

Medicare Administrative Contractor (MAC) Update

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Medicare 1965 The Beginning



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Medicare 2008: The Metamorphosis



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Medicare 2011 A New Direction?



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PPACA: The Patient Protection and Affordable Care Act of 2010

- Imposes a deadline of 60 days to report and return overpayments to the appropriate Medicare and Medicaid contractors.
- Failure to do so may put you at risk of a possible violation of the False Claims Act (FCA)

Fraud Enforcement and Recovery Act (FERA)

- May apply when an entity "knowingly and improperly avoids or decreases an obligation" to pay money to the United States.
- "the previously undefined 'obligation' necessary for a violation...is now defined as an established duty, whether or not fixed...arising from the retention of any overpayment."

Increased Regulatory Authority

- HHS announced on 1/24/11 new rules authorized by the Affordable Care Act intended to reduce health care fraud.
 - New Medicare, Medicaid and CHIP provider screening and enforcement measures
 - The authority to suspend payments when a credible allegation of fraud is being investigated.
- Under the new rules, if there has been a credible fraud allegation, payments can be suspended while an action or investigation is underway.

Guidance for Implementing Permissive Exclusion Authority Under Section 1128(b)(15) of the Social Security Act

- New OIG guidance released 10-20-10
- Section 1128(b)(15) authorizes the OIG to exclude owners, officers, executives and / or managing employees of a sanctioned from participation in federal health care programs

Projected Improper Payments for Medicare Fee-for-Service



Fiscal Reporting Year	Improper Amount <i>(in billions)</i>	Improper Rate
2010	\$34.3	10.5%
2011	\$30.3	8.5%
2012	\$23.1	6.2%
2013	\$23.1	5.8%

RACs Are But the Tip of the Audit Iceberg...



Who	What
RACs	Recovery Audit Contractors
MACs	Medicare Administrative Contractors
CERT	Comprehensive Error Rate Testing
MIP	Medicaid Integrity Plan
MIG	CMS Medicaid Integrity Group
MICs	Medicaid Integrity Contractors
MIG	Medicaid Inspector General
PERM	Payment Error Rate Measurement
PSCs	Program Safeguard Contractors
ZPICs	Zone Program Integrity Contractors
OIG	Office of the Inspector General
DOJ	Department of Justice

A Target Rich Environment

- Short stays
- PEPPER Targets(PEPPER contract sole source to Texas Medical Foundation)
- Kyphoplasty
- AICDs / Pacemakers / Angioplasty / Stents
- Readmission
- SNF Qualifying Stays
- Protect yourself with sound concurrent review and RAC Readiness Audits

Who Are The MACs?

- Responsible for both Part A & B claims payments
- Responsible for pre-payment review and post payment focused review
- MACs will need to build medical necessity review competency similar to that of QIOs
- A RAC denial could be considered a MAC failure
- Expect aggressive case review and pre-payment denials based upon medical necessity for admission setting

MAC Target Areas

National Government Services:

- Medical necessity reviews of 5 DRG's (313, 391, 392, 640 and 641)
- Chest pain, esophagitis/gastroenteritis, nutritional/metabolic disorders
- They believed the majority of the 1-3 days stays should have been treated in observation status

First Coast Service Options

- Performed pre/post payment targeted reviews including medical necessity/appropriateness of admission
- Including: DRG 313 (chest pain) 55% error rate, 552 (medical back) 70% error rate, 392 (gastroenteritis) 49% error rate, 641 (nutritional/metabolic) 49% error, 227 cardiac defibrillator 20% error rate
- Total \$1.3 M and 31% overall error rate

Collated by: Metropolitan Chicago Healthcare Council

MAC Target Areas

Trailblazer Health Enterprises

- Reviewed 250 inpt claims of DRG 247 (PCI with stent placement)
- Denied 98.8% (87% chart did not support inpatient level of care and 11% incomplete or no documentation received)

Noridian Administrative Services

- Identified chest pain, gastroenteritis, spinal procedures, sepsis, CHF, COPD, DM as areas for audit

Cahaba GBA

- Focused on coding and medical necessity of inpt claims of chest pain, medical back and kidney/UTI
- Found that IQ was not met and medical necessity was not established/documentated

Collated by: Metropolitan Chicago Healthcare Council

MAC Challenge

- Not all MACs have part A experience
- Several are new to non-coding medical necessity admission status issues
- Numerous examples of guidance provided that appears to not be consistent with statutes, regulations and manual guidance
- Examples:
 - Time as sole basis for admission status
 - Failure to consider results of appeals
- You need to be prepared to defend yourself and stand up for your rights.

Examples

- DRG 313 – “Our opinion is that if a patient with chest pain has negative enzymes and a normal EKG, they are an outpatient”
 - In this group 68/69 were successfully appealed
- A MAC audited elective PCI and denied 98% of 250 claims
 - In this group 97-98% of appealed cases successfully overturned at ALJ level.
- Your finance department may want to cave in– but your UR committee needs to let them know you are doing it right and need to stand up.

Not Standing Up has Consequences

- We have seen several MAC's request corrective action plans prior to the appeals process and indicated that the appeals process does not impact their actions
- Actions seemingly inconsistent with the CMS Program Integrity Manual
- Incidentally, one of the contractors that said has had 100% percent of the denials issued overturned – so I wonder what their “corrective action” plan will be!

New issue: Coverage

- CERT Alert on April 1, 2010 alerted hospitals that the Eligibility for Payment for Dual Chamber Pacemakers was going to be a Cert Target
- http://www.customcoder.net/reader/article_print/224500
- There are specific indications in the NCD that indicate Medical Necessity
- Note that this is not the medical necessity question of “setting”, but rather the medical necessity question of covered indications
- This can be pretty specific:
- The beneficiary’s predominant rhythm was atrial fibrillation with mention of bradycardia. The medical record is not sufficiently documented to show the heart rates and their correlation to the beneficiary’s symptoms. For example the beneficiary has a reported symptom of sweating, but that symptom is not correlated to Holter Monitor findings.

Pacemaker Continued



- This type of audit can produce concerning results for some hospitals
 - Ultimate conclusion could be that the hospital is performing unnecessary surgeries
 - Also, many facilities do not use NCD guidance as a screen(pre-cert) prior to performance of the procedure
 - Even if the procedure is necessary, many physicians have not received education about specific documentation requirements
 - We would suggest doing a small review of 20-30 of these procedures to compare against the NCD to identify what issues, if any, exist and then come up with a plan.

MLN Matters[®]

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- CMS contractors are not required to automatically deny a claim that does not meet the admission guidelines of a screening tool.
- CMS considers the use of **screening criteria as only one tool** that should be utilized by contractors to assist them in making an inpatient hospital claim determination.
- For each case, the review staff will utilize the following when making a medical necessity determination
 - Admission criteria;
 - Invasive procedure criteria;
 - CMS coverage guidelines;
 - Published CMS criteria; and
 - Other screens, criteria, and guidelines (e.g., **practice guidelines that are well accepted by the medical community**).

Why All the Confusion?

- Most Case Managers use criteria such as Interqual & Milliman (as they must) to judge medical necessity
- Criteria use Severity of Illness(SI) and Intensity of Service(IS) to establish medical necessity
- Admission Criteria are screening tools with a failure rate (15-20%)
 - May now be up to 23-25%, IQ 2011 may be higher
- Secondary Physician Review is **REQUIRED**

What Are The Standards and Regulations Regarding Physician Decisions of Medical Necessity??

- HCFA Ruling 95-1

- “Medicare contractors, in determining what **"acceptable standards of practice" exist within the local medical community**, rely on published medical literature, a consensus of expert medical opinion, and consultations with their medical staff, medical associations, including local medical societies, and other health experts. "Published medical literature" refers generally to scientific data or research studies that have been published in peer-reviewed medical journals or other specialty journals that are well recognized by the medical profession, such as the "New England Journal of Medicine" and the "Journal of the American Medical Association." By way of example, consensus of expert medical opinion might include recommendations that are derived from technology assessment processes conducted by organizations such as the Blue Cross and Blue Shield Association or the American College of Physicians, or findings published by the Institute of Medicine.”

HCFA Ruling 93-1

- “if the medical evidence is inconsistent with the physician's certification, the medical review entity considers the attending physician's certification only on a **par with the other pertinent medical evidence**. The review entity also considers factors such as the condition of the patient upon admission, the nature of the primary diagnosis, the existence of co-morbid conditions”

COMPLIANCE IS NOT ALTRUISM

“Compliance is not an act of corporate altruism,” Trusiak says. “Compliance is in the financial self-interest of the provider because the provider can better manage its exposure on the front end through disclosure to the OIG or remittance to the MAC, rather than reacting to a federal investigation by the U.S. attorney’s office or OIG.”

Judgment??

When analyzing site-of-service cases, Trusiak says the “critical factor” is medical judgment. If physicians always admit certain kinds of patients regardless of their specific medical circumstances, the government may challenge claims for those admissions — and hospitals can’t hide behind a physician’s judgment.

What's The Bottom Line?

- It is no longer a matter of if, but a matter of when you will be audited
- You will need to be right in the eyes of the law
- Being “right” requires a concurrent process that is legally defensible to both avoid auditor denials and retrospectively manage and appeal inappropriate auditor denials

Questions?

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