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# Payment Problems Still Plague Medicare Programs

*Law360, New York (August 06, 2014, 10:50 AM ET) --*

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The Senate Special Committee on Aging released a staff report on July 9 critiquing Medicare payment integrity programs for failing to curb the dramatic increase, from 8.5 to 10.1 percent, in the improper payment rate for Medicare fee-for-services during fiscal year 2013. The report, "Improving Audits: How We Can Strengthen the Medicare Program for Future Generations," validates providers' complaints "that the ... audits and claims review processes are duplicative and poorly coordinated, placing an undue burden on providers, while doing little to reduce improper payments," and explores case studies underscoring the adverse impacts of these practices.

The report attributes the increase in improper payments, in part, to deficiencies in the multiple prepayment and postpayment integrity programs implemented by CMS over the past several years. Prepayment programs include the National Correct Coding Initiatives edits, including medically unlikely edits, and Medicare Administrative Contractor ("MAC") reviews. Postpayment claims review programs include the Comprehensive Error Rate Testing program, Recovery Audit Contractor ("RAC") program, postpayment review activities by MACs and fraud investigations by Zone Program Integrity Contractors. Because these contractors report to different parts of CMS, coordination between the programs is lacking.

CMS recently has created an additional contractor, the Supplemental Medical Record Review Contractor ("SMRC"), which will report to the same group within the Office of Financial Management with authority over the RAC program. While the SMRC program apparently was devised to reduce authentication and medical necessity errors, the U.S. Department of Health and Human Services has provided little explanation as to how SMRCs would differ from or coordinate with RACs.

Highlighting the experiences of hospitals, health systems, DME providers and practitioners, the report details an auditing mechanism rife with duplicative requests for documentation from RACs, confusing technical requirements for submitting requested documentation and a backlog of appeals resulting in an up to two-year waiting period to recover reimbursements for services rendered, due to CMS' authority to recover funds while an appeal is pending.

The report also notes that some hospitals are being forced to divert resources to employ additional personnel to handle audit requests. The necessity for hiring additional staff is attributed, in part, to the fact that RAC requests are still delivered by mail, requiring providers to inefficiently maintain RAC records in cumbersome three-ring binders. Moreover, medical records from independent providers and

the hospital (both of whom generally employ distinct record management systems), must be scanned to RAC specifications, including margin size, necessitating additional training and procedures to conform providers' normal scanning protocols to RAC requirements. The report further acknowledges that providers are incurring additional costs to employ vendors to assist in the appeals process.

Indeed, the American Hospital Association's RACTrac Survey results found that 55 percent of hospitals reported costs of more than $10,000 for handling the RAC process in the first quarter of 2012, with 33 percent spending more than $25,000, and 9 percent, more than $100,000. These enormous costs were incurred even though two-thirds of records reviewed by RACs did not involve an improper payment.

While commending CMS for the quantity of funds returned to the Medicare trust fund through the RAC program, the report acknowledges that much of the recovered reimbursements remain under appeal and that some portion will eventually be returned to providers, with interest. Therefore, it is unknown at present what percentage of the $8.9 billion recovered since the inception of the program will remain in the trust fund.

Referencing studies reflecting a high RAC overturn rate, the report also criticizes the incentives extended to RACs, emphasizing that "RACs do not face a penalty if their decisions are overturned on appeal, other than the loss of the contingency fee associated with that claim." This, the report concludes, encourages the contractors "to keep improper payments high, rather than to educate providers about how they can better prevent improper payments in the future."

The committee report includes the following recommendations to improve program integrity, among others:

1. CMS should streamline postpayment reviews rather than rely on multiple auditors that focus on the same areas, in order to avoid redundant audits;
2. CMS should consider focusing incentives in a manner which encourages contractors to achieve a reduction of improper payment rates, rather than rewarding them solely on the amount of improper payments identified;
3. CMS should ensure consistency among local coverage decisions, target high cost, highly utilized services and avoid creating inconsistent access to care in different regions; and
4. "CMS should emphasize provider education as a means of reducing improper payments, to include a means of systematically gathering feedback from stakeholders to understand whether educational efforts are reaching their intended audiences."

Senate Committee Chairman Bill Nelson, D-Fla., and Ranking Member Susan Collins, R-Maine, recently introduced S. 2361 to address some of the issues identified in the report.

In the U.S. House of Representatives, an Oversight and Government Reform Subcommittee on Energy Policy, Health Care, and Entitlements received testimony on July 10 from Nancy Griswold, the chief administrative law judge at HHS' Office of Medicare Hearings and Appeals, concerning the present Medicare appeals backlog. Judge Griswold attributed the backlog to a sharp increase in the number of appeals, coupled with flat funding from Congress. The Chairman, Rep. Lankford, R-Okla., called on HHS to balance enforcement efforts with a system that permits providers to focus on patient care. This hearing followed a July 9 hearing of a different subcommittee during which members vehemently criticized CMS and other federal agencies for not doing enough to crack down on fraud.

While the will appears present on both sides of Congress to address the issue of Medicare appeals backlogs and redundant auditing programs, it remains to be seen whether a common sense approach to fraud enforcement will be capable of passage in the face of continued withering criticism of the agencies responsible for implementing such reforms.

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