Report on
Medicare Compliance

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Weekly News and Compliance Strategies on CMS/OIG Regulations, Enforcement Actions and Audits

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To Speed Appeals, ALJs Weigh Mediation; Providers Are Urged to Fix 'Deficiencies'

In the near future, administrative law judges (ALJs) may resolve some appeals of Medicare claim denials through mediation and statistical sampling with extrapolation. That would speed up decisions, which take six months or more, and reduce the disturbing backlog of cases. Right now, however, the adjudication of ALJ cases will happen faster if providers reduce their paperwork errors, officials from the Office of Medicare Hearings and Appeals (OMHA) said at a Feb. 12 hearing in Washington, D.C.

"We get a lot of deficient requests for hearings," Chief Administrative Law Judge Nancy Griswold said. The assignment of cases to ALJs slows to a crawl when paperwork is missing key elements, such as Medicare appeal numbers, or providers submit medical records that are already forwarded to ALJs by the qualified independent contractor — a move providers make because they say the QIC drops the ball or the records get lost.

The ALJs' gargantuan workload and the resulting backlog has been the talk of the compliance town and led to the hearing, where OMHA aired its plans for greater efficiency, including electronic filing, and solicited feedback from providers. Given the statistics, OMHA has a long road ahead and recoupment will hit providers hard for months or years while they wait for ALJs to weigh in on their appeals of claim denials.

For example, OMHA doesn't even open appeals for 15 weeks after receiving them, said Jane Cironi, director of the OMHA central operations division. It takes 18 to 22 weeks to acknowledge the request for a hearing and up to 28 months before hearings

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With Admissions Off the Table, Auditors Will Focus on the Medical Necessity of Services

With recovery audit contractors (RACs) banned from inpatient admission reviews under the two-midnight rule until Oct. 1, they are expected to turn their attention to the medical necessity of the services themselves, including spine and cardiac procedures and chemotherapy and blood-clotting drugs. Medicare administrative contractors (MACs) have found these to be fertile ground for errors, since they are typically high-cost and/or high-volume services that may not be covered at all or are not supported by documentation or not reimbursable for the patient's condition.

"RACs are spending most of their time going after medical necessity for level of care, but there are huge amounts of money for auditors in [questioning] the medical necessity of the services themselves," said Ronald Hirsch, M.D., vice president of the regulations and education group at Accretive Physician Advisory Services, at a Feb. 6 webinar sponsored by RACMonitor.com. Often the services are medically necessary, but documentation is AWOL, because physicians tend to think of it as an administrative hassle. But it's more than that, he said. "Studies show that patients who have good documentation in their medical records have better outcomes."

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RACs made their bones on claim denials for inpatient services they contend could have been provided on an outpatient basis. The two-midnight rule will change all that when the RAC audit moratorium ends because CMS now generally presumes that inpatient stays that cross two midnights are medically necessary *(RMC 2/10/14, p. 1)*. As a result, RACs will look for new sources of revenue from the potential lack of medical necessity for drugs, tests and procedures, Hirsch said.

Medicare pays only for services that are reasonable and necessary. "When physicians are doing things in the hospital, there are guidelines from Medicare about what is covered and what's not covered" — national coverage determinations (NCDs) and local coverage determinations (LCDs), Hirsch said. Medicare doesn't pay for services because "the doctor always did it that way" or feels compelled to try to do something for the patient, or because the patient insists on having the treatment or the device company representative is pushing a product.

Also, just because a procedure is FDA-approved doesn't mean it's covered by Medicare and/or other payers. "Medicare coverage and FDA approval are not the same," Hirsch said. *A prime example:* minimally invasive lumbar decompression (MILD), a procedure to treat lumbar spinal stenosis. FDA approves drugs and devices if they are deemed safe and effective, but Medicare and other payers may not agree. Some MACs — NGS, Novitas, Noridian and First Coast Service Options — don't cover MILD. When it explained in its 2012 LCD why it won't pay for MILD, NGS said "the literature thus far is not considered sufficiently mature or robust to establish efficacy and coverage. Further patient outcome studies with blinding, controls and randomization with larger numbers of patients followed over a longer period [of] time to determine efficacy are felt to be needed prior to allowing coverage."

CMS chimed in with a Jan. 9, 2014, NCD that states "percutaneous image guided lumbar decompression (PILD) for lumbar spinal stenosis (LSS) is not reasonable and necessary under section 1862(a)(1)(A) of the Social Security Act." Some private insurers have followed suit, including UnitedHealthcare and Cigna, Hirsch said. "Hospitals may review procedures and see they are FDA-approved, but no one is stopping to review for each insurance company and see it is not covered," Hirsch said (see box, p. 3).

Beware Bait and Switch

Hospitals also have to be on guard for the MILD "bait and switch," he said. Sometimes physicians schedule covered spine procedures, such as a discectomy, but the day of the surgery a noncovered MILD is performed instead, Hirsch said. Maybe the MILD manufacturer's sales rep showed up with a toolkit and the physician went along with the idea, or the physician didn't realize the implication of switching gears. Or maybe the physician knew the score, he said. Either way, the hospital won't be paid for the procedure.

Add-on payments are another area vulnerable to denials for lack of medical necessity. Auditors will question the medical necessity of services that were billed separately from the service or procedure. For example, Medicare pays for the drug Kcentra, which reverses bleeding caused by warfarin, a blood thinner. Kcentra costs $1,587.50 per dose, and it's not covered when patients are bleeding but not on warfarin. "They'll take back the money," Hirsch said. Similarly, Medicare covers blood-clotting factors, such as NovoSeven, but only for hemophiliac patients. The drug, which costs $10,000 per vial, presents an interesting dilemma for hospitals, Hirsch said. "NovoSeven is indicated in hemorrhages in hemophiliacs because the bleeding stops after you give it to them. But trauma surgeons and neurosurgeons have started to use it when patients who aren't hemophiliacs have uncontrolled bleeding, but that's not a covered indication under Medicare," he said. Hospitals face com-

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peting medical and financial pressures: Medicare won't pay for a pricey drug that might help uncontrolled bleeding — and yet some patients who survived the bleeding episode had blood clots "so the safety and effectiveness is still in question," Hirsch said. "Hospitals need to sit down with their doctors and come up with specific guidelines."

Chemotherapy drugs may be on the RAC hit list given their cost. Because chemo drugs are administered at outpatient clinics, there's little oversight of the drug choices that physicians make for their patients, Hirsch said. "Pharmacists are checking dosage and looking for contraindications and interactions, but probably not pulling out the guidelines to see if the drug is appropriate for that cancer." For example, Provenge — a prostate-cancer drug that costs $33,000 per dose and is given in three doses two weeks apart — "is effective, but only in the right clinical situation," Hirsch said. CMS has an NCD for Provenge, which states that the drug is covered for patients with documented surgical or chemical castration

Obtaining Complete Information from Physicians Before Surgery

Ronald Hirsch, M.D., vice president of the regulations and education group at Accretive Physicians Advisory Services, says he developed this form to help hospitals elicit information they need from physicians to ensure procedures are medically necessary and will be covered by Medicare and other payers. That includes the diagnosis, CPT code so the hospital staffer can determine whether the surgery is on the Medicare inpatient-only list *(RMC 1/13/14, p. 1)* and precertifications required by private payers. It also serves as a valid preadmission order, Hirsch says. Find the form at www.ronaldhirsch.com and contact him at rhirsch@accretivehealth.com.

Presurgical Physician Orders

FAX to 1-888-555-1234- Pre-Admission Testing when reservation made
If Inpatient or Ext. Recovery bed needed, also fax to 1-888-555-1313- bed control
Call 1-888-555-1414 for reservations

Patient Name: _____Phone: _____
Birth Date: _____
Surgery Date: _____ Surgery Time: _____
Time of Arrival: _____

Consent to Read: (please spell out complete surgery with no abbreviations, specify left and right)
_____
_____

Diagnosis: _____ ICD Code: _____

CPT Code(s) of procedure: _____, _____, _____

Insurance: _____ Pre-auth Number: _____

Patient Status: (check one): ___Inpatient ___Day Surgery ___Extended Recovery

Note: Observation cannot be ordered pre-op; for use only after routine recovery.
Extended Recovery should be chosen for overnight stays that are part of routine recovery.
Refer to the Medicare inpatient-only list for surgeries that must be done as Inpatient and require pre-op inpatient order.

Anesthesia guidelines for medical necessity will be followed for all procedures with anesthetic.

Other Pre-admission Orders/Instructions: _____
_____
_____

___Please initiate pre-procedure orders upon patient arrival.

Other Pre-procedure Orders/Instructions: _____
_____

Physician Signature: _____ Staff completing form: _____
Date: _____

and evidence that the disease progressed after castration. Physicians may order it, often at the patient's insistence, even in the absence of covered indications, he said. That's why "it has the potential to be a big area for RACs." Patients may get the drug if it's not covered, but they will have to pay for it after signing an advance beneficiary notice or hospital-issued notice of noncoverage, he noted.

Some outpatient procedures also are ripe for RAC reviews and/or are already under the medical-necessity microscope. Cataract surgery is one of them. There are LCDs that set forth the surgery and documentation requirements, which make deviations an automatic claim denial. The stats on "cataract extraction" aren't encouraging; a recent review of claims paid by Palmetto GBA, a MAC, resulted in the denial of 88% of claims, Hirsch said.

The major reason for denials of cataract-surgery claims is the lack of documentation of patient eye exams, but it's usually because that documentation is housed in physician offices, Hirsch said. When hospitals get their hands on the documentation, he assumes they are able to get paid. But it's preferable to prevent appeals by ensuring the ophthalmologist's medical-necessity documentation — how cataracts affect the patient's activities of daily living — are in the hospital chart.

Cardiac procedures are probably the no. 1 target. For example, there are a lot of claim denials for dual chamber pacemakers and that will continue even though CMS updated the NCD for single and dual chamber pacemakers. The NCD covers both kinds of pacemakers equally for documented non-reversible symptomatic bradycardia due to sinus node dysfunction and for documented non-reversible symptomatic bradycardia due to second degree and/or third degree atrioventricular block (see *MLN Matters* 8825).The problem, Hirsch said, is that the NCD applies to claims with dates of service on or after Aug. 13, 2013. That means RACs and other reviewers can deny claims for pre-August 13 procedures to implant pacemakers on the grounds they were not medically necessary according to the NCD, even though the literature on which the NCD revision was based has been widely accepted for about three years, Hirsch said. The cutoff is arbitrary, he said, and he thinks hospitals should argue that on appeal, notwithstanding the letter of the NCD's law.

And beware denials for intensity-modulated radiation therapy (IMRT) because additional documentation requests (ADRs) are coming in from auditors, Hirsch said. IMRT is a more precise form of radiation therapy that spares surrounding tissue, but it's expensive. "Auditors want to make sure the extra precision is medically indicated and not because reimbursement is higher," he said. University of Maryland Medical Center in Baltimore, for example, recently received 101 ADRs for IMRT and most were ultimately denied.

Joint replacement has been on the MAC radar screen for a while and RACs will get their licks in too. Often it's a matter of lacking the documentation to show that more conservative treatment — physical therapy, medication — was exhausted before resorting to surgery *(RMC 4/23/12, p. 1)*. In its review, First Coast Service Options found that 92% of the claims denied did not have documentation to support the medical necessity for MS-DRG 470 (major joint replacement or reattachment of lower extremity without major complications and comorbidities).

"Joint replacement has been under scrutiny since 2011, but when a MAC audit was done in Ohio in mid-2013, they were still able to deny 32% of claims. So clearly the message is not getting out to all hospitals," Hirsch said.

Contact Hirsch at rhirsch@accretivehealth.com. ✧

CCOs Empower Staff to Develop Solutions that Will Work for Them

On three occasions, compliance officer Jenny O'Brien rode with paramedics at her health system to help them find a solution to the risk posed by unlocked medication boxes in four ambulance "barns" around the city. Donuts in hand, she showed up for midnight to 8 a.m. shifts over the course of several months and discussed the paramedics' dilemma. If they lost their keys to the box or forgot ever-changing passcodes, patient safety was at risk, but unlocked boxes were a target for drug theft.

O'Brien's goal was to help them come up with their own solution. While that process took many months, when it was finally implemented, it stuck, says O'Brien, who is now chief compliance officer for UnitedHealthcare in Minnetonka, Minn.

"Change has to be driven within," she says, with the compliance officer acting as an agent of change.

The first time O'Brien traveled with the paramedics, she "got to know who they were and walked in their shoes." The next time, she asked the paramedics for ideas

on solving the lockbox problem. "They started coming up with various ideas," she says. One proposal was to use a passcode that was not changed too often so paramedics could remember it and quickly get their hands on medicines needed for patients. "The third time I went out there, they told me how successful they were, so we rolled it out across all four ambulance barns," she says. "It was not because I said they had to do it. It was because they came up with an idea and they owned it. The compliance issue went away because the operational part of it was fixed." That's an example of "letting the other person have your way." The ability to influence decision making in organizations is a critical skill for compliance officers because it helps them bring about sustainable process changes, O'Brien says.

Audits Can Supersede Everything Else

Sometimes the importance of process improvement gets lost in all the auditing and monitoring that compliance officers oversee. "Compliance officers are expected to be reducing risks against such a broad spectrum that they don't get to take a systematic look at underlying processes," says Mark Pastin, president of the Council of Ethical Organizations. And the methodology for addressing compliance risks is not as well established as in other areas, such as quality improvement, he says. For example, if there's a suspicious hospital-borne infection, treating each person will not eradicate it. "You have to find out what's causing it, but we don't always look at underlying fault from a system viewpoint" in compliance, Pastin says.

For compliance officers to be influential in their organizations, employees have to perceive them as a resource and an agent of change. That is more likely to happen when employees see themselves as accountable for what's going on in their department and think about how their department affects the wider organization, says Brian Kozik, compliance officer at Lawrence General Hospital in Lawrence, Mass. He has gotten that message across as much as possible through compliance education and by attending hundreds of monthly senior leadership meetings.

Sometimes it's obvious that it pays off. In early February, Kozik got a call from the director of the cardiac cath lab, who was concerned about the ripple effects of unused supplies. Nurses open packages, such as catheters, in preparation for the procedure, but sometimes they aren't used. They can't be returned to stock because they are no longer sterile, but she wasn't sure what the implications were in terms of the inventory system and charges to patients or payers. "I went to the lab and watched what they were doing," Kozik says. He saw the bind the cath lab nurse was in and hooked her up with the finance department to work through the inventory and charging challenges. "Maybe there is a more efficient way to charge it back," he says. "This is a great engagement. That's how you do process improvement. The nurse took ownership. The worst thing you can do is jump on people and say 'stop doing what you are doing.'"

Process improvement can benefit from a root-cause analysis using an approach borrowed from quality and risk management, says Ami Zumkhawala-Cook, chief compliance officer at Holy Spirit Health System in Camp Hill, Pa. "It's a formal process of stepping through events or processes to determine why something has happened," she says. The goal is prevention. For example, if a fax is misrouted, in addition to determining why, you may want to dig into where it was transmitted, how it happened and whether there is a systemic problem (i.e., an outdated contact list in the fax machine). The more people involved in a root-cause analysis, the more people are involved in finding a solution and then thinking more broadly about other problems. "It gives them a better perspective on compliance," Zumkhawala-Cook says. And they start to think about the "compliance whys and the finance whys. There are so many aspects to every operational activity carried out in health care."

Change Process from the Ground Up

Kozik and Zumkhawala-Cook emphasize how important education is to process improvement. Holy Spirit recently implemented a new compliance and HIPAA education program that's longer, more detailed and interactive. "It has resulted in so many questions coming to the compliance program," Zumkhawala-Cook says. At Kozik's hospital, when new managers come on board, they go through a 30-day rotation of meetings with key leadership, including accounting, payroll, information systems and compliance and privacy officers. "There are 1,800 employees here and all of them are compliance officers," he says.

Breaking down silos also helps promote process improvement. When Kozik does a compliance review, he discusses the problem with the relevant department in terms of how it affects the organization up and down the line. "I tell them there really is a revenue chain. If we don't capture the patient's demographic information correctly at registration, no matter how good the clinical care and outcome, if the patient gets a denial because we did not capture the information correctly, that's all the patient will remember," he says. That's why, when doing a review, Kozik starts with registration and goes through the claim and payment process, sitting with staff and asking how they would improve the process if they had the resources. They are the ones who know best how to improve work flow, he says.

continued

Process changes also are a natural result of compliance becoming more embedded in an organization. At UnitedHealthcare, O'Brien has structured the compliance department so that her compliance staffers are located with the business units they support rather than having them all sitting as one compliance department. Similarly, at her former health system, compliance staffers were dispatched to the hospital, pharmacy and clinics. "People didn't come to visit me, I went to visit them." O'Brien says. At UnitedHealthcare, she has compliance people "spread out throughout the offices" and "part of the conversation at the water cooler." They are, for example, embedded with the sales team. The efforts are paying off, she said, because recently, the sales team asked if the compliance person would join them on sales calls to give feedback on sales and marketing compliance.

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OMHA Starts Plan to Speed Appeals

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with ALJs are assigned, Griswold noted. In fiscal year 2011, the 59 ALJ teams, which include the judge, staff attorneys and paralegals, received 59,600 appeals, she said. That number rose to 65 ALJ teams receiving 350,629 appeals in FY 2013. And the pile is growing, with 15,000 appeals filed weekly. Complicating the numbers nightmare is the fact they are "all performed in the paper world," Cironi said.

To cope with the demand, OMHA received a budget increase of 18.6% for FY 2014, Griswold said. That money will be used partly to open a new office this year — the first in the central time zone — that can tackle more cases. (The four existing ALJ teams are in Arlington, Va.; Cleveland, Ohio; Miami, Fla.; and Irvine, Calif.).

Because of the backlog, OMHA last year changed the way providers file ALJ appeals. Instead of sending them to regional ALJs, all requests go to the central operations division in Cleveland, where Cironi's office assigns them

CMS Transmittals and *Federal Register* Regulations

Feb. 6 — Feb. 13

Live links to the following documents are included on *RMC*'s subscriber-only Web page at www.AISHealth.com. Please click on "CMS Transmittals and Regulations" in the right column.

Transmittals

(R) indicates a replacement transmittal.

Pub. 100-03, National Coverage Determinations

- Medicare NCD for Beta Amyloid Positron Emission Tomography in Dementia and Neurodegenerative Disease, Trans. 160NCD, CR 8526 (Feb. 6, 2014; eff. Sept. 27, 2013; impl. July 7, 2014)
- NCD for Single Chamber and Dual Chamber Permanent Cardiac Pacemakers, Trans. 161NCD, CR 8525 (Feb. 6, 2014; eff. Aug. 13, 2013; impl. July 7, 2014)
- Fluorodeoxyglucose Positron Emission Tomography for Solid Tumors, Trans. 162NCD, CR 8468 (Feb. 6, 2014; eff. June 11, 2013; impl. March 7, July 7, 2014)
- Chapter 1, Language-Only Update, Trans. 159NCD, CR 8506 (Feb. 5; eff./impl. Oct. 1, 2014)

Pub. 100-04, Medicare Claims Processing Manual

- Update to Chapter One, Trans. 2876CP, CR 8442 (Feb. 7; eff./impl. March 7, 2014)
- Implementing the Part B Inpatient Payment Policies from CMS-1599-F (R), Trans. 2877CP, CR 8445 (Feb. 7, 2014; eff. for admissions as of Oct. 1, 2013; impl. April 7, 2014)
- Therapy Modifier Consistency Edits, Trans. 2868CP, CR 8556 (Feb. 6; eff. July 1; impl. July 7, 2014)
- Medicare NCD for Beta Amyloid Positron Emission Tomography in Dementia and Neurodegenerative Disease, Trans. 2871CP, CR 8526 (Feb. 6; eff. Sept. 23, 2013; impl. July 7, 2014)
- NCD for Single Chamber and Dual Chamber Permanent Cardiac Pacemakers, Trans. 2872CP, CR 8525 (Feb. 6, 2014; eff. Sept. 23, 2013; impl. July 7, 2014)
- Fluorodeoxyglucose Positron Emission Tomography for Solid Tumors, Trans. 2873CP, CR 8468 (Feb. 6, 2014; eff. June 11, 2013; impl. March 7, July 7, 2014)
- Chapter 25 Update, Trans. 2874CP, CR 8577 (Feb. 6; eff./impl. March 7, 2014)
- Enforcement of the 5 Day Payment Limit for Respite Care Under the Hospice Medicare Benefit, Trans. 2867CP, CR 8569 (Feb. 5; eff. July 1; impl. July 7, 2014)
- Addition of New Fields, Expansion of Existing Model 1 Discount Percentage Field in the Inpatient Hospital Provider Specific File and Update of Model 4 Bundled Payment of Care Initiative Payment Calculation to Include Uncompensated Care Payment, Trans. 2870CP, CR 8546 (Feb. 5; eff. July 1; impl. July 7, 2014)

Pub. 100-08, Medicare Program Integrity Manual

- Revision to Chapter 12 - The Comprehensive Error Rate Testing Program, Trans. 504PI, CR 8591 (Feb. 5; eff./impl. March 6, 2014)
- Removing Prohibition, Trans. 505PI, CR 8425 (Feb. 5; eff./impl. March 6, 2014)

Pub. 100-20, One-Time Notification

- CWF Editing for Vaccines Furnished at Hospice - Correction, Trans. 13390TN, CR 8620 (Feb. 6; eff. Oct. 1, 2013; April 7, 2014)
- Reporting Principal and Interest Amounts When Refunding Previously Recouped Money on the Remittance Advice, Trans. 13420TN, CR 84, CR 85 (Feb. 6; eff. July 1; impl. July 7, 2014)
- Modifying the Daily Common Working File to Medicare Beneficiary Database File to Include Diagnosis Codes on the HIPAA Eligibility Transaction System 270/271 Transaction, Trans. 13360TN, CR 8456 (Feb. 5; eff. July 1; impl. July 7, 2014)

Federal Register Regulations

- None published.

to ALJs, eventually. The goal of "central docketing" is to evenly distribute the workload and forward case files "when ALJs have the docket and physical space to accommodate a hearing," Griswold said. Notwithstanding the "deferred assignment process," on Feb. 3, 2014, central operations "began limited assignment of hearing requests" to ALJs, Cironi said. It helps that productivity has increased, Griswold said. Each ALJ decided 4.9 cases per day last year, up from 3.6 in 2011.

It will take more than one approach to get the appeal process back on track, Griswold said. She and other officials described plans underway and explained how providers play a big role in expediting appeals.

Part of the solution will be moving from a paper-based system to an electronic system, said Bruce Goldin, director of OMHA's information management and systems division.

There are three initiatives underway, two short-term and one long-term:

(1) A public website (the ALJ Appeal Status Information System), which Goldin said should be up and running around May. Providers could use the portal to track their level two (QIC) and level three (ALJ) appeals. The website will provide data on where the case is, who it's assigned to, whether a hearing has been scheduled and if a decision has been mailed.

(2) The Medicare Appeals Template System, a document-generation system that OMHA is piloting in the Miami field office. Goldin hopes for a nationwide rollout during the second quarter of 2014.

(3) Electronic Case Adjudication and Processing Environment (ECAPE), which is the long-term solution. Providers will be able to file requests for hearings electronically, and OMHA can assign and schedule them the same way. Almost everything will be done online, from submission of records to handing down ALJ decisions. The record will be shared by providers and OMHA, Goldin said. The timeframe for phase one of the project is spring 2015, after the contract is awarded to a vendor this spring or summer. "There are lots of hoops we have to jump through, but we are working on it," he said.

As long as appeals are on paper, Cironi said, they would go down a lot easier and quicker if providers avoided common errors and didn't submit medical records twice. Here are her DOs and DON'Ts to help providers get ALJ decisions faster:

◆ ***Prominently list the Medicare appeal number on your request for an ALJ hearing.*** Medicare appeal numbers, which are assigned by the QIC, are sometimes missing or wrong. OMHA uses Medicare appeal numbers to docket requests for hearings. "It mirrors the QIC record," Cironi said. "It will be drawn up and associated with the record in our databases and appeal. There is a one-to-one relationship between the Medicare appeal number and the ALJ number." Appeal filings also may mismatch the Medicare appeal number, the beneficiary name, and/or the health insurance claim number, she said.

◆ ***Don't submit clinical evidence to OMHA because QICs are required by regulation to send all the paperwork from prior levels of appeal.*** Resubmitting the records slows down the appeals process because OMHA clerks have to match up the cases manually, which Cironi says is unnecessary and redundant. Providers, however, beg to differ. At the hearing, several providers said when they get before the ALJ, they find the record is incomplete. "QICs often don't transmit the full file," one provider said during the question-and-answer period. "That's why we transmit additional documents."

◆ ***Submit only new evidence to the ALJ, and once the case has been assigned, send it directly to the ALJ, not OMHA's central operations division.*** But there are limits. "If you are submitting new evidence to the ALJ that was not previously submitted at any prior level of appeal, the evidence must be accompanied by a statement explaining why the evidence was not previously submitted," Cironi said, citing 42 CFR §405.1018 and 405.1028. "The ALJ will then examine any new evidence to determine whether there was good cause to submit the evidence for the first time at the ALJ level."

◆ ***Make it clear when you are aggregating appeals,*** either because there are multiple appeals with the same Medicare appeals number or multiple appeals grouped together with different Medicare appeal numbers.

With their talk of paperwork glitches at the hearing, it seemed as if OMHA officials were "placing blame on the victims — the appellants who are not receiving reimbursement for care that may ultimately be found to be necessary — for OMHA's backlog predicament, rather than placing the blame on the system itself," says attorney Jessica Gustafson, with The Health Law Partners in Southfield, Mich. However, there was some merit to the points Cironi and Griswold made. For example, providers should send only one copy of their medical records to OMHA. "But I felt a little uncomfortable that the message seemed to be that providers are responsible for OMHA's backlog when it's actually the result of the much higher volume of claims denials in today's audit environment, and only then by extension the higher volume of appeals submitted, that has created this issue for OMHA," Gustafson says.

Gustafson also is hard-pressed to dissuade providers from sending records to ALJs despite OMHA's entreaty. "Experience tells us case files get lost and QICs don't always send them up" to the ALJs.

Looking ahead, OMHA has plans for "alternative adjudication models," with statistical sampling "the most

viable option" for cutting through the ALJ quagmire, Jason Green, director of the program evaluation and policy division, said at the hearing. Mediation is also on the table. No details were provided, but attorney Drew Wachler, who attended the hearing, says both approaches have potential.

With statistical sampling, suppose a hospital has 40 cases before an ALJ. The ALJ reviews a sample of the cases. If the ALJ determines the overturn rate for the sample is 65%, that would be extrapolated to all 40 cases, says Wachler, who is with Wachler & Associates in Royal Oak, Mich. "Both parties" — CMS and the hospital — "would have to agree [in advance] to be bound by it," he says.

Wachler also thinks there is a need for mediation. "Each hospital would take a percent on the dollar to not sit there for three years" while its appeal wends through the process, he says. And it spares hospitals the expense of paying physicians to consult on cases and testify at hearings.

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NEWS BRIEFS

◆ **In a new Medicare compliance review, the HHS Office of Inspector General said that UMass Memorial Medical Center (UMMC) was overpaid $1.646 million.** OIG reviewed 232 inpatient and outpatient claims, which were mostly submitted in 2010 and 2011. Of them, the hospital did not comply with Medicare billing requirements for 158 claims, OIG contends. Among its errors, OIG says, UMMC billed for inpatient stays that should have been billed as outpatient or observation services, didn't report medical device credits with the proper value and condition codes, billed patient transfers as discharges, made DRG coding errors and billed for evaluation and management that were not significant and separately identifiable from their associated procedures. UMMC agreed with the bulk of OIG's findings, but not all of them. For example, the hospital disagreed that it owed Medicare for a replaced medical device because it did not pursue a warranty or receive a manufacturer credit. Visit http://go.usa.gov/BPB.

◆ **A few days after unveiling the 2014 Work Plan with kwashiorkor as an audit target *(RMC 2/10/14, p. 1)*, OIG issued two reports on hospitals that incorrectly billed Medicare for this severe form of protein malnutrition that's rare in the U.S.** *(RMC 1/7/13, p. 1)*. From 2010 to 2012, Mercy Medical Center in Des Moines, Iowa, collected $3,189,000 for inpatient claims that included a diagnosis code for kwashiorkor, and OIG reviewed $3,052,291 for 102 of these claims. The hospital used diagnosis code 260 for kwashiorkor but should have used other malnutrition codes. While the kwashiorkor codes didn't upgrade MS-DRG reimbursement for 88 of the claims, it affected 14 others, causing an overpayment of $88,996. Mercy blamed the errors on its encoder software, and has implemented corrective actions in its health information management department. In its other audit report, OIG said Christus Saint Vincent Regional Medical Center in Sante Fe did not comply with kwashiorkor billing requirements on any of the 115 claims reviewed from 2010 through 2012. That affected reimbursement on 29 claims, which led to a $147,262 overpayment. Christus also attributed the errors to a software glitch, but said it's been fixed. The hospital "conducted a follow up review and verified that there have been no additional inpatient Medicare claims submitted with code 260 (Kwashiorkor) through September 30, 2013," it said in its response to the audit. View the Mercy audit at http://go.usa.gov/BQjG and the Christus audit at http://go.usa.gov/BRgA.

◆ **Baylor All Saints Medical Center at Fort Worth was overpaid $371,952, according to the Medicare compliance review conducted by OIG.** The hospital did not comply with billing requirements for 123 of the 244 inpatient and outpatient claims that OIG reviewed. For example, the hospital "incorrectly billed Medicare using its acute care provider number instead of its inpatient rehabilitation facility or psychiatric facility provider number." OIG also contends the hospital billed for inpatient admissions that should have been outpatient services, billed same-day readmissions as separate stays and "insufficiently documented" some outpatient services. The hospital disputed 34 of OIG's findings on inpatient claims with respect to level of care. It said that Baylor All Saints "provided inpatient level of care services based on the physician order and the patients' presenting condition" and plans to appeal the overpayment findings. However, the hospital agreed to refund the rest of the overpayments. View the report at http://go.usa.gov/BPKB.

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