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United States Senate

COMMITTEES:
APPROPRIATIONS

BANKING, HOUSING, AND URBAN AFFAIRS

VETERANS' AFFAIRS

August 1, 2013

The Honorable Kathleen Sebelius
Secretary
U.S. Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Ave., S.W.
Washington, D.C. 20201

Dear Secretary Sebelius:

I am writing to request an update regarding efforts by the Centers for Medicare & Medicaid Services (CMS) to update and improve the Medicare Recovery Audit Program (the "Program") to achieve the proper balance between safeguarding Medicare finances and avoiding costly, undue burdens on hospitals and health care providers. Also, I would like to offer my assistance in helping you achieve this objective. Reducing fraud, waste, and abuse in Medicare is an extremely important goal that I fully support, however we also must be careful not to overburden providers to an extent that restricts their ability to administer a wide range of quality health care to patients, especially in rural states like our home state of Kansas where hospitals are essential to the survival and success of communities.

On April 24, 2013, I had the opportunity to discuss with you a variety of health care issues in a Senate Appropriations Labor-HHS-Education Subcommittee hearing on the Administration's Fiscal Year (FY) 2014 budget request for the Department of Health and Human Services (HHS). One issue we discussed dealt with the Program. The workload of HHS' Office of Medicare Hearings and Appeals (OMHA) has increased 247 percent from FY 2006 to FY 2013. I understand that much of this increase is the result of the aging population – as more Americans use the Medicare system, claims increase. But, I am also concerned that some of the increase is attributable to audits through the Program that yield incorrect results and are then appealed. Over half of the cases sent to OMHA are overturned, and of the remaining cases, 37 percent are overturned through the Departmental appeal process. During this hearing, I was pleased that you noted you were working with your Department on ways to address this issue.

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Additionally, as Ranking Member of the Senate Appropriations Labor-HHS-Education Subcommittee, I worked to include language in the report accompanying the Senate FY 2014 Labor-HHS-Education appropriations bill directing HHS to work with providers to address issues with Program audits. This report language is as follows:

> "The Committee is concerned by both the growing backlog of cases at OMHA and the high rate of claims overturned by the Office. Over half of the cases sent to OMHA are overturned; of the remaining cases, 37 percent are overturned through the departmental appeal process. The Department is urged to work with providers at the early stages of the audit process so that only a small number of cases are ultimately appealed and the loss of provider time, energy, and resources due to incorrect audit results are limited."

Could you please detail your current and planned efforts to increase the accuracy of the Program audit process and reduce both the number of audit cases appealed and incorrect audit results? Also, what changes are you making to the Program i.) to focus HHS resources most efficiently on the providers and services that are at most risk for fraud, waste, and abuse; and ii.) to clarify regulations to make the audit appeals process more efficient and simplify this process for hospitals and providers?

As I travel throughout Kansas visiting hospitals and talking with administrators, providers, and staff, I frequently hear concerns regarding the cost, administrative burden, and regulatory uncertainty of the Program. I am concerned these hospitals, many of which are small, rural hospitals and Critical Access Hospitals, are being forced to divert already scarce resources away from caring for patients to appeal audit decisions that end up being overturned on appeal a large majority of the time. Even if a hospital is successful in an appeal, the facility must still expend significant money, time, and energy to work through the appeal process. Enclosed are several Kansas examples highlighting these issues.

Thank you for our continued dialogue regarding the importance of preserving Medicare and strengthening patients' access to hospitals and other health care providers in their home communities. I would like to work with to improve the Program and look forward to your responses to my questions.

Very truly yours,

Jerry Moran

Enclosure

cc: The Honorable Marilyn Tavenner, Administrator, Centers for Medicare and Medicaid Services

Medicare Recovery Audit Program – Concerns from Kansas Hospitals

- On July 9, 2013, a hospital received a letter from its contracted Recovery Audit Contractor (RAC) dated July 3, 2013, regarding the closure of 11 RAC Rehabilitation cases for patients seen in the Acute Rehab Unit (ARU) of the hospital. These cases had a payment value over $100,000. This notification served to inform the hospital that the cases were no longer being scrutinized by the RAC for improper payments. No explanation of why the cases were closed was provided. These cases were originally requested by the RAC on June 14, 2013, with a submission deadline of July 29, 2013. Upon notification of the closure of the cases, a considerable amount of time had been devoted to compiling the complete medical record for each case and conducting a pre-review with the appropriate staff. While 11 cases is a relatively limited number for a request, ARU cases are complex, lengthy, and involve multiple departments, physicians and personnel. This scenario has played out many times at the hospital regarding the RAC initiative – pulling multiple records to comply with a request only to have it cancelled days prior to the submission deadline. In this situation, the only explanation provided consists of "*[RAC] is closing the requests listed on the attached list while we investigate this issue with CMS.*" As the audited provider, the hospital has invested significant resources on fulfilling the request, yet it does not receive the outcome of the "investigation" or an explanation for the closure of the cases.

  It is important to also note that three of the 11 cases noted above were duplicate requests that had been previously reviewed and approved by the hospital's state Quality Improvement Organization (QIO) a year previously. Because of the potential for unnecessary duplicate audits, the hospital must research each case and provide proof if a case has been previously reviewed by the state QIO. This issue is not isolated to this hospital – other facilities have reported the same concern. Commonly, the RACs request records that are not allowed for review per the RAC Scope of Work, but documentation is required from the provider to prove duplication.

- Recently, a hospital complied with a RAC request for 78 rehabilitation records. Three of those records were previously reviewed by the state QIO and therefore were excluded from additional reviews. The hospital gathered the remaining 75 records, conducted a pre-review before submission, gathered proof of the three duplicate reviews and submitted the records to its Region D RAC. The hospital received notification of closure on the three duplicate cases two weeks following the submission of records. Additionally, the hospital also received a "RAC Overturn" letter on 64 of those cases. Over 90 percent of the records in this request were determined to be documented correctly by the audit contractor. Since the inception of RAC, the hospital has consistently had a low denial ratio and high compliance rate for the cases requested for audit. While the hospital supports a process of oversight for accurate and proper medical record documentation, the volume of requests should be in sync for providers who fit the category of a "low denial percentage."

- A hospital received over 100 outpatient services (Medicare Part B) denials for payment from RAC for respiratory services provided in the Emergency Department. The payment received for these services were greater than $14,000. After extensive investigation, reviewing the Medicare Billing Manuals, communicating with a network of other providers and billing consultants, it was determined that the RAC was incorrect to deny payment. The hospital was compelled to begin the appeals process and defend payment for the services already rendered to the patients. On July 18, 2013, the hospital received notification from the RAC "concluding that the improper payment determination should be overturned." This is a classic example of valuable health care resources devoted to researching these accusations of improper payment only to discover that the audit contractor made a mistake.

- To date, a hospital has provided 3,511 medical records requested by the RAC for Medicare Part A services. Two-thirds (2,101) of the reviews of these records resulted in a "No Finding" letter, meaning that the RAC agreed with the payment for the claim. The majority of the requests received for Part A are for short hospital stays to determine the medical necessity for an acute level of care. As the hospital proceeds through the appeals process with the remaining cases, it has a track record of overturning 98 percent of payment denials.

  There are no clear-cut coverage determinations or guidance from CMS to determine the inpatient acute level of care. The decision to admit a patient for an inpatient acute level of care is a complex medical judgment made after the physician has considered the patient's medical history and current medical needs. The decision to admit a patient for inpatient care is not made in isolation – the provider seeks input from case management as well as limited guidance available from CMS and other payers. With RAC audits, the provider's bedside clinical decision making can be usurped by an auditor three years later who concludes that the patient could have been treated on an outpatient basis. The treating physician was the professional on the scene examining and caring for the patient and who was unquestionably in the best position to certify the necessity of acute inpatient services.

- Reports from one hospital stated that the volume of records requested was 110 records every 45 days for the period March 2012 – March 2013. The last two requests were at the 45-day interval but requested a reduced number of records from 110 to 96 and 74, respectively. The hospital continues to have 2-3 claims per Additional Development Request (ADR) that are either duplicates of previous audits or greater than the three year look back allowed for reviewed. The process to get these removed from the audit often extends beyond the due date of the audit. This results in the hospital receiving notice that records were not received which is another step to deal with. Although there is supposed to be communication with the Medicare Administrative Contractor to avoid this, it becomes the hospital's burden of proof to provide all the information for any claims it identifies with these issues.

- A hospital appeals the majority of its denials and these are handled through an outside contractor. The hospital has appeals at each level of the appeal process up through the fourth level. Very few appeals are overturned at the first level. There are a larger number of appeals overturned at the second level. Some appeals at the third level (Administrative Law Judge (ALJ)) have been overturned but a larger number are being remanded back to the Reconsideration level and the hospital has yet to receive any results from the remands. With hundreds of denied claims in the various levels of appeal, it is difficult to understand how reports can claim the benefit of the program. It seems that those assumptions cannot be made until the appeal process is exhausted and the final decision is made.

  Over the last three to four months, this hospital has seen a large increase in RAC automated reviews. But these denials are now being refunded to the hospital because the RAC applied the rules incorrectly, thus the denials were made in error. There are as many as 30 denials with each automated denials. Another example of rework is the claims that are denied and then overturned before the demand letter for refund it received.

  There is another process that was implemented by CMS in the handling of recoupment. This is a three step process to take back the money. When the hospital receives a demand letter it has multiple claims listed and the only way to offset the payment is to offset all claims/denials. This involves thousands of dollars when the hospital may only agree with the findings of one denial.

  The whole process of handling the RAC audits has impacted this organization. The hospital has added 2.5 full-time employees, purchased an audit tracking tool and contracted with a medical advisor to handle appeals. The workload in multiple departments has increased dramatically and has necessitated overtime expenses. Another frustration is the backlog of responses to appeals. The hospital has been told that its ALJ appeals could take up to a year and the fourth level a year and a half to two years.