American Hospital Association®

Program Integrity

Background

In recent years, the Centers for Medicare & Medicaid Services (CMS) has drastically increased the number of program integrity auditors that review hospital payments to identify improper payments. CMS's audit contractors focused on improving payment accuracy include recovery audit contractors (RACs) and Medicare administrative contractors (MACs). Medicare and Medicaid RACs are charged with identifying improper Medicare and Medicaid fee-for-service payments – both overpayments and underpayments. RACs are paid on a contingency fee basis, receiving a percentage of the improper payments they identify and collect. MACs serve as providers' primary point-of-contact for enrollment and training on Medicare coverage, billing and claims processing. They also conduct pre-payment and post-payment audits.

No one questions the need for auditors to identify billing mistakes; however, many auditors conduct redundant audits that drain time, funding and attention that could more effectively be focused on patient care. For example, according to AHA's RAC*Trac* survey of 2,300 participating hospitals, there was a 61 percent increase in the number of records requested for RAC audits during 2012. These Medicare claims now collectively represent more than $6 billion in Medicare payments, an 83 percent increase from the claims requested for RAC audits through 2011. In addition, RAC*Trac* data show that hospitals appeal about 41 percent of all Medicare claims denied by a RAC, and in such cases, hospitals are successful at overturning the RAC denial 72 percent of the time.

Hospitals are drowning in the deluge of unmanageable medical record requests and inappropriate payment denials. CMS and Congress need to make the audit processes more fair and transparent.

AHA View

Hospitals take seriously their obligation to properly bill for the services they provide to Medicare and Medicaid beneficiaries and are committed to working with CMS to ensure the accuracy of Medicare and Medicaid payments. The AHA recognizes the need for auditors to identify billing errors; however, redundant government auditors, unmanageable medical record requests and inappropriate payment denials are wasting hospital resources and contributing to growing health care costs. More oversight is needed by CMS of audit contractors to prevent inaccurate payment denials and to make its overall auditing effort more transparent, timely, accurate and administratively reasonable.

Audit Relief through Legislation. Introduced by Reps. Sam Graves (R-MO) and Adam Schiff (D-CA), the *Medicare Audit Improvement Act of 2013* (H.R. 1250), proposes transparent and fair audit practices and assistance to hospitals in mitigating excessive overall audit burden. This AHA-supported legislation would establish annual limits on documentation requests from RACs, impose financial penalties on RACs if they fall out of compliance with program requirements,

make RAC performance evaluations publicly available and allow denied inpatient claims to be billed as outpatient claims if necessary, among other provisions. In addition, the bill would limit the number of "additional document requests" to 2 percent of hospitals claims, with a maximum of 500 per 45 days. H.R. 1250 also would require a physician to review the claim. Currently, RAC and MAC programs are allowed to have non-physician auditors review and deny care that a physician determined was necessary for a patient.

RAC Relief through the Courts. Medical necessity represents the top reason RACs deny claims; however, roughly half of the medical necessity denials were for claims where the RAC claimed treatment should have been provided on an outpatient basis rather than on an inpatient basis, not because the care was medically unnecessary. In these cases, CMS denies the claim in full and only permits the hospital to rebill for selected ancillary Part B services (e.g., diagnostic laboratory tests and x-rays), rather than for full Part B payment. In a complaint filed Nov. 1, 2012, with the U.S. District Court for the District of Columbia, the AHA and five hospital organizations asked the court to both overturn the nonpayment policy and direct the government to reimburse hospitals that have been denied payment for these medically necessary services.

CMS Responds. In response to the lawsuit, on March 13 CMS issued two regulations: an "Administrator's Ruling," which made immediate (temporary) changes to its prior rebilling policy, and a proposed rule, which would implement a permanent change. The Administrator's Ruling allows hospitals to seek Part B payment when claims are denied by a Medicare auditor as not medically necessary under Part A. The ruling applies to all new denials after March 13, prior denials that are still eligible for appeal, and appeals currently in process. Under the ruling, however, hospital would not be permitted to bill for those services that "require an outpatient status" for the time period the beneficiary spent in the hospital as an inpatient. The proposed rule limits rebilling to only those claims for services provided in the prior year. While CMS attempts to provide a permanent solution to rebilling problems, **the AHA remains concerned that the proposed rule applies only to services provided within the previous year. Since RACs often review claims that are more than a year old, the practical effect would be many denials would be ineligible for rebilling. Therefore, the AHA intends to press ahead with the litigation, unless and until a final rule provides full Part B reimbursement without unreasonable restrictions.** We also will use the comment process to urge the agency to adopt a final rule that ensures that hospitals receive full reimbursement for all reasonable and necessary services provided to Medicare beneficiaries both in the past and in the future.

Preventing Improper Payments. CMS must invest in proactive steps to prevent improper payments and thereby alleviate the need for audits and denials in the first place. Doing so would reduce hospital burden and mitigate the current

backlog that exist for auditors and the appeals process. The AHA continues to urge CMS to offer more substantial provider education to assist hospitals in proactively identifying the most common payment errors and the remedies needed to eliminate errors and related payment denials.

In addition, the AHA has member educational resources to help hospitals better understand the RAC and Medicare appeals processes. A series of *Member Advisories* and Audit Education webinars can be accessed through AHA's RAC policy portal under "Education and Tools" at www.aha.org/rac.