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NEWSLETTER

The Medicare Audit Improvement Act Proposes Significant Changes and Penalties for Medicare Contractors

Fall 2012

In response to the increased use by the Centers for Medicare & Medicaid Services (CMS) of contractors to enhance its program integrity efforts, hospitals have complained of a "deluge of redundant audits, unmanageable medical record requests and inappropriate payment denials." *See* Letter from Rick Pollack, Executive Vice President, American Hospital Association, to Rep. Sam Graves (Oct. 16, 2012). Heeding the refrain, Representative Graves (R-MO) introduced legislation, H.R. 6575, proposing significant revisions for various Medicare contractors with regard to adjudication, payment and auditing of hospital claims, and any related recovery efforts. The legislation does not address contractor interactions with other types of providers. More specifically, the proposed legislation targets the work of Medicare administrative contractors (MACs), recovery audit contractors (RACs), zone program integrity contractors (ZPICs), comprehensive error rate testing (CERT) contractors, as well as other contractors created pursuant to 42 U.S.C. §135ddd(h) (collectively referred to as "Medicare Contractors"). Not only does the proposed legislation significantly alter how Medicare Contractors conduct their review of hospital claims, but in some instances it also subjects them to financial penalties.

In a significant departure from the current contracting structure, the legislation proposed by Rep. Graves, and supported by a bipartisan group of five additional representatives (Rep. Akin (R-MO), Rep. Long (R-MO), Rep. Schiff (D-CA), Rep. McCollum (D-MN) and Rep. Hanna (R-NY)), would impose penalties (of an amount to be determined by the Secretary) on RACs in a number of instances. First, the bill would subject RACs to financial penalties for failure to complete an audit within time frames to be specified by the Secretary. Financial penalties would also be assessed against a RAC that fails to provide a hospital with the requisite demand letter in a timely fashion, as determined by the Secretary. Finally, the bill requires that RACs be assessed a financial penalty for every hospital claim denial that is overturned on appeal.

With respect to a hospital's production of records to Medicare Contractors, the bill sets annual limits on the number of "additional documentation requests" Medicare Contractors may make of a hospital in the pursuit of complex pre- or post-payment Part A claims audits. Under the proposed legislation, requests for additional documentation from all Medicare Contractors combined would be limited to the lesser of 2 percent of a hospital's total annual claims volume or 500 "additional document requests" to a hospital during any one 45-

day period during the year. It is not clear from the legislation precisely what constitutes an additional documentation request, or how such requests are counted; nevertheless, were such a requirement passed, Medicare Contractors would need to carefully coordinate auditing activities amongst one another.

The legislation also limits a Medicare Contractor's medical necessity review and audit activities. First, the bill constrains medical necessity audits to only those hospitals that demonstrate "widespread" medical necessity claims errors. The bill requires that "post-payment and pre-payment medical necessity audits" be limited to hospitals with "widespread" error rates, initially defined as hospitals with claims error rates in excess of 40 percent for each particular medical necessity audit. (The bill confusingly refers to this as a "widespread payment error rate;" however, it appears that the legislation is concerned not with the accuracy of the Medicare Contractor's payments, but with the accuracy of the claims submitted by the hospital.) If at some point in the medical necessity audit it is determined that the hospital's medical necessity claim errors no longer meet the "widespread" error rate threshold, the Medicare Contractor would be required to terminate that audit and "other similar audits."

Further, the pre-payment medical necessity review efforts of MACs would be restricted to only those instances enumerated by the Secretary in "prepayment review guidelines." The guidelines are intended to establish "consistent criteria" for pre-payment reviews to include identification of thresholds or practices that would permit a prepayment review, as well as specifying prepayment review timelines and termination criteria for the MACs.

Two of the bill's amendments address hospitals' complaints that Medicare Contractors are denying payment for medically necessary services because the care was provided in the wrong setting. Currently, a Medicare Contractor may deny a Part A claim if an inpatient admission was not medically necessary, even if the same treatment would be medically necessary on an outpatient basis. The bill alters the current procedures and allows hospitals to resubmit and receive payment for such a claim under Part B, despite the fact that the service was rendered in an inpatient setting. For purposes of timely claims filing, this particular class of claims would be deemed original claims for payment under Part B upon resubmission. The revisions proposed in this amendment are echoed in a recent lawsuit filed against the Secretary of Health and Human Services by the American Hospital Association (AHA) in which the AHA seeks an order stating that "all hospitals that have received Part A denials based upon the wrong setting of care be paid full Part B reimbursement." *See Am. Hosp. Ass'n v. Sebelius, No. 1:12-cv-1770 (D.D.C. filed Nov. 1, 2012)*. The second amendment in this area would ensure that hospitals participating in the AB Rebilling Demonstration have an ability to pursue appeals of medical necessity decisions in these situations.

The bill also requires that Medicare Contractors obtain a physician's review and certification of any claim denied for reasons of medical necessity. Medicare Contractors may use non-physician employees for initial review and identification of suspect claims; however, should the reviewing physician subsequently determine that the denial was not appropriate, the claim would automatically be deemed medically necessary and approved. Mandated review of all claims denied for medical necessity are likely to increase Medicare Contractor costs. In addition, it is unclear what the certification requirement would entail and how such a requirement would affect the physician's malpractice coverage and related licensing concerns.

Finally, in an effort to increase the transparency of Medicare Contractor activities, H.R. 6575 requires the Secretary to publish statistics on the CMS website detailing each Medicare Contractor's audits, denials and appeals. The data reported would include the number of audits conducted by Medicare Contractor annually, broken down further into various "audit type" categories (*e.g.,* automated audits, complex audits, medical necessity review, Part A claims, etc.). Within each audit type, the Secretary would be required to publish detailed information regarding a Medicare Contractor's number of denials, number of appeals, denial rate, appeals rate and the effective denial rate (*i.e.,* the denial rate adjusted for those denials overturned on appeal). The Secretary is to issue a report documenting the outcome of every appeal of a Medicare Contractor's claim denial at each of the five levels of review. Although the bill is silent as to who must gather and report the information to the Secretary for publication, such detailed data is likely to be sought directly from the Medicare Contractors.

Almost all provisions of this bill would require revision to CMS's current agreements with its contractors. Thus, the bill would make all provisions, except the provision pertaining to documentation requests, effective for all contracts entered into or "renewed" after enactment of the legislation. The provision limiting additional documentation requests would be effective upon enactment.

Clearly, the American Hospital Association complaints have garnered some traction with Congress, but how much is yet to be determined. As a result of the imprecise drafting of the bill, it is unclear how many of these provisions would be implemented and integrated with the numerous other requirements of Medicare Contractors. Nevertheless, each of the proposed provisions appears to alter Medicare Contractor operations and costs related to adjudicating and auditing hospital claims significantly, and contractors should recognize that fact before agreeing to contract modifications incorporating the new requirements. Wiley Rein will continue to track this legislation and report on any advances or revisions.