American Hospital Association

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August 21, 2008

Kerry N. Weems
Acting Administrator
Centers for Medicare & Medicaid Services
Hubert Humphrey Building
200 Independence Avenue, S.W., Room 445-G
Washington, DC 20201

RE: CMS-1400-GNC, Medicare Program: Criteria and Standards for Evaluating Intermediary and Carrier Performance During Fiscal Year 2009.

Dear Mr. Weems:

On behalf of our more than 5,000 member hospitals, health systems and other health care organizations, and our 38,000 individual members, the American Hospital Association (AHA) appreciates the opportunity to comment on the performance of the fiscal intermediaries (FIs) contracted by the Centers for Medicare & Medicaid Services (CMS).

In particular, we are concerned about medical necessity reviews. While the AHA supports the hospital review function performed by FIs and acknowledges the need for this oversight mechanism, we continue to be concerned that FIs and other reviewers, such as recovery audit contractors (RACs), are applying inconsistent and often overly restrictive interpretations of Medicare coverage and payment policy and lack adequate CMS oversight. Our concerns and related recommendations are articulated below.

FURTHER PROVIDER EDUCATION NEEDED ON HOSPITAL REVIEW

As the hospital review function transfers from the quality improvement organizations (QIOs) to the Medicare administrative contractors (MACs), FIs and other CMS entities, clarification of the distinct review functions for each reviewer is needed to assist hospitals in understanding the specific protocols of each reviewer. While CMS this summer distributed some brief materials on hospital review that provide some basic insights on hospital review processes, we urge the agency to supplement these materials with more detail on the following items:

- Reporting and appeals timeframes for reviewers and hospitals.
- Medical records request and submission protocols, including:
  - Deadlines;
  - Data parameters;

  - Instructions for electronic submission; and
  - Reimbursement for copying and mailing costs.
- Pre- and post-payment review protocols.
- Probe audit protocols.
- Partial payment criteria for claims that are partially denied due to recoding or other circumstance.
- Rebilling protocols for claims denied and identified as appropriate for another setting.
- Extrapolation protocols for reviewers and hospitals.
- Medical necessity review process and criteria including the use of commercial screening tools.
- Description of the role of physician review.
- Contact information for medical directors overseeing hospital review and resources for other hospital review questions.
- Appeals process for denials that are disputed by hospitals, including:
  - Deadlines for appealing denials at each stage of the process;
  - Flow chart showing the process;
  - Process for notifying hospitals of denial amounts and recoupment timeframes;
  - Guidelines for assessing and paying interest on appeals.
- Other related processes.

Clearly, the potential for confusion is high since the hospital review process is multi-faceted, and because the transition of this process away from the QIOs converges with the MAC phase-in and the rollout of the permanent RAC program. We offer our assistance in helping to disseminate to hospitals all future provider notices related to hospital review by FIs and MACs, and all other CMS entities conducting hospital review. In addition, we suggest that CMS host an open door call on the specific protocols on hospital review by FIs and MACs, and would be pleased to help promote such a call.

ROLE OF COMMERCIAL SCREENING TOOLS

CMS' June 2008 program integrity materials indicate that commercial screening tools will be used by FIs/MACs/RACs. We urge CMS to further clarify how these tools will be used in the medical necessity review process. We believe that the use of commercial screening tools is inconsistent with the Medicare program integrity manual's requirement that medical necessity review consist of individualized assessment of each medical record. In addition, using a commercial screening tool for medical necessity determinations violates the manual's prohibition on "rules of thumb" criteria. In place of commercial screening tools, physicians and other auditors should conduct each review based on individualized review of the medical chart. The program integrity manual also requires medical necessity reviews to rely on Medicare coverage criteria based on "authoritative evidence" or generally accepted practice, as supported by medical evidence.

OPEN QUESTIONS REGARDING HOSPITAL REVIEW

Based on prior FI review of inpatient rehabilitation facilities, we have ongoing concerns about inadequate FI execution of medical necessity review. Based on this experience, we raise the following questions about how FIs and MACs will conduct hospital review.

Contractor Training.

- What payment, policy and coding training will be required for FIs and MACs conducting hospital review?
- How will CMS and contractors ensure that individual reviewers have appropriate policy competency on the types of claims to be reviewed before they conduct reviews?

Correcting and Addressing Patterns of Errors.

- How will CMS address patterns of errors identified by medical necessity reviews?
- Are processes in place to inform CMS of patterns of errors identified through FI/MAC review; and to correct such errors through CMS systems fixes and proactive education?
- How will CMS educate providers on error-prone claims to prevent avoidable denials in the future?

Contractor Performance.

- How will CMS measure the performance of contractors conducting medical necessity review?
- What penalties will be imposed on MACs or FIs with poor performance, as indicated by contractor outcomes on key performance metrics such as the rate of claims denials overturned through the Medicare appeals process?
- Will contractor performance outcomes be posted on CMS' Web site?

LOCAL COVERAGE DETERMINATIONS

As we expressed in comment letters on numerous inpatient rehabilitation local coverage determinations issued by FIs, we are concerned that they are unilaterally narrowing national Medicare coverage criteria and issuing proposals that are neither evidence-based nor consistent with standard medical practice. These practices violate CMS' national program integrity and coverage guidelines. We ask that CMS take a more active role in monitoring and preventing any such practices, which ultimately restrict access to medically necessary care.

If you have any questions or concerns about our comments or the attached report, please contact Rochelle Archuleta, senior associate director of policy, at (202) 626-2320 or rarchuleta@aha.org.

Sincerely,

Rick Pollack
Executive Vice President