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The Honorable Kevin Brady
Chairman
Committee on Ways and Means
Subcommittee on Health
United States House of Representatives
1102 Longworth House Office Building
Washington, D.C. 20515

RE: *Ideas to Improve Medicare Oversight to Reduce Waste, Fraud, and Abuse* (April 30, 2014)

Dear Chairman Brady,

The American Medical Rehabilitation Providers Association (AMRPA) appreciates the opportunity to provide our recommendations and innovative solutions on how to more effectively prevent and combat fraud, waste, and abuse (FWA) in the Medicare program in connection with the Subcommittee's hearing held on April 30, 2014. AMRPA is the national trade association representing more than 500 freestanding inpatient rehabilitation hospitals, inpatient rehabilitation units of general hospitals (IRH/Us), outpatient rehabilitation service providers, skilled nursing facilities (SNFs) as well as a number of long-term care hospitals (LTCHs). AMRPA members work with approximately 600,000 patients per year to maximize patient health, functional skills, independence and participation in society.

AMRPA is supportive of eliminating fraud and abuse in the Medicare program. We appreciate the Subcommittee's efforts to bring together the federal agencies responsible for the execution and oversight of FWA initiatives including the Centers for Medicare and Medicaid Services (CMS), the Office of the Inspector General (OIG), and the Government Accountability Office (GAO) at the April 30 hearing to determine what steps they have taken to strengthen the integrity of the program while protecting Medicare beneficiaries and the Medicare Trust Fund. Members of the Subcommittee raised important questions about prevention of FWA including removal of the Social Security number from the Medicare identification card and strengthening the provider enrollment process to preclude fraudulent providers from enrolling in and billing the Medicare program. However, we remain extremely concerned that the current panoply of FWA programs is complex, redundant, overly burdensome, and inadvertently creates barriers to access to care for medical rehabilitation patients. We think it is critical that the Subcommittee host a second hearing featuring stakeholders from the provider and consumer communities to gain a better understanding of the challenges, both financial and administrative, of the audit and appeals process and to provide suggestions that will maintain the integrity of the Medicare program while preserving access to healthcare services. To ensure federal fraud and abuse resources are

appropriately targeted, AMRPA offers recommendations for the Subcommittee's consideration. Specifically:

I. Rehabilitative Care is Critically Important to Patients Working to Overcome Difficult—and Often Devastating—Conditions

Rehabilitative care is an essential component of the health care delivery system that works with patients to minimize physical and cognitive impairments, maximize functional ability, and restore lost functional capacity. The goal of rehabilitation is to return patients to home, work, or an active retirement. Individuals may require rehabilitative services for a variety of reasons including trauma, disease, or congenital deformity. Conditions treated by rehabilitation providers include, but are not limited to, spinal cord injuries, head and brain injuries, hip or other fractures, amputations, strokes, neurological disease, cardiovascular disease, pulmonary disease, and musculoskeletal disease.

In recent years, many have seen the dramatic impact of rehabilitation on the lives of people facing drastic changes in their lives because of illness or injury. After intense rehabilitation received in rehabilitation hospitals, former Representative Gabby Giffords (D-AZ), Senator Tim Johnson (D-SD) and Senator Mark Kirk (R-IL) have made incredible strides in their ability to walk, speak, carry out other activities of daily life, and return to their communities. While Senators Johnson and Kirk and Representative Giffords are public examples of the importance of rehabilitation treatment and the contributions of our nation's rehabilitation hospitals, there are hundreds of thousands of Americans each day who are fighting to regain their own ability to function through medical rehabilitation programs. Most of them succeed. More than 74 percent of our patients return to their communities.

II. Multiple Medicare Compliance Contractors Threaten Patient Access to Care, Burden Suppliers, and Do Not Effectively Address Fraud and Abuse

In the last decade, Congress and the Administration have created multiple entities designed to combat fraud and abuse in the Medicare program. These contractors include Medicare Administrative Contractors (MACs), Recovery Auditors (RAs), and Program Integrity Contractors such as Program Safeguard Contractors (PSCs) and Zone Program Integrity Contractors (ZPICs). The creation of these entities was rooted in the justifiable desire to protect Medicare resources. However, these entities have failed to protect the programs' resources while burdening patients and providers.

Medicare FWA contractors have been exceptionally active in denying claims for various, often confusing, reasons. These denials are ultimately overturned in the vast majority of cases. Government sources show a similar—if not a severe—pattern. A report issued by CMS in March 2011, entitled *A/B Medicare Administrative Contractor (MAC) Composite Benchmark Metric Report: March 31, 2011*, examined the effectiveness of the MACs based on certain benchmarks such as number of denials overturned on appeal. The report examined MAC performance for the first six months of 2010. Of note, approximately 42 percent of MAC denials for Part A services and 58 percent of denials for Part B services were overturned on the first level of appeal, the redetermination level. These statistics indicate that FWA resources are being

misspent on activities that do not effectively target actual fraud. In her testimony before the Subcommittee, Kathleen King, Director of Health Care for the GAO, noted that while CMS does conduct oversight of the MACs, these reviews are not timely and that mistakes can be made by these contractors before a problem is identified and corrected which calls into question the effectiveness of Medicare contractors in preventing and correcting FWA.

These denials, and the resulting appeals process that providers must undertake, impose significant burdens on providers. The traditional appeals process has four steps before a provider can appeal to a federal District Court. As a result, providers must slowly wind their way through the appeals process in a costly exercise that at best can take 18-24 months. However, in December 2013 the Office of Medicare Hearings and Appeals (OMHA) informed Medicare providers and beneficiaries that due to the high volume of appeals to the third level of the Medicare appeals process, hearings before the Administrative Law Judge (ALJ) would be delayed at least 28 months. According to OMHA, the average processing time for an ALJ appeal decision as of April 2014 was 346 days despite a statutory mandate that ALJ cases be decided within 90 days of the date the appeal is filed¹. Recent studies and surveys on the implementation of the RA program demonstrate significant burdens on providers. The delay and cost of the Medicare appeals process is wholly unacceptable, in violation of the law, and creates a chilling effect for beneficiary access to care.

These burdens are widespread and cumulative. Each of the various contractors can contact a provider at the same time and request multiple documents. At times, the various contractors request the same documents, ensuring redundancy and inefficiency in the system. The multiplicity of contractors, the volume of requests and potential denials, and the lengthy appeals process is overwhelming—and excessively costly at multiple levels—for providers.

Some of the burden originates from misaligned incentives built in to the payment structures of certain contractors. Federal authorities have long said that health care consultants should avoid contingency payments due to the incentives for upcoding, misbilling, and other improper claims. This applies equally to contractors, who have incentives to improperly deny legitimate claims for the sake of maximizing the contractor's own profit. The incentives to identify "overpayments"—even those that are later overturned—are demonstrated by recent analysis of CMS data. Although RAs are authorized to identify and correct underpayments to providers, the clear focus of these contractors is on the identification of overpayments. According to a CMS report analyzing the first quarter 2014 results of RA activities, RAs found a total of \$665 million in overpayments but only \$71.5 million in underpayments.

Likewise, in identifying overpayments, seen as the primary mission of the contractors, these contractors themselves may be wasting federal dollars. For example, in a separate report analyzing the effectiveness of Medicaid Integrity Contractors, the Department of Health and Human Services (HHS) OIG found that "[f]ew of the audits assigned to Audit MICs from January through June 2010 identified overpayments."² Of the 370 audits assigned to Audit MICs, 81 percent either did not identify overpayments or are unlikely to identify overpayments.

¹ 42 USC 1395ff(d)(1)(A)

² Office of the Inspector General, Department of Health and Human Services, Early Assessment of Audit Medicaid Integrity Contractors, OEI-05-10-00210 (Mar. 2012).

The skewed incentives that reward some contractors based on the number of claims they deny has created significant, unnecessary and costly problems.

Unfortunately, these administrative costs and burdens ultimately impact patient care. Clinical staff working on defending denials may be taken away from their direct patient care responsibilities to respond to voluminous and redundant documentation requests from multiple contractors. Additionally, providers may be hesitant to admit certain categories of clinical cases if these categories are subject to close to 100 percent review, no matter how successful the outcome of the final appeal. The negative impact to patient care and optimal patient treatment deserves further oversight and review.

While the work of contractors to combat fraud and abuse is vital, the cost of pursuing appeals, coupled with the high rate of success by providers on appeal, indicates that current fraud and abuse programs are not working effectively and are in need of reform. As discussed more fully below, Congress must immediately take several specific steps to begin to reform current FWA programs.

III. To Improve Federal Fraud, Waste, and Abuse Efforts, Congress Should Consolidate Contractors, Establish a Contractor Clearinghouse, Limit Records Requests, Penalize Inefficient Contractors, and Ensure Qualified Reviewers

Addressing these issues can be accomplished in a way that maintains the focus on preventing fraud while lessening burdens on providers and patients. Specifically, Congress can take the following actions to ensure FWA funds are being used effectively:

- Consolidate the number of Medicare compliance contractors, including claims processing and program integrity contractors, and clarify each contractor's responsibility, scope of authority to request records, and ability to deny payments;
- Establish a government-wide clearinghouse that coordinates the activities of these contractors, including all requests for records;
- Create reasonable absolute numbers of records that can be requested in any 60-day period;
- Increase transparency regarding the sources contractors use when adjudicating provider claims. When CMS contractors use proprietary, subscription-based services that interpret or reinterpret Medicare coverage and admission policies for purposes of making their own coverage or medical necessity determinations, they should be required to release those materials to the providers that are subject to claims review;
- Prohibit contingency payments to RAs and any other contractors seeking to identify and collect overpayments to eliminate the perverse incentives to deny claims inappropriately;
- Penalize contractors that trigger overpayment demands or denials that are overturned at high rates;

- Subject cases that MACs identify for review to prior authorization.³ Providers that demonstrate a high degree of accuracy over time could ultimately be able to attest, without pre-authorization, that the services billed meet Medicare coverage guidelines;
- Assure that compliance contractors and others reviewing appeal requests utilize appropriately qualified staff and issue decisions in a timely fashion to prevent lengthy and unnecessary delays in the resolution of these appeals;
- Require that ALJ decisions comply with the statutory timeframes for issuing timely decisions; and
- Eliminate the Qualified Independent Contractor (QIC) level of appeals (the second level of the Medicare appeals process). These contractors appear to “rubber stamp” the decision made at the first level of appeal and a majority of these decisions are ultimately appealed to the ALJ. If this level of appeal was eliminated it would create at least a portion of the resources necessary to administer the ALJ level of appeal as intended by Congress.

AMRPA supports the letter signed by Senate Finance Committee Ranking Member Orrin Hatch (R-UT), Energy and Commerce Committee Chairman Fred Upton (R-MI), former Senate Finance Committee Chairman Max Baucus (D-MT), Energy and Commerce Committee Ranking Member Henry Waxman (D-CA), Senate Judiciary Committee Ranking Member Charles Grassley (R-IA), Senator Tom Coburn (R-OK), Representative Cliff Stearns (R-FL), Senator Tom Carper (D-DE), Representative Diane DeGette (D-CO), Representative Charles Boustany (R-LA), and Representative John Lewis (D-GA) to the GAO requesting a study on the coordination of contractor efforts to ensure that beneficiaries are receiving the care to which they are entitled and that contractors are working efficiently.⁴

IV. Providers with Pending Appeals Should Not Be Subject to False Claims Act Liability as a Result of the ACA’s “60 Day Repayment Rule.”

The Affordable Care Act requires a provider to report and repay overpayments or face potential False Claims Act liability.⁵ Unfortunately, the provision does not address how this requirement interacts with the appeals process for providers contesting a contractor’s decision to reject a claim. Congress and CMS should make clear that providers appealing a denied claim are not subject to the 60 day reporting requirement until the conclusion of the appeals process.

Under current practice, if a contractor reviews and then denies a claim, it issues a demand letter for the repayment. The provider may then respond in one of three ways: (1) repay the claim;

³ This prior authorization should be based on the existing inpatient rehabilitation hospital and unit medical necessity coverage guidelines found at 42 CFR 412. 622(a)(3) – (a)(5).

⁴ Letter from Orrin Hatch (R-UT), Energy and Commerce Committee Chairman Fred Upton (R-MI), Senate Finance Committee Chairman Max Baucus (D-MT), et. al. to Gene Dodaro, Comptroller General of the United States (June 26, 2012).

⁵ Patient Protection and Affordable Care Act, § 6402(a), 42 U.S.C. § 1320a-7k (2010).

(2) seek to have repayment delayed while it pursues the appeals process; or (3) follow the traditional appeals process and repay the claim. The traditional appeals process allows for a review of the contractor's decision to deny the claim. However, the process is extremely time-consuming. The appeals process involves five phases, and as noted, above can take well over a year.

AMRPA is concerned that Section 6402(a) of the Affordable Care Act may cause problems for providers seeking to pursue the appeals process. Section 6402(a) requires a person who has received an overpayment to report and return the overpayment within 60 days of its identification. On February 16, 2012, CMS published in the *Federal Register* a proposed rule entitled "Medicare Program: Reporting and Returning of Overpayments" implementing this requirement. The proposed rule does not acknowledge nor address the relationship among the appeals process, the recoupment process, and the requirement to repay overpayments within 60 days. The proposed rule does not specify whether the potential overpayment in question is to be identified by the provider or the contractor. If identified by the contractor, the 60-day window to repay to avoid a false claims determination does not appear to take into consideration provider appeal rights.

This presents providers with a difficult decision. The provider may wait to repay a potential overpayment until the appeals process is exhausted but in so doing risk additional penalties for filing a false claim for failure to repay these funds within 60 days. Alternately, the provider could repay the funds while simultaneously appealing and wait to be reimbursed if the denial is subsequently overturned during the appeals process. While we recognize overpayments should be returned in a timely fashion, providers should clearly have the ability to challenge denials and overpayment demands, using well-established administrative mechanisms, without fear of False Claims Act liability.

The proposed rule also authorizes a ten year look-back period which subjects any claim submitted within the last ten years to the 60-day repayment period. If finalized, the look-back period would create a significant administrative burden for providers. A provider could be required to review all claims from the last ten years of the type that a MAC or RA is reviewing to ensure an overpayment was not received.

Recommendation: Congress Should Allow Providers to Exhaust the Appeals Process Before Imposing False Claims Act Liability

To ensure that providers do not face inappropriate False Claims Act liability, Congress and CMS should:

- Make the appeals and recoupment processes available to providers prior to having to repay a claims that may fall within the scope of Section 6402 (a) of the ACA;
 - One approach is for CMS to address this concern in the definitions of "identification" and "reconciliation" in the final rule implementing this provision. These terms must be defined in such a way that a provider could avail itself of the recoupment and appeals processes and essentially stay repayment of the claim until the appeals process is exhausted; and

- Continue to monitor the response rate of the entity responsible for reviewing appeals at each level to guarantee that decisions are issued within the specified timeframes of the appeals process.

V. Contractors Often Deny Claims Based on Meaningless, Technical Compliance Problems and Overlook the Clinical Judgment of Physicians

AMRPA remains very concerned that the various contractors often overzealously search for minor, technical reasons to deny claims rather than concentrating on uncovering actual fraudulent activity. AMRPA recognizes that full and complete documentation of the patient's status and of the medical record is critical to assuring proper care for medical rehabilitation patients, starting with the point of referral and the preadmissions screening. In addition, AMRPA appreciate that payers can establish reasonable documentation requirements to ensure payment for services is appropriate. However, strict and completely rigid attention to the technical aspects of this documentation creates an unnecessary burden for providers and an inappropriate barrier for patients as providers are forced to spend time and effort meeting detailed contractor requirements.

AMRPA believes that in reviewing claims these technical aspects should be considered secondary to the overall clinical assessment and the needs of the patient. For example, denials have been issued for missing deadlines by as little as an hour. Rehabilitation providers are required to perform a post-admission evaluation within 24 hours of the patient's admission to the IRH/U. AMRPA has learned that contractors have denied claims if the physician signature was provided an hour late, even if the evaluation demonstrated that a patient needed an inpatient rehabilitation level of care. It appears that contractors are focusing on technical requirements and overlooking the clinical judgment of the physician and the needs of the patient.

Recommendation: Congress Should Protect Patient Care by Creating Standards that Penalize Consistently Non-Compliant Providers while Reducing the Focus on Technical Mistakes

To improve the efficiency of federal fraud, waste, and abuse efforts, Congress should ensure that contractors are focused upon providers with a history of non-compliance, not providers who have made minor, technical mistakes. Congress should work to:

- Create a "non-compliance threshold" that withholds payment to consistently non-compliant providers while not penalizing providers for infrequent, technical mistakes;
 - For example, a threshold might be set that denies payment for exceeding time requirements by more than 10 or 20 percent of the standard, or denies payment when a recurring pattern of non-compliance is observed during an audit (more than 30 percent of the records reviewed, for example); and
- Establish a "medical judgment" standard that recognizes the responsibility and authority of the physician to make medical determinations. As part of this standard, establish a

physician “compliance rate” such that contractors only deny payments when a certain threshold of denied claims is reached.

VI. Congress Should Immediately Act to Implement Fraud, Waste, and Abuse Reform

In conclusion, AMRPA appreciates the opportunity to share our concerns regarding fraud and abuse initiatives undertaken by the federal government and provide our recommendations. AMRPA strongly supports ensuring that taxpayer dollars are being spent appropriately and that Medicare beneficiaries are protected. AMRPA believes that current FWA programs are duplicative, burdensome, and ineffective and encourages Congress to reform the current initiatives to ensure a streamlined and timely process. Ultimately, such reforms will allow the government to prevent FWA and allow providers to focus on their core missions—ensuring their patients achieve the best clinical outcomes.

If you have any questions, please do not hesitate to contact Carolyn Zollar (czollar@amrpa.org), Sarah Warren (swarren@amrpa.org) or Martha Kendrick (mkendrick@pattonboggs.com).

Sincerely,



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