

The Fifth National Medicare RAC Summit

How to Evaluate the Effectiveness of Your RAC Appeal
Strategies – Are You Maximizing Defense Strategies?

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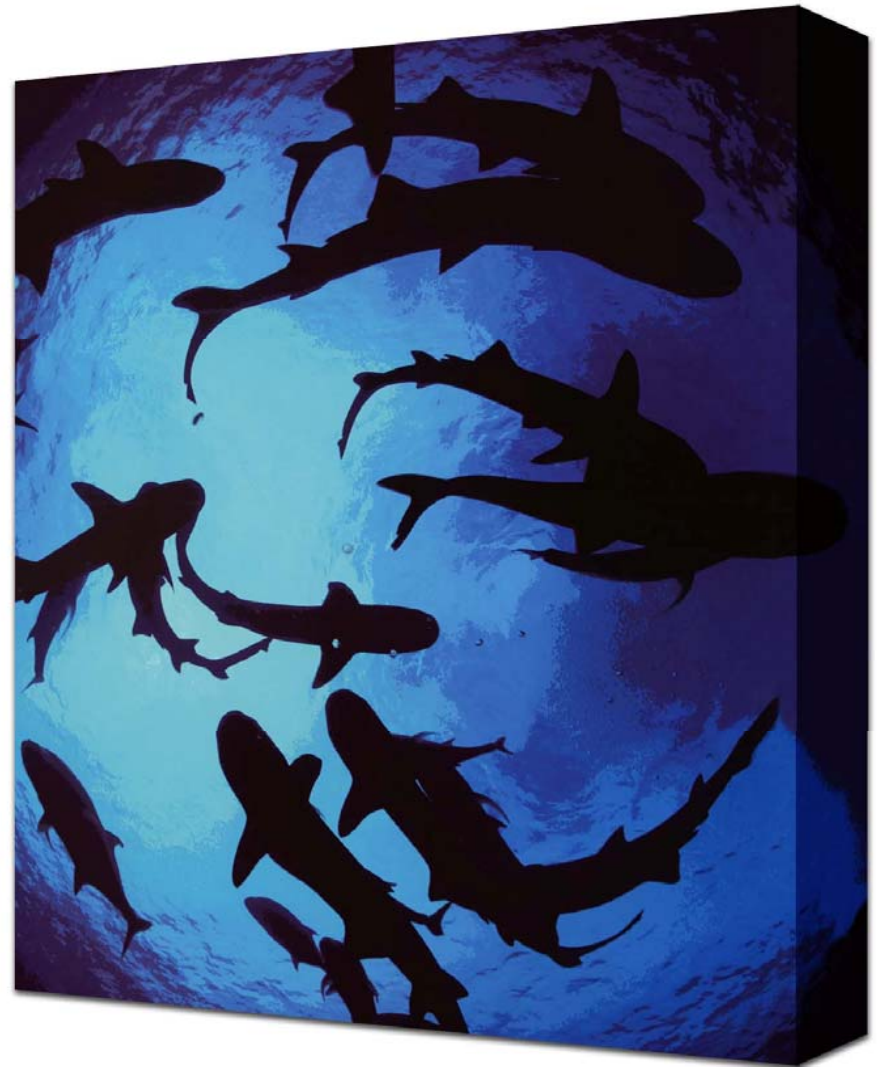
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The Big Picture

- RAC
- MAC
- MIC
- OIG
- ZPIC
- Expansion of the RAC Program to Medicare Part C and D
- CERT
- MUEs
- Managed Care- Private RACs



Objectives:

1. To Discuss Why RAC Response Should Be Applied to All Government Audits & Payers
2. Some Tips & Tools on Best Practice Response to Government & Commercial Audits/Denials
3. To Reveal the Absolute Key to Preventing Denials!!!!

Background

- CMS - 2009 Financial Report
 - Expenditures exceeded income in 2008 and are expected to continue to do so in 2009 and later
 - **Complete exhaustion of Medicare Part A trust funds by 2017**
 - “In the absence of corrective legislation, a depleted HI trust fund would initially produce payment delays, but would quickly lead to a curtailment of HC services to beneficiaries.”
 - Bringing the fund into actuarial balance over the next 75 years ... would require very **substantial increases in revenues and/or reductions in benefits**. These changes are needed in part as a result of the impending retirement of the baby boom generation.

GAO Report: January 2008 & 2009 updates on the Nation's long term fiscal outlook.

- Rapidly rising health care costs are considered by the GAO to be the nation's number one fiscal challenge. The GAO states:
 - ... updated simulations continue to illustrate that the **long-term fiscal outlook is unsustainable**. ... According to the Social Security Administration nearly 80 million Americans will become eligible for Social Security retirement benefits over the next two decades—an average of more than 10,000 per day.
 - Although Social Security is important because of its size, **the real driver of the long-term fiscal outlook is health care spending**. Medicare and Medicaid are both large and projected to continue growing rapidly in the future.

Meanwhile....

- Improper Payments GAO Report – April 2009
 - Medicare & Medicaid comprise 50% of reported government wide improper payments for FY 2008.
 - \$10.4 billion in Medicare fee-for service
 - \$6.8 billion in Medicare Advantage
 - **\$18.6 billion in Medicaid**
- President's Remarks to Joint Session of Congress
 - "...we've estimated that most of this plan [PPACA] can be paid for by finding savings within the existing health care system, a system that is currently full of waste and abuse."
- **CMS committed to "aggressive corrective actions"**

CMS Actuary's Estimated Financial Effects of Patient Protection and Affordable Care Act, As Introduced in the Senate (Dec. 10, 2009)

- ...Over time, a sustained reduction in payment updates, based on productivity expectations that are difficult to attain, would cause Medicare payment rates to grow more slowly than, and in a way that was unrelated to, the providers' costs of furnishing services to beneficiaries.
- Thus, providers for whom Medicare constitutes a substantive portion of their business could find it difficult to remain profitable and, absent legislative intervention, might end their participation in the program (possibly jeopardizing access to care for beneficiaries).
- Simulations by the Office of the Actuary suggest that roughly **20 percent of Part A providers would become unprofitable within the 10-year projection period as a result of the productivity adjustments.**

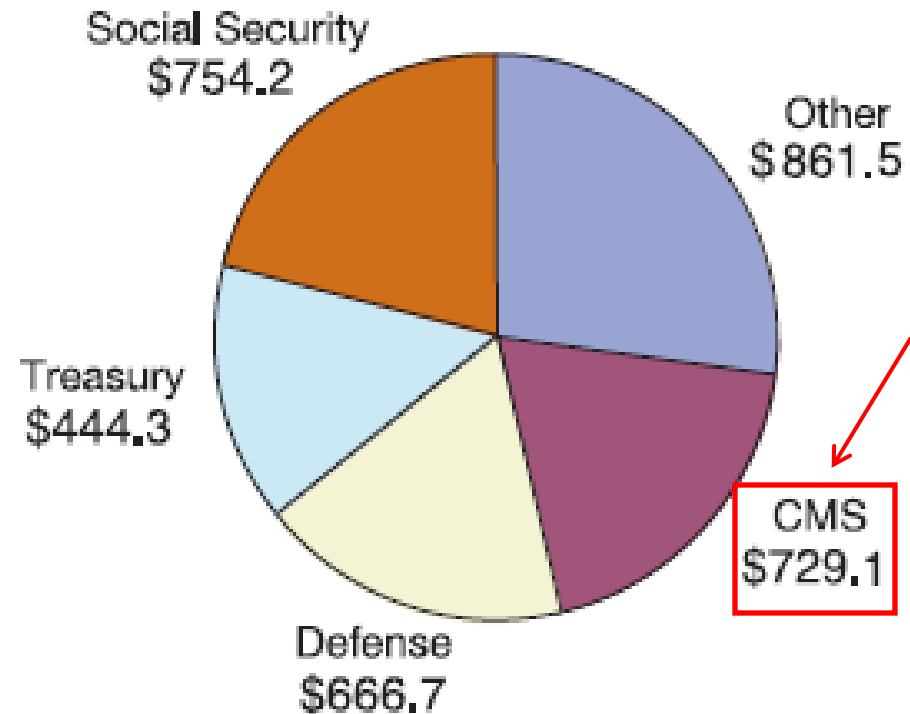


CMS 2010 Financial Report

2010 Federal Outlays

- **Medicare & Medicaid payments represent:**

- 62 cents of every \$ spent on nursing homes
- 48 cents of every \$ received by hospitals
- 28 cents of every \$ spent on physicians



Source: U.S. Treasury

\$ in billions

CMS Perception of Error Rate

1. 2009's error rate 7.8 percent (an increase over the FY 2008 level of 3.6 %, but new methodology used)
2. CMS to work closely with its contractors to reduce the error rate
3. FFS claims to receive more vigilant review **before** being processed and paid
(Query – are you capturing all denied & underpaid claims?)
4. More vigilant review expected to result in more accurate and better documented claims

RAC /MAC Results

CMS RAC Program Evaluation June 2008

(As of March 27, 2008 with \$317 billion available for review)

- **RAC “Corrected” > \$1.03 billion in improper payments**
 - **96% (\$992.7 million) in overpayments to providers**
 - 4% (\$37.8 million) in underpayments

Meanwhile, in same period.....

- **Medicare Claims Processing Contractors**
 - Corrected \$13 million in overpayments
 - \$0.1 million in underpayments
- AND**
- **Denied \$1.8 billion in claims prior to payment**

Medicare Administrative Contractor (MAC) Overview

- The Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA) created Medicare Administrative Contractor (MACs) to replace all work by FIs & Carriers by 2011.
- Centralizes information once held separately
- Once Part A & Part B consolidated into integrated MACs, “improvements” expected
- A/B MACs required to develop integrated & consistent approach to medical coverage
- **MACs required to focus on more accurate claims payments; “performance-based” contracts**



Types of MAC Pre & Post Payment Review

- **Automated** – decisions made at system level when a “clear policy” exists.
(i.e., a statute, regulation, NCD, coverage provision in an interpretative manual, or **LCD**)
- **Routine** - rule-based determination performed by “**specially trained MR staff**”; requires hands on review of claim/claim history but no clinical judgment
- **Complex** – involves application of clinical judgment by “licensed medical professional”

Medicaid Programs

Medicare Integrity Program (MIP) - established through the Deficit Reduction Act of 2005 (DRA) as the first comprehensive Federal strategy to prevent and reduce “fraud and abuse” in the \$300 billion joint Federal/State Medicaid program.

Medicaid RAC Contractors – mandated by the PPACA

Medicaid Fraud Control Units (MFCU)

- Entity of state government, certified by DHHS
- Majority of the 50 MFCUs are located in the office of the state attorney general
- Investigates fraud

Your Tax Dollars Appropriated for the MIP, MIG, MIC Activities:

- Appropriations for the program totaled \$105 million by the end of 2008, plus \$75 million for FY2009 and each year thereafter.
- Total to date: Over \$180 million
- In FY 2008 the three types of MICs received **\$20,510,469** of the \$105 million in appropriations

MIP Results? ROI?

2008- \$18.6 billion in Improper Medicaid payments

- Secretary of Health & Human Services' June 2009 Report to Congress on the MIP for **Fiscal Year 2008**:
 - "... an impressive year of program accomplishments for the MIP"
 - Secretary Sebelius states only that "at the end of FY 2008, preliminary findings from the test audits had identified approximately **\$8 million in overpayments.**"
- **Report to Congress on the MIP for Fiscal Year 2009**
 - FY 2009 marked the first full year of the national Medicaid provider audit program.
 - At the end of FY 2009, over 600 audits were underway in close to half of the States & an estimated **\$8.5** million in final overpayments identified through both direct provider audits and automated reviews of State claims.

MEDICARE

RAC

MAC

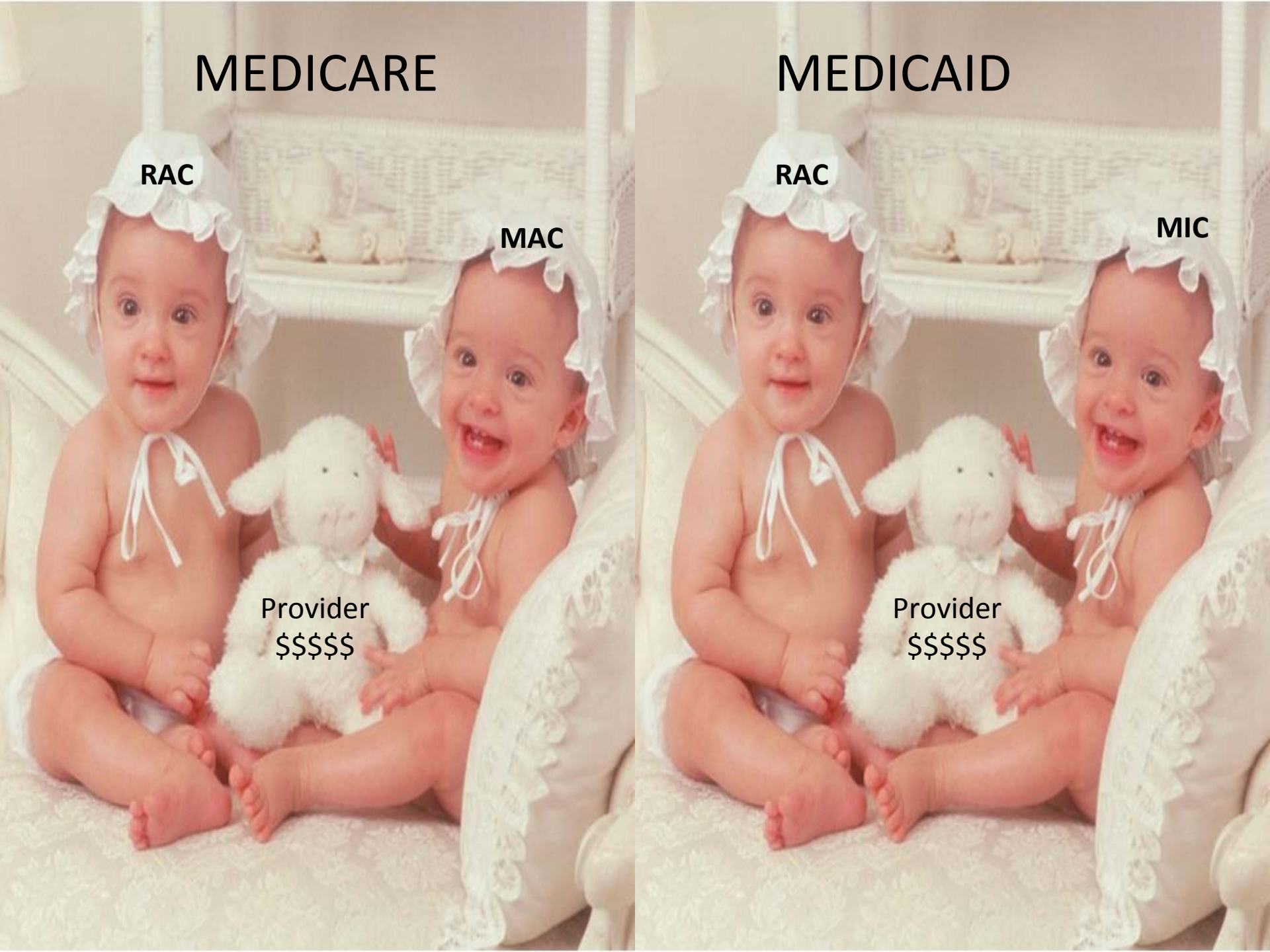
Provider
\$\$\$\$\$

MEDICAID

RAC

MIC

Provider
\$\$\$\$\$





New York State Medicaid Fraud Control Unit 2009 Annual Report

- Obtained 148 convictions, the most unit has ever recorded
- Filed criminal charges against 139 defendants
- Obtained ordered recoveries & Court Orders requiring payment of **\$274 million in civil damages** & \$8.9 million in criminal restitution (Actual total **\$283,243,016**), **surpassing recoveries in 2006, 2007, and 2008**

TERAGRID



MIG Data Engine began development in April 2008

- Previously no analytical database.
- Presently hosted at Federally-funded, national super Computer network known as **Teragrid**.
- Can hold 25 terabytes of data & can expand 6 times in a few years.
- Became operational in Jan 2009; data from all states loaded into system.

MAC “Provider Tracking System” (PTS)

- MACs must have a PTS
- Will identify all providers & track all contacts to correct “problems” such as medical necessity issues & repeated “billing abusers”
- Information coordinated with ZPIC
- Quarterly reassessments to see if behavior has changed
- Information shared with Administrative Law Judge when cases appealed



Alabama Medical Review of LCD A-03-03 (Replacement of Lower Extremity Joint)

- May 2005 – Error Rate 88.78% (\$1,585,067 charges denied of 107 Claims reviewed for 49 Providers)
- December 2005 – Error Rate 91.25% (\$1,034,375 charges denied of 100 Claims reviewed for 42 Providers)
- Majority of denials because “documentation in the medical record did not provide sufficient justification for the services rendered”

The OIG's 10 Most Wanted

Office of Inspector General: U.S. Department of Health and Human Services

This Web page contains information about OIG's most-wanted health care fugitives.

In all, we are seeking more than 170 fugitives on charges related to health care fraud and abuse. Click any of the photos below for more information about the fugitives or [view captured fugitives](#)



Etienne Allonce
DOB: 06-28-1965
Height: UNK
Weight: UKN

NEW



Tarek Wehbe
DOB: 11-29-1964
Height: 5'8"
Weight: 214 lbs

NEW



Carlos Benitez
DOB: 08-03-1961
Height: 5'9"
Weight: 180 lbs



Luis Benitez
DOB: 06-06-1966
Height: 5'11"
Weight: 195 lbs

OIG
★
MOST WANTED
FUGITIVES



REPORT A
FUGITIVE

<http://oig.hhs.gov/fugitives/>

In a Best Practice World....

Every denial prompts an **analysis** to determine what occurred, then two simultaneous actions are taken:

Intervention Track & **Prevention Track**



The Absolute Key To Denial Prevention!!



And now, a true tale.....

US Senate Committee on Finance Report on Stent Usage at a [Maryland Hospital]

December, 2010

- The MD hospital billed >6.6 million in total; 3.8 million paid by Medicare
- Dr. Mark Midei may have implanted 585 medically unnecessary stents
- Volume of stent procedures decreased over entire Baltimore region after allegations made public
- Dr. Midei stripped of his privileges
- Dr. Midei filed a \$60 million lawsuit against MD hospital
- Hospital paid \$22 million to Feds to settle suit it engaged in kick back scheme with Dr. Midei
- Many malpractice lawsuits against hospital in progress

US Senate Committee on Finance Report on Stent Usage at a [Maryland Hospital]

December, 2010

- The hospital's peer review process permitted Dr. Midei, as Chair of the Cardiology Department, to select cardiology cases, including his own, for peer review
- MD Hospital has since revised peer review practices
- Recommended that the Maryland Office of Health Care Quality “*augment existing standards required of hospital peer review process to include review of volume and medical necessity*” to prevent unnecessary procedures in the future

Physician Compare Website

- Starting January 1, 2013, CMS has to implement a plan for making information on physician performance public on the Physician Compare Web Site.
- The Affordable Care Act requires that the measures for public reporting of physician performance include, to the extent practicable, the following:
 - Measures collected under the Physician Quality Reporting System
 - An assessment of patient health outcomes and the functional status of patients;
 - An assessment of the continuity and coordination of care and care transitions, including episodes of care and risk-adjusted resource use;
 - An assessment of efficiency;
 - An assessment of patient experience and patient, caregiver, and family engagement;
 - An assessment of the safety, effectiveness, and timeliness of care; and
 - Other information as determined appropriate by the Secretary.

Excerpt of Medicare Criteria for Covered Inpatient Services

“The physician or other practitioner responsible for a patient's care at the hospital is also responsible for deciding whether the patient should be admitted as an inpatient. **Physicians should use a 24-hour period as a benchmark, i.e., they should order admission for patients who are expected to need hospital care for 24 hours or more, and treat other patients on an outpatient basis.**”

- **Physicians must learn to document their reasoning for expectation that patient will need 24 hours of care!**

Maximizing Defense Strategies



Best Practice Denial Management

Maximize Defense Strategies

Intervention Track

Purpose:

To prevent retraction or obtain full payment

Methodology:

To pursue all appeal levels until payment received or appeal and dispute resolution procedure exhausted.



Prevention Track

Purpose:

To prevent future occurrences.

Methodology:

Provide appropriate feedback to Hospital staff

Track all denials by Physician and Coder

Educate & respond according to data

#1: Best Practice Appeal for all Wrongfully denied cases

1. Evaluate your resources for appeals & have back-up plan for volume or complexity that exceeds your resources
 - Do the math – how many cases can be appealed & followed up on in a day?
2. Second Opinion for cases where appeal writer can not support the case
3. Recognize that denial reason may change at every level of appeal – calculate resources for re-write
4. Consider Benchmarking results through alpha-split

Best Practice Denial Analysis

1. Determine all relevant criteria/rules that apply.
2. Determine all relevant criteria/rules that DO NOT apply.
3. Obtain ALL relevant documentation.
4. Paginate Documentation
5. Write appeal that explains how facts met criteria

AND

6. Write specific feedback for documentation improvement purposes

Proposed Approach to Implementing Ethics & Compliance Program of the PPACA

- Use of 7 elements of an effective compliance & ethics program as described in Chapter 8 of U.S. Federal Sentencing Guidelines Manual
- Elements instill a commitment to prevent, detect & **correct** inappropriate behavior & ensure compliance with all applicable laws, regulations & requirements & include:
 - Use of audits to monitor compliance & assist in reduction of problem areas
 - System to enforce appropriate disciplinary action against employees who have violated internal compliance policies or Federal health care program requirements

Comparison of Medicare Contractors' Appeal Statistics

CMS RAC Program Evaluation June 2008

Table 8. Comparison of Medicare Contractors' Appeal Statistics

	Percentage of Denials Appealed by Providers	Percentage of Appealed Denials with Decision in Provider's Favor	Percentage of All Denials with Decision in Provider's Favor
Claims processing contractors ^a	4.0%	59.0%	2.3%
RACs ^b	14.0%	33.3%	4.6%

^aFor all States from FY 2005 to FY 2007.

^bFrom March 27, 2005, through March 27, 2008.

Note: Appeals by Medicare claims processing contractors include those in all States.

Source: Medicare claims processing contractors.

Results of Overwhelmed Appeals Team

To Whom It May Concern,

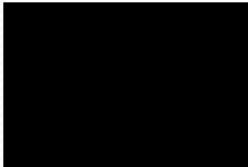
The above patient was admitted to our facility on [REDACTED] and discharged on [REDACTED]. The dates of [REDACTED] through [REDACTED] were denied. Please accept this letter as appeal of the denial. Medical records are enclosed to assist you in your review process.

Thank you for your assistance in this matter.

Sincerely,

[REDACTED] RN, CCM

Ready for a Quiz?



Daily Order Summary
Discharge Version



Transfer Patient - Level of Care: Regular Room

04/18/2007 17:40 101 Entered By: 

☒ Same Day ☐ Admit ☐ Observe ☐ Inpatient ☐ Minor

Procedure: _____

Diagnosis: ventral hernia

Special Equipment: _____

Surgeon/First Assist: _____

Surgeon Available Date/Time: _____

Cancer Stage: possible T 1 N 0 M 0

Estimated Length Surgery: _____

2 Follow Rules

A. Do key Hospital employees & Physicians know the rules?

- Ongoing systematic education & training essential – testing is key.
- How many of your Attending Physicians would pass a Quiz on Inpatient vs. Observation vs. Outpatient status?
- How many physicians write orders and progress notes that are legible?
- Can you pick up an EHR and determine why the admitting MD felt the patient required 24 hours or more of care?

B. Can your facility respond timely to a rule change?

LCD Development Process

- Described in Medicare Program Integrity Manual, Chapter 13
- Contractor LCD shall be based on:
 - Published authoritative evidence
 - **General acceptance by medical community**
- LCDs that require a Comment & Notice period:
 - All new LCDs
 - Revised LCDs that restrict existing LCDs
 - Revised LCDs that make a substantive correction

LCD Development Process

- When comment & notice required-
 - Draft LCD requires a minimum comment period of 45 days
 - Final LCD requires a minimum notice period of 45 days
- Contractors LCD Status Page includes:
 - Date of release of Draft for comment
 - e-mail & postal address for comments
 - end date for comment period
 - current status
 - date of release for Notice
 - web site link to active LCD

#3 Collect accurate & meaningful data

Accurate & Meaningful Data Includes:

- **Refined** denial/variance codes linked to accountable Departments, individuals (i.e., Coders & **Physicians**), and entity
- Denial/variance codes linked to Contract provisions and/or DRG, CPT, etc.
- Detailed denial/audit database & **feedback** tool



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Denial Reason	Status Message	Additional Case Details	Amt. Referred	Total Amt. Verified	Attending Physician
APC List Procedure	Paid In Full	FI - Fully Favorable Result 10/17/08	32,482.33	32,520.23	Snow White, M.D.
APC List Procedure	Paid in full	FI - Fully Favorable Result 10/7/08	32,482.33	32,520.23	Snow White, M.D.
APC List Procedure	Medical Records Under Clinical Review	Request for Reconsideration due 2/27/09	30,937.42	0.00	Snow White, M.D.
APC List Procedure	Paid In Full	FI - Fully Favorable Result 8/21/08	32,482.33	32,482.33	Snow White, M.D.
APC List Procedure	Paid In Full	FI - Fully Favorable Result 8/26/08	45,441.90	45,441.90	Snow White, M.D.
APC List Procedure	Paid In Full	FI - Fully Favorable Result 8/26/08	30,937.42	30,937.42	Snow White, M.D.
APC List Procedure	Paid In Full	FI - Fully Favorable Result 8/22/08	31,813.42	31,813.42	Snow White, M.D.
APC List Procedure	Paid In Full	FI - Fully Favorable Result 8/22/08	31,813.42	31,813.42	Snow White, M.D.
APC List Procedure	Paid In Full	FI - Fully Favorable Result 10/15/08	32,482.33	32,520.23	Snow White, M.D.
APC List Procedure	Paid In Full	FI - Fully Favorable Result 10/15/08	47,854.02	47,926.65	Snow White, M.D.
APC List Procedure	Paid In Full	FI - Fully Favorable Result 9/4/08	30,937.42	30,937.42	Snow White, M.D.
APC List Procedure	Paid In Full	FI - Fully Favorable Result 8/26/08	32,482.33	32,482.33	Snow White, M.D.
			412,146.67	381,395.58	Snow White, M.D.
APC List Procedure	Medical Records Under Clinical Review	Request for Reconsideration due 3/6/09	7,854.21	0.00	Peter Pan, M.D.
APC List Procedure	Medical Records Under Clinical Review	Request for Reconsideration due 2/10/09	12,973.86	0.00	Peter Pan, M.D.
APC List Procedure	Paid In Full	FI - Fully Favorable Result 9/22/08	7,822.21	7,822.21	Peter Pan, M.D.
APC List Procedure	Paid In Full	FI - Fully Favorable Result 9/22/08	11,808.38	11,808.38	Peter Pan, M.D.
APC List Procedure	Paid In Full	FI - Fully Favorable Result 9/5/08	11,643.99	11,643.99	Peter Pan, M.D.
APC List Procedure	Not Appealable	Not Appealed	13,006.10	0.00	Peter Pan, M.D.
APC List Procedure	Not Appealable	Not Appealed	12,014.10	0.00	Peter Pan, M.D.
APC List Procedure	Not Appealable	Not Appealed	12,054.10	0.00	Peter Pan, M.D.
APC List Procedure	Not Appealable	Not Appealed	11,705.99	0.00	Peter Pan, M.D.
APC List Procedure	Not Appealable	Not Appealed	11,643.99	0.00	Peter Pan, M.D.
APC List Procedure	Not Appealable	Not Appealed	11,768.38	0.00	Peter Pan, M.D.
			124,295.31	31,274.58	Peter Pan, M.D.

Lack of Authorization – what does this denial really mean?

Refined Code Examples

1. Auth Obtained/Erroneously denied
2. Adm. Scheduled/Hosp. failed to contact for Auth
3. Additional days requested/auth approval for lower level of care
4. Additional days requested/auth refused
5. Additional days not requested/stay exceeded auth
6. Auth not obtained but not required

Accountable Dept/Entity

1. Payor
2. Patient Access, UM
3. UM, Payor, Attending Physician
4. UM, Payor, Attending Physician
5. UM, Attending Physician
6. Payor

#4 Ability & Willingness to Act on Your Data

- Require Physicians to know & follow rules – yes, you can do this!!
- Develop action plans for dealing with problem payers & problem physicians

Enforcement is Key!!



In Summary....

- 1) Utilize Your RAC Tracking Tool for Compliance & Documentation Improvement Initiatives
- 2) Consider Expanding RAC Tracking/Appeal processes to all payers
- 3) Education, Education, Education!
- 4) Follow Medicare, Medicaid & Managed Care/Commercial Rules
- 5) Collect accurate and meaningful data
- 6) Best Practice Appeal for all wrongfully denied cases
- 7) Ability & willingness to act on your data –
Feedback & Enforcement to ensure that Physicians know & follow Medicare criteria & documentation requirements!!!

Questions?

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