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PROFESSIONAL LIABILITY UNDERWRITING SOCIETY

The Torture RAC

Medicare Overpayment Issues and Disputes

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Regulatory Environment – "Impenetrable, Tortuous"

"There can be no doubt but that the statutes and provisions … involving the financing of Medicare and Medicaid, are among the most completely impenetrable texts within the human experience."

"… not only are they dense reading of the most tortuous kind, but Congress also revisits the area frequently, generously cutting and pruning in the process and making any solid grasp of matters addressed merely a passing phase."

Rehabilitation Assn. of Virginia v. Kozlowski
42 F.3d 1444, 1450 (4th Cir. 1994)

Regulatory Environment – By the Numbers

$996 B	**Annual Medicare / Medicaid spending (FY 2012)**
5.6 B	**Est. number of Medicare / Medicaid claims processed per year**
8.0 %	**Average Medicare / Medicaid payment error rate**
3 – 10%	**Percentage range of dollars lost annually to healthcare fraud**
$4.3 B	**Amount recovered in fraud judgments / settlements (FY 2013)**

Medicare Overpayment Issues and Disputes

Who is asking for the information?

How are they asking for it?

What is the basis?

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CMS Contractors and the Claims Review Process

- CMS has traditionally relied on contractors to perform pre- and post-payment audit and review functions both to prevent and recover improper payments

RAC Recovery Audit Contractor (Also Medicaid RACs)	**MAC** Medicare Administrative Contractor	**CERT** Comprehensive Error Rate Testing
ZPIC Zone Program Integrity Contractor	**PSC** Program Safeguard Contractor	**MIC** Medicaid Integrity Contractor

Recovery Audit Contractors (RACs)

"Recovery Auditors are unique and distinct from other contractors due to their ability to conduct widespread postpayment review."

CMS Report to Congress, Recovery Auditing in Medicare and Medicaid (FY 2012)

"RACs are bounty hunters paid on a contingency fee based on the money clawed back from denied claims"

American Hospital Association, The RAC Burden (2014)

"The RAC incentive structure is not based on reducing future improper payments, but on recovering past improper payments"

U.S. Senate Special Committee on Aging, Committee Staff Report, Improving Audits: How We Can Strengthen the Medicare Program for Future Generations (2013)

Expanding RACs & Role

- **Medicare Modernization Act (2003)**
  - 3-year demonstration project (2005-2008) in 6 states (AZ, CA, FL, MA, NY, SC) resulted in a $1 B overpayment recovery
- **Tax Relief and Health Care Act (2006)**
  - Makes the RAC program permanent and expands it nationwide
- **Affordable Care Act (2010)**
  - Expands RAC program to Medicare Parts C & D (in process) and Medicaid (100% state participation nearing completion)
- **RAC Prepayment Review Demonstration (2012–2015)**
  - Applies to certain DRGs and underway in 7 HEAT states (CA, FL, IL, LA, MI, NY, TX) and 4 states (MI, NC, OH, PA) with high volume of short inpatient stays

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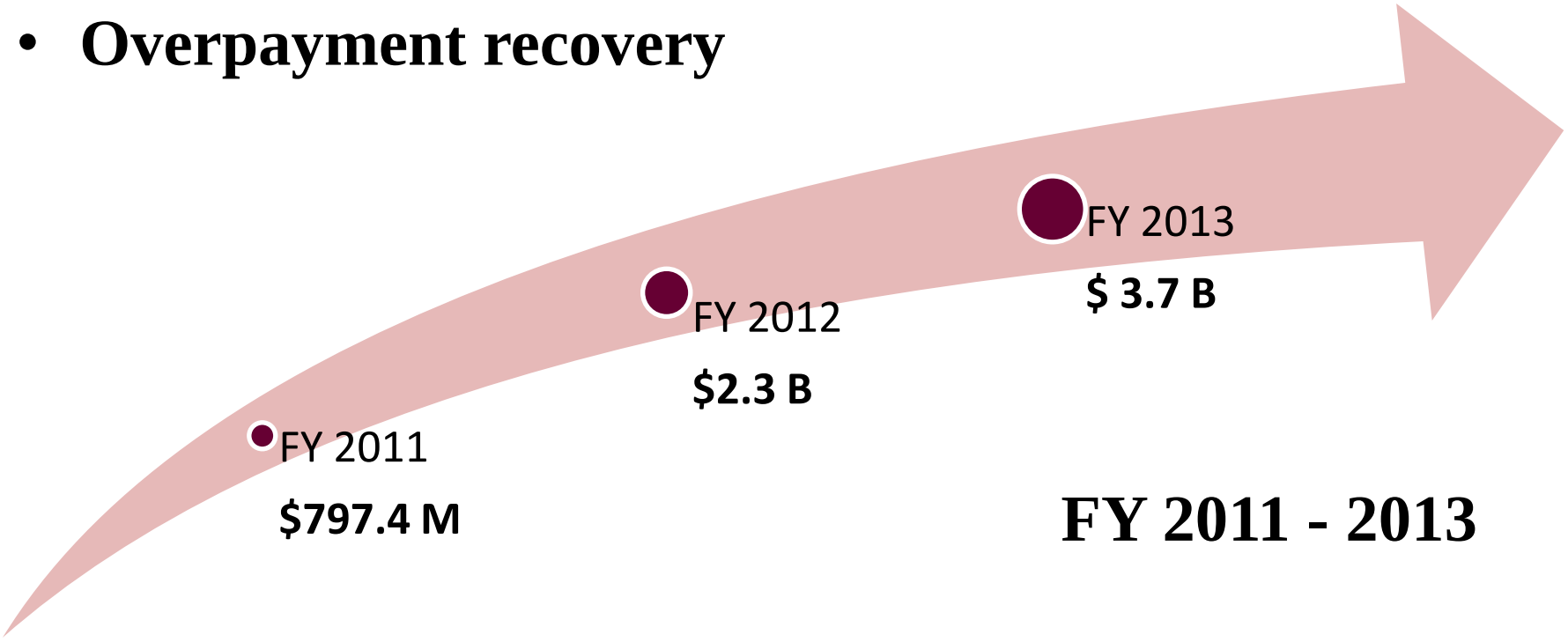
RAC Facts

- **Primary activities**
  - Recommend audit issues to CMS for approval
  - Detect and recover overpayments; identify underpayments
  - Conduct post payment reviews
    - Reviews limited to 3-year look back period
  - Conduct pre-payment reviews for certain diagnosis related groups (DRGs)
    - 3-year demonstration project (2012 – 2015)
  - State Medicaid RACs

RAC Facts

- **Paid on a contingency fee basis**
  - Typically 9 -12.5% of the improper payment identified
  - Fee returned if RAC determination is overturned on appeal
- **Overpayment recovery**



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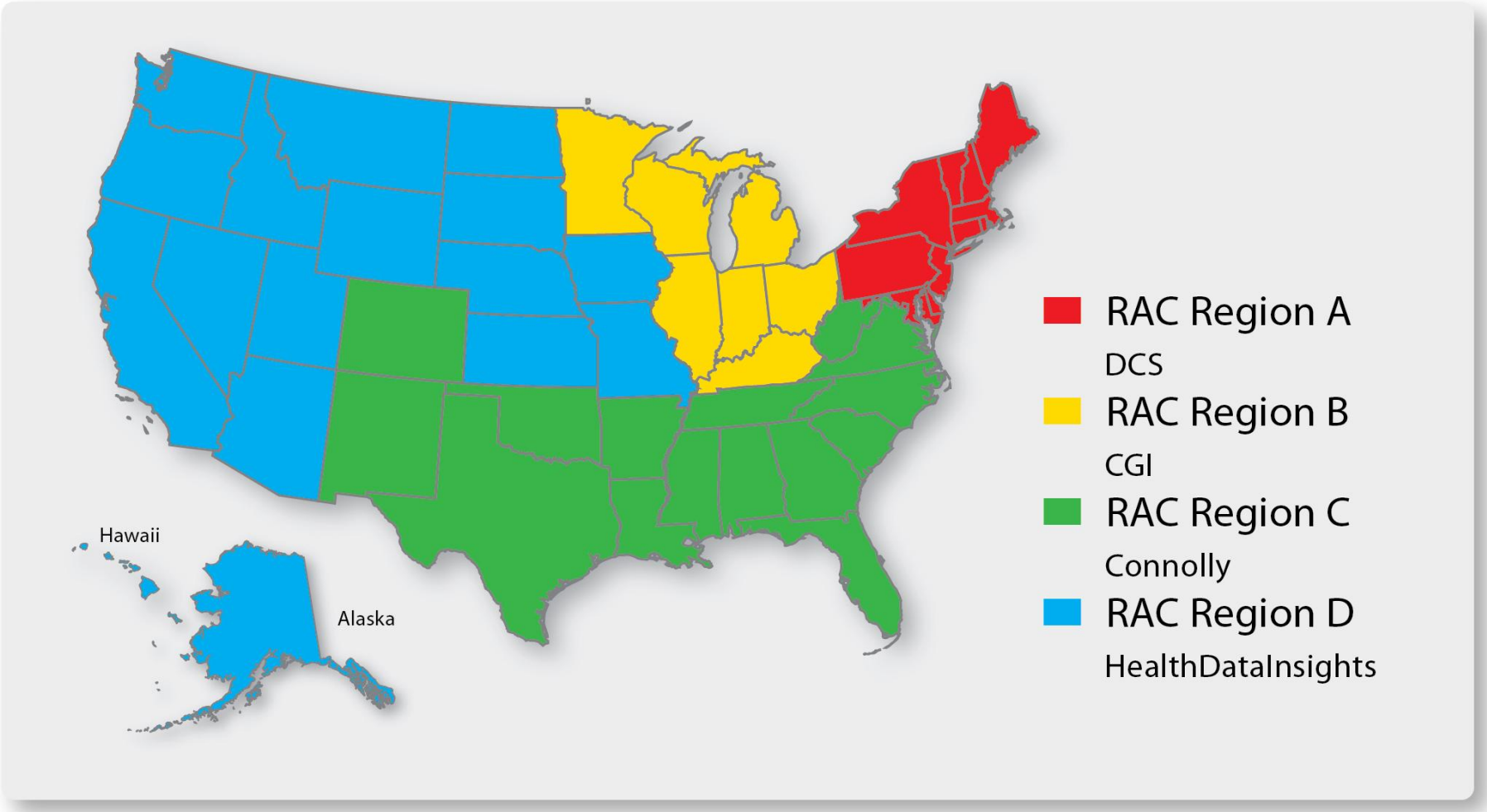
More RAC Facts

- **Medicare FFS (Parts A and B), Part C, Part D**
- **Staffing requirements**
  - RACs must employ nurses, therapists, certified coders, and a physician contracted medical director
- **Collection and repayment**
  - The Medicare Administrative Contractors (MACs) are responsible for collecting the improper payments identified by the RACs
- **Jurisdictions**
  - Medicare FFS RACs are responsible for identifying overpayments and underpayments in a geographically defined area that is roughly a quarter of the country

RAC Jurisdictions



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RAC Review Processes

Automated Review	Complex Review
• **Automated review** Uses proprietary claims data mining software to detect improper payments — e.g., duplicate services, coding errors • **Semi-automated review** Automated review triggers request for supporting documentation	• **Medical record review** Review of supporting medical records by a coder or clinician (depending on type of review) to determine if a payment error occurred — e.g., medical necessity • ***96% of denied dollars were for complex denials*** — Source: AHA

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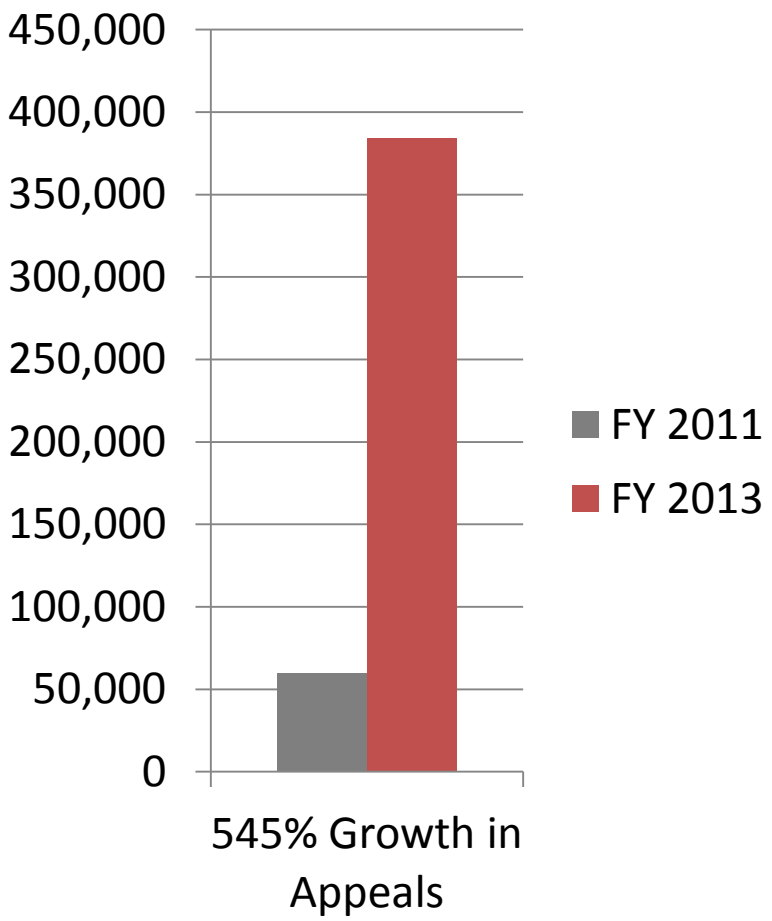
RAC Review Areas

- **Examples of CMS approved audit issues**

PHYSICIANS	DURABLE MEDICAL EQUIPMENT (DME)	HOSPITAL OUTPATIENT
• Intensity modulated radiation therapy (IMRT) **Medical Necessity –** • Percutaneous transluminal angioplasty • Sacral nerve stimulation for urinary incontinence **Condition of Coverage Review –** • Major joint replacement • Surgical management of morbid obesity	• CPM billed for non-total knee replacement patients • Negative pressure wound therapy pumps **Medical Necessity –** • Osteogenesis stimulators **Prepayment Review –** • DME group 2 – pressure reducing support svcs.	• Incorrect billing of non-coronary vascular and lower extremity stents • Intensity modulated radiation therapy (IMRT) **Medical Necessity –** • Percutaneous transluminal angioplasty **Pre-Payment Review** • Trastuzumab (Herceptin), J9355 – multi-dose vial waste

Spike in Medicare Appeals



- **RAC program rollout**
  - Cited as a chief contributor to the sharp uptick in appeals
- **CMS statistics (FY 2012)**
  - RACs identified 1.419 M claims as overpayments
  - 7% (99,492) of RAC claims challenged and overturned on appeal
- **Timeframe for adjudication of incoming appeals**
  - 387 days as of June 2014

Source: Office of Medicare Hearings and Appeals (July 10, 2014)

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RAC Stats

AHA RACTrac survey of 1,165 hospitals (Q1 2014)

94% Hospitals that experienced RAC activity	**$3 B** Dollar amount of RAC denied claims in Q 1
48% Spent >$25,000 to manage RAC process	**50%** Appealed RAC denials
1,481 Average number of RAC medical record requests per hospital in Q 1	**63%** Of ALL claims appealed are still sitting in the appeals process
57% Percent of medical records reviewed by RACs that did not contain an overpayment	**66%** Percent of claims overturned in favor of the provider after completing the appeals process

RAC Audit "Pause"

- **CMS announcement (Feb. 18, 2014)**
  - Suspends document requests associated with RAC claims reviews until the new RAC contracts are in place
  - Once the new contracts are in effect, RACs may audit claims for dates of service occurring during the pause
  - Pause also applies to the RAC pre-payment review demonstration
- **CMS announcement (Aug. 4, 2014)**
  - "Due to the continued delay in awarding new Recovery Auditor contracts, the CMS is initiating contract modifications to the current Recovery Auditor contracts to allow the Recovery Auditors to restart some reviews."
  - "Most reviews will be done on an automated basis, but a limited number will be complex reviews of topics selected by CMS."

RAC Audit Changes

- **CMS announcement (Feb. 18, 2014)**
  - Effective with the new contracts, RACs will:
    - Wait 30 days to allow for a discussion before sending claim to the MAC for adjustment
    - Confirm receipt of discussion request w/in 3 days
    - Wait until the 2nd level of appeal is exhausted before receiving contingency fee
  - Revised addt'l documentation request (ADR) limits
    - Diversified across different claim types (e.g., inpatient vs. outpatient)
    - Adjusted in accordance with a provider's denial rate

RAC Litigation

- **HHS Office of Medicare Hearings and Appeals announcement (Jan. 7, 2014)**
  - Imposes 2-year moratorium on assignment of new appeals to the ALJ level due to pending backlog of over 480,000 appeals
- **Am. Hosp. Ass'n v. Sebelius, D.D.C. (May 22, 2014)**
  - Mandamus action filed by the AHA contends ALJ appeals moratorium stems from "Enormous increases in the rates of appeal, in significant part by providers challenging inappropriate denials by over-zealous RACs"
  - "HHS's delays in resolving Medicare appeals affect human health and welfare by compromising the economic well-being of hospitals across the country"

RAC Legislation

- **HR 1250 / S 1012 - Medicare Audit Improvement Act**
  - Consolidated limit for medical record requests
  - Financial penalties for overturned appeals
  - Medical necessity audits focus on widespread payment errors
  - Physician review required for Medicare claims denials
  - RAC performance evaluations and statistics on Internet
  - Subjects HHS compliance with guidelines for reopening and revising benefit determinations to administrative and judicial review
- **Bipartisan bill introduced Mar. 2013; 185 co-sponsors**

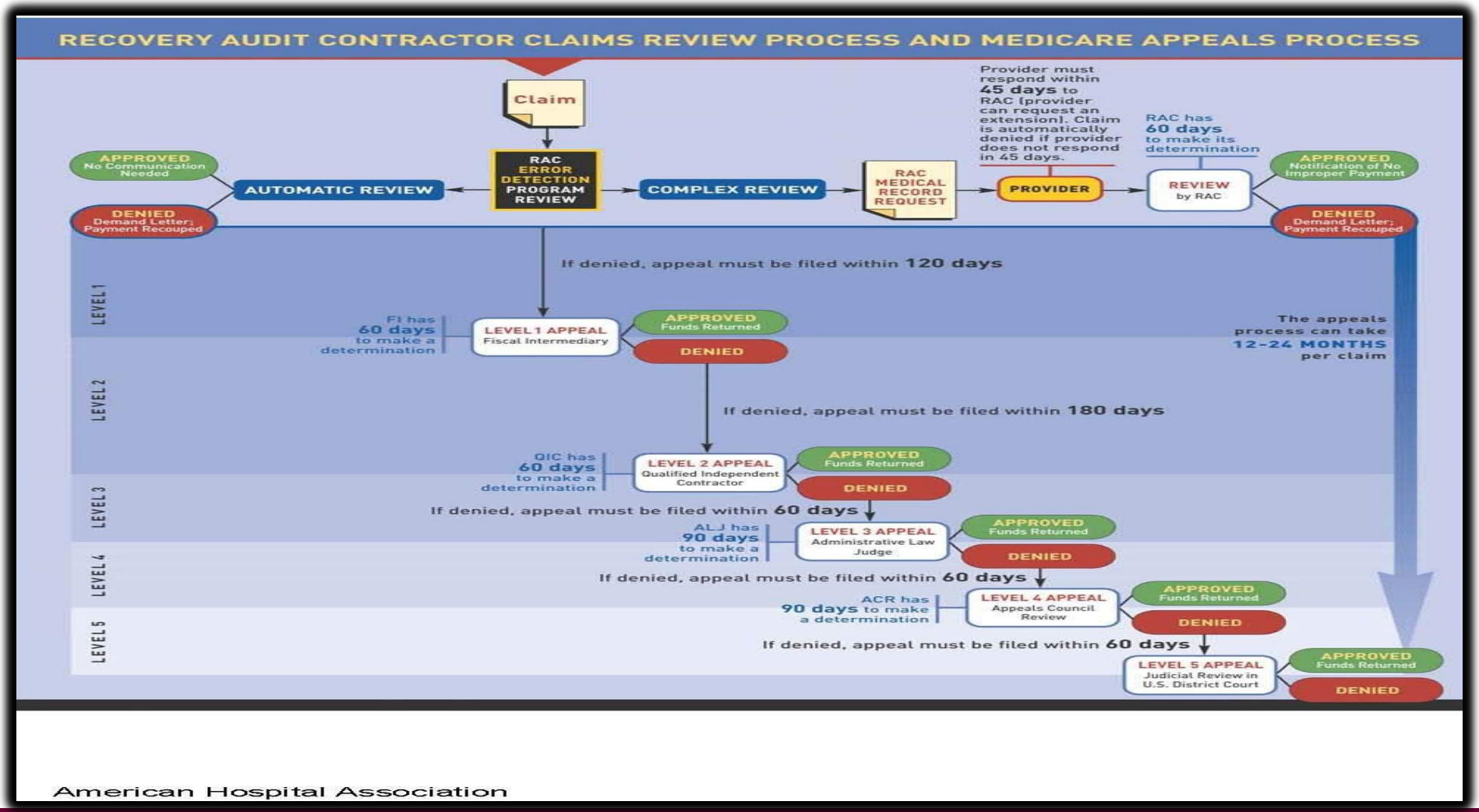
Other Medicare Claims Reviewing Contractors

- **Medicare administrative contractors (MACs)**
  - Conduct data analysis comparing providers to peers
  - High error rates can result in prepayment reviews
- **Comprehensive error rate testing (CERT) contractors**
  - Identify high-risk areas; measure improper payments
    - Medicare Parts A and B; DME MACs (DMACs)
  - Randomly select statistically-valid sample of claims
  - Conduct postpayment review
  - Publish results annually
  - Produce a national Medicare FFS error rate

Other Medicare Claims Reviewing Contractors

- **Zone program integrity contactors (ZPICs)**
  - Ensure integrity of all Medicare-related claims
    - Parts A, B, C, D; hospice, DME; coordination of Medi-Medi data matches
  - Perform data analysis and data mining
  - Conduct medical reviews in support of benefit integrity
  - Support law enforcement and answer complaints
  - Investigate fraud and abuse
  - Recommend recovery of federal funds through administrative action
  - Refer cases to law enforcement

Medicare Claims Appeals Process



American Hospital Association

Medicare Claims Appeal

- **Level 1 – Redetermination**
  - To the MAC
  - On the record
  - 120 days to appeal
  - Only 30 days to stop recoupment
  - Interest accrues
  - Decision within 60 days

Medicare Claims Appeal

- **Level 2 – Reconsideration**
  - To the Qualified Independent Contractor
  - On the record
  - 180 days to appeal
  - Only 60 days to stop recoupment
  - Interest accrues
  - Decision within 60 days
  - All evidence must be submitted

Medicare Claims Appeal

- **Level 3 – Administrative Law Judge**
  - To an ALJ
  - In person, video, or phone
  - 60 days to appeal
  - Recoupment is not stopped
  - Amount in controversy requirement
  - Decision within 90 days

Medicare Claims Appeal

- **Level 4 – Medicare Appeals Council**
  - To the MAC
  - Can request a hearing or briefing
  - 60 days to appeal

Medicare Claims Appeal

- **Level 5 – Federal Court**
  - To Federal District Court
  - Briefing and request for hearing
  - 60 days to appeal
  - Amount in controversy requirement

Managing the Payment Dispute

Do your due diligence

- Determine the scope of the issues
- Conduct factual due diligence
- Understand the regulatory/reimbursement scheme

Managing the Payment Dispute

Manage the appeal

- Be prepared to appeal
- Understand reasons for denial
- Interest
- Recoupment
- Sampling issues

Managing the Payment Dispute

Manage the appeal

- Internal and external reviews
- Position papers
- Contractor participation
- Evidentiary issues
- Involvement of legal counsel

Managing the Payment Dispute

Manage the appeal

- Track payment disputes and appeals
- Cost benefit analysis
- Corrective action

New Pilot Programs to Address ALJ Appeals Backlog

- **Settlement conference facilitation pilot**
  - Alternative dispute resolution process for Part B claims

    "The facilitator [a CMS employee] does not make official determinations on the merits of the claims at issue and does not serve as a fact finder but may help the appellant and CMS see the relative strengths and weaknesses of their positions"
  - If a resolution is reached
    - Parties will sign a settlement agreement and the request for an ALJ hearing will be dismissed
  - If a resolution cannot be reached
    - The appealed claims will return to the ALJ hearing process for adjudication (and to their original place in the queue)

New Pilot Programs to Address ALJ Appeals Backlog

- **Statistical sampling pilot program**
  - Adjudication of a group of appeals (involving at least 250 claims) using statistical sampling
  - Must be a single Medicare provider or supplier to participate
  - Multiple providers or suppliers owned by a single entity may participate if they agree to a single payment
  - Only appeals currently assigned to an ALJ or filed between April 1 - June 30, 2013 are eligible for the pilot
  - Unclear how many hospitals have a sufficient amount of claims pending at the ALJ level to qualify for the statistical sampling pilot program

New Pilot Programs to Address ALJ Appeals Backlog

- **Statistical sampling pilot program**
  - Pre-hearing conference with an ALJ to confirm consent to statistical sampling
    - Consent to statistical sampling may be withdrawn up to the point when the pre-hearing conference order becomes binding
    - At which point the appeals will be returned to the standard ALJ process (but unclear as to where in the queue)
  - Appeals combined into a single appeal and assigned to a new ALJ for a hearing on the sample units selected by the government's statistical expert
  - Post-hearing, CMS contractor extrapolates ALJ's decision on the sample units to the universe of claims
    - A MAC will effectuate the decision based on the extrapolated amount

Claims Appeal Settlement Offer

- **CMS settlement offer to resolve backlog for denials of short stay inpatient claims (Announced Aug. 29, 2014)**
  - "CMS is now offering an administrative agreement to any hospital willing to withdraw their pending appeals in exchange for timely partial payment (68% of the net allowable amount)"
    - Hospitals opting for settlement must settle all such pending appeals
  - Eligibility
    - Inpatient status claims "denied on the basis that services may have been reasonable and necessary but treatment on an inpatient basis was not"
    - Claims with date of admissions before Oct. 1, 2013
    - Applies to acute care hospital and CAH facility types only
    - May exclude hospitals with pending FCA litigation or investigations
  - Deadline for settlement requests = Oct. 31, 2014

One Last Thought …

- **How could you lose my dog ?!?!**