Hot Topics II
The New Frontier in Recovery Auditing:
Medicare Advantage Clinical Audits

Medicare RAC summit
Washington, D.C.
December 2012

Shannon Pavel, RN, CPHM
Clinical Appeals and Denials Coordinator
What might be lurking in your facility?
Auditors are marketing their services

- A deep focus on **recovering the most overpayments** possible
- We’ll find the errors and **return more dollars** to your bottom line
- Learn more about how we can go beyond your expectation to recover **the most money possible**
- **Recover more dollars.**

- “*they are easy to work with and always make and usually exceed their numbers*”
  Mngr., Overpayment Recovery Large Health Plan

- “*We keep raising the bar, and ..... Consistently exceeds our goals and recovery expectations.*”
  Procurement Mngr., One of the nation’s leading Health Insurance Payers
Historical Audit Activity: Our Experience

- 2009 Primarily Medicare Recovery Audit Program activity
- 2010 HealthSpring
  - iCRS
- 2011 Humana
  - Varis
  - HDI (Health Data Insights)
  - National Audit
  - Connolly
- 2011 United Healthcare/AARP
  - Preventable Readmissions
  - Optum Insights
  - Amenity Consulting
- 2012 Blue Cross of Alabama
  - Connolly
- 2012-20123
  - The frequency, volume, and number of vendors performing audits continues to grow exponentially
Non RAC Program Audits

Non-RAC Denials

Non-RAC Medical Record Requests

Nov-Dec 2009

2010

2011

Jan-Nov 2012

3 1 44 205 193 572 296 1017

Non-RAC Denials

Non-RAC Medical Record Requests
Revenue Cycle Components

- Registration and Insurance Verification
- Denials Management
- Billing
- Account Management
- Utilization Review/Case Management
- Contract Management
- Health Information Management
- Appeal backlogs
- Reconciling status
- Balancing the checkbook
- Analyzing financials
- Compliance initiatives
- Reporting to executives
- Data entry
- Processing mail
- Searching for lost mail
- Other responsibilities

RAC Coordinator
Types of Clinical Audits

- Post-payment and Pre-payment
- DRG validation
- Medical Necessity
- Inpatient status order
- Readmissions
<table>
<thead>
<tr>
<th>Medicare</th>
<th>Medicare Advantage</th>
</tr>
</thead>
<tbody>
<tr>
<td>One audit company</td>
<td>Multiple audit companies</td>
</tr>
<tr>
<td>Designated provider address</td>
<td>No ability to designate an address</td>
</tr>
<tr>
<td>Medical record request limits</td>
<td>No established limits for requests</td>
</tr>
<tr>
<td>Standard appeal process</td>
<td>Appeal process varies by plan</td>
</tr>
<tr>
<td>Look back limited to 3 years</td>
<td>Look back limits established by plan</td>
</tr>
<tr>
<td>Established timeframes</td>
<td>Timeframes established by auditor</td>
</tr>
<tr>
<td>Reimbursement for copies of records</td>
<td>No reimbursement for copies</td>
</tr>
</tbody>
</table>
Provider Survival Strategies
Tracking and Trending

- Delegate a coordinator to log all requests, denials, and appeals
- Request correspondence go to a designated address
- Utilize a tracking software to log requests and denials
- Organize a spreadsheet of issues
- Create payor scorecards and compare metrics
What You Should Know

- Do you have a **Contract**?

- **Contract Language**
  - Recoupment limits
  - Prompt pay provisions
  - Dispute resolution process

- **Provider Manual**
  - Appeal timeframes
  - Levels of appeal
  - Where to send appeals
What You Should Know (continued)

- The **Medicare Manuals** i.e. the rules
  - Inpatient definition
  - Non-same day readmission rules

- Internal **Utilization Review Process**
  - Does the plan perform concurrent utilization review?

- **Provider Representative Meetings**
Who You Should Know

- Your facility’s **Provider Representative**
- Internal **Contracting Representative**
- Who internally receives the correspondence?
- Who is responding to the auditor?
Appeal Strategies

- Appeal even if it appears past timely
- Aggressively appeal
- Track response times and send delinquent notices
- Maintain shipment tracking numbers
Appeal Strategies (continued)

- Scrutinize appeal responses

- If you aren’t satisfied seek assistance from your provider representative

- Notify your internal Contracting Representative of consistent problems.
Non Contracted Facilities

- Medicare Managed Care Manual Chapter 13 Section 10.3.3 Appeals

- 5 level appeal process
  - Level 1-to the health plan
  - Level 2-Independent Review Entity (QIC) i.e. Maximus
  - Level 3-ALJ
  - Level 4- Medicare Appeals Council
  - Level 5-Judicial Review
Problems-Our Experience

- Appeal response cut and pasted at every level
- Appeal response not applicable to the patient’s clinical picture
- Extended time to process appeals
- Lost medical records and appeals
- Inability to obtain rationale for denials
- Inpatient admissions approved concurrently and denied retrospectively
- Limited time to reply to medical record requests
- Inappropriate Non-same day readmission denials
When All Else Fails

Arbitration:
The submission of a dispute to one or more impartial persons for a final and binding decision, known as an “award”.
American Arbitration Association

Sample Contract Language:
In the event of a dispute between the hospital and (payer) which cannot be settled by mutual agreement......such dispute shall be resolved by binding arbitration, conducted by a single arbitrator. The cost of any arbitration proceeding(s)hereunder shall be borne equally by the parties. Each party shall be responsible for its own attorneys’ fees and such other costs and expenses incurred related to the proceedings.
Summary
If they told you to jump off a cliff....

- Centralize tracking and responding
- Question, Question, Question!
- Be skeptical
- Know the rules
- Demand answers (but be nice)
- Don’t give up
- Be the squeaky wheel