MAD on day 31	• Finding and No Finding letter generated

Operations Audit

CHANGE HEALTHCARE

PROPRIETARY & CONFIDENTIAL 46

The Discussion Period

Purpose:

- Provides an opportunity for the provider to submit additional information if you disagree with the review determination.
- RAC takes into consideration additional information, re-audits the account, and either upholds or overturns the original decision.
- One benefit of filing a discussion period is that if the decision is overturned, the RAC will not send an adjustment to the MAC. No further action will be required on your part.

Timeframe:

- Provider has 30-calendar days to submit a request for a discussion period.
- The 30-day period begins from the date of the Review Results Letter.
  - For automated reviews it's the Initial Findings Letter ("IFL")
  - For complex reviews it's the Review Results Letter ("RRL")
- The discussion period request is acknowledged via the provider portal within 1 day.
- The RAC has 30-days from receipt of the discussion period request to respond to the provider.
- Providers will be notified of the discussion period review outcome via a letter and the provider portal will be updated to reflect the date and outcome of the discussion review decision.
  - If the audit is overturned in the providers favor, the audit is closed and no further action will be required on your part. If the audit decision is upheld, the MAC is notified and a demand letter will be mailed by the MAC.
  - If you disagree with the Discussion decision, you can file an appeal to the MAC for Reconsideration. You have 120 days from the date of Demand letter to file an appeal.

CHANGE HEALTHCARE

Appeals (We Will Get Into More Later)

Process Overview

- Providers do not always have to file an appeal. You are encouraged to file a discussion prior to an appeal.
  - This gives the RAC the opportunity to evaluate the original determination
  - If the review determination is to overturn the finding, no further action will be taken
  - It lessens the administrative burden for both you and your Medicare Administrative Contractor (MAC)
- If the Provider feels the RAC determination to uphold a decision during the discussion period was not sufficient, the provider has the right within the specified timeframe to file an appeal.
- MACs manage the appeals process. The timeframes are clearly defined in the demand letter a provider receives.

CHANGE HEALTHCARE

New: The RAC Validation Contractor (RVC)

Per the RVC SOW:

- The RVC shall review a random sample of claims on which the RAC has made improper payment determinations and the claims have been adjusted. The RVC shall also review any written correspondence sent to the providers for clarity and accuracy. The RVC shall submit reports to CMS on their findings.
- The RVC shall conduct special studies upon request from CMS and will submit an analysis of their recommendations and findings.
- The RVC shall meet and communicate with CMS and the RACs about their review findings, as well as developing public relations material upon CMS' request.
- The RVC shall ensure compliance with all SOW and CMS system requirements, including Information Technology (IT) systems security policies, procedures and practices. This includes participating in the necessary security testing to obtain an Authority to Operate (ATO).

CHANGE HEALTHCARE

PROPRIETARY & CONFIDENTIAL 49

New: The RAC Validation Contractor (RVC)

- CMS will provide up to 1,000 randomly selected claims per month to send to the RVC. The type of claims will be proportional to the provider types that the RAC reviews (inpatient hospital, inpatient rehabilitation facility, outpatient hospital, skilled nursing facility, physician, lab/ambulance/other carrier, home health, and DME). CMS will notify the RACs which claims were selected for review and the RACs will forward the claim information to the RVC within seven (7) business days or unless otherwise specified by CMS. The accuracy review begins once the RVC receives claim detail information from the RAC.
- The RACs are given the opportunity to dispute an RVC "denial." The RACs are given 30 days to file a dispute and then the RVC has only 10 days to submit a response to the dispute. If the RVC determines that the RAC was indeed correct, the RVC must not only reverse their denial but must also submit a corrective action plan to the CMS outlining how they plan to prevent future inappropriate denials. If the RVC stands by their original denial, the case then goes to CMS who makes a final determination.

CHANGE HEALTHCARE

PROPRIETARY & CONFIDENTIAL 50

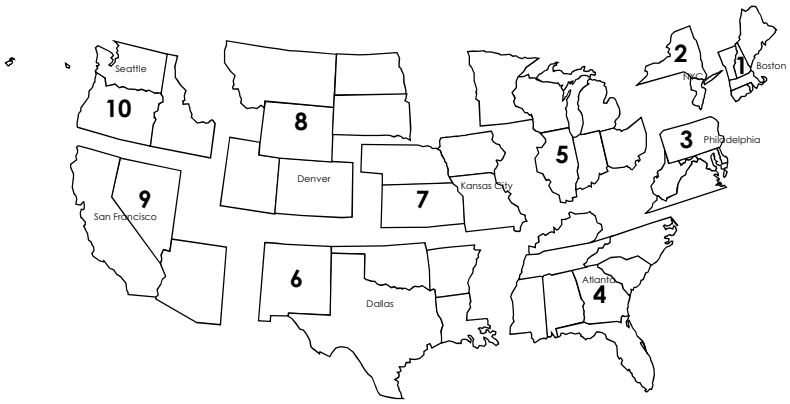
New: The RAC Validation Contractor (RVC)

- Notably absent from this process is the provider; if a claim was denied by the RAC, reviewed by the RVC and the RVC determines that the RAC denial was inappropriate, there is no provision for the RAC denial itself to be automatically overturned.
- The provider still must go through the formal appeal process and in fact the provider will never be notified that the RVC determined that the RAC denial was inappropriate.
- Also absent is any formal plan for corrective actions required by the RACs for high rates of RVC denials nor any changes to their contingency fees; CMS will receive reports from the RVC on RAC performance but what is done with that information is left to CMS.
- The RVC will also be used by CMS for two other duties.
  - They will be tasked with occasional special studies to review "topics of interest" to CMS and will review new issues that the RAC has proposed to CMS to be added to the list of approved issues. The new issue proposal process itself requires the RAC to produce a "package" outlining the proposed issue, their planned edit guidelines, their review guidelines for complex reviews, the claim selection criteria and their references. The RVC will determine if each new issue package is ready to be presented to the CMS Review Plan Team for consideration.
  - And finally, it seems no audit agency can be contracted by CMS without a plan to audit that agency so the RVC will be required to perform a quality assurance audit on 30% of the claims audited by its own staff for accuracy.
- An RFP was submitted by CMS on 12/7/17

CHANGE HEALTHCARE

PROPRIETARY & CONFIDENTIAL 51

CMS Regions



Region 1 – Boston
Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont

Region 2 – New York
New Jersey, New York, Puerto Rico, and the Virgin Islands

Region 3 – Philadelphia
Delaware, District of Columbia, Maryland, Pennsylvania, Virginia, and West Virginia

Region 4 – Atlanta
Alabama, Florida, Georgia, Kentucky, Mississippi, North Carolina, South Carolina, and Tennessee

Region 5 – Chicago
Illinois, Indiana, Michigan, Minnesota, Ohio, and Wisconsin

Region 6 – Dallas
Arkansas, Louisiana, New Mexico, Oklahoma, and Texas

Region 7 – Kansas City
Iowa, Kansas Missouri, and Nebraska

Region 8 – Denver
Colorado, Montana, North Dakota, South Dakota, Utah, and Wyoming

Region 9 – San Francisco
Arizona, California, Hawaii, Nevada, American Samoa, Commonwealth of the Northern Mariana Islands, Federated States of Micronesia, Guam, Marshal Islands, and Republic of Palau

Region 10 - Seattle
Alaska, Idaho, Oregon, and Washington

CHANGE HEALTHCARE

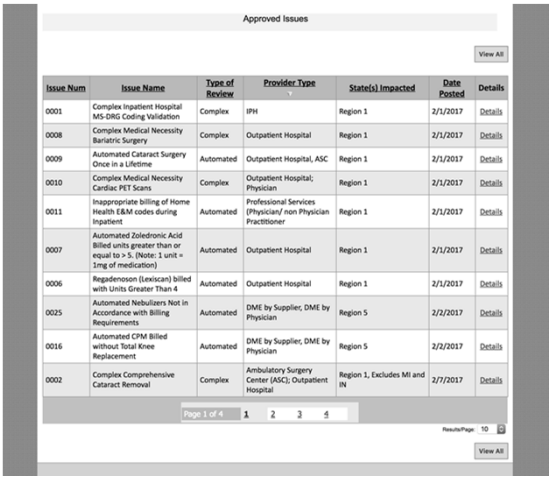
PROPRIETARY & CONFIDENTIAL 52

Performant RAC: Regions 1 & 5

- 28 complex review issues have been approved
- 38 automated review issues have been approved
- Updated: 6/23/17
- The approved issues may be found at:
  - https://performantrac.com/audit-issues/?order=desc&filter=provider_type

CHANGE HEALTHCARE

Sample Issues (Performant)



Approved Issues

View All

Issue Num	Issue Name	Type of Review	Provider Type	State(s) Impacted	Date Posted	Details
0001	Complex Inpatient Hospital MS-DRG Coding Validation	Complex	IPH	Region 1	2/1/2017	Details
0008	Complex Medical Necessity Bariatric Surgery	Complex	Outpatient Hospital	Region 1	2/1/2017	Details
0009	Automated Cataract Surgery Once in a Lifetime	Automated	Outpatient Hospital, ASC	Region 1	2/1/2017	Details
0010	Complex Medical Necessity Cardiac PET Scans	Complex	Outpatient Hospital; Physician	Region 1	2/1/2017	Details
0011	Inappropriate billing of Home Health E&M codes during Inpatient	Automated	Professional Services (Physician/ non Physician Practitioner	Region 1	2/1/2017	Details
0007	Automated Zoledronic Acid Billed units greater than or equal to > 5. (Note: 1 unit = 1mg of medication)	Automated	Outpatient Hospital	Region 1	2/1/2017	Details
0006	Regadenoson (Lexiscan) billed with Units Greater Than 4	Automated	Outpatient Hospital	Region 1	2/1/2017	Details
0025	Automated Nebulizers Not in Accordance with Billing Requirements	Automated	DME by Supplier, DME by Physician	Region 5	2/2/2017	Details
0016	Automated CPM Billed without Total Knee Replacement	Automated	DME by Supplier, DME by Physician	Region 5	2/2/2017	Details
0002	Complex Comprehensive Cataract Removal	Complex	Ambulatory Surgery Center (ASC); Outpatient Hospital	Region 1, Excludes MI and IN	2/7/2017	Details

Page 1 of 4 1 2 3 4

Results/Page: 10

View All

Source: https://performantrac.com/audit-issues/

CHANGE HEALTHCARE

Performant Contact Information

Performant Recovery:

- Toll free number: 1-866-201-0580
- Fax number: 1-325-224-6710
- Web site address: https://www.PerformantRAC.com
- E-mail address: info@performantRAC.com
- Hours of operation: 8:00 AM to 4:30 PM EST

The MAC is your Primary Contact for Payment and Level 1 Appeal Inquiries

- The MAC will handle all processes related to recoupments, appeals, refunds, etc.
- Michigan and Indiana – Jurisdiction 8 - WPS
- Ohio and Kentucky – Jurisdiction 15 CGS
- New York, Vermont, New Hampshire, Maine, Massachusetts, Rhode Island, and Connecticut – Jurisdiction K NGS

CHANGE HEALTHCARE

Cotiviti Healthcare: Regions 2 & 3

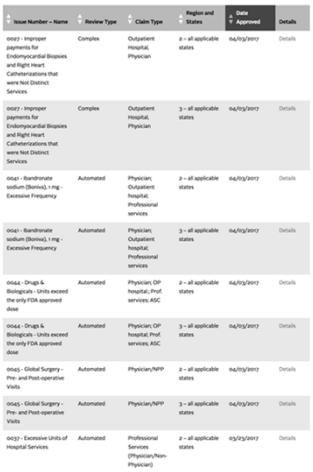
- Cotiviti provides payment integrity solutions to government and commercial health plan clients. Here is the link to the CMS Approved Audit Issues. http://www.cotiviti.com/healthcare/who-we-serve/cms-approved-issues

Most recent update: February 26, 2018

- 25 complex audit issues approved
- 57 automated audit issues approved

CHANGE HEALTHCARE

Cotiviti Sample Issues:



Issue Number – Name	Review Type	Claim Type	Region and States	Date Approved	Details
0027 - Improper payments for Endomyocardial Biopsies and Right Heart Catheterizations that were Not Distinct Services	Complex	Outpatient Hospital, Physician	2 – all applicable states	04/03/2017	Details
0027 - Improper payments for Endomyocardial Biopsies and Right Heart Catheterizations that were Not Distinct Services	Complex	Outpatient Hospital, Physician	3 – all applicable states	04/03/2017	Details
0041 - Bandronate sodium (Boniva), 1 mg - Excessive Frequency	Automated	Physician; Outpatient hospital; Professional services	2 – all applicable states	04/03/2017	Details
0041 - Bandronate sodium (Boniva), 1 mg - Excessive Frequency	Automated	Physician; Outpatient hospital; Professional services	3 – all applicable states	04/03/2017	Details
0044 - Drugs & Biologicals - Units exceed the only FDA approved dose	Automated	Physician; OP hospital; Prof. services; ASC	2 – all applicable states	04/03/2017	Details
0044 - Drugs & Biologicals - Units exceed the only FDA approved dose	Automated	Physician; OP hospital; Prof. services; ASC	3 – all applicable states	04/03/2017	Details
0045 - Global Surgery - Pre- and Post-operative Visits	Automated	Physician/NPP	2 – all applicable states	04/03/2017	Details
0045 - Global Surgery - Pre- and Post-operative Visits	Automated	Physician/NPP	3 – all applicable states	04/03/2017	Details
0057 - Excessive Units of Hospital Services	Automated	Professional Services (Physician/Non-Physician)	2 – all applicable states	03/23/2017	Details

Source: http://www.cotiviti.com/healthcare/who-we-serve/cms-approved-issues

CHANGE HEALTHCARE

PROPRIETARY & CONFIDENTIAL 57

Cotiviti Contact Information

Provider Services

- (866) 360-2507
  RACInfo@Cotiviti.com
  (inquiries only, no medical documentation)
- Provider Service Specialists are available Monday through Friday from 8:00am to 6:30pm EST excluding Federal Holidays
- Fax: (203) 529-2995

Mailing Address

- Cotiviti - CMS Recovery Audit
  Spring Mill Corporate Center
  Suite 6125
  555 E. North Lane
  Conshohocken, PA 19428

CHANGE HEALTHCARE

PROPRIETARY & CONFIDENTIAL 58

HMS Federal

- Region 4 RAC.
  - https://racinfo.hms.com/home.aspx
- 13 complex review issues have been approved
- 29 automated review issues have been approved
- Updated 10/24/17
- The approved issues may be found at:
  - https://racinfo.hms.com/Public1/NewIssues.aspx

CHANGE HEALTHCARE

HMS Federal Contact Information

- Part A Providers
  - Telephone (877) 350-7992
  - Fax (702) 240-5595
- Part B Providers
  - Telephone (877) 350-7993
  - Fax (702) 240-5510
- Email: racinfo@hms.com
- Address: HMS Federal
  9275 West Russell Road, Suite 100, MS 12M
  Las Vegas, NV 89148

CHANGE HEALTHCARE

Medicaid RACs

- Implementation date was effective January 1, 2012.
- Review claims up to 3 years from date claim was filed (unless extension is received via state plan amendment-ex. 5 years in Ohio).
- Subject matter is state dependent.

CHANGE HEALTHCARE

Medicaid RACs (Continued)

- Must coordinate with (1) U.S. Department of Justice; (2) Federal Bureau of Investigation; (3) Office of Inspector General of U.S. Department of Health and Human Services; (4) State Medicaid Fraud Control Units; and (5) CMS.
- Must afford providers appeal rights (State dependent).

CHANGE HEALTHCARE

Medicaid RACs (Continued)

- Paid based on contingency fee unless State law does not permit (must request exception from CMS).
- Medicaid RAC fees must be returned if overpayments are identified at any level of appeal.
- HMS is the primary Medicaid Recovery Auditor
- For more information, refer to the CMS FAQ on Medicaid RACs
- For the latest Medicaid RAC activity by state: http://www.medicaid-rac.com/medicaid-rac-activity/

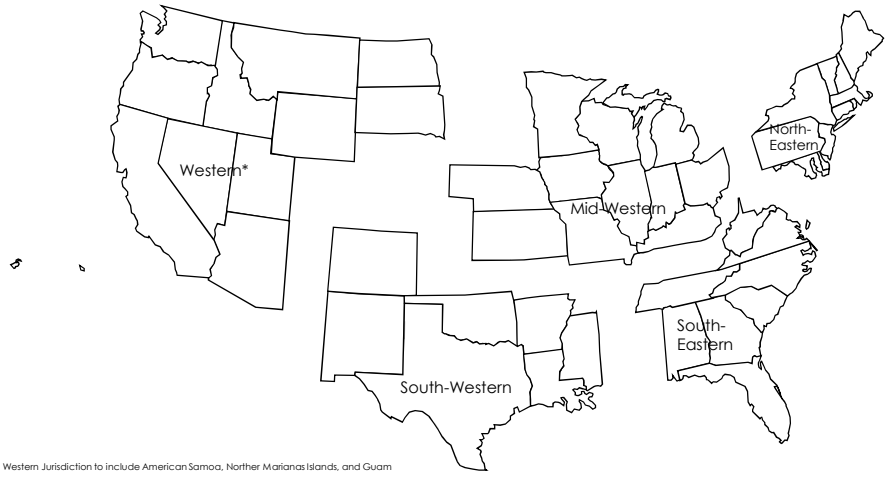
CHANGE HEALTHCARE

The New UPIC: What is it?

- The Unified Program Integrity Contractors (UPICs) perform fraud, waste & abuse detection, deterrence, and prevention activities for Medicare and Medicaid claims processed in the US.
- The UPICs perform integrity related activities associated with Medicare Parts A, B, DME, HH and Hospice, Medicaid, and the Medicare-Medicaid data match program (Medi-Medi).
- The UPIC contracts operate in 5 separate geographical jurisdictions in the US and combine and integrate functions previously performed by the Zone Program Integrity Contractor (ZPIC), Program Safeguard Contractor (PSC) and Medicaid Integrity Contractor (MIC) contracts.

CHANGE HEALTHCARE

UPIC Geographical Regions



*Other territories of the Western Jurisdiction to include American Samoa, Norther Marianas Islands, and Guam

CHANGE HEALTHCARE

PROPRIETARY & CONFIDENTIAL 65

UPIC Contractors

- The Centers for Medicare and Medicaid Services (CMS) has awarded the first Unified Program Integrity Contractor (UPIC) jurisdiction, Midwestern, to AdvanceMed, a wholly owned subsidiary of NCI, Reston, Virginia. The UPIC Midwestern, covering the states of Illinois, Indiana, Iowa, Kansas, Kentucky, Michigan, Minnesota, Missouri, Nebraska, Ohio, and Wisconsin, was scheduled to be fully operational on October 20.
- Under this award, AdvanceMed will perform fraud, waste, and abuse detection and prevention activities for Medicare and Medicaid claims processed within the Midwestern jurisdiction.
- AdvanceMed will focus on analysis of managed care encounter and fee-for-service claims data, and coordination with appropriate partners for referral and resolution of identified issues for Medicare and Medicaid programs.
- AdvanceMed's specific work will include lead screening, investigation, medical review, remedy implementation, and collaboration with CMS; federal, state, and local governments; law enforcement; and other CMS partners and

CHANGE HEALTHCARE

PROPRIETARY & CONFIDENTIAL 66

UPIC Contractors

- AdvanceMed
- Health Integrity LLC
- HMS Federal
- Noridian Healthcare Solutions
- Safeguard Services LLC
- StrategicHealthSolutions LLC
- TriCenturion

CHANGE HEALTHCARE

CERT (Comprehensive Error Rate Testing)

- Defines "improper payment" as:
  - Payments that should not have been made, or payments made in an incorrect amount (including over and underpayments)
  - Payment to an ineligible recipient
  - Payment for an ineligible service
  - Any duplicate payment
  - Payment for services not received
  - Payments for an incorrect amount

CHANGE HEALTHCARE

CERT Process

- Claims are selected randomly
- The CERT Documentation Contractor requests for medical records
  - If a provider fails to submit a requested record, it counts as an error
- Reviews conducted by nurses, medical doctors and certified coders at the CERT Review Contractor. Claims determined to be paid incorrectly are scored as errors.
  - Insufficient documentation
  - Medical necessity
  - Incorrect coding
  - Other (duplicate payments, no benefit category, other billing errors)

CHANGE HEALTHCARE

CERT Process (Continued)

- Error rates are calculated and reported in the DHHS Agency Final Report, CMS Financial Report, and semi-annual Improper Payment Reports
- The fiscal year (FY) 2016 Medicare FFS program improper payment rate was 11 percent, representing $41.08 billion in improper payments, compared to the FY 2015 improper payment rate of 12.09% or $43.33 billion in improper payments

CHANGE HEALTHCARE

CERT Corrective Actions

- CMS and contractors analyze error rate data and develop Error Rate Reduction Plans to reduce improper payments
- Corrective actions include:
  - Refining error rate measurement processes
  - Improving system edits
  - Updating coverage policies and manuals
  - Conducting provider education efforts

CHANGE HEALTHCARE

CERT 101

- Medicare Comprehensive Error Testing (CERT)

  https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/CERT/
- CMS implement CERT to measure improper payment in the Medicare fee-for-service (FFS) program.
- The current CERT Contractors are:
  CERT Review Contractor – AdvanceMed
  CERT Statistical Contractor – The Lewin Group, Inc.
- All CERT medical records are to be sent to the following:
- CERT Documentation Center
  1510 East Parham Road
  Henrico, VA 23228
  Fax: 804-261-8100
  Customer Service: 443-663-2699
  Toll Free: 888-779-7477
  Email: certmail@admedcorp.com
- https://certprovider.admedcorp.com/

CHANGE HEALTHCARE

What is the PERM?

- Payment Error Rate Measurement
- The PERM program measures improper payments in Medicaid and CHIP and produces error rates for each program.
- The error rates are based on reviews for fee-for-service (FFS), managed care, and eligibility components of Medicaid and CHIP in the fiscal year under review.
- It is important to note the error rate is not a "fraud rate" but simply a measurement of payments made that did not meet statutory, regulatory or administrative requirements.

CHANGE HEALTHCARE

What is the PERM? (Continued)

- FY 2008 was the first year in which CMS reported error rates for each component of the PERM program.
- CMS uses a 17 state review for PERM. Each state is reviewed once every 3 years.

Cycle	Medicaid and CHIP States Measured by Cycle
Cycle 1	Arkansas, Connecticut, Delaware, Idaho, Illinois, Kansas, Michigan, Minnesota, Missouri, New Mexico, North Dakota, Ohio, Oklahoma, Pennsylvania, Virginia, Wisconsin, Wyoming
Cycle 2	Alabama, California, Colorado, Georgia, Kentucky, Maryland, Massachusetts, Nebraska, New Hampshire, New Jersey ,North Carolina, Rhode Island, South Carolina, Tennessee, Utah, Vermont, West Virginia
Cycle 3	Alaska, Arizona, District of Columbia, Florida, Hawaii, Indiana, Iowa, Louisiana, Main, Mississippi, Montana, Nevada, New York, Oregon, South Dakota, Texas, Washington

CHANGE HEALTHCARE

PERM Components

- Fee-For-Service (FFS)
  - Sample consists of FFS claims
  - Federal Contractor conducts Medical review & data processing reviews on sampled FFS claims
- Managed Care
  - Sample consists of at-risk capitated payments
  - Federal Contractor conducts data processing review (no medical review) on sampled managed care payments
- Eligibility reviews were not part of the FY 2014-2016 PERM cycles

CHANGE HEALTHCARE

PROPRIETARY & CONFIDENTIAL 75

PERM Review

Medical Review – conducted on sampled FFS claims

- Review of the provider's medical record supporting the service(s) claimed, Code of Federal Regulations that are applicable to conditions of payment, and the State's written policies to determine whether the service was medically necessary, reasonable, provided in the appropriate setting, billed correctly, and coded accurately.

Data Processing Review – conducted on sampled FFS and managed care payments

- On site or remote review of the claim and other information available in the State's Medicaid Management Information System, related systems, or outside sources of provider verification.

Eligibility Review – conducted on sampled eligibility cases

- Active case review – Review of last caseworker action for recipients on the Medicaid/CHIP eligibility rolls
- Negative case review – Review of caseworker action to deny or terminate recipient from Medicaid/CHIP coverage

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PROPRIETARY & CONFIDENTIAL 76

PERM Sample Sizes

- Each state is assigned a state-specific sample size for each component
- Sample sizes are based on the state's prior year component error rate and payment variation
- The maximum sample size is 1,000 for each component
- If a state does not have a prior year error rate for that component, the state is assigned the base sample size (500 FFS, 250 managed care, 504 eligibility active, 204 eligibility negative)

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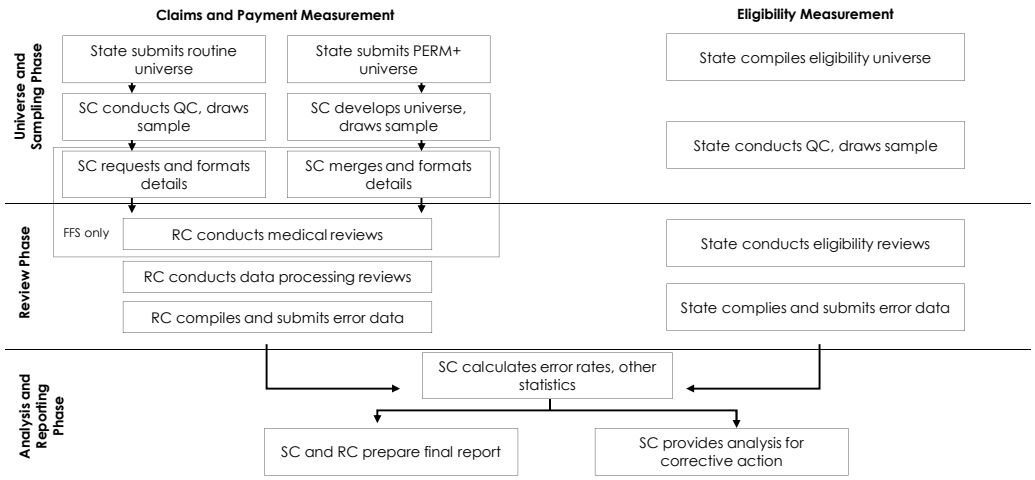
PERM Process



SC = Statistical Contractor; RC = Review Contractor

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PERM Corrective Actions

- Each state submits a Corrective Action Plan (CAP) to CMS after they receive their error rates, no later than 90 days after state-specific error rate information is issued
- State CAPs must address all errors identified by the PERM review
- CMS also develops and implements CAPs at the federal level

CHANGE HEALTHCARE

PROPRIETARY & CONFIDENTIAL 79

What is a QIO?

- CMS's Quality Improvement Organizations
- CMS contracts with one organization in each state, as well as the District of Columbia, Puerto Rico and the US Virgin Islands
- QIOs are private, mostly not-for-profit organizations staffed by doctors and other health care professionals who are trained to review medical care and help beneficiaries with complaints about the quality of care and to implement improvements in the quality of care available throughout the spectrum of care.
- QIO contracts are 3 years in length, with each 3 year cycle referenced as an ordinal "SOW"

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PROPRIETARY & CONFIDENTIAL 80

What Do QIOs Do?

- CMS identifies the core functions of the QIO Program as:
  - Improving quality of care for beneficiaries
  - Protecting the integrity of the Medicare Trust Fund by ensuring that Medicare pays only for services and goods that are reasonable and necessary and that are provided in the most appropriate setting; and
  - Protecting beneficiaries by addressing individual complaints, provider based notice appeals, violations of EMTALA, and other responsibilities as articulated in the QIO related law

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Types of QIOs

There are two types of QIOs that work under the direction of the Centers for Medicare & Medicaid Services in support of the QIO Program:

- ***Beneficiary and Family Centered Care (BFCC)-QIOs***
  - BFCC-QIOs help Medicare beneficiaries exercise their right to high-quality health care. They manage all beneficiary complaints and quality of care reviews to ensure consistency in the review process while taking into consideration local factors important to beneficiaries and their families. They also handle cases in which beneficiaries want to appeal a health care provider's decision to discharge them from the hospital or discontinue other types of services. Two designated BFCC-QIOs serve all 50 states and three territories, which are grouped into five regions.
- ***Quality Innovation Network (QIN)-QIOs***
  - The QIO Program's 14 Quality Innovation Network-QIOs (QIN-QIOs) bring Medicare beneficiaries, providers, and communities together in data-driven initiatives that increase patient safety, make communities healthier, better coordinate post-hospital care, and improve clinical quality. By serving regions of two to six states each, QIN-QIOs are able to help best practices for better care spread more quickly, while still accommodating local conditions and cultural factors.

CHANGE HEALTHCARE

The OIG Work Plan FY 2018-2019

- The OIG has changed their process. They are no longer publishing an annual work plan. Now the OIG website is updated monthly to ensure that it more closely aligns with the work planning process.
- The OIG Work Plan monthly update includes the addition of newly initiated work plan items, which can be found on the Recently Added Items page. Also, completed Work Plan items will be removed and recently published reports can be found on OIG's What's New page which is no longer grouped by industry sector.
- The OIG work plan is now an evolving document, which will be revised and updated, as necessary, to ensure that OIG oversight operations remain relevant, timely, and responsive to priorities.
- *OIG Work Plan FY 2018-2019 Criteria for identifying the activities to focus on, include:*
  - Goals and objectives contained in the strategic plan
  - Results from organizational risk assessments
  - Congressional mandates
  - Availability of resources and expertise

CHANGE HEALTHCARE

The OIG Work Plan FY 2018-2019

- *OIG Work Plan FY 2018-2019 Goals:*
  - Promote Positive Change
  - Foster Increased Accountability and integrity
  - Address Core Challenges
  - Harness Outstanding Talent, Leadership and Effective Operations
- The web-based OIG Work Plan FY 2018-2019 will continue to evolve as OIG pursues complete, accurate, and timely public updates regarding planned, ongoing, and published work.

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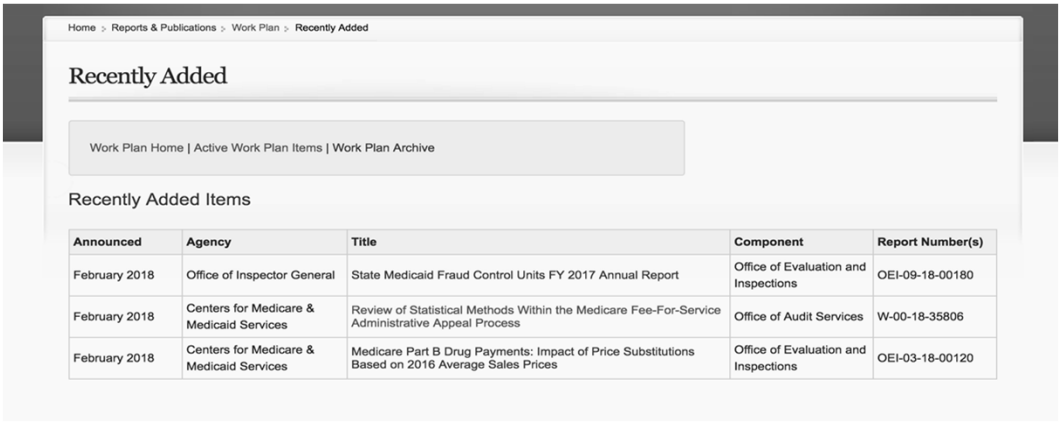
Recently Added to the OIG Work Plan



Home > Reports & Publications > Work Plan > Recently Added

Recently Added

Work Plan Home | Active Work Plan Items | Work Plan Archive

Recently Added Items

Announced	Agency	Title	Component	Report Number(s)
February 2018	Office of Inspector General	State Medicaid Fraud Control Units FY 2017 Annual Report	Office of Evaluation and Inspections	OEI-09-18-00180
February 2018	Centers for Medicare & Medicaid Services	Review of Statistical Methods Within the Medicare Fee-For-Service Administrative Appeal Process	Office of Audit Services	W-00-18-35806
February 2018	Centers for Medicare & Medicaid Services	Medicare Part B Drug Payments: Impact of Price Substitutions Based on 2016 Average Sales Prices	Office of Evaluation and Inspections	OEI-03-18-00120

Source: https://oig.hhs.gov/reports-and-publicatons/workplan/updates.asp

CHANGE HEALTHCARE

Active Work Plan Items (Excerpt)

February 2018	Centers for Medicare & Medicaid Services	Medicare Part B Drug Payments: Impact of Price Substitutions Based on 2016 Average Sales Prices	Office of Evaluation and Inspections	OEI-03-18-00120
Completed	Centers for Medicare & Medicaid Services	Comparison of Average Sales Prices to Average Manufacturer Prices - Mandatory Review	Office of Evaluation and Inspections	OEI-03-16-00540, OEI-03-17-00360
January 2018	Centers for Medicare & Medicaid Services	Financial Impact of Health Risk Assessments and Chart Reviews on Risk Scores in Medicare Advantage	Office of Evaluation and Inspections	OEI-03-17-00470
January 2018	Centers for Medicare & Medicaid Services	OIG Toolkit to Identify Patients at Risk of Opioid Misuse	Office of Evaluation and Inspections	OEI-02-17-00560
January 2018	Centers for Medicare & Medicaid Services	Potential Abuse and Neglect of Medicare Beneficiaries	Office of Audit Services	W-00-18-35805
January 2018	Centers for Medicare & Medicaid Services	Questionable Billing for Off-the-Shelf Orthotic Devices	Office of Evaluation and Inspections	OEI-07-17-00390
January 2018	Centers for Medicare & Medicaid Services	Status Update on States' Efforts on Medicaid-Provider Enrollment	Office of Evaluation and Inspections	OEI-05-18-00070
January 2018	Centers for Medicare & Medicaid Services	Hospitals Billing for Severe Malnutrition on Medicare Claims	Office of Audit Services	W-00-17-35804
December 2017	Centers for Medicare & Medicaid Services	Review of CMS Systems Used to Pay Medicare Advantage Organizations	Office of Audit Services	W-00-18-35804

Source: https://oig.hhs.gov//reports-ans-publications/workplan/active-item-table.asp

CHANGE HEALTHCARE

The Medicare Appeals Process

- Currently a 5 step process as defined by CMS in December of 2009 (74 Federal Register 65296)
  - First Level-Redetermination
  - Second Level-Reconsideration
  - Third Level-Administrative Law Judge Hearing
  - Fourth Level-Medicare Appeals Council
  - Fifth Level-Federal District Court
- Overloaded system, causing at least a 2-3 year delay at the ALJ level
- RAC contractors must now assist CMS through the appeals process

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The Appeals Process

- Medicare Parts A & B Appeals Process

Level 1 – Redetermination by a Medicare Administrative Contractor (MAC)

Level 2 – Reconsideration by a Qualified Independent Contractor (QIC)

Level 3 – Administrative Law Judge(ALJ) Hearing or Review by Office of Medicare Hearings and Appeals (OMHA)

Level 4 – Review by the Medicare Appeals Council (Council)

Level % – Judicial review in the U.S. District Court

Target Audience: Medicare Fee-For-Service (also known as Original Medicare)

The Hyperlink Table, at the end of this document, provides the complete URL for each hyperlink.

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Recent Changes to the Appeals Process

The changes in the final rule are primarily focused on the third level of appeal and will:

- Permit designation of Medicare Appeals Council decisions (final decisions of the Secretary) as precedential to provide more consistency in decisions at all levels of appeal, reducing the resources required to render decisions, and possibly reducing appeal rates by providing clarity to appellants and adjudicators.
- Expand OMHA's available adjudicator pool by allowing attorney adjudicators to decide appeals for which a decision can be issued without a hearing, review dismissals issued by a Qualified Independent Contractor (QIC) or Independent Review Entity (IRE), issue remands to Centers for Medicare & Medicaid Services (CMS) contractors, and dismiss requests for hearing when an appellant withdraws the request. This change will allow ALJs to focus their efforts on conducting hearings and adjudicating the merits of more complex cases.
- Simplify proceedings when CMS or CMS contractors are involved by limiting the number of entities (CMS or contractors) that can be a participant or party at the hearing (although additional entities may submit position papers and/or written testimony or serve as witnesses).
- Clarify areas of the regulations that currently causes confusion and may result in unnecessary appeals to the Medicare Appeals Council.
- Create process efficiencies by eliminating unnecessary steps (e.g., by allowing ALJs to vacate their own dismissals rather than requiring appellants to appeal a dismissal to the Medicare Appeals Council); streamlining certain procedures (e.g., by using telephone hearings for appellants who are not unrepresented beneficiaries, unless the ALJ finds good cause for an appearance by other means); and requiring appellants to provide more information on what they are appealing and who will be attending a hearing.
- Address areas for improvement previously identified by stakeholders to increase the quality of the process and responsiveness to customers, such as establishing an adjudication time frame for cases remanded from the Medicare Appeals Council, revising remand rules to help ensure cases keep moving forward in the process, simplifying the escalation process, and providing more specific rules on what constitutes good cause for new evidence to be admitted at the OMHA level of appeal.

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Helpful Terms

Amount in Controversy (AIC): The threshold dollar amount remaining in dispute that is required for a Level 3 and Level 5 appeal. The AIC increases annually by a percentage increase tied to a consumer price index.

Appeal: The process used when a a party (for example, a beneficiary, provider, or supplier) disagrees with an initial determination or a revised determination for health care items or services.

Appellant: A person or entity filing an appeal.

Determination: A decision made to pay in full, pay in part, or deny a claim.

Escalation: When an appellant requests that an appeal pending at the QIC level or higher be moved to the next level because the adjudicator was not able to make a decision within a specified time.

Non-Participating: Physicians and suppliers who choose to either accept or not accept Medicare assignment on a claim-by-claim basis. Non-participating physicians and supplies have limited appeal rights.

Party: A person or entity with a right to appeal an initial determination or subsequent administrative appeal decision.

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First Level of Appeal: Redetermination by a MAC

- Performed by the claim processing contractor, this appeal must be received within 120 days of the initial determination, and decided by the contractor within 60 days of receipt.
- It is a second look at the claim

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Redetermination FAQs

Question	Answer
When must I file a request?	You must file a request for redetermination within **120 days** of receipt of the Remittance Advice (RA) that lists the initial determination.
How do I file a request?	File your request **in writing** by following the instructions provided in the RA. Your request must be sent to the address listed on the RA or filed in person (or follow instruction from your MAC on filing electronically). You may also file a request for redetermination by completing Form CMS-20027 (Medicare Redetermination Request Form – 1st Level of Appeal). Find more information about the requirements for requesting a Council review following an OMHA decision on the Medicare Appeals Council webpage. **REMEMBER** • You, ore your representative, must include your **name and signature** • Attach any supporting documentation to your redetermination request
Is there a minimum AIC requirement?	**No.**
Who makes the decision?	**MAC staff** unassociated with the initial claim determination perform the redetermination.
How long does it take to make a decision?	MACs generally issue a decision within **60 days** of receipt of the request for redetermination. You will receive notice of the decision via Medicare Redetermination Notice (MRN) from your MAC, or if the initial decision is reversed and the claim is paid in full, you will receive a revised RA.

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First Level of Appeal: Redetermination (Continued)

- The request for redetermination must be filed within 120 days of the provider's receipt of the demand letter. For purposes of the filing deadline, the date of receipt will be presumed to be 5 calendar days after the date of the demand letter, unless there is evidence to the contrary
- The Medicare contractor may extend the120 day filing deadline upon showing of good cause

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First Level of Appeal: Redetermination (Continued)

- Some examples of good cause:
  - The provider was prevented by serious illness from contacting the contractor in person, in writing, or through a friend, relative or other person
  - The provider had a death or serious illness in his or her immediate family
  - Important records of the provider were destroyed or damaged by fire or other accidental cause

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Examples (Continued)

- The contractor gave the provider incorrect or incomplete information about when and how to request a redetermination
- The provider did not receive notice of the determination or decision; or
- The provider sent the request to a government agency in good faith within the time limit, and the request did not reach the appropriate contractor until after the time periods to file a request expired.

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First Level of Appeal: Redetermination (Continued)

- Requests for redetermination must be in writing and must include:
  - The beneficiary's name
  - The Medicare health insurance claim (HIC) number
  - The specific services and/or items for which the redetermination is being requested and the specific dates of service
  - The name and signature of the provider or the provider's representative

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First Level of Appeal: Redetermination (Continued)

- The provider should include any evidence that the provider believes should be considered by the contractor in making its redetermination

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First Level of Appeal: Redetermination (Continued)

- In conducting the redetermination, the contractor will review the evidence and findings upon which the initial determination was based, and any additional evidence the provider submits. There is no hearing at the redetermination stage; rather the contractors decision is based solely on the written evidence
- The contractor is required to issue its redetermination decision within 60 days of its receipt of the request for redetermination

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Second Level of Appeal: Reconsideration

- If you disagree with the MAC redetermination decision, you may request a reconsideration by a QIC.

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Reconsideration FAQs

Question	Answer
When must I file a request?	You must file a request for redetermination within **180 days** of receipt of the MRN or RA.
How do I file a request?	File your request **in writing** by following the instructions provided on the MRN or RA. You may also file a request for reconsideration by completing Form CMS-20033 (Medicare Reconsideration Request Form – 2nd Level of Appeal). Find more information about the requirements for requesting reconsideration on the Second Level of Appeal: Reconsideration by a QIC webpage. **REMEMBER** • **Clearly explain** why you disagree with the redetermination decision • You, or your representative, must include your **name and signature** • You should submit: • A copy of the RA or MRN • Any evidence noted in the determination as missing • Any other evidence relevant to the appeal • Any other useful documentation Documentation submitted after you file the reconsideration request may extend the QUIC's decision timeframe. **Note:** Evidence not submitted at the reconsideration level may be excluded from consideration at subsequent levels of appeal unless you demonstrate good cause for submitting the evidence late.
Is there a minimum AIC requirement?	**No.**
Who makes the decision?	The **QIC** conducts the reconsideration, which is an independent review of the initial determination, including the redetermination and all issues related to payment of the claim. The reconsideration may include review of medical necessity issues by a panel of physicians or other health care professionals.
How long does it take to make a decision?	Generally , a QIC sends a decision to all parties within within **60 days** of receipt of the request for reconsideration. If the QIC cannot complete its decision in the applicable timeframe, it will inform you of your rights and the procedures to escalate the case to all ALJ. **Note:** Before escalating your appeal to an ALJ, if you do not receive a decision on the reconsideration within 60 days, consider allowing an additional 5 to 10 days for mail delays.

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Second Level of Appeal: Reconsideration (Continued)

- The request for reconsideration must be filed within 180 days of the provider's receipt of the redetermination decision. For purposes of the filing deadline, the date of receipt will be presumed to be 5 calendar days after the date of the notice of redetermination, unless there is evidence to the contrary
- The QIC (Qualified Independent Contractor) may extend the 180 day filing deadline upon showing of good cause

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Second Level of Appeal: Reconsideration (Continued)

- The request for reconsideration must be in writing, and must include:
  - The beneficiary's name
  - The Medicare Health Insurance Claim (HIC) number
  - The specific services and items for which the reconsideration is requested and the specific dates of service
  - The name and signature of the provider or the provider's representative; and
  - The name of the contractor that made the redetermination

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PROPRIETARY & CONFIDENTIAL 102

Second Level of Appeal: Reconsideration (Continued)

- The provider must submit all necessary evidence in support of its appeal. Evidence may be submitted at any time before the QIC issues its decision. New evidence cannot be submitted at subsequent levels of appeal absent a showing of good cause

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Second Level of Appeal: Reconsideration (Continued)

- There is no hearing at the reconsideration stage; rather, the QIC will conduct an on-the-record review of the written evidence
- The QIC is not bound by LCDs or CMS program guidance but the QIC must give substantial deference to these policies if they are applicable to the particular case

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Second Level of Appeal: Reconsideration (Continued)

- The QIC is required to issue its reconsideration decision within 60 days of its receipt of the request for reconsideration. If the QIC does not issue its decision within 60 days, the provider may escalate the appeal to the ALJ level

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Third Level of Appeal: ALJ Hearing

- If you disagree with the reconsideration decision or wish to escalate your appeal because the reconsideration period passed, you may request an ALJ hearing. The ALJ hearing gives you the opportunity—via video teleconference (VTC), telephone, or occasionally in person—to explain your position to an ALJ.
- The U.S. Department of Health & Human Services (HHS) Office of Medicare Hearings and Appeals (OMHA), which is independent of CMS, is responsible for the Level 3 Medicare claims appeals.

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ALJ Hearing FAQs

Question	Answer
When must I file a request?	You must file a request for an ALJ hearing, or a waiver of hearing, within **60 days** of receipt of the reconsideration decision letter or file a request with the QIC for OMHA review after the expiration of the reconsideration period.
How do I file a request?	File your request **in writing** by following instructions provided in the reconsideration letter. You may also request an ALJ hearing by completing the Request for ALJ Hearing or Review of Dismissal (Form OMHA-100) and the multiple claim attachment (Form OMHA-100A) as needed. These forms are new as of January 2017. If you do not want a telephone hearing, you may ask for an in-person or VTC hearing, but you must demonstrate good cause. The ALJ determines whether the case warrants an in-person hearing on a case-by-case basis (there are exceptions to these procedures for unrepresented beneficiary appellants). If you would prefer to not have a hearing, you may ask for an on-the-record review by filling out the Waiver of Rights to an ALJ Hearing form (For OMHA-104) and submitting it with the OMHA-100 form. If an on-the-record review is granted, an OMHA attorney adjudicator will issue a decision based on the information within the administrative record along with any evidence submitted with the request. Find more information about the requirements for requesting an ALJ hearing, including additional forms you may need, on the Office of Medicare Hearings and Appeals webpage. **REMEMBER** • You **must** send a copy of the ALJ hearing request to all other parties to the QUIC reconsideration. If you are requesting the case be escalated to the Council, you must send a copy of the request to all other parties **and** to the ALJ. • The ALJ sets hearing preparation procedures. CMS or its contractors may become a party to, or participate in, an ALJ hearing after providing notice to the ALJ and the parties to the hearing.

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ALJ Hearing FAQs

Question	Answer
Is there a minimum AIC requirement?	Yes. You may only request an ALJ hearing if a certain dollar amount remains in controversy following the QIC's decision. The Third Level of Appeal AIC Threshold is updated annually. Find our how the AIC amount is calculated on the OMHA FAQs webpage.
Who makes the decision?	The **ALJ or attorney adjudicator** makes the decision. If the OMHA cannot complete a decision in the applicable timeframe, it will inform you of your rights and procedures to escalate the case to the Council. The ALJ or attorney adjudicator forwards the decision and case file to the Administrative QIC (AdQIC), which serves as the central manager for all OMHA Original Medicare claim case files. In certain situations, the AdQIC may refer the case to the Council on CMS behalf. If no referral is made to the Council, and the ALJ or attorney adjudicator decision overturns a previous denial (in whole or in part), the AdQIC notifies the MAC it must pay the claim, according to the OMHA decision, within 30-60 days.
How long does it take to make a decision?	Due to a record number of appeal requests, there continues to be a delay in OMHA ALJ hearing assignments. OMHA remains committed to processing ALJ hearing requests in the order received and as quickly as possible, given pending requests and adjudicatory resources. OMHA prioritizes Part D prescription drug denial cases that qualify for expedited status and Medicare beneficiary issues. Additional delay can result from: • Appellant's failure to send notice of the hearing request to other parties • The discovery request process • Reconsideration-level escalations • Request for an in-person hearing • Submission of additional evidence not included with the hearing request If OMHA does not issue a decision within the applicable timeframe, you may ask OMHA to escalate the case to the Council. Note: New appeal requests are processed as quickly as possible. You will receive an Acknowledgement of Request letter after your case is entered in to the OMHA case tracking system. Find more information on these timeframes on the Office of Medicare Hearings and Appeals webpage. Note: As part of the efforts to reduce the outstanding number of ALJ hearing requests, OMHA implemented two pilot programs: Settlement Conference Facilitation (SCF) and Statistical Sampling Initiative. SCF is an alternative dispute resolution process that uses mediation principles. Statistical Sampling initiative applies to appellants with a large volume of claim disputes.

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Fourth Level of Appeal: Medicare Appeals Council

- If you disagree with the ALJ decision, or you wish to escalate your appeal because the ALJ ruling timeframe passed, you may request a Medicare Appeals Council review.
- The HHS Departmental Appeals Board (DAB) Medicare Operations Division administers the Appeals Council review.

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Medicare Appeals Council FAQs

Question	Answer
Why must I file a request?	You must file a request for Council review within **60 days** of receipt of the ALJ's decision or after the OMHA ruling timeframe expires.
How do I file a request?	File your request in writing by following the instructions provided by OMHA. You may also request a Council review by completing the Request for Review of ALJ Medicare Decision/Dismissal (Form DAB-101) or the electronic version accessible through the DAB E-File webpage. Find more information about the requirements for requesting a Council review following an OMHA decision on the Medicare Appeals Council webpage. **REMEMBER** • **Explain** which part of the OMHA decision you disagree with and your reasons for the disagreement • You **must** send a copy of the Council review request to all the parties included in OMHA's decision
Is there a minimum AIC requirement?	**No.**
Who makes the decision?	The Council makes the decision. If the Council cannot complete its decision in the applicable timeframe, it will inform you of your rights and procedures to escalate the case to U.S. District Court. The Council forwards the decision and case file to the AdQIC< which serves as the central manager for all Council Original Medicare claim case files. If the Council decision overturns a previous denial (in whole or in part), the AdQIC notifies the MAC it must pay the claim according to the Council's decision within 30-60 days.

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Medicare Appeals Council FAQs

- Question
  - How long does it take to make a decision?
- Answer
  - Generally, the Council issues a decision within **90 days** from receipt of a request for review of an ALJ decision. If the Council review stems from an escalated appeal, then the Council has **180 days** from the date of receipt of the request for escalation to issue a decision. A decision may take longer due to a variety of reasons.
  - If the Council does not issue a decision within the applicable timeframe, you may ask the Council to escalate the case to the judicial review level.
  - If you are requesting escalation to U.S. District Court, a copy of the request must be sent to all other parties **and** to the Council.

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PROPRIETARY & CONFIDENTIAL 111

Fifth Level of Appeal: Judicial Review in Federal District Court

- If you disagree with the Appeals Council decision, or you wish to escalate your appeal because the Appeals Council ruling timeframe passed, you may request judicial review. Table 5 provides questions and answers about judicial review in U.S. District Court

Question	Answer
Why must I file a request?	You must file a request for judicial review within **60 days** of receipt of the Appeals Council's decision or after the Appeals Council ruling timeframe expires.
How do I file a request?	The Appeals Council's decision (or notice of right to escalation) contains information on how to **file a claim in U.S. District Court.**
Is there a minimum AIC requirement?	**Yes.** You may only request judicial review if a certain dollar amount remains in controversy following the Medicare Appeals Council decision. The Fifth Level of Appeal AIC threshold is updated annually.
Who makes the decision?	The **U.S. District Court** makes the decision.

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PROPRIETARY & CONFIDENTIAL 112

Tips for Filing an Appeal

- **Make all appeal requests in writing!**
- Starting at Level 1, consolidate into one appeal as many similar claims as possible
- File timely requests with the appropriate contractor
- Include a copy of the decision letter(s) issued at the previous level
- Include a copy of the demand letter(s) if appealing an overpayment determination
- Include a copy of the Appointment of Representative (AOR) form if representing a provider/supplier/beneficiary
- Respond promptly to the contractor requests for documentation
- Sign your request for appeal

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Appeal Process Summary

Level	Summary of review process	Who performs the review?	When must you request an appeal?	When should you get a decision?	AIC	Links to Forms
1st Level – Redetermination by a Medicare Administrative Contractor (MAC)	Document review of initial claim determination	MAC	Up to 120 days after you receive initial determination	60 days	No	CMS-20027 CMS-20031
2nd Level – Reconsideration by a Qualified Independent Contractor (QIC)	Document review of redetermination; submit any missing evidence or evidence relevant to the appeal	QIC	Up to 180 days after you receive MRN/RA	60 days	No	CMS-20033
3rd Level – Administrative Law Judge (ALJ) Hearing or Review by Office of Medicare Hearings and Appeals (OMHA)	May be an interactive hearing between parties or an on-the-record review	ALJ or attorney adjudicator	Up to 60 days after you receive notice of QIC decision or after expiration of the applicable QIC reconsideration timeframe if you do not receive a decision	May be delayed due to volume	Yes	OMHA-100 OMHA-100A OMHA-104
4th Level – Review by the Medicare Appeals Council (Council)	Document review of ALJ's decision (but you may request oral arguments)	Council	Up to 60 days after you receive notice of OMHA's decision or after expiration of the applicable OMHA decision timeframe if you do not receive a decision	90 days if appealing an OMHA decision or dismissal or 180 days if ALJ review time expired without an ALJ decision	No	DAB-101
5th Level – Judicial Review in U.S. District Court	Judicial review	U.S. District Court	Up to 60 days after you receive notice of Council decision or after expiration of the applicable Council review timeframe if you do not receive a decision	No statutory time limit	Yes	No HHS form available

Source: The U.S. Centers for Medicare & Medicaid

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Take Away Strategies: Tips for Preparation

- Immediately check your address on the letter to ensure it is the correct and complete physical address
- Call and make contact with the auditors
- Call and advise your health care attorney and have him/her present at the audit and/or site visit
- Conduct a self-inspection immediately
- Make sure all patient health records are properly secured and your medical record handling and storage are compliant with HIPAA standards

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Take Away Strategies: Tips for Preparation (Continued)

- Set aside a room for auditors if an onsite audit is requested
- Require photographic identification and identifying information for each member of the audit team
- Assign a contact person to serve as the communication liaison between the auditors and your attorney
- Keep a copy of every document or paper you provide for the audit
- Do not voluntarily advise the auditors of suspicions of wrong doing or ask if what you are doing is correct

CHANGE HEALTHCARE

Take Away Strategies: Tips for Preparation (Continued)

- Keep good copies of and document your transmittal of any documents to the auditors
- Make sure your policies and procedures are current
- Contractors and their agents frequently use statistical sampling and extrapolation to estimate the amount of overpayment. The Medicare Program Integrity Manual, CMS Pub. 100-08, Ch. 3, Section 3.10, contains requirements for contractors using statistical sampling, which are generally very permissive. It can be beneficial to engage a statistics expert to challenge the methodology.

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Data Mining

- Federal agencies are making significant investments in technology and data analytics tools
- There are significant federal efforts underway to build data sources that house Medicare/Medicaid data.
- General Accountability Office (GAO) surveyed 128 federal departments and agencies and found that 52 currently use, or are planning to use, data-mining programs for scores of activities ranging from improving service, performance, and human resource management to analyzing intelligence and uncovering terrorist activities.
- Data mining refers to the use of computer programs to plumb vast stores of records, including private information, for hidden patterns and relationships among disparate pieces of information.

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Data Mining (Continued)

- Many of the outsourced companies that are contracted by the Federal agencies have a talent pool of public health experts, healthcare administrators, investigators, nurses, physicians, statisticians, network engineers, medical trainers and IT specialists that can create data mining tools that analyzes claims data to detect potential fraud (resulting in automated audits)

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Benefits of Data Mining

- The huge amounts of data generated by healthcare transactions are too complex and voluminous to be processed and analyzed by traditional methods. Data mining provides the methodology and technology to transform these mounds of data into useful information for decision making.
  - Can help healthcare insurers detect fraud and abuse
  - Can help healthcare organizations make customer relationship management decisions
  - Can help physicians identify effective treatments and best practices
  - Can assist in patients receiving better and more affordable healthcare services

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What Can We Do?

- Review your claims data on an ongoing basis
- View claims that fail due to system edits, MUE's, and provider defined edits
- Coding Compliance software can help track potential issues
- Address identified issues
- If the RAC can do it, so can you!

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Following the Rules

- Official Coding Guidelines (OCGs)-these are updated on an annual basis. Make sure that your staff is provided with the most recent OCGs. Have a coding meeting to discuss the latest OCGs
  - https://www.cdc.gov/nchs/data/icd/10cmguidelines_fy2018_final.pdf
  - https://www.cms.gov/Medicare/Coding/ICD10/Downloads/2018-PCS-Guidelines.pdf
  - Create policies and procedures as needed using guidance from the OCGs
- Coding Clinic and CPT Assistant are also invaluable in educating staff on current guidelines. These are available in the reference section of all encoder software.

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Medicare/Medicaid Manuals

- Depending on your provider type, make sure that you have reviewed the Medicare/Medical Manuals and shared with your staff
- Stay on top of CMS Transmittals
- There are a number of vendors that provide daily updates for a set fee
- Make sure your encoder is providing the latest Correct Coding Initiative (CCI) edits (remember they are updated quarterly). Part A edits are one version behind Part B edits.
- Make sure the business/finance office software is also on the latest version

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References

Resource	Website
Appeals Laws, Regulations, and Guidance	Social Security Act, Section 1869 https://www.ssa.gov/OP_Home/ssac/title18/1869.htm 42 Code of Federal Regulations (Part 405, Subpart I) https://www.gpo.gov/fdsys/pkg/CFR-2015-title42-vol2/pdf/CFR-2015-title42-vol2-part405-subpart.pdf Medicare Claims Processing Manual, Chapter 29 https://www.cms.gov/Regulation-and-Guidance/Guidance/Manuals/Downloadsclm104c29.pdf
Appeals Process by Medicare Part	https://www.hhs.gov/about/agencies/omha/the-appeals-process
MAC Contact Information	https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map
Medicare Appeals Council	https://www.hhs.gov/about/agencies/omha/the-appeals-process
Medicare Learning Network® (MLN) Guided Pathways	https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNEdWebGuide/Downloads/Guided_Pathways_Provider_Specific_Booklet.pdf
MLN Matters® SE1521 Limiting the Scope of Review on Redeterminations or Reconsiderations of Certain Claims	https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1521.pdf
OMHA	Https://www.hhs.gov/about/agencies/omha
OMHA Medicare Appellant Forum	https://www.hhs.gov/about/agencies/omha/about/special-initiatives/appellant-forums
Original Medicare Appeals	https://www.cms.gov/Medicare/Appeals-and-Grievances/OrgMedFFSAppeals
Part C Appeals	Medicare Managed Care Appeals & Grievances https://www.cms.com/Medicare/Appeals-and-Grievances/MMCAG "Part C Appeals: Organization Determination, Appeals & Grievances" Web-Based Training (WBT) Course https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/WebBasedTraining.html

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References

Resource	Website
Part D Appeals	Medicare Prescription Drug Appeals & Grievances http://www.cms.gov/Medicare/Appeals-and-Grievances/MedPrescriptDrugApplGriev "Part D Coverage Determinations, Appeals & Grievances" WBT Course https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN//MLNProducts/WebBasedTraining.html
QICs	https://www.cms.gov/Medicare/Appeals-and-Grievances/OrgMedFFSAppeals/ReconsiderationbyaQualifiedIndependentContractor.html
Reopenings	https://www.cms.gov/Outreach-and-Education/Medicare0Learning-Network-MLN/MLNMattersArticles/Downloads/MM4147.pdf https://www.cms.gov/Outreach-and-Education/Medicare0Learning-Network-MLN/MLNMattersArticles/Downloads/SE0420.pdf https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c34.pdf https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1426.pdf
Settlement Effectuation Instructions for the Department of Health and Human Services (DHHS) Office of Medicare Hearings and Appeals (OMHA) Settlement Conference Facilitation (SCF) Pilot	https://www.cms.govRegulations-and-GuidanceGuidance/Transmittals/Downloads/R1588OTN.pdf Part A Specific Instructions https://www.cms.gov/Regulations-and-Guidance/GuidanceTransmittalsDownloadsR1633OTN.pdf
U.S. District Courts	http://www.uscourts.govabout-federal-courts/court-role-and-structure

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- To learn how our **Coding and Compliance Advocate** services can help, visit: changehealthcare.com/solutions/coding-compliance-advocate

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