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Executive Health Resources
Agenda

• National Review of Audit Landscape
• Prepayment Review Project
• Proactive vs. Reactive Best Practices
• Update on 1455 and 1599 proposed Rules
Update from RAC TRAC 2012 Q4

(4) Nearly 60,000 medical records requests have been made to survey respondents since last quarter.

(4) Nearly 2/3 of cases where medical records were pulled did not have an overpayment.

(4) 61% of medical necessity denials reported were for 1-day stays.

(5) Hospitals reported appealing more than 40% of all RAC Denials with a 72% Success Rate. Number of hospitals that continue to report data to AHA appears to be going down. May be related to the workload they already have just reacting to the appeals.

(5) Nearly 75% of appealed claims are still sitting in the appeal process.

(9) 90% of reporting hospitals are experiencing RAC Activity.

(17) Average value of Medical Record requested in complex reviews (before the denial decision is made) ranges by region from $8,243 to $9,630.

(20) $1.3 billion in complex and automated denials were reported to AHA through Q4 2012.

*2012 Q4 version of the Rac Trac report. Each Item starts with the report page number in ( ).
Update from RAC TRAC 2012 Q4, con’t.

(23) Nationwide – AHA is reporting an average of $5,358 for a complex denial

(36) Through 2012 Q4, Complex Case Denials – Top Volume:
Region C – CGI – AHA volume 65,982

(41) AHA reported the top 5 Medical Necessity Denials with the largest financial impact – Reported # of hospitals with these denials

247 - PERC CARDIOVASC PROC W DRUG-ELUTING STENT W/O MCC – 21% of hospitals
312 – SYNCOPE & COLLAPSE – 14% of hospitals
392 – ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS W/O MCC – 13% of hospitals
313 – CHEST PAIN – 13% of hospitals – EHR OT Rate for this is 92%
491 – BACK & NECK PROC EXC SPINAL FUSION W/O CC/MCC – 5% of hospitals

(51) AHA reports % overturned as wins / closed – EHR Reports % overturn as wins / closed but went at least though the ALJ level.
A – Performant – AHA win rate = 81%

*2012 Q4 version of the Rac Trac report. Each Item starts with the report page number in ( ).
## CMS Recovery Amounts

<table>
<thead>
<tr>
<th>Period</th>
<th>Fiscal Year</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>October 2009 – September 2010</td>
<td>FY2010</td>
<td>$92.3</td>
</tr>
<tr>
<td>October 2010 – September 2011</td>
<td>FY2011</td>
<td>$939.3</td>
</tr>
<tr>
<td>October 2011 – September 2012</td>
<td>FY2012</td>
<td>$2,400.7</td>
</tr>
<tr>
<td>October 2012 – December 2012</td>
<td>Q1 FY2013</td>
<td>$779.2</td>
</tr>
<tr>
<td>January 2013 – March 2013</td>
<td>Q2 FY2013</td>
<td>$657.5</td>
</tr>
</tbody>
</table>

Total corrections so far equal $4.8 billion with $4.5 billion being overpayments.

## CMS Recovery Amounts (Through Q2 FY2013)

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

### Quarterly Newsletter

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

Recovery Auditor (RA) Pre-Payment Project

- The Demonstration will take place between August 27, 2012 through August 26, 2015.

- The 11 states included in this Demonstration are CA, FL, IL, LA, MI, MO, NC, NY, PA, OH, and TX.

- Focus on claims with high improper payment rates
  - Begin with short inpatient stays (< 2 days)
  - Inpatient Hospital stays only

- Just like the Part A to Part B Rebilling Demo…look for this demo to end early…with more widespread application to all states
RA Pre-Payment Project (con’t)

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

• The Recovery Auditors (RACs) will target the originally published MS-DRGs, however, they will be phased in throughout the first few months of the Demonstration:

  – August 27: MS-DRG 312 SYNCOPE & COLLAPSE
  – Dec. 26: MS-DRG 069 TRANSIENT ISCHEMIA
  – TBD: MS-DRG 377 G.I. HEMORRHAGE W MCC
  – TBD: MS-DRG 378 G.I. HEMORRHAGE W CC
  – TBD: MS-DRG 379 G.I. HEMORRHAGE W/O CC/MCC
  – TBD: MS-DRG 637 DIABETES W MCC
  – TBD: MS-DRG 638 DIABETES W CC
  – TBD: MS-DRG 639 DIABETES W/O CC/MCC

• Percent of claims to be reviewed is unknown at this time
RAs Pre-Payment Project:
Q and A from CMS Open Door Forum

- Normal CMS appeals process
- Time is in calendar days and not business days
- Date is based on claim submission date (not date of service)
- RA receives same contingency fee payment
- No physicians or Part B claims to be reviewed
  - (However, Connolly and CGS are auditing E&M Code 99215)
- CAHs and PIPs CAN be included in program
Best Practices to Prevent Denials
Review Cases Concurrently

Recognize that this is about daily tactics:

1. Case Management applies current, strict admission criteria to 100% of the medical cases placed in hospital beds, and documents this review in an auditable format.
2. ALL cases that do not pass criteria (regardless of admission order status) are referred to a Physician Advisor who is an expert in CMS rules and regulations and clinical standards of care.
3. The Physician Advisor reviews the case, speaks with admitting physician when needed, makes their recommendation based upon UR standards, and documents the decision in auditable format in the patient chart or in UR documentation.
4. Attending physician changes order, as appropriate.
5. Should run 7 days a week/365 days a year.
Three-Tiered Tactical Approach to RAC Appeals

• All appeals should be designed to prepare for the ALJ

• Your argument must address three key components to have a high likelihood of success:
  – **Clinical**: Strong medical necessity argument using evidence-based literature
  – **Compliance**: Need to demonstrate a compliant process for certifying medical necessity was followed
  – **Legal**: Want to demonstrate, when applicable, that the RAC has not opined consistent with the SSA
Best Practice Approach

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

• Summary of CMS 1455-NR and 1455-P
• Recommendations for cases in appeal process
  – Cases for potential withdrawal
• Concurrent review recommendations
  – What cases NOT likely do not need second level review
• Overview of 1599 (IPPS update) proposal
  – Considerations and potential next steps
Reasons for Proposed Rulings

• Overburdened Appeals Process
  – Processing Delays/Escalation
  – ALJ Remands

• Questions Regarding Legitimacy of “Partially Favorable Decisions”
  – What decisions can appeals entities (MAC, QIC, ALJ) make regarding payment for care provided?
Key Elements of CMS 1455 NR (Interim Rule)

• Medicare review contractors are now subject to a limited scope of review - Part B payment cannot be considered during the review of a Part A claim
  – Appeals remanded from the ALJ to the QIC will now be sent back to the ALJ for review of the Part A claim

• Providers have the opportunity to rebill Part A claims
  – To rebill for Part B, hospitals must either withdraw their Part A appeals or no longer pursue an appeal of a denial of Part A services.
  – Rebilling is not subject to standard timely filing deadlines, but does have a rebilling timeframe – generally 180 days.

• Termination of the A/B Rebilling Demonstration project
## Interim Rule vs. Proposed Rule

<table>
<thead>
<tr>
<th></th>
<th>Prior to New Rulings</th>
<th>CMS Ruling 1455</th>
<th>CMS Proposed Rule</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Self Auditing</strong></td>
<td>Bill Part B Ancillaries only. Subject to limitations of Cond Code 44</td>
<td>Allows providers to rebill only for claims denied by a Medicare contractor</td>
<td>Allows providers to rebill inpatient Part A claims denied as a result of a “self-audit”</td>
</tr>
<tr>
<td><strong>Part B Rebilling</strong></td>
<td>Only allowed if Judge determined appropriate. No regulations</td>
<td>Rebilling of covered Part B charges when the Part A claim is denied as not medically reasonable and necessary</td>
<td>More restricted Part B rebilling to claims for services rendered to beneficiaries enrolled in Medicare Part B</td>
</tr>
<tr>
<td><strong>Timeliness for Rebilling</strong></td>
<td>Only if within timely filing (one year) or Judge orders (no time limit)</td>
<td>Allows for rebilling 180 days from denial or lost appeal</td>
<td>Standard timely filing requirements (1 year from the date of service) on rebilled claims</td>
</tr>
<tr>
<td><strong>Impact to Beneficiary</strong></td>
<td>To be held harmless</td>
<td>Upon rebilling, requires hospital to adjust beneficiary billing</td>
<td>Upon rebilling, requires hospital to adjust beneficiary billing</td>
</tr>
</tbody>
</table>
Current Cases in Appeals
What should we do with cases under appeal today?

• There is not one answer - different hospitals have different considerations:

  – Periodic Interim Payment (PIP)
  – Critical Access Hospital (CAH)
  – Short term acute care hospital
  – Participation in the A → B rebilling project
  – UM process in place during hospital stay (of denied case)
  – Documentation by physician and UM Dept
  – Auditor performing denial
Considerations

• No action during interim rule period is a viable approach

• Regarding cases currently in the appeals process, your decision should hinge on:
  – Time Value of Money
  – Probability of winning on appeal

• What is the facility’s position on rebilling the patient for Part B?
Evaluation of Claims in Appeal

- Request reimbursement data for DRG’s
- Operationally may be difficult given time period
  - Consider focusing on:
    - Highest dollar cases
    - Highest volume cases
- Recalculate the Part B payment under 1455:
  - Hospital stay outpatient claim amount
  - ER and other outpatient charges 72 hours prior to admission
  - Balance due from beneficiary?
- Work with finance to determine the tradeoffs on:
  - Staff resources to evaluate the claims and do re billing
  - Expected success in the appeals process
  - Time it will take to get through the appeals process/your institutions time value of money
  - Impact on beneficiary
Case Example

• Claim comparison
  – Part A payment
  – Part B payment
    ▪ 12x for outpatient hospital charges
    ▪ 13x for charges 72 hours prior to admission
  – Patient responsibility
Removing Cases from Appeal

Handling your own appeal:

• Requests for withdrawal of pending Part A claim appeals must be sent to the adjudicator with whom the appeal is currently pending, except where the appeal has been remanded from an ALJ to a QIC.

• If the case is at the ALJ, or was remanded to the QIC by an ALJ for a Part B determination, instructions can be found at: http://www.hhs.gov/omha/Data/cmsruling.html
2014 IPPS Proposal 1599

Medical Necessity Review Criteria
Proposed 2014 IPPS Changes

• Also known as CMS 1599 or Federal Register May 10, 2013

• 339 (FR) or 1424 pages

• Updates in many areas:
  – GME updates
  – Hospital readmission program
  – COPs
  – Vaccines
  – Payment
  – Others
Proposed 2014 IPPS Changes

• Timeline:
  – CMS will accept comments until June 25
  – Plan to finalize Rule by Aug 1
  – Goes into effect on Oct 1

• Key pages regarding Inpatient Medical Necessity: 657-688 (1599)
  – Consider document search for “medical review criteria”
Proposed 2014 IPPS Changes

- Two (2) midnights will serve as *preumption* of IP status
- Increased physician documentation requirements
- Requires a physician order for inpatient status
- Inpatient time starts when the patient is moved to an inpatient area
  - No longer based on the physician’s order
  - Will add emphasis on through put in the ER
  - Could magnify LOS issues
Proposed 2014 IPPS Changes

• Auditors should focus on:
  – 0,1 inpt stays
  – 2,3 day inpt stays with evidence of “gaming the system”

• CMS expects a net of 40,000 additional inpt cases (based on data from 2009-2011)
  – Resulting in $220 million additional dollars
  – 0.2% cut proposed to remain budget neutral
Questions Regarding 1599

• What does “presumption” mean?
  – Never?
  – Most of the time?
  – Sometimes with the appropriate documentation?

• Suggested change in admission UM process?

• Expected impact on 3 day SNF rule?

• Will the DRGs be modified?

• Do you expect this to be a positive net on hospital finances?

• What is impact and hospital approach to the beneficiary?
1599 Proposed Rule Recommendations

- Currently a proposal, will not be finalized for a couple months
  - Expect to see changes AND a final ruling
- Determine impact on your hospital and take advantage of the comment period (ends June 25th)
- Medical necessity documentation will take on additional importance
- UM review will remain critical to submitting a correct claim
  - Likely will be changes in best practices
  - Especially around: documentation, timing of review, quality of care
Key Takeaways

• If you are treating patients and submitting claims, you will be audited
• Not all auditors are created equal
• Best defense for prepayment review is a good front end review process
• 1455 adds additional appeal options; think carefully
• Analyze impact of 1599 and comment to CMS
Questions?