Update on Contractor Audits and Disputes

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Presentation Caveat

This PowerPoint has been developed to facilitate today’s discussion on contractor audits and disputes. The content herein does not reflect official positions of the Office of Medicare Hearings and Appeals or Community Health Systems.
Goals of Session

• Explore Current Environment
• Provide Update on RAC Program and RAC Contract Awards
• Discuss Appeal Backlog and Proposed Solutions
• Examine Two-Midnight Rule Developments and Related Audits

Current Environment

Medicare and Medicaid programs signed into law
July 30, 1965
Dec. 8, 2003

3-year RAC demonstration authorized as part of Medicare Modernization Act
Oct. 2009

Permanent RAC implemented for Medicare Parts A and B
March 2010

OMHA implements deferred assignment of requests filed after 04/0/13
July 15, 2013

Non-Midnight Rule
Oct. 1, 2013

Chief Judge Griswold testifies before U.S. House
July 10, 2014

3-year RAC demonstration authorized

Court of Federal Claims enjoins CMS from awarding new RAC contracts in 3 regions pending CGI case appeal
Sept. 2, 2014

OMHA implements global settlement offer
Aug. 28, 2014

OMHA requests information published
Nov. 19, 2014

Congressman Brady unveils the HIP Act discussion draft
Nov. 19, 2014

History
Complicating Factors: Constant Legislative, Regulatory and Litigation Developments

• OMHA ALJ Appeal Backlog
  – Largely due to RAC reviews of patient status
• Changing Reimbursement/Coverage Standards
  – Example: Two-Midnight Rule for hospital inpatient admissions
  – Recent Medicare Payment Advisory Commission (MedPAC) discussions of potential short-stay admission DRG
• Potential Legislative Change
  – House Ways & Means Discussion Draft
• Litigation
  – American Hospital Association litigation

RAC Contract Awards

RAC Basics

• The RAC program’s stated mission is to “reduce Medicare improper payments through the efficient detection and collection of overpayments, the identification of underpayments and the implementation of actions that will prevent future improper payments”
• RACs are responsible for:
  – Reviewing Medicare Fee-For-Service claims to determine if improper underpayments or overpayments were made
  – Identifying common billing errors, trends, and other Medicare payment issues
• RACs are paid on a contingency fee basis
• Although RACs have historically been limited to postpayment reviews, CMS implemented the RAC Prepayment Review Demonstration in 2012
### RAC Contracting Developments

Existing RAC contracts were set to expire on June 1, 2014. CMS is currently in the procurement process for the new RAC contracts.

- **February 2014**: CMS temporarily suspended complex RAC audits as part of the transition to the next round of RAC contracts.
- **June 2014**: Existing RAC contracts expired.
- **August 2014**: CMS initiated contract modifications to allow current RACs to restart some reviews.
- **December 2014**: CMS announced contract extensions to allow current RACs to perform active reviews until December 31, 2015.

Ongoing since January 2014: CGI pre-award bid protest and federal lawsuit challenged a provision of the new contracts that would delay the RACs’ receipt of contingency payments until after the claim is upheld on the second level of review. The Court of Federal Claims issued a preliminary injunction preventing CMS from awarding RAC contracts in Regions 1, 2, and 4 until the case is resolved on appeal.

### Current status of RAC contracts

RAC Regions 1, 2, 3, and 4. In light of the CGI lawsuit, CMS expects the new RAC contracts for Regions 1, 2, and 4 to remain unresolved until late summer of 2015. CMS is continuing the procurement process for Region 3.

New RAC in Region 5. CMS awarded the DME HH/H RAC contract to Connolly in December 2014. Performant Recovery Inc. filed a bid protest over the award of the DME HH/H RAC contract on January 6, 2015. Existing RAC contracts were set to expire on June 1, 2014. CMS is currently in the procurement process for the new RAC contracts.

### RAC Program Changes

- Many aspects of the RAC program are controversial.
- On December 30, 2014, CMS announced significant program improvements that “will be effective with each new contract award.”
- Consequently, the program improvements, which include several significant measures that aim to reduce provider burden, will not be implemented in the current four fee-for-service RAC contracts that were extended in December 2014.

### RAC Program Changes

**A. Reducing Provider Burden**

1. CMS will establish revised ADR volume limits based on a provider’s compliance with Medicare rules.
2. CMS will limit RAC look-back periods to 6 months from the date of service for patient status reviews. In cases where hospital submits claim within 3 months of the date of service:
   - CMS will limit ADR volume limits to 3 months
   - CMS will limit ADR volume limits to 6 months
3. CMS will establish revised ADR volume limits that will be diversified across claim types (e.g., inpatient, outpatient).
4. CMS-established ADR limits will include instructions to incrementally apply the limits to new providers under review.
5. At the beginning of the new contracts, CMS will not increase ADR limits for physicians.
6. If a backlog were to exist, CMS would require incremental adjustments to ensure there was not a full recovery of a Periodic Interim Payment.
7. RACs must have a Contractor Medical Director, who is a physician, and are encouraged to have a panel of specialists available for consultation.
8. RACs must wait 30 days to allow for a discussion request before sending the claim to the MAC for adjustment.
9. RACs must confirm receipt of a provider’s discussion request or other written correspondence within 3 business days.
10. CMS will work with RACs to enhance their provider portals.
11. CMS will work with RACs to enhance their provider portals.
12. RACs will not receive a contingency fee until the second level of appeal is exhausted.
RAC Program Changes

B. Enhancing CMS' Oversight

1. CMS will provide further information about the RAC program through increased public reporting of data such as appeals, Quality Assurance activities, and timeliness standards.

2. CMS will require RACs 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.

3. RACs will be 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. Failure to do so will result in CMS placing the RAC on a corrective action plan.

4. CMS will continue to post Provider Compliance Tips to the CMS website.

C. Increasing Program Transparency

1. CMS established a Provider Relations Coordinator to offer more efficient resolutions to affected providers.

2. CMS will require the RACs to provide consistent and more detailed review information concerning new issues to their websites.

3. CMS will require the RACs 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.

4. CMS will consider developing a Provider Satisfaction Survey.

Appeal Backlog and Proposed Solutions

Medicare Appeals Framework: Part A/B Claims Overview

- **Five Appeal Levels:**
  1. First Level: Redetermination (CMS contractor)
  2. Second Level: Reconsideration (CMS contractor)
  3. Third Level: Administrative Law Judge (ALJ) Hearing (Office of Medicare Hearings and Appeals)
  4. Fourth Level: Medicare Appeals Council Review (Departmental Appeals Board)
  5. Fifth Level: Judicial Review (Federal District Court)

- Opportunity for (non-optional) discussion with adjudicator occurs at Level 3 hearing.
OMHA Workload – Receipts

*Data provided by OMHA. FY14 receipts are based on estimated receipts through year end. Includes appeals with RFH Date in listed year and does not include reopenings. Run Date: November 13, 2014

OMHA Workload – Received and Decided

Medicare Appeals Backlog

- **2012 to 2013**: Appeals increase exponentially
- **July 2013**: OMHA implements deferred assignment for requests received after April 1, 2013, and beneficiary appeal prioritization — announced on the OMHA website
- **December 2013**: OMHA sends letter to providers updating the status of operations and announcing OMHA Forum
  - Assignment of new ALJ requests may take 24 to 28 months and post-assignment hearing wait times will likely exceed 6 months
- **February 2014**: Limited assignments to ALJs begins
- **February 2014**: OMHA Medicare Appeals Forum
- **June 2014**: OMHA announces two pilot programs
  - Statistical Sampling & Settlement Conference Facilitation
Medicare Appeals Backlog

- **July 2014**: Testimony from Chief ALJ Griswold
  - The upward trend in appeal requests “took an unexpectedly sharp turn and OMHA experienced an overall 545% growth in appeals”
  - As of July 1, 2014, OMHA reported a backlog of over 800,000 pending appeals
  - OMHA is “receiving one year’s worth of appeals every four to six weeks”
- **August 2014**: CMS announces Global Settlement Offer
- **October 2014**: OMHA Medicare Appeals Forum
- **November 2014**: OMHA Request for Information published
- **November 2014**: House Ways & Means Discussion Draft

OMHA Pilot Programs

- **Statistical Sampling Pilot**:
  - Provides an option for addressing large volumes of claim disputes at the ALJ level
  - Provider and supplier appeals filed within specified time periods
- **Settlement Conference Pilot**:
  - Alternate dispute resolution process designed to bring the appellant and CMS together to discuss a mutually agreeable resolution
  - For claims for Part B items or services appealed to the ALJ level filed within specified time periods

Information on OMHA pilots: [www.hhs.gov/omha](http://www.hhs.gov/omha)

CMS Global Settlement Offer

- For post-payment reviews of claims that were denied on the basis that the inpatient admission was not reasonable and necessary but care would have been reasonable and necessary in an outpatient setting, CMS will make payment of 68% of the “net paid amount” of the denied inpatient claims included in a provider’s settlement
- Only certain facilities eligible:
  - Acute Care Hospitals, including those paid via the Prospective Payment System, Periodic Interim Payments, and Maryland waiver
  - Critical Access Hospitals
- CMS states that hospitals may *not* choose to settle some claims and continue to appeal others – “all in or all out.”
- Settlement requests were due on **October 31, 2014**
Global Settlement Offer: Provider Concerns

- Settled claims will be “denied” in a provider’s PS&R report
  - Reimbursement implications for, among other things: Graduate Medical Education Payments, Medicare EHR Incentive Program, and Bad Debt
- Timing
  - CMS set no mandatory timetable for when it must countersign an Administrative Agreement
- Impact on RACs
  - Will RACs be required to return at least a portion of their contingency fees if a provider settles with CMS?

OMHA Request for Information

- OMHA published a Request for Information soliciting suggestions from the public regarding how to address the backlog of pending cases — 79 Fed. Reg. 65660 (Nov. 5, 2014)
- Specifically, OMHA requested:
  - Suggestions related to the statistical sampling initiative and settlement conference facilitation;
  - Other suggestions for addressing the increased workload and backlog of appeals at the ALJ level; and
  - Suggestions regarding current regulations that apply to the ALJ level of the Medicare claim and entitlement appeals process that could be revised to streamline the adjudication process
- Comments were due on December 5, 2014

RFI Responses

- Based on publicly available comments, similar themes pervade the RFI responses from providers:
  - Backlog of appeals and increase in ALJ appeal requests are symptoms of a larger problem that is outside of OMHA’s control, and may derive from the fundamental structure of the RAC program
  - Ensure more meaningful review at levels one and two
  - Implement a moratorium on recoupment of overpayments through at least the third level of appeal
  - Create a broader, permanent settlement facilitation program
  - Implement a uniform docketing system
Recent Updates

• Beginning October 27, 2014, MACs are required to defend their medical review decisions through the ALJ level of appeal by either taking participant or party status at the hearings.

• In letters submitted to HHS in early December 2014, the American Hospital Association and American Medical Association stated that RACs are the “underlying cause” of the Medicare appeals backlog. The American Coalition for Healthcare Claims Integrity has taken the opposite view.

• OMHA’s backlog of beneficiary appeals has improved substantially in the past year. However, about 900,000 appeals still remain unresolved, most filed by hospitals and other healthcare providers.

OMHA Updates & Tips

• Updates from OMHA on Operations

• Looking forward in 2015

• Practice tips – before and at OMHA

Two-Midnight Rule
Two-Midnight Rule: Basic Overview

- CMS implemented the Two-Midnight rule to “provide clarification about when a patient should be admitted to the hospital”
  - Under the prior rule, many RAC audits seized on patient status
- Under the Two-Midnight Rule, the physician should order inpatient services “if he or she expects that the beneficiary’s length of stay will exceed a 2 midnight benchmark or if the beneficiary requires a procedure specified as inpatient-only…”
  - It is the physician’s “expectation” that controls, not actual time in the hospital
- Many providers are concerned that the Two-Midnight rule has not resolved the inpatient admission ambiguity

Two-Midnight Rule “Probe & Educate” Period

- RACs are prohibited from conducting patient status reviews on claims with dates of admission between October 1, 2013 and March 31, 2015
- MACs are instructed to conduct patient status reviews of 10 – 25 claims depending on hospital size
  - May repeat probe reviews depending on results
  - Time permitting, certain providers may be subject to a third probe
- Current expiration date of Probe & Educate: March 31, 2015
  - House Ways & Means Discussion Draft proposes extending an additional 6 months (to October 1, 2015)

What Happens After The “Probe & Educate” Period

- The Probe & Educate period prohibits RACs from conducting patient status reviews on claims with dates of admission between October 1, 2013 and March 31, 2015
  - Where will RACs focus when prevented from reviewing patient status claims?
  - Can the RACs whose contracts have been extended conduct post-payment patient status reviews on claims with dates of admission after March 31, 2015?
  - How will patient status reviews by RACs differ from reviews by MACs during the Probe & Educate period?
Appendix:
Contractor Landscape

Contractor Landscape
• Significant number of government contractors reviewing federal healthcare provider reimbursement
  – Medicare Recovery Audit Contractors (RACs)
  – Medicare Administrative Contractors (MACs)
  – Zone Program Integrity Contractors (ZPICs)
  – Supplemental Medical Review Contractors (SMRCs)
  – Comprehensive Error Rate Testing (CERT) Contractors
  – Medicaid RACs
  – Medicaid Integrity Contractors (MICs)
• Each contractor has a defined scope of authority
• OIG has emphasized the need for effective CMS oversight and coordination of contractors
**Medicare and Medicaid Scrutiny of Georgia Providers**

**Medicaid**
- Health Integrity (Audit MIC)
- Strategic Health Solutions and Information Experts (Education MICs)
- Georgia Medicaid Fraud Control Unit (MFCU)
- Myers & Stauffer LC (Medicaid RAC)

**Medicare**
- Cahaba Government Benefit Administrators (A/B MAC)
- CGS (DME MAC)
- Connolly (A/B RAC)
- Connolly (DME & HH/H RAC)

**Potential Fraud**
- NCI AdvanceMed (ZPIC)
- UPIC (To Be Determined)

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**Appendix: Two-Midnight Rule**

**Two-Midnight Rule**

- Effective for inpatient admissions on or after October 1, 2013
- Inpatient Defined: An individual is considered an inpatient of a hospital if formally admitted as an inpatient pursuant to an order for inpatient admission by:
  - A physician, or
  - Other qualified practitioner
CMS Two-Midnight Rule Guidance

• CMS has issued guidance, updated previous guidance, proposed changes, or responded to provider questions at least 34 times through its website, provider forums, and other transmittals
  – To date, manual guidance has not been issued
• On October 31, 2014, CMS released the FY 2015 Outpatient Prospective Payment System (OPPS) Final Rule, revising the Two-Midnight Rule certification requirement
  – Effective January 1, 2015, a physician certification is only required for long-stay cases – defined as 20 days or longer – or outlier cases