American Hospital Association®

Program Integrity

Background

In recent years, the Centers for Medicare & Medicaid Services (CMS) has drastically increased the number of program integrity auditors that review hospital claims to identify improper payments. These audit contractors include recovery audit contractors (RACs) and Medicare administrative contractors (MACs). RACs are charged with identifying improper Medicare and Medicaid fee-for-service payments – both overpayments and underpayments. They are paid on a contingency fee basis, receiving a percentage of the improper payments they identify and collect. MACs conduct pre-payment and post-payment audits and also serve as providers' primary point-of-contact for enrollment and training on Medicare coverage, billing and claims processing.

No one questions the need for auditors to identify billing mistakes; however, responding to the increasing number of audits and challenging inappropriate denials drains hospitals' time, funding and attention that could more effectively be focused on patient care. For example, according to AHA's RAC*Trac* survey of 2,400 participating hospitals, there was a 60 percent increase in the number of records requested for RAC audits during 2013. These Medicare claims now collectively represent almost $10 billion in Medicare payments, a 56 percent increase from the claims requested for RAC audits through 2012. In addition, through 2013, RAC*Trac* data show that hospitals appeal almost half of all Medicare claims denied by a RAC, and in such cases, hospitals are successful at overturning the RAC denial 64 percent of the time[1].

AHA View

Hospitals are drowning in the deluge of unmanageable medical record requests and inappropriate payment denials. CMS and Congress need to make the audit processes more fair and transparent.

Hospitals take seriously their obligation to bill properly for the services they provide to Medicare and Medicaid beneficiaries and are committed to working with CMS to ensure the accuracy of Medicare and Medicaid payments. However, redundant government auditors, unmanageable medical record requests and inappropriate payment denials are wasting hospital resources and contributing to growing health care costs. More oversight of these audit contractors is needed by CMS to prevent inaccurate payment denials and to make the auditing effort more transparent, timely, accurate and administratively reasonable.

Audit Relief through Legislation. The Medicare Audit Improvement Act (H.R. 1250/S. 1012) would ensure transparent and fair audit practices and provide assistance to hospitals in mitigating excessive overall audit burden. Introduced by Reps. Sam Graves (R-MO) and Adam Schiff (D-CA) and Sens. Mark Pryor (D-AR) and Roy Blunt (R-MO), this AHA-supported legislation would establish annual limits on documentation requests from RACs and other auditors; impose financial penalties on RACs if they fall out of compliance with program requirements; make RAC performance evaluations publicly available; and allow denied

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[1] Of the 36 percent of denials not overturned, in many instances, hospitals withdrew their appeals in order to rebill the claim under Medicare Part B.

inpatient claims to be billed as outpatient claims without regard for existing filing limitations, among other provisions. Currently, the RAC and MAC programs are allowed to have non-physician auditors review and deny care that a physician determined was necessary for a patient. The Medicare Audit Improvement Act would require a physician to review and approve inpatient medical necessity denials.

Audit Relief through the Courts. Medical necessity represents the top reason RACs deny claims. However, roughly half of the medical necessity denials are not because the RAC believes the care was unnecessary, but rather because the RAC claimed treatment should have been provided on an outpatient basis rather than on an inpatient basis. In these cases, CMS has historically denied the claim in full and only permitted the hospital to only rebill for selected ancillary Part B services (e.g., diagnostic laboratory tests and X-rays), rather than for full Part B payment. In a complaint filed Nov. 1, 2012, with the U.S. District Court for the District of Columbia, the AHA and five hospital organizations asked the court to both overturn the nonpayment policy and direct the government to reimburse hospitals that have been denied payment for these medically necessary services.

CMS Responds. In response to the lawsuit, CMS made substantial changes to its rebilling policy. The agency's March 2013 "Administrator's Ruling" allows hospitals to seek Part B payment when claims are denied by a Medicare auditor as not medically necessary under Part A. Under the ruling, however, hospitals are not permitted to bill for those services that "require an outpatient status," such as observation services and outpatient visits, including emergency department visits. The ruling applies to new denials made from March 13, 2013 through Sept. 30, 2013, to prior denials that are still eligible for appeal, and appeals currently in process. It allows hospitals to rebill even if the rebilled Part B claim does not meet an existing regulatory requirement that a claim must be filed within one year of the date the services were provided (the one-year timely filing limit).

Also in 2013, CMS separately finalized a rule that specified that hospitals may rebill under Part B only if they meet the one-year timely filing limit, effective for denials of services provided on or after Oct. 1, 2013. While CMS attempted to provide a permanent solution to rebilling problems, the AHA was disappointed that the final rule allows rebilling only for services within the one-year timely filing limit. Since RACs often review claims that are more than a year old, the practical effect is that many denials will be ineligible for rebilling. Therefore, upon analysis of the final rule, the AHA decided to press ahead with litigation in order to ensure that hospitals receive full reimbursement for all reasonable and necessary services, without unreasonable restriction.

An Overburdened Appeals Process. The Department of Health and Human Services (HHS) Office of Medicare Hearings & Appeals (OMHA) in December 2013 announced that it has suspended assignment of appeals to an administrative

law judge (ALJ) until it clears a significant backlog in its appeals workload. As a result, hospitals must wait an estimated two years before their appeals are heard by an ALJ, during which time the disputed funds are recouped by CMS. An ALJ is the third level of appeal when a provider appeals a denied claim, and hospitals have experienced a high level of success at the ALJ level. Specifically, the HHS Office of Inspector General has shown that hospitals win an overturn of appealed Part A claim denials 72 percent of the time at this level. According to RAC*Trac* data, hospitals have more than $1 billion at stake in the appeals process and are now facing several years before they will receive a final determination on appealed claims.

The recent, dramatic increase in the ALJs' workload largely results from inappropriate RAC denials, which motivate hospitals to appeal in order to receive payment for medically necessary services they delivered to Medicare beneficiaries. The AHA urges OMHA and CMS to work together to remedy this situation as soon as possible. In the meantime, CMS should implement policies to mitigate the impact of the ALJ backlog on hospitals, such as not requiring hospitals to repay claims denied by RACs until after an ALJ hearing; enforcing statutory timeframes within which appeals determinations must be made; and addressing systemic issues within the RAC program that lead to avoidable claim denials and appeals.

Preventing Improper Payments. CMS must take proactive steps to prevent improper payments and thereby alleviate the need for audits and denials in the first place. Doing so would reduce hospital burden and mitigate the current backlog that exists for auditors and the appeals process. The AHA continues to urge CMS to offer more substantial provider education to assist hospitals in proactively identifying the most common payment errors and the remedies needed to eliminate errors and related payment denials. In addition, the AHA offers member educational resources to help hospitals better understand the RAC and Medicare appeals processes. A series of *Member Advisories* and Audit Education webinars can be accessed through AHA's RAC policy portal under "Education and Tools" at *www.aha.org/rac*.