Statement of Jennifer J Carmody, CPA
Billings Clinic

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Senate Finance Committee Hearing
on

"Program Integrity: Oversight of Medicare Recovery Audit Contractors"

Chairman Baucus, Ranking Member Hatch and members of Senate Finance Committee, my name is JJ Carmody. I am the Director of Reimbursement Services for Billings Clinic, in Billings, Montana.

The Billings Clinic is a physician-led health care organization, consisting of a multi-specialty physician group practice, a 285-bed hospital, and a 90-bed skilled nursing and assisted living facility. We are a member of the Mayo Clinic Care Network, and the only Magnet-designated health care organization in Montana and Wyoming. For the past two years, Billings Clinic has received an "A" rating for the Hospital Safety Score by The Leapfrog Group. Our system includes partnerships with 10 critical access hospitals serving communities in Montana, Wyoming and the western Dakotas.

For the past 15 years, I have worked in the Finance Division at Billings Clinic in a variety of roles. Much of my job is to review the impact of Medicare policy decisions on the cost and delivery of patient care at Billings Clinic. I also actively participate in the compliance program in our organization.

Like health care organizations all across the U.S., we are dedicated to ensuring access to the highest quality health care possible while providing the greatest value for every dollar spent on medical treatment. We strive to deliver the right care at the right time in the right setting.

In pursuit of this goal, we have participated in a number of innovative payment reform models, such as the Physician Group Practice Demonstration, the Medicare Shared Savings Plan and the Bundled Payment Initiative.

I began my career as a Medicare cost report auditor working for the fiscal intermediary in Montana. I started out in a contracted position auditing hospitals for compliance with Medicare cost reporting regulations – it was a role not dissimilar to the role of a Recovery Audit Contractor (RAC).

However, I was not paid based on the Medicare savings I recovered from hospitals. My job was to ensure the integrity of the information reported to Medicare and to make sure the most accurate data was available for the development and refinement of Medicare payment systems.

Since my role was not judged based on recoveries, I found that a good, cooperative and working relationship was easy to develop and useful for all involved.

The Billings Clinic has a vigorous compliance program
Billings Clinic was an early adopter of a formal compliance program in the late 1990s. Our compliance program incorporates the recommended OIG elements, which allow for early detection of claims processing errors, as well as timely return of overpayments.
The compliance structure at Billings Clinic incorporates a multidisciplinary approach that allows the independence and appropriate skill required to detect, prevent and report claims processing concerns.

Compliance staff works with claims processing system design, modification and deployment in an effort to ensure that claims are filed accurately the first time. In addition, the compliance program proactively monitors data for trends that may cause compliance risks, performs risk assessments and conducts various proactive audits.

The impact of RAC audits is increasing
Since the RAC began auditing Billings Clinic in May 2010, we have seen roughly 6,000 records requested for more than $45 million. That amounts to about 14% of our overall Medicare payments.

Because CMS significantly increased the maximum number of record requests in March 2012, we expect to see this volume increase significantly in the near future.

Today, we have about $8 million in claims sitting somewhere in the RAC pipeline. That amount is about 17% of the $45 million tagged for review since 2010. Of that, nearly $3.3 million has been appealed and is awaiting a decision (2010=$100,000; 2011=$900,000; 2012=$2.3 million).

The balance of these claims is awaiting an initial determination by the RAC, or, if they have been denied, they are awaiting a decision by Billings Clinic on whether to file an appeal. Most of these are related to the current year.

Thus far, about 75% of claims requested for complex review have been upheld or verified as acceptable by the RAC with no further review required.

Of the remaining 25%, approximately 1% has been determined to be underpaid, resulting in additional payment to Billings Clinic, whereas 7% (about $2.8 million) has been repaid to Medicare.

From 2010 through 2012, 20% of all cases were appealed. Of these, 65% are still awaiting a decision (676 cases). Billings Clinic has been successful on appeal 84% of the time, winning 308 cases while losing 57.

These results are fairly comparable to data from the American Hospital Association that show only one third of the hospital charts requested by RACs are found to contain a payment error. Additionally, 72% of RAC denials that are appealed are overturned in favor of hospitals.

Billings Clinic does not take the decision to appeal lightly. For us, it is a costly endeavor. On average, an appeal could cost a minimum of $400. Furthermore, it diverts staff time and attention from current tasks, such as improving patient care, quality and safety.

It would appear that the RAC is expanding the number and types of claims it is reviewing, without significantly justifying a history of noncompliance on our part. This seems to contradict

the intent of the program, which was to focus on areas where evidence of widespread errors exists.

Unfavorable findings by the RAC have generally been related to situations where the RAC feels that a procedure or stay should have been considered outpatient, but Billings Clinic considered it to meet inpatient criteria.

When we couple this RAC activity with all of the other entities currently reviewing our patient billing, the combined audit activity becomes overwhelming. In total, we are currently being audited by the Medicare RAC, Medicaid, Medicare Advantage, commercial payers and others.

Substantial resources required to manage RAC audits and appeals
With this level of scrutiny, the administrative resources required to respond to these reviews has become a major cost to our organization.

Billings Clinic currently estimates that it spends roughly 8,600 work hours and approximately $240,000 per year for internal staff to manage audits and appeals. That is in addition to the $45,000 per month (or over $500,000 per year) that Billings pays an outside contractor, EHR, to help with medical necessity reviews.

EHR helps us navigate the sometimes confusing and vague regulations surrounding patient status (i.e. inpatient versus outpatient). This company, led by expert physicians, helps our care managers and physicians determine patient status on difficult Medicare cases from the onset of an admission. If one of the cases determined to qualify as inpatient by EHR is later questioned by the RAC, then EHR assists our appeal. It is important to note that although not all the cases reviewed by EHR are later reviewed by the RAC, implementation of this contract was in direct response to anticipated RAC activities.

The Billings Clinic's internal resources include, patient financial services staff, who spend time tracking requests and processing Medicare/RAC recoveries as well as checking data integrity. Billings Clinic also utilizes Healthcare Information Management clerical staff for copying, printing, collating and validating medical records information to send to the RAC.

The Coding Resource department also plays a role in any unfavorable RAC decisions involving DRG (diagnostic related groups) reviews. Each denial is assessed by two nurse coders who review the denial to determine whether an appeal is defensible. Billings Clinic management monitors RAC denial trends and reviews documentation for follow up training with physicians and staff.

The Care Management department has a dedicated full-time nurse who works solely on RAC issues. Other clerical staff and another nurse provide part-time support as well.

The compliance department plays a key role in coordinating RAC response. They serve as a general liaison to our senior executive team and other key departments. Compliance personnel are responsible for data analytics. These analytics are used for reporting and risk mitigation. They ensure that follow-through and education are being done in a timely manner.

Various other departments throughout Billings Clinic are involved in the RAC process, including legal, finance and payer relations. They all play a role, although they have not been closely tracking the time and expense related to this regulatory burden. In addition, many physicians and clinicians have dedicated time to increase their understanding of the documentation

requirements and RAC interpretations of Medicare requirements in order to avoid disagreements in the future.

How the RAC process can be improved
Billings Clinic has a number of recommendations for Congress and the administration to consider that would improve the RAC process.

First, the RAC process is adversarial and does little to prevent inappropriate billing. If Billings Clinic were able to devote the resources on compliance and physician education that it spends to defend against RAC investigations, we could do a far better job of preventing billing problems.

Second, When RACs deny a Part A claim and determine that care should have been provided on an outpatient basis, hospitals should be paid the outpatient payment amount in full. In addition, when rebilling these Part A denials, no timely filing limit should apply. The timely filing limit prevents providers from filing claims that a RAC has identified as appropriate for outpatient care. We suggest that Congress examine creating an exception for claims audited by RACs that could be processed outside of the timely filing requirements.

Third, CMS should do a better job of issuing clear and concise guidelines so that misinterpretation of coding and other criteria are not used in a "gotcha" mentality. We can't afford to lose sight of the bigger picture of Medicare – and its goal to deliver high quality care to the right beneficiaries at the right time.

One example of this lack of clear guidance is the confusion surrounding inpatient versus observation status. As has been the widely accepted practice, physicians are prescribing inpatient services that they think are necessary based on their professional judgment. However, CMS and RAC reviewers systematically think these cases do not merit the higher level of reimbursement for the Part A DRG.

As a result, the payment system is not rewarding accepted practice and is pushing more patients into observation status. CMS has noted in its most recent proposed rule that there has been a nationwide increase in observation status. Billings Clinic believes that this is a direct result of RAC reviews, which put providers in a situation where they are more likely to choose observation status out of fear of an inpatient denial.

RAC denials eliminate payment for medically necessary services rendered to patients simply because of a disagreement about the admission status. The decision that the accounts should have been billed as outpatient is being made retrospectively by reviewers who have the advantage of hindsight and are using it to second guess the opinion of physicians treating patients in real time, often emergent, situations. We recommend that RAC reviewers be allowed to use only the clinical information that was available to the physician at the time of the admission.

An example of a claim we have pending appeal where this guidance would be helpful is as follows: A 74 year old female presents to the emergency room with difficulty breathing. She had open heart surgery approximately two weeks earlier following a heart attack. Her oxygen levels were well below normal. She was diagnosed with a blood clot in the lung and was started on IV blood thinners. The RAC denied this as not medically necessary as an inpatient because in reviewing the whole record her length of stay was only two days due to appropriate and expeditious treatment. However, the mortality rate for this type of patient is extremely high, and

she met the definition of an inpatient, according to accepted Medicare criteria at the time she was admitted.

Fourth, the number of record requests should be limited.

Fifth, RACs should not continue to audit claims that are found over time to have a low error rate. Congress and CMS should do a better job of evaluating the performance of the RACs. A small percentage of records requested actually have errors plus the rate of denials overturned is high. These are indicators that CMS should do a more effective job of focusing the RACs' efforts.

Sixth, RAC reviews should not harm beneficiaries financially. Out of pocket expenses can change drastically when patient status is changed. An example of this is related to the change from the inpatient deductible to the outpatient coinsurance. These changes are confusing and upsetting to patients who don't understand why they were in a hospital bed but still considered an outpatient.

Seventh, health care providers are required to meet prescribed timelines when submitting data to RACs upon initial request and every step of the process, but RACs are not. This double standard extends beyond the RAC review every step of the appeal process and is a root cause for the high percentage of appeals Billings Clinic has remaining unresolved.

Conclusion

I fully agree that audit and oversight are critical to the Medicare program. I think everyone in the industry would share this view.

But the current structure of the RAC program frustrates our efforts to achieve this goal. Significant changes are needed to ensure that the program protects patient care and to promote administrative efficiencies for providers.

Throughout this process, we can't lose sight of Medicare's goal to deliver high quality care.

Thank you for your attention, and I am happy to take any questions you may have.