

Section-By-Section of H.R. 1250

Medicare Audit Improvement Act of 2013

Sec. 1: Short Title

Sec. 2: Establish a Consolidated Limit for Medical Record Requests

- Establish a combined maximum amount of medical record requests for hospital Part A audits by Medicare Recovery Auditor Contractors (RACs), Medicare Administrative Contractors (MACs) and Comprehensive Error Rate Testing (CERT) auditors, based on the total number of claims and by claim type.
 - For all pre-payment and post-payment hospital audits, the maximum number of medical record requests may not exceed 2.0% of hospital discharges for the previous calendar year, with a maximum of 500 ADRs per 45 days per hospital organization. The limit is 350 per 45 days for hospitals that receive less than \$1 million in Medicare inpatient hospital payments.
 - The number of claims is also capped at 2% for each type of hospital setting (i.e., inpatient, outpatient, skilled nursing facility, inpatient rehabilitation, etc.)

Sec. 3: Improve Auditor Performance

- Implement financial penalties for recovery auditors that have a pattern of failure to comply with these and other basic program requirements. Penalties will be paid to the Medicare program.
 - Complete audits within the required deadlines;
 - Timely issuance of “demand letters” per CMS’s guidelines, to inform hospitals of the denial and related appeals rights.
 - The Secretary shall establish the frequency and amount of these penalties.
- For appeals decided in favor of the provider, a recovery auditor must pay a penalty to providers to offset the cost of the appeal. This amount would be established by the HHS Secretary.
- Medical necessity audits by recovery auditors are focused on widespread payment errors.
 - CMS must identify patterns of payment error using a statistically significant sample of claims.
 - CMS may approve medical necessity audits for widespread errors with at least a 40% error rate. This error rate must be adjusted to account for denials overturned through the appeals process.
 - This applies to both pre-payment and post-payment audits.
- CMS must establish consistent criteria for pre-payment audits by recovery auditors and Medicare administrative contractors.

Sec. 4: Improve Recovery Auditor Transparency

- Require CMS to annually publish the following auditor information for each of these categories of audits: by automated, complex, and medical necessity review; Part A, Part B, DME; Part A medical necessity);
 - For each of these data categories, report the following:
 - Number of denials;
 - Number of appeals;
 - Net denials; (Total denials minus denials overturned on appeal.)

Sec. 5: Accurate Payment for Rebilled Claims

- Allow hospitals to be paid the full Part B payment for inpatient claims denied during a RAC audit or during the appeals process, when the care is found to be appropriate at the outpatient level. Under current RAC payment rules, hospitals only receive a fraction of the full outpatient payment amount.
- Clarifies that all claims denied by a MAC, RAC, or CERT contractor, if found to be suitable at a lower payment amount, may be “rebilled” as an outpatient claim. Under current RAC payment rules, RACS may audit claims that are up to 3 years old, but hospitals may only seek rebilling for eligible denials that are up to 1 year old.

*Note: In a separate move, CMS issued a proposed rule on March 13, 2013 that would allow hospitals to be paid full Part B payment for inpatient claims denied during a RAC audit, when the care is found to be appropriate at the outpatient level **if the claim is one year old or less**. This time limitation is particularly problematic to hospitals considering RACs audit claims for services provided during the **previous three years**. It is uncertain what CMS’ final regulation will be and until that is known, Section 5 of the Medicare Audit Improvement Act remains necessary.*

Sec. 6: Physician Review for Medicare Denials

- Require that a RAC, MAC and CERT physician validate whether a denial is warranted when a non-physician auditor identifies a potential denial.

Sec. 7: Assuring Due Process for Reopening

- Provides hospitals with due process appeals rights to ensure that RACs and MACs are following Medicare rules when auditing claims that are older than one year.