EHR
EXECUTIVE HEALTH RESOURCES
The Physician Advisor Company®

"All the President's Men": Medicare Denials and Appeals

Joe Crea, DO, MHA, FACOEP

Senior Medical Director

Audit, Compliance and Education (ACE)

NJ HFMA

June 10, 2014

AMERICAN HOSPITAL ASSOCIATION ENDORSED BY THE

AHA Solutions, Inc., a subsidiary of the American Hospital Association, is compensated for the use of the AHA marks and for its assistance in marketing endorsed products and services. By agreement, pricing of endorsed products and services may not be increased by the providers to reflect fees paid to the AHA.

PEER REVIEWED by HFMA*

* HFMA staff and volunteers determined that this product has met specific criteria developed under the HFMA Peer Review Process. HFMA does not endorse or guarantee the use of this product.

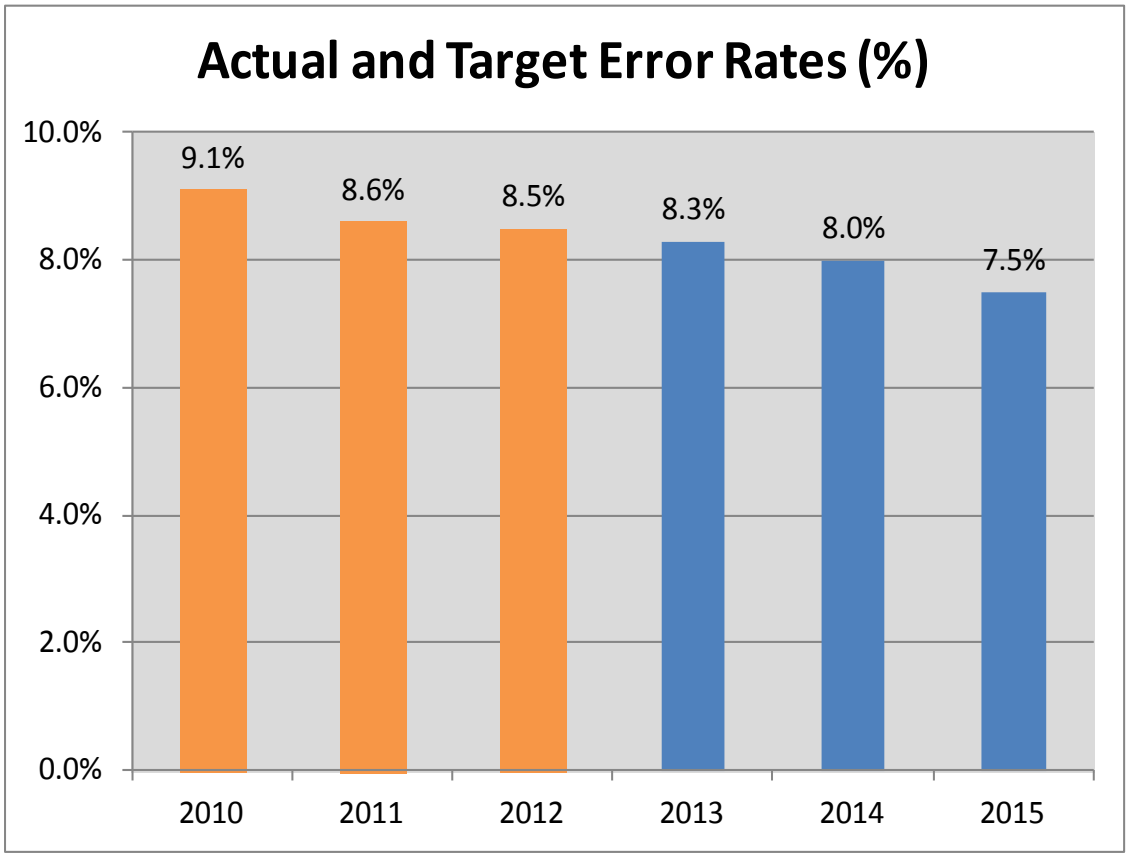
PHILADELPHIA BUSINESS JOURNAL 2013 BEST PLACES TO WORK

2008 ★ 2009 ★ 2010 ★ 2011 ★ 2012 ★ 2013

Improper Payment Report

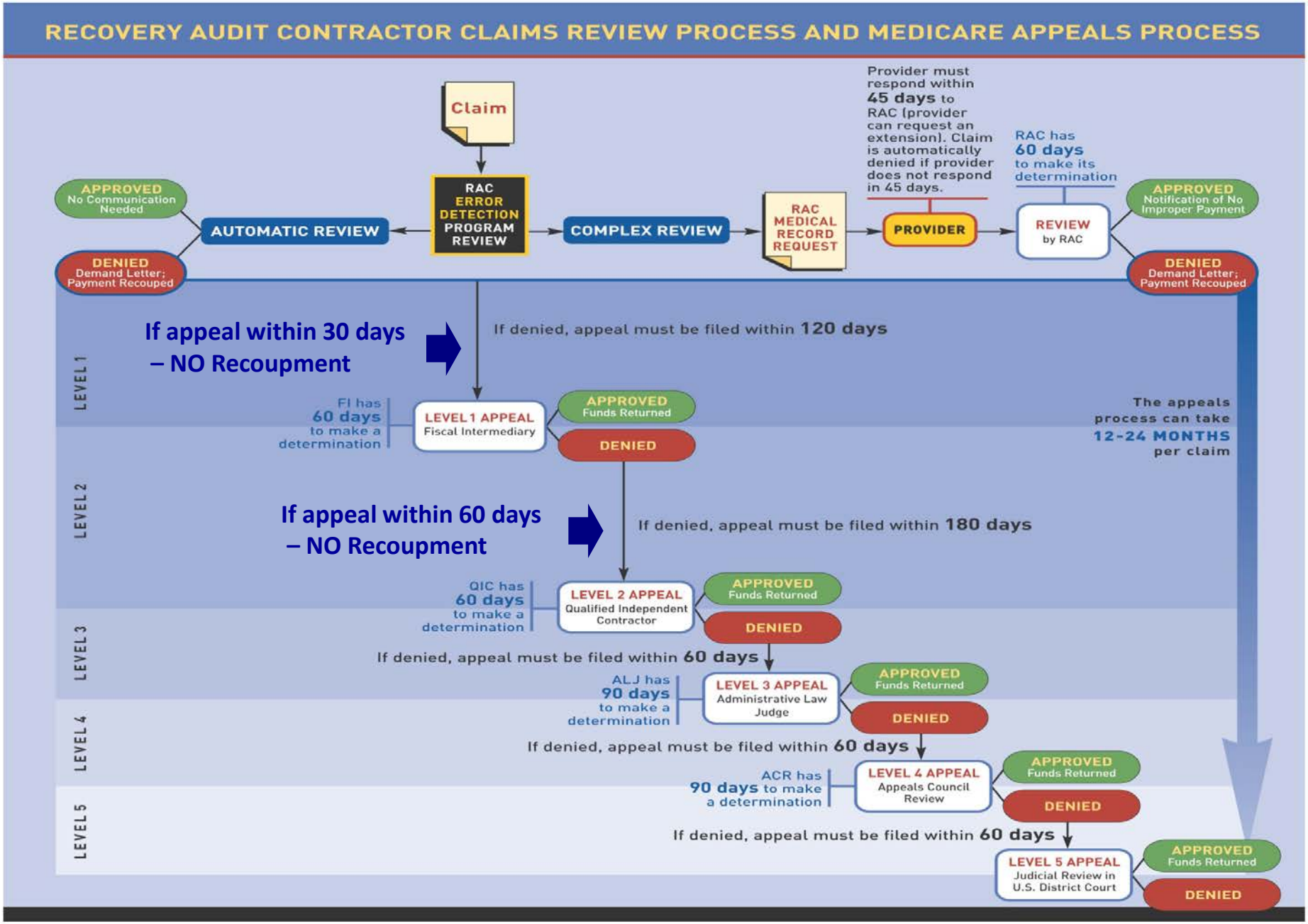
***Estimated $31.2 billion in improper payments in 2013.**

"The primary causes of improper payments, as identified in the Medicare FFS Improper Payments reports, are insufficient documentation errors, medically unnecessary services, and to a lesser extent, incorrect coding."



*From the FY2012 HHS Agency Financial Report (AFR)

RECOVERY AUDIT CONTRACTOR CLAIMS REVIEW PROCESS AND MEDICARE APPEALS PROCESS



EHR
EXECUTIVE HEALTH RESOURCES
The Physician Advisor Company®

Denials:
The Decision

AHA Solutions, Inc., a subsidiary of the American Hospital Association, is compensated for the use of the AHA marks and for its assistance in marketing endorsed products and services. By agreement, pricing of endorsed products and services may not be increased by the providers to reflect fees paid to the AHA.

* HFMA staff and volunteers determined that this product has met specific criteria developed under the HFMA Peer Review Process. HFMA does not endorse or guarantee the use of this product.

2008 ★ 2009 ★ 2010 ★ 2011 ★ 2012 ★ 2013

Types of Reviews

MPIM, Ch. 3

Applies to MACs, CERT, Recovery Auditors, and ZPICs.

- **Prepayment:** Occurs when a reviewer makes a claim determination before claim payment, which always results in an *initial determination*.
- **Postpayment:** Occurs when a reviewer makes a claim determination after the claim has been paid, which results in either *no change* to the initial determination or a *revised determination* indicating that an overpayment or underpayment has occurred.

Types of Reviews

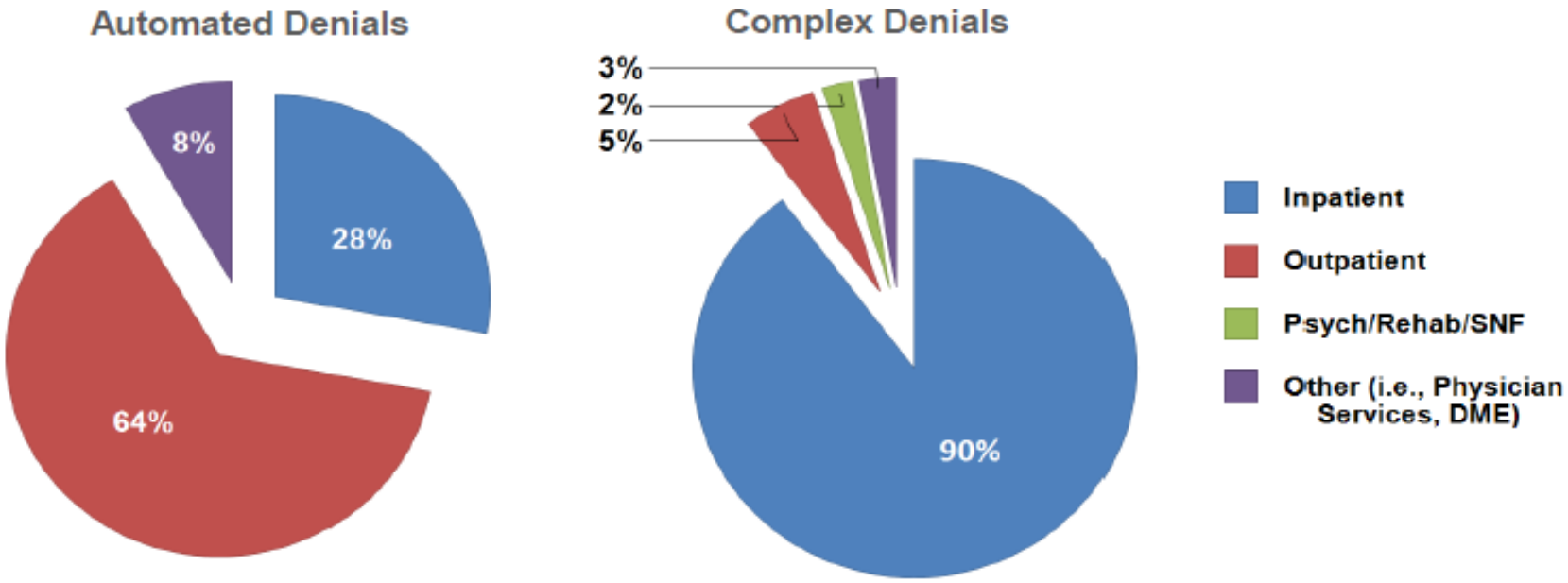
MPIM, Ch. 3

- **Reviews of Medicare payments include:**
  - *Automated reviews* - computer software algorithms detect improper payments;
  - *Complex reviews* - human reviews of medical records and other documentation; and,
  - *Semi-automated reviews* - automated reviews that require additional supporting documentation for a complex review.
- **Improper payments:**
  - Incorrect payment amounts
  - Incorrectly coded services
  - Non-covered services (e.g. “not reasonable and necessary”)
  - Duplicate services

In terms of dollars, the top service area for automated denials was outpatient and for complex denials, inpatient.

Percent of Participating Hospitals by Top Service Area for Denials by Dollar Amount for Medical/Surgical Acute Hospitals with RAC Activity, 1st Quarter 2014

Survey participants were asked to rank denials by service, according to dollar impact.



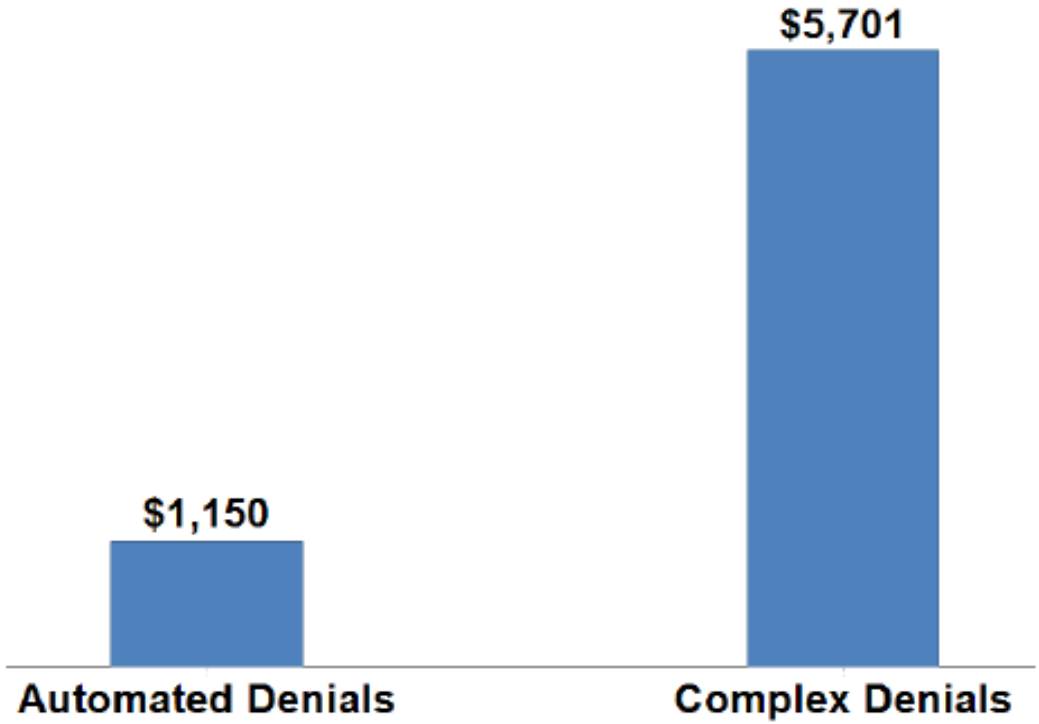
Source: AHA. (April 2014). RAC*TRAC* Survey
AHA analysis of survey data collected from 2,489 hospitals: 2,221 reporting activity, 268 reporting no activity through March 2014. 1,165 hospitals participated this quarter. Data were collected from general medical/surgical acute care hospitals (including critical access hospitals and cancer hospitals), long-term acute care hospitals, inpatient rehabilitation hospitals and inpatient psychiatric hospitals.

24

The average dollar value of an automated denial was $1,150 and the average dollar value of a complex denial was $5,701.

Average Dollar Value of Automated and Complex Denials Among Hospitals Reporting RAC Denials, through 1st Quarter 2014

Average Dollar Amount of Automated and Complex Denials Among Reporting Hospitals, by Region		
RAC Region	**Automated Denial**	**Complex Denial**
NATIONWIDE	$1,150	$5,701
Region A	$513	$5,864
Region B	$762	$5,209
Region C	$1,204	$5,605
Region D	$1,698	$6,081



Source: AHA. (April 2014). RAC*TRAC* Survey
AHA analysis of survey data collected from 2,489 hospitals: 2,221 reporting activity, 268 reporting no activity through March 2014. 1,165 hospitals participated this quarter. Data were collected from general medical/surgical acute care hospitals (including critical access hospitals and cancer hospitals), long-term acute care hospitals, inpatient rehabilitation hospitals and inpatient psychiatric hospitals.

23

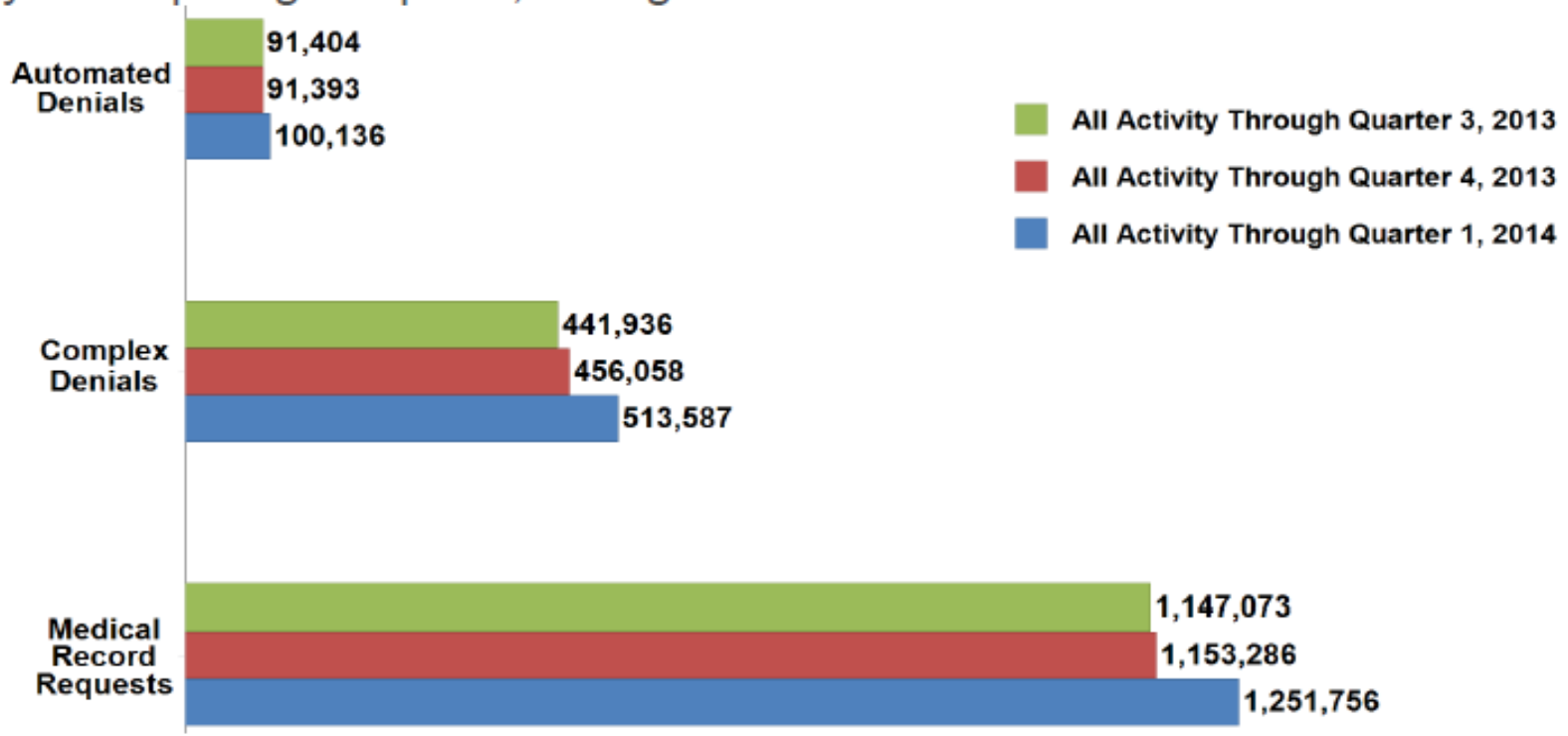
Additional Documentation Request
MPIM, Ch. 3

There are 2 types of record requests that a provider may receive:

- For service-specific prepayment review:
  - MR notifies providers that the service/claim has been selected for review and the specific reason for its selection by system-generated ADR; and,
  - The ADR serves as notification of review as well as a request for medical records.
- For provider-specific prepayment review or any post-payment review:
  - MR notifies providers of the selection for review and the specific reason for its selection;
  - Whether the review is prepayment or postpayment; and,
  - The list of claims and/or services for which medical records are required.
- If the supporting documentation is not provided within the designated timeframe (30 days), the service or claim may be denied (45 days).
- HIPAA permits disclosure of PHI for treatment, *payment*, or health care operations.

Participants continue to report increases in RAC denials and medical record requests.

Reported Automated Denials, Complex Denials and Medical Records Requests by Participating Hospitals, through 1st Quarter 2014*



*Response rates vary by quarter.

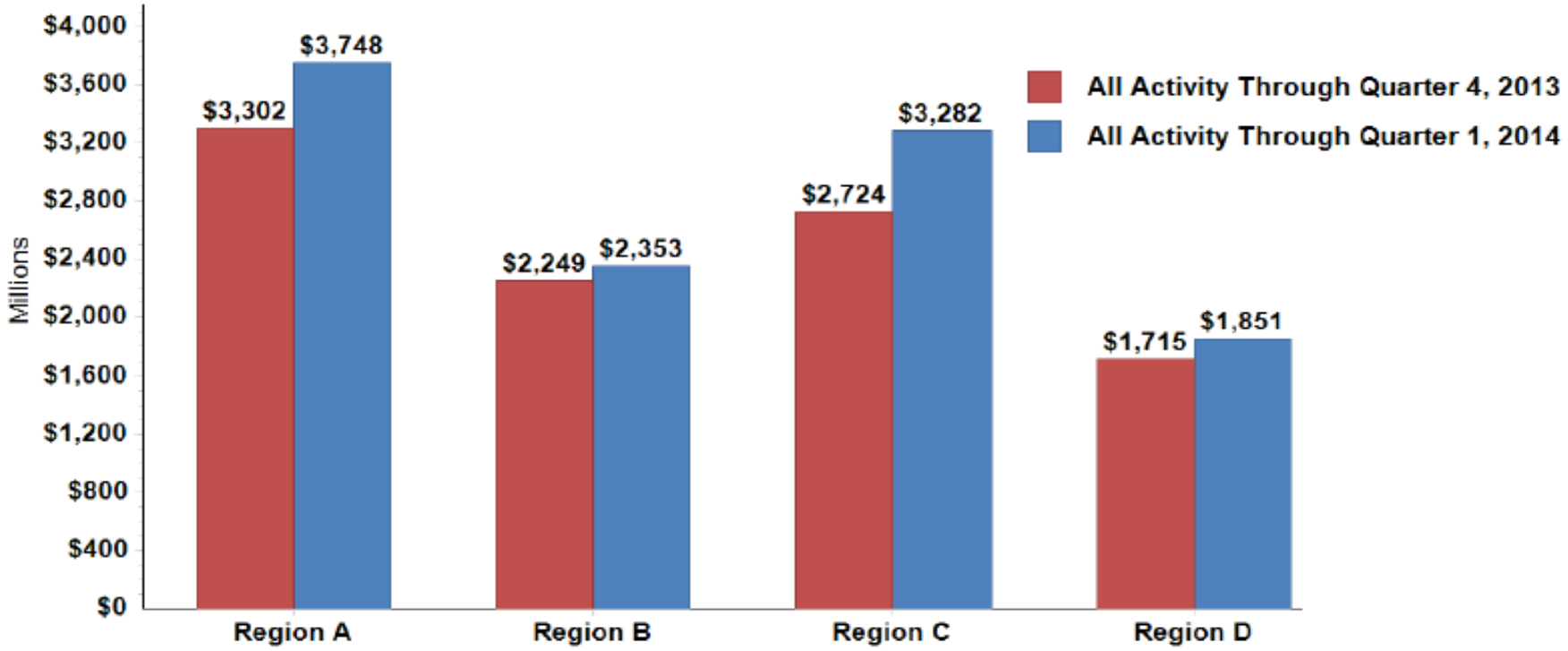
Source: AHA. (April 2014). RAC*TRAC* Survey

AHA analysis of survey data collected from 2,489 hospitals: 2,221 reporting activity, 268 reporting no activity through March 2014. 1,165 hospitals participated this quarter. Data were collected from general medical/surgical acute care hospitals (including critical access hospitals and cancer hospitals), long-term acute care hospitals, inpatient rehabilitation hospitals and inpatient psychiatric hospitals.

13

Among participating hospitals, over $11 billion in Medicare payments were targeted for medical record requests through the 1st quarter of 2014.

Medicare Payments Associated with Medical Records Requested from Participating Hospitals, through 1st Quarter 2014, in Millions*



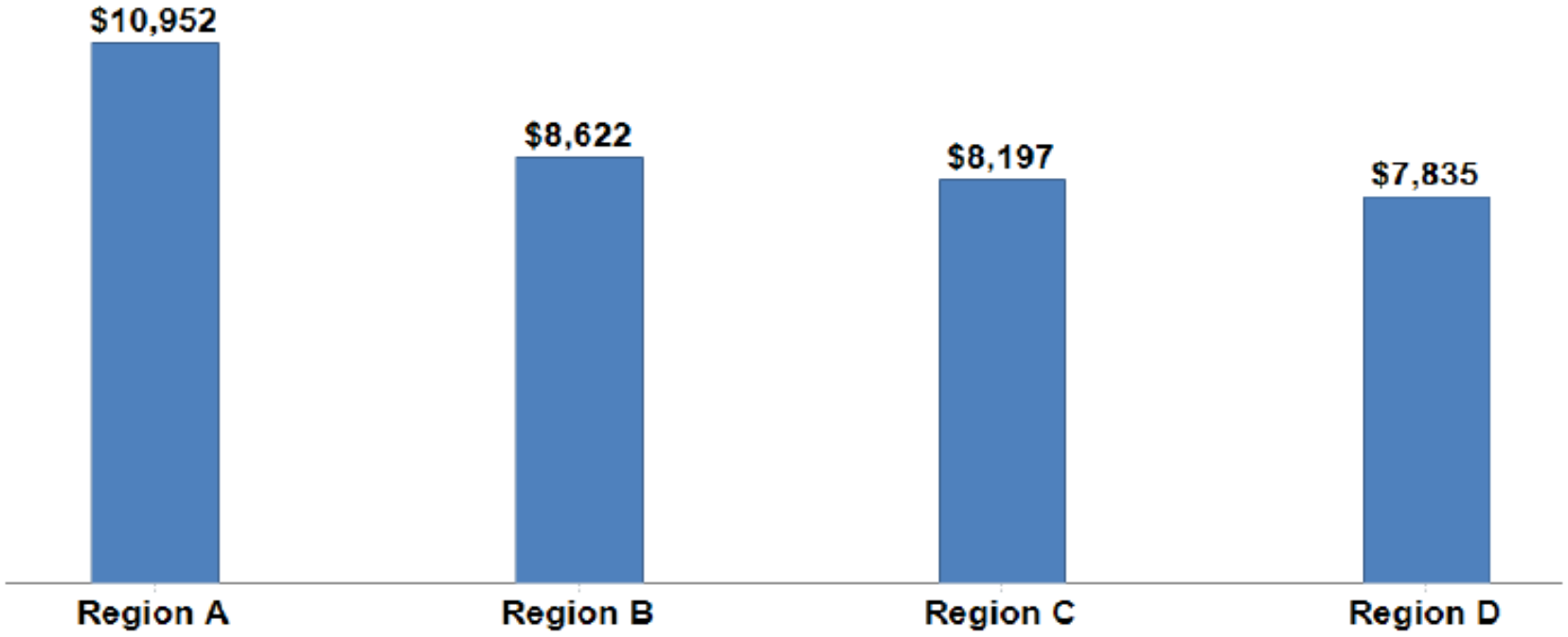
*Response rates vary by quarter.

Source: AHA. (April 2014). RAC*TRAC* Survey

AHA analysis of survey data collected from 2,489 hospitals: 2,221 reporting activity, 268 reporting no activity through March 2014. 1,165 hospitals participated this quarter. Data were collected from general medical/surgical acute care hospitals (including critical access hospitals and cancer hospitals), long-term acute care hospitals, inpatient rehabilitation hospitals and inpatient psychiatric hospitals.

The average value of a medical record requested in a complex review was highest in Region A.

Average Value of a Medical Record Requested in a Complex Review Among Hospitals Reporting RAC Activity, through 1st Quarter 2014



Source: AHA. (April 2014). RAC*TRAC* Survey
AHA analysis of survey data collected from 2,489 hospitals: 2,221 reporting activity, 268 reporting no activity through March 2014. 1,165 hospitals participated this quarter. Data were collected from general medical/surgical acute care hospitals (including critical access hospitals and cancer hospitals), long-term acute care hospitals, inpatient rehabilitation hospitals and inpatient psychiatric hospitals.

16

EHR
EXECUTIVE HEALTH RESOURCES
The Physician Advisor Company®

Denials:
Medicare Administrative Contractor (MAC)

AHA Solutions, Inc., a subsidiary of the American Hospital Association, is compensated for the use of the AHA marks and for its assistance in marketing endorsed products and services. By agreement, pricing of endorsed products and services may not be increased by the providers to reflect fees paid to the AHA.

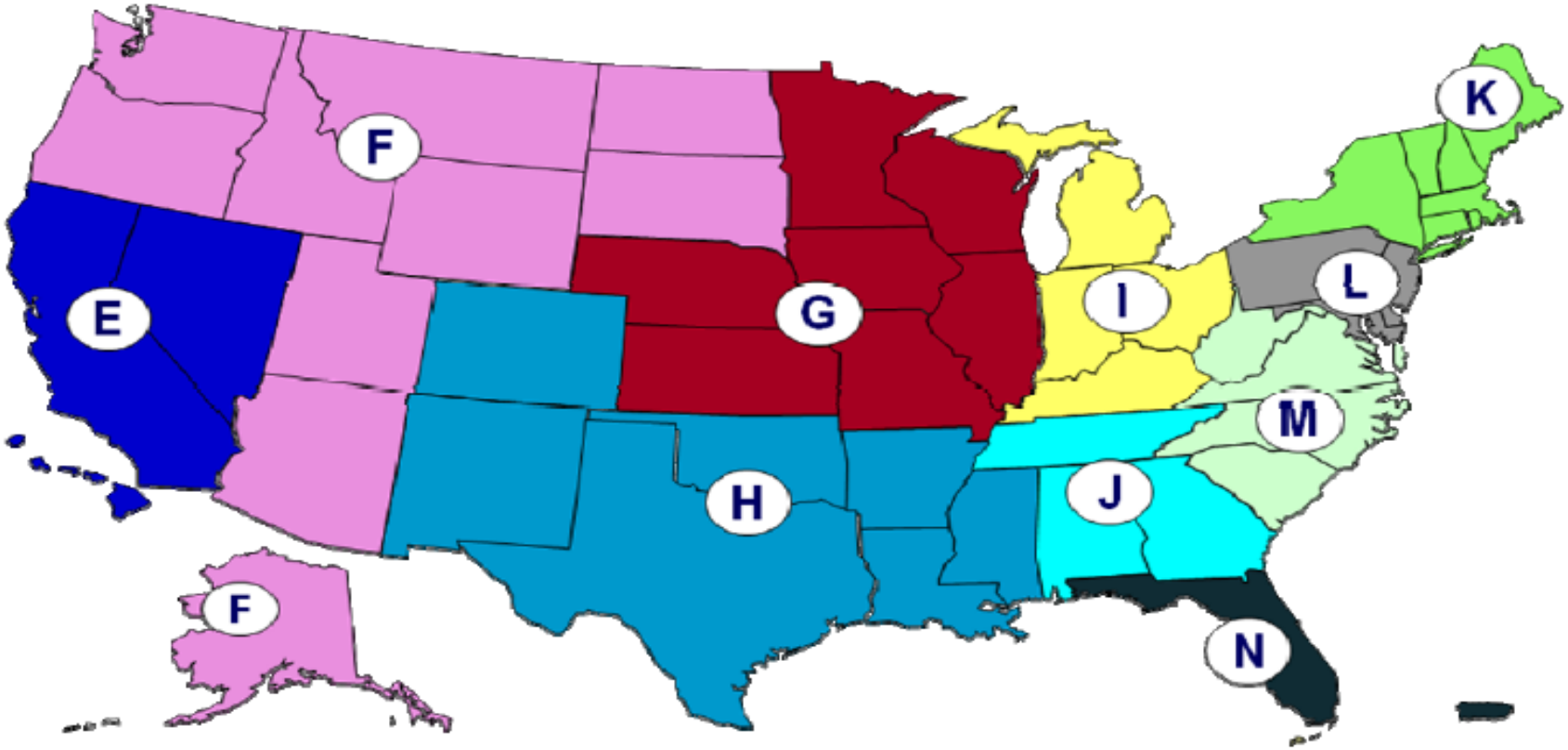
PEER REVIEWED by HFMA*

* HFMA staff and volunteers determined that this product has met specific criteria developed under the HFMA Peer Review Process. HFMA does not endorse or guarantee the use of this product.

PHILADELPHIA BUSINESS JOURNAL 2013 BEST PLACES TO WORK

2008 ★ 2009 ★ 2010 ★ 2011 ★ 2012 ★ 2013

Consolidated A/B MAC Jurisdictions



Source: CMS

MAC Activity

- Primary responsibility is processing claims.
- Now auditing hospitals and physicians
  - Mobile audits
  - Prepayment reviews
  - Few claim/chart limits
  - Focusing on medical necessity
- Increased denial activity, especially during contract renewal periods.
- Frequently, guidance provided appears to be inconsistent with statutes, regulations, and manuals.

MAC Activity

- **MACs may review claims as part of routine monitoring or as part of other targeted reviews**.
- Some MACs have suspended their targeted prepayment reviews during the Probe and Educate period; others have not as they are under no obligation to do so.
- MACs will continue other types of inpatient hospital reviews:
  - Coding reviews
  - Medical necessity of a surgical procedure provided to a hospitalized beneficiary.

Medical Review (MR) Edits

MPIM, Ch. 3

MR edits either automatically pay all or part of a claim, automatically deny all or part of a claim, or suspend all or part of a claim so that a trained clinician or claims analyst can review the claim and associated documentation (including ADRs) in order to make determinations about coverage and payment as being medically reasonable and necessary.

Medical Review (MR) Edits

MPIM, Ch. 3

- **MACs:**
  - Are encouraged to use prepayment and postpayment screening tools or natural language coding software.
  - **Shall not deny** a payment simply because the claim fails a single screening tool criterion (i.e. requires manual review).
  - **Have the discretion** to disclose to providers the screening tools in use (e.g. posting on website).
- RAs **shall** use screening tools **and disclose** their use to the providers per their SOW.
- MACs and RAs **shall not** target providers for their preferred method of maintaining or submitting documentation.

Specific MAC Activity

MAC	Activity / Focus
Cahaba	Current Prepayment Medical Review Log for Part A (updated August 6, 2012; not all inclusive): DRGs 069, 190-2, 242-4, 226-7, 247, 249, 251, 287, 312-3, 392, 460, 470, 552, 641, 981-3
CGS	Recently completed Prepayment Reviews, included DRGs 246-249, 690, Cardiac Pacemaker Implants, 312, and Procedure Codes 33.27 and 86.22
First Coast	Prepayment Review: DRGs 069, 153, 328, 357, 455, 473, 517, 226-7, 242-5, 247, 251, 253-4, 264, 287, 313, 392, 458, 460, 470, 490, 552, 641
Novitas	Prepayment Review
NGS	Mobile Audit & Prepayment Review
NHIC	Prepayment Review
Noridian	Prepayment Review for DRGS 243-4, 251, 227, 312, 1-day stays
Palmetto	Recently completed Prepayment Reviews: DRGs 177, 280, 441, 064, 193, 219, 377, 682, 871, 853, 189, 190, 227, 243-4, 460, 945
WPS	WPS's current prepay edits include 48-hour OBS, high dollar claims, and short-term acute care

“Probe and Educate”

- Originally: Oct. 1 – Dec. 31, 2013
- Extended at least until September 30, 2014; may go to March 31, 2015.
- Focus on Inpatient claims less than 2-midnights absent evidence of systematic gaming, abuse, or delays.
- Up to 10 claims per small hospital; up to 25 claims for larger hospitals.
- CMS requests that the MACs re-review all claim denials under the Probe & Educate process to ensure consistency with the most recent guidance.
- Link for more information: www.cms.gov/medical-review

Selecting Hospital Claims for Review:
Admissions on or after 10/1/2013

- Released October 31, 2013.
- Issued guidance to Medicare Administrative Contractors (MACs) about how to select hospital claims for review during the “Probe and Educate” program for admissions that occur October 1, 2013 through September 30, 2014, and possibly March 31, 2015.
- Applies to acute care inpatient hospital facilities, Long-Term Care Hospitals (LTCHs), Critical Access Hospitals (CAHs), and Inpatient Psychiatric Facilities (IPFs).
- Excludes Inpatient Rehabilitation Facilities (IRFs).

"Probe and Educate"

Number of Claims in Sample That Did NOT Comply with Policy (Dates of Admission October 2013 – September 2014)

Sample	No or Minor	Moderate to Significant	Major
10	**0-1**	**2-6**	**7 or more**
25	**0-2**	**3-13**	**14 or more**
Action	• Deny non-compliant claims. • Send results letters explaining each denial. • No more reviews will be conducted under Probe and Educate Process.	• Deny non-compliant claims. • Send results letters explaining each denial. • Offer 1:1 phone call. • **REPEAT Probe & Educate process with 10 - 25 claims.**	• Deny non-compliant claims. • Send results letters explaining each denial. • Offer 1:1 phone call. • Repeat Probe & Educate. • **If problems continue, repeat P&E with 100-250 claims.**

MAC Re-review of Probe & Educate Denials

- CMS will waive the 120 day timeframe for redetermination requests received before September 30, 2014 for claim denials under the Probe & Educate process that occurred on or before January 30, 2014.
- Claim denials that occurred on or before January 30, 2014 for which an appeal has been filed will also be subject to re-review.
- Claims for which the denial is affirmed following re-review will be transferred to appeals automatically for a redetermination.

Source: http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Medical-Review/InpatientHospitalReviews.html

Preliminary Results
(February 7, 2014)

- **MACs requested 29,158 records; reviewed 6,012.**
- **CMS cited the following common reasons for denial:**
  - Missing or flawed inpatient admission order;
  - Short-stay procedures not on the IP-only list;
  - Short stays for medical conditions where the record fails to support an expectation of two midnights;
  - Physician attestation statements without supporting medical record documentation.

NGS
(As of March 31, 2014)

Hospitals included in “Probe and Educate” reviews:

- J6 hospitals = 274
- ADRs sent: 2195
- Records received: 1832
- Claims reviewed: 1311
- Claims denied in full: 982
- Claims paid: 329
- **Favorable determinations: 25%**
- Of denials:
  - 71.8% no documentation of 2-MN expectation
  - 13.5% no documentation of unforeseen 1-MN stay

Source: NGS website (5/20/14)

EHR
EXECUTIVE HEALTH RESOURCES
The Physician Advisor Company®

Denials:
Recovery Auditor (RAC)

AHA Solutions, Inc., a subsidiary of the American Hospital Association, is compensated for the use of the AHA marks and for its assistance in marketing endorsed products and services. By agreement, pricing of endorsed products and services may not be increased by the providers to reflect fees paid to the AHA.

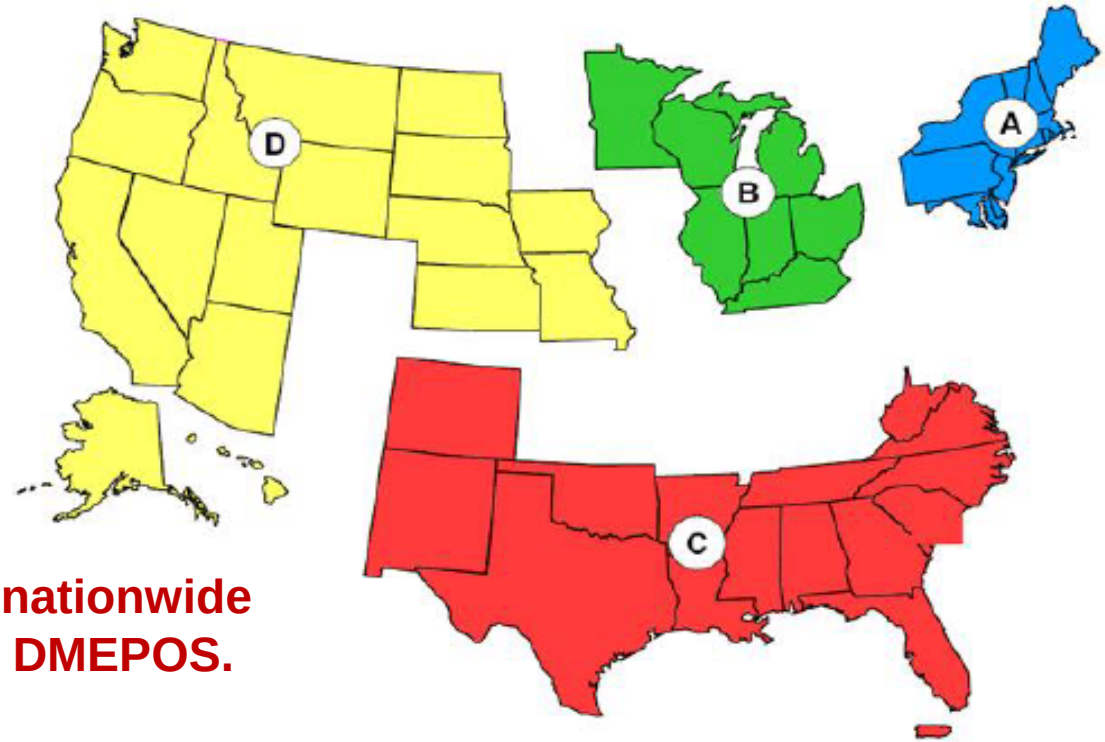
* HFMA staff and volunteers determined that this product has met specific criteria developed under the HFMA Peer Review Process. HFMA does not endorse or guarantee the use of this product.

2008 ★ 2009 ★ 2010 ★ 2011 ★ 2012 ★ 2013

There are four RAC regions nationwide. Participation in RAC*TRAC* is generally consistent with hospital representation in each of the RAC regions.

Distribution of Hospitals by RAC Region and Hospitals Participating in RAC*TRAC* by RAC Region, through 1st Quarter 2014

	Percent of Hospitals Nationwide	Percent of Participating Hospitals by Region
Region A	15%	16%
Region B	19%	23%
Region C	40%	35%
Region D	26%	26%



Plan to create 5th nationwide RAC for HHH and DMEPOS.

Source: Centers for Medicare and Medicaid Services

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

*Figures rounded to nearest tenth; Nationwide figures rounded based on actual collections. Figures provided in millions. All correction data current through March 31, 2014.

	OVERPAYMENTS COLLECTED	UNDERPAYMENTS RETURNED	TOTAL QUARTER CORRECTIONS	FY TO DATE CORRECTIONS
Region A: Performant (*formerly Diversified Collection Services*)	$132.8	$9.5	$142.3	$255.3
Region B: CGI (CGI Federal)	$88.9	$5.0	$93.9	$204.1
Region C: Connolly	$322.5	$49.2	$371.7	$820.8
Region D: HDI (HealthData Insights)	$120.8	$7.8	$128.6	$360.4
Nationwide Totals	**$665.0**	**$71.5**	**$736.5**	**$1,640.6**

TOP ISSUE PER REGION

*Based on collected amounts through March 31, 2014

CMS Recovery Amounts

	FY	Total Corrections
October 2009 – September 2010	2010	$92.3
October 2010 – September 2011	2011	$939.3
October 2011 – September 2012	2012	$2,400.7
October 2012 – September 2013	2013	$3,834.8
October 2013 – March 2014	Q1-Q2 2014	$1,640.6
Total National Program*		**$8,907.7**

***Of total corrections, ~$8.4 billion (94%) are overpayments.**

Source: http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Recovery-Audit-Program/Recent_Updates.html

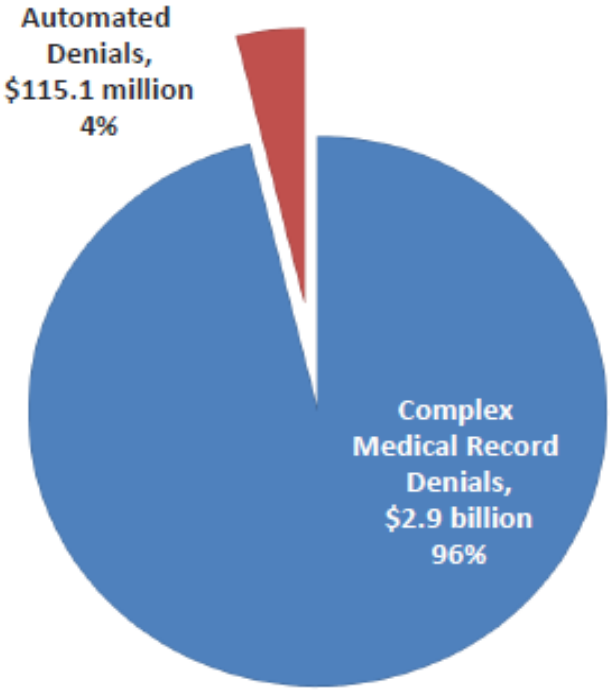
RAC*Trac*

Q1-2014 (1,165 hospitals)

- 69% reported spending >$10K in Q4 managing the RAC process; 48% >$25K; 11% >$100K.
- 38% of hospitals indicated short-stay medical necessity denials were the most costly (a 12% decrease from Q4-2013).

96% of denied dollars were for complex denials.

Percent and Dollar Amounts of Automated Denials Versus Complex Denials for Participating Hospitals, through 1st Quarter 2014

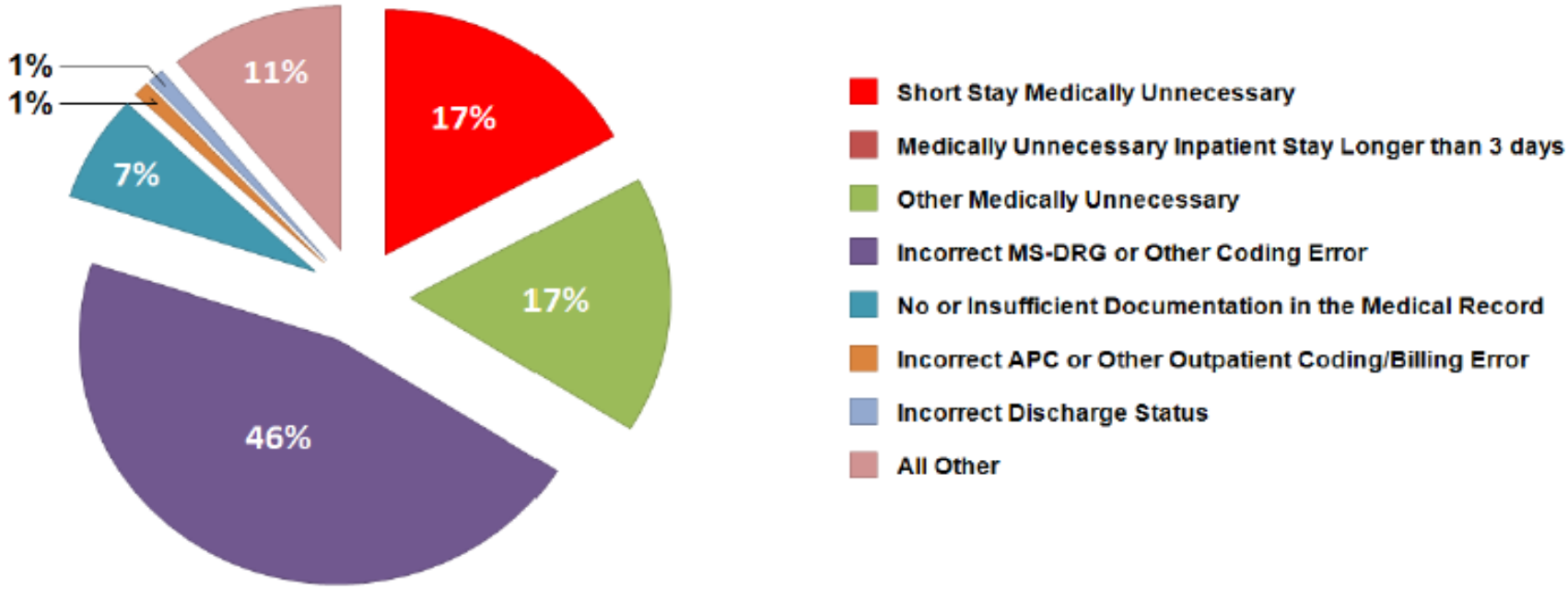


Source: AHA. (April 2014). RAC*TRAC* Survey
AHA analysis of survey data collected from 2,489 hospitals: 2,221 reporting activity, 268 reporting no activity through March 2014. 1,165 hospitals participated this quarter. Data were collected from general medical/surgical acute care hospitals (including critical access hospitals and cancer hospitals), long-term acute care hospitals, inpatient rehabilitation hospitals and inpatient psychiatric hospitals.

Region A: Incorrect MS-DRG or coding error has grown rapidly as the top reason for complex denials.

Percent of Participating Hospitals by Top Reason for Complex Denials by Dollar Amount for Medical/Surgical Acute Hospitals with RAC Activity, 1st Quarter 2014, Region A

Survey participants were asked to rank denials by reason, according to dollar impact.



Source: AHA. (April 2014). RAC*TRAC* Survey
AHA analysis of survey data collected from 2,489 hospitals: 2,221 reporting activity, 268 reporting no activity through March 2014. 1,165 hospitals participated this quarter. Data were collected from general medical/surgical acute care hospitals (including critical access hospitals and cancer hospitals), long-term acute care hospitals, inpatient rehabilitation hospitals and inpatient psychiatric hospitals.

37

RAC*Trac*

Q1-2014 (1,165 hospitals)

- 63% of appealed claims are still in the appeals process.
- 57% of medical records reviewed by RACs **did not** contain an overpayment.
- 66% of short-stay denials were for wrong setting **not** because medically unnecessary.
- 55% (from 70%) appealed short-stay denials.
  - Hospitals reported appealing 50% of all RAC denials, with a 66% success rate in the appeals process.
  - An additional 13,000 claims were reported as withdrawn from the appeals process (i.e. rebilling).

0-1 Day Stays not Reviewed
CMS FAQs (12/23/13)

- CMS will not permit Recovery Auditors to review inpatient admissions of less than 2 midnights after formal inpatient admission that occur between October 1, 2013 and (now) March 31, 2015.
- These reviews will be disallowed permanently; that is, the Recovery Auditors will never be allowed to conduct patient status reviews for claims with dates of admission during that time period.
- This is related to the RAC contracting process that is now working through protests by the contractors.

Important Dates

- **February 21, 2014 -** the last day a Recovery Auditor sends a post-payment Additional Documentation Request (ADR).
- **February 28, 2014 -** the last day a MAC sends pre-payment ADRs for the Recovery Auditor Prepayment Review Demonstration.
- **June 1, 2014 -** last day a Recovery Auditor sends improper payment files to the MACs for adjustment.

EHR
EXECUTIVE HEALTH RESOURCES
The Physician Advisor Company®

Appeals

AHA Solutions, Inc., a subsidiary of the American Hospital Association, is compensated for the use of the AHA marks and for its assistance in marketing endorsed products and services. By agreement, pricing of endorsed products and services may not be increased by the providers to reflect fees paid to the AHA.

PEER REVIEWED by HFMA*

* HFMA staff and volunteers determined that this product has met specific criteria developed under the HFMA Peer Review Process. HFMA does not endorse or guarantee the use of this product.

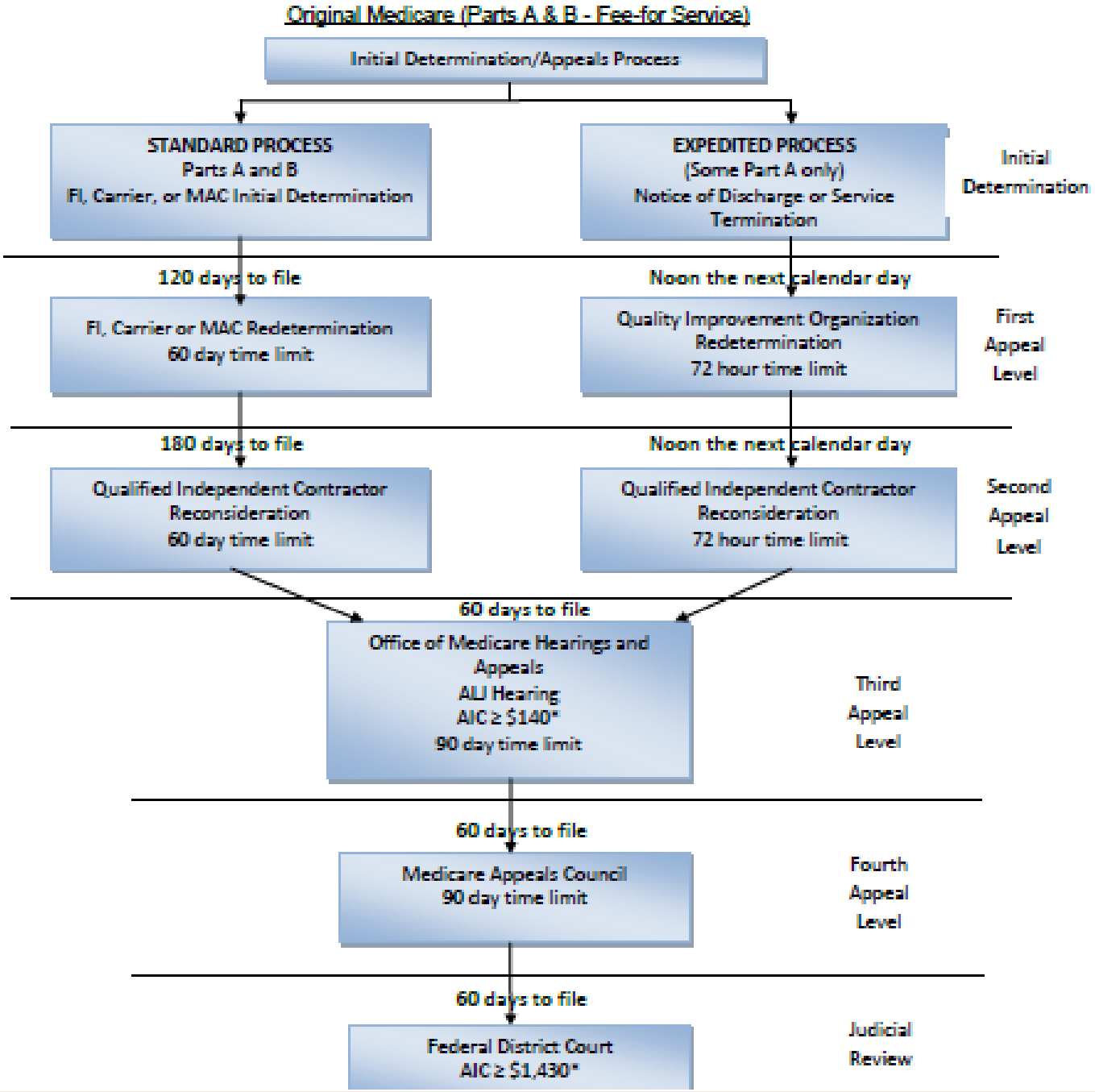
PHILADELPHIA BUSINESS JOURNAL 2013 BEST PLACES TO WORK

2008 ★ 2009 ★ 2010 ★ 2011 ★ 2012 ★ 2013

Appeals

MLN ICN006562, January 2013

- If a provider disagrees with a MR determination, the provider may request an “independent” re-examination of a claim.
- Subsequent actions MAY NOT be delayed pending the results of an appeal.

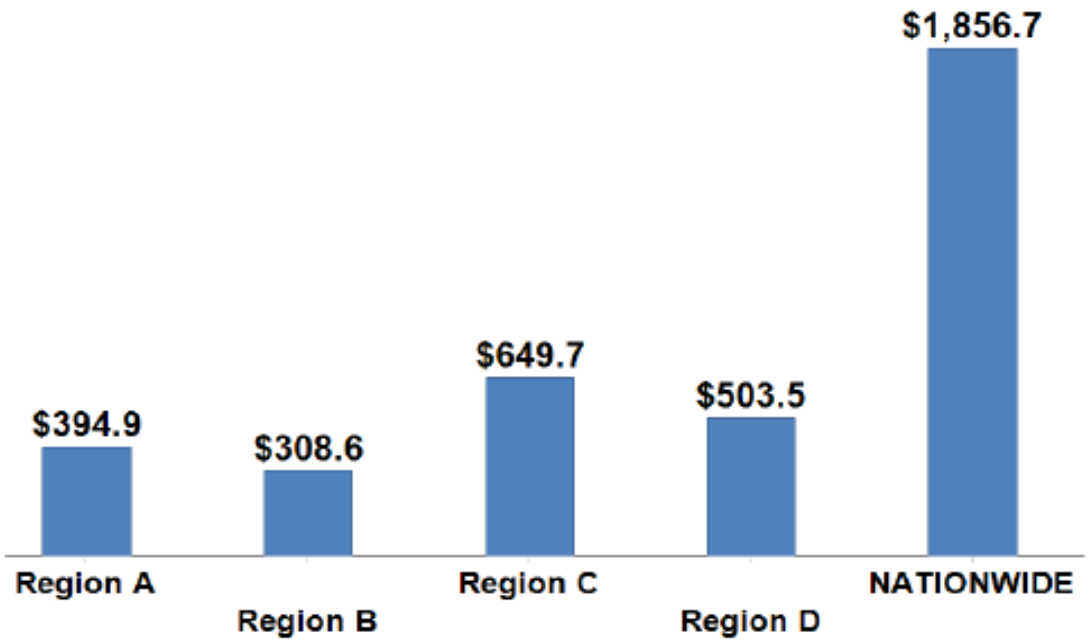


Graphic from CMS

The value of appealed claims exceeds $1.8 billion dollars. Hospitals report appealing an average of 386 claims to date.

Total Dollar Value, Percent and Average Number of Appealed Claims for Hospitals with Automated or Complex RAC Denials, through 1st Quarter 2014, Millions

	Percent of Hospitals with Any Appealed Denials	Average Number of Appealed Denials per Hospital
NATIONWIDE	89%	386
Region A	89%	390
Region B	89%	279
Region C	91%	388
Region D	84%	502



Source: AHA. (April 2014). RAC*TRAC* Survey
AHA analysis of survey data collected from 2,489 hospitals: 2,221 reporting activity, 268 reporting no activity through March 2014. 1,165 hospitals participated this quarter. Data were collected from general medical/surgical acute care hospitals (including critical access hospitals and cancer hospitals), long-term acute care hospitals, inpatient rehabilitation hospitals and inpatient psychiatric hospitals.

47

Redetermination and Recoupment

Section 935 Limitation on Recoupment, NGS

- **Recoupment**: overpayment recovery from current payments due or future claims.
- An overpayment of ≥$10 initiates a demand letter.
  - May submit a rebuttal statement– recoupment will cause financial hardship– within 15 calendar days from the date of a demand letter.
  - The rebuttal statement is not an appeal or a means of disagreeing and does not cease recoupment.
  - For disagreement, contact RAC during the discussion period or appeal.
- If no response after 30 calendar days from the date of the first demand letter, a second demand letter may be sent.
  - Interest accrues if payment is not received by the 31st calendar day from the date of the first demand letter.
  - Simple interest compounded daily at the higher of the private consumer and current funds rates (range 10.75% - 14.125%).
- If full payment is not received 40 calendar days after the date of the first demand letter, recoupment begins on day 41.
- In order to stop the initial recoupment, a redetermination request must be filed within 30 calendar days from the date of the first demand letter; if after 30 calendar days, any recoupment will not be refunded.

Reconsideration

Section 935 Limitation on Recoupment, NGS

- If no overturn, within 60 calendar days after notice may appeal to Qualified Independent Contractor (QIC); otherwise, recoupment may resume.
- Recoupment resumes on Day 76 if no action taken.
- Recoupment ceases or not initiated when MAC receives notice of reconsideration by QIC.
- Any already recouped funds are applied first to accrued interest then principal.
- **QIC reconsideration can have 3 outcomes:**
  - Full reversal (favorable) – MAC adjusts the overpayment and amount of interest.
  - Partial reversal (partially favorable) - revised demand letter; may apply excess to any other debt.
  - Affirmation (unfavorable) - recoupment may resume on the 30th calendar day after the date of notice of reconsideration.
- **Recoupment then continues regardless of further appeals until reversal or payment.**

EHR
EXECUTIVE HEALTH RESOURCES
The Physician Advisor Company®

Appeals:
Administrative Law Judge (ALJ)

AHA Solutions, Inc., a subsidiary of the American Hospital Association, is compensated for the use of the AHA marks and for its assistance in marketing endorsed products and services. By agreement, pricing of endorsed products and services may not be increased by the providers to reflect fees paid to the AHA.

* HFMA staff and volunteers determined that this product has met specific criteria developed under the HFMA Peer Review Process. HFMA does not endorse or guarantee the use of this product.

2008 ★ 2009 ★ 2010 ★ 2011 ★ 2012 ★ 2013

Of the claims that have completed the appeals process, 66% were overturned in favor of the provider.

Summary of Appeal Rate and Determinations in Favor of the Provider, for Hospitals with Automated or Complex RAC Denials, through 1st Quarter 2014*

				Completed Appeals		
	Appealed	Percent of Denials Appealed	Number of Denials Awaiting Appeals Determination	Number of Denials Not Overturned from Appeals Process** (Withdrawn/Not Continued)	Number of Denials Overturned in the Appeals Process	Percent of Appealed Denials Overturned *(as a Percent of Total Completed Appeals)*
NATIONWIDE	267,085	52%	171,967	29,621	58,748	66%
Region A *	17,833	53%	10,418	3,393	3,135	48%
Region B	52,717	49%	29,427	7,938	13,372	63%
Region C	118,720	50%	81,458	10,338	25,043	71%
Region D	77,815	56%	50,664	7,952	17,198	68%

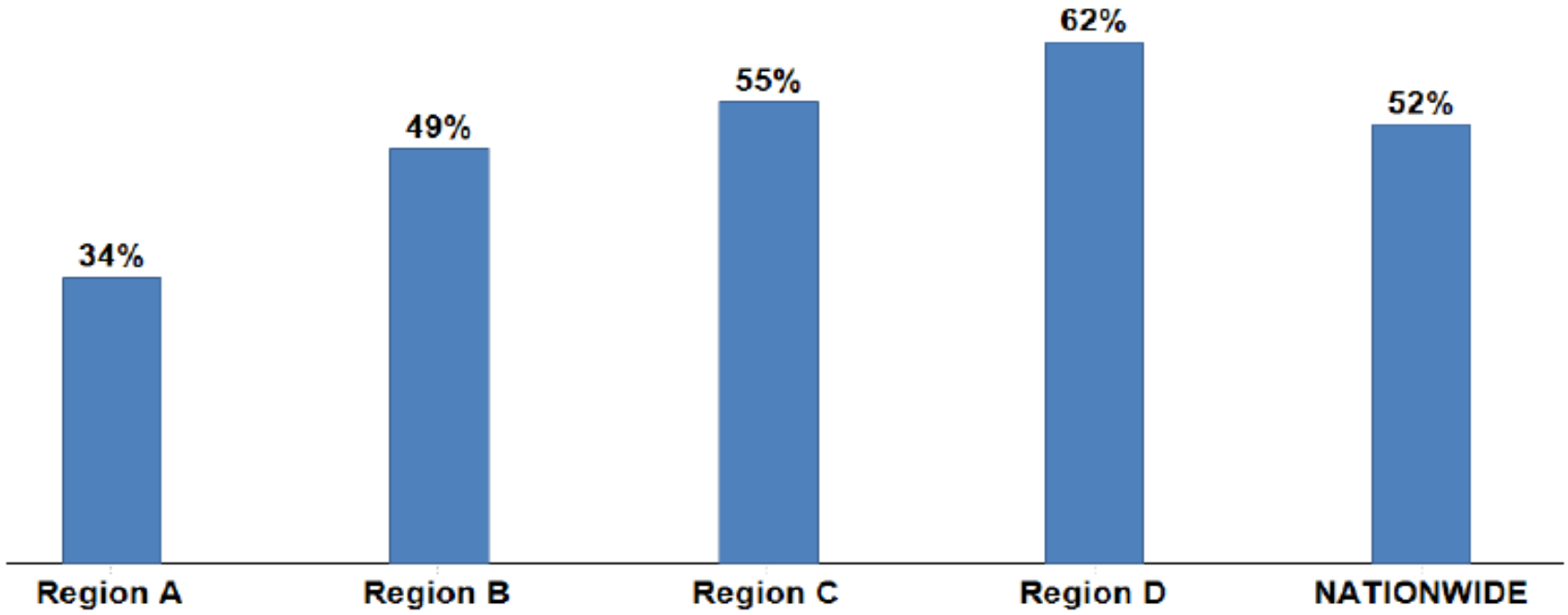
**Manual survey entries only for Region A. Due to survey submission error, total appeals may be greater than the sum of ending/withdrawn/overturned appeals.*
*** May include appeals withdrawn to re-bill.*

*Response rates vary by quarter.
Source: AHA. (April 2014). RAC*TRAC* Survey
AHA analysis of survey data collected from 2,489 hospitals: 2,221 reporting activity, 268 reporting no activity through March 2014. 1,165 hospitals participated this quarter. Data were collected from general medical/surgical acute care hospitals (including critical access hospitals and cancer hospitals), long-term acute care hospitals, inpatient rehabilitation hospitals and inpatient psychiatric hospitals.

55

For over 50% of claims appealed to the ALJ, the judge has taken longer than the statutory limit of 90 days to provide a determination to the hospital.

Percent of Appeals for which ALJ has taken Longer than the Statutory Maximum of 90 Calendar Days to Issue a Decision, through 1st Quarter 2014



Source: AHA. (April 2014). RAC*TRAC* Survey
AHA analysis of survey data collected from 2,489 hospitals: 2,221 reporting activity, 268 reporting no activity through March 2014. 1,165 hospitals participated this quarter. Data were collected from general medical/surgical acute care hospitals (including critical access hospitals and cancer hospitals), long-term acute care hospitals, inpatient rehabilitation hospitals and inpatient psychiatric hospitals.

52

OMHA State of the Union

- OMHA received an estimated 350,000 appeal requests in FY2013; over four times its decision-making capacity.
- Currently 480,000 appeals awaiting assignment to an ALJ.
- In January 2014, OMHA received 15,000 appeal requests per week; up from 1250 two years ago.
- Avg. processing time rose to 329.8 days so far in FY2014 from 94.9 days in 2009.
- Significant increases are still expected for the remainder of the year (343.6 days in December 2013).
- Received an 18.6% increase in appropriations over FY2013 operating level.

OMHA Backlog

- **15 weeks** from receipt to open mail; stamped as of the date it was physically received not opened.
- **18-22 weeks** from the date mail is received until it is entered into OMHA's database; becomes searchable in response to inquiries.
- Up to **28 months** from receipt until case is assigned to a judge.
- **6 months** for a hearing date after a case is assigned.

EHR
EXECUTIVE HEALTH RESOURCES
The Physician Advisor Company®

Appeals:
Medicare Appeals Council and Federal Court

AHA Solutions, Inc., a subsidiary of the American Hospital Association, is compensated for the use of the AHA marks and for its assistance in marketing endorsed products and services. By agreement, pricing of endorsed products and services may not be increased by the providers to reflect fees paid to the AHA.

PEER REVIEWED by HFMA*

* HFMA staff and volunteers determined that this product has met specific criteria developed under the HFMA Peer Review Process. HFMA does not endorse or guarantee the use of this product.

PHILADELPHIA BUSINESS JOURNAL 2013 BEST PLACES TO WORK

2008 ★ 2009 ★ 2010 ★ 2011 ★ 2012 ★ 2013

Review by the DAB

MLN ICN006562, January 2013

- If an ALJ issues an adverse decision, the enrollee or the enrollee's representative may appeal to the DAB for issues of process or application of law.
- The request must be filed within 60 calendar days from the date the ALJ's decision notice.
- Requests for standard reviews must be made in writing; expedited reviews may be made orally.
- If the Medicare Appeals Council's decision is unfavorable, a request for review by a **Federal District Court** if:
  - The amount in controversy (AIC) ≥$1430; and,
  - Filed within 60 calendar days of the DAB decision.

EHR
EXECUTIVE HEALTH RESOURCES
The Physician Advisor Company®

Best Practices for Appeals

AHA Solutions, Inc., a subsidiary of the American Hospital Association, is compensated for the use of the AHA marks and for its assistance in marketing endorsed products and services. By agreement, pricing of endorsed products and services may not be increased by the providers to reflect fees paid to the AHA.

* HFMA staff and volunteers determined that this product has met specific criteria developed under the HFMA Peer Review Process. HFMA does not endorse or guarantee the use of this product.

2008 ★ 2009 ★ 2010 ★ 2011 ★ 2012 ★ 2013

Best Practice Approach

- Demonstrate a consistently followed Utilization Review process for every patient.
- Educate medical staff on documentation practices to avoid future technical issues.
- Prove that the error rate within your hospital is not accurate by focusing on successfully appealing denials.
- Hospitals need to be prepared to defend their decisions and advocate for their rights.

3-Tiered Approach to Appeals

- All appeals should be prepared to be presented to the ALJ.
- Your argument must address 3 key components to have any likelihood of success:
  1. **Clinical:** Strong medical necessity argument using evidence-based literature
  2. **Compliance:** Need to demonstrate that a compliant process for certifying medical necessity was followed.
  3. **Regulatory:** Want to demonstrate, when applicable, that the RA's determination is not consistent with the Social Security Act (SSA).

Medical Necessity

- ***Documentation is the difference!***
- Explicitly detail why the care provided was medically necessary in the inpatient setting.
- The critical factors:
  - The judgment of the admitting physician referencing:
    - Local and national standards of medical care
    - Relevant medical literature and other materials
    - Published clinical guidelines
  - Utilization management criteria
  - Local and national coverage determinations
  - CMS guidance (e.g. Medicare Benefit Policy Manual)

What Hospitals should do to Maximize Success

Hospitals need to defend their decisions and advocate for their (and patient's) rights!

- Appeal when appropriate even if it's a high percentage of cases.
- Challenge the contractors' interpretations.
- Share concerns with CMS Regional Office.

What Hospitals should do to Maximize Success

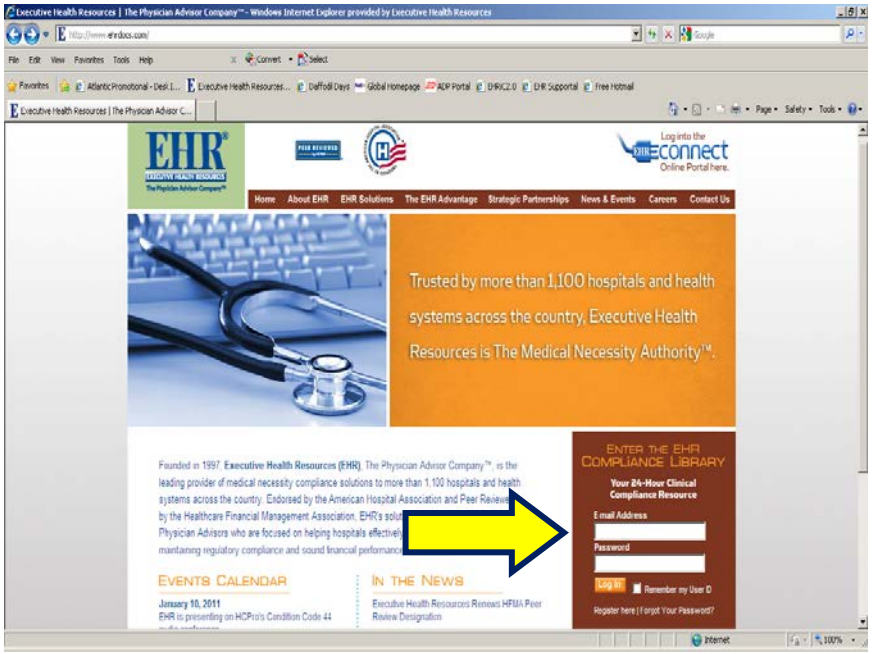
Must evaluate "new" technical components:

- Order
- Authentication/Co-signature as required
- Expectation of 2 MN stay
- Elements of Certification
- Documentation to support all of the above, in addition to Medical Necessity

Questions?

Joe Crea, DO, MHA, FACOEP
Senior Medical Director
Audit, Compliance and Education (ACE)
jcrea@ehrdocs.com
484-843-0170

Get the Latest Industry News & Updates



EHR's Compliance Library
Register today at
www.ehrdocs.com

twitter

Follow EHR on Twitter!

@EHRdocs

http://www.twitter.com/EHRdocs

About Executive Health Resources

AHA Solutions, Inc., a subsidiary of the American Hospital Association, is compensated for the use of the AHA marks and for its assistance in marketing endorsed products and services. By agreement, pricing of endorsed products and services may not be increased by the providers to reflect fees paid to the AHA.

EHR has been awarded the exclusive endorsement of the American Hospital Association for its leading suite of Clinical Denials Management and Medical Necessity Compliance Solutions Services.

* HFMA staff and volunteers determined that this product has met specific criteria developed under the HFMA Peer Review Process. HFMA does not endorse or guarantee the use of this product.

EHR received the elite Peer Reviewed designation from the Healthcare Financial Management Association (HFMA) for its suite of medical necessity compliance solutions, including: Medicare and Medicaid Medical Necessity Compliance Management; Medicare and Medicaid DRG Coding and Medical Necessity Denials and Appeals Management; Managed Care/Commercial Payor Admission Review and Denials Management; and Expert Advisory Services.

2008 ★ 2009 ★ 2010 ★ 2011 ★ 2012

EHR was recognized as one of the “Best Places to Work” in the Philadelphia region by Philadelphia Business Journal for the past five consecutive years. The award recognizes EHR’s achievements in creating a positive work environment that attracts and retains employees through a combination of benefits, working conditions, and company culture.