

Health care audits to start in earnest

Expanded CMS program is expected to wring billions from industry

Medicaid & Medicare

By Carol Lundberg

With billions of dollars at stake, government contractors are going after hospitals and health care providers, who they say have been overpaid.

So far, more than \$1.03 billion has been recovered from health care providers by the Centers for Medicare and Medicaid Services (CMS).

The CMS Recovery Audit Contractor (RAC) program launched in 2005 in the three states with the highest number of Medicare expenditures — California, Florida and New York. In 2007, it expanded to include Arizona, South Carolina and Massachusetts.

By the end of summer, the RAC program will include all 50 states.

Despite the high stakes, only 22.5 percent of claims have been disputed by the providers. Royal Oak health care lawyer Andrew Wachler of Wachler & Associates says it's a mistake not to fight the claims.

"My recommendation would be to appeal assertively," Wachler said. "Don't be the low-hanging fruit."

At a time when the government is seeking to reform health care, every nickel of possible waste is being scrutinized.

"We all know we have to contain costs, and there is a great emphasis on health care reform. We have to provide the best services to the greatest number of people," Wachler said.

But the RAC program is aggressive to the point of being abusive, he added, and should not incentivize auditors to find al-



LW photo by Gary Gosselin

Health care attorney Jessica L. Gustafson says providers are paying for mistakes they didn't make.

leged overpayments to providers.

At the same time the RAC auditors, who are paid a contingency fee, have recovered \$1 billion, they have found only \$37.8 million in underpayments to providers, said Wachler, who defended providers in California, Massachusetts and New York with

a 90 percent success rate.

But the \$1 billion in recovered payments doesn't necessarily mean that the providers had been erroneously overpaid, said Jessica L. Gustafson, of Southfield-based The Health Law Partners PC.

Coding errors and the question of med-

ical necessity come up fairly universally in the audits, she said. One of the most contested areas is that of short stays in hospitals.

"The criteria are really not clear," Gustafson said. "No one is trying to pull one over on anyone. But more often than not, providers are going to be paying for mistakes they didn't make. There have been a lot of cases where CMS definitely walked away with some of the providers' money, and they shouldn't have."

That's because most hospitals she's worked with, thus far in Florida and California, "will only appeal items that are over a certain amount," she said. "And CMS knows that."

As a result, most of the money recouped by the auditors is not repaid to CMS because the provider was actually overpaid. It's just that the documentation isn't sufficient, or there was an error in the paperwork.

A far cry from the supposed fraud and waste the RAC program was established to uncover, she said.

Michigan health care providers will start receiving records requests from RAC auditors any time now, Gustafson said. The reviews are being delayed, except for automated reviews, which can begin any time.

"Those are for only the most egregious errors," said Charles MacKelvie, principal of Miller, Canfield, Paddock and Stone PLC's Chicago office. "Like a payment for treating a man who's pregnant."

Gustafson said coding reviews will start in September, and reviews of medically necessary procedures will not start in Michigan until January of next year.

Most of the payment denials are the result of failure to meet Medicare's medically necessary criteria, MacKelvie said, and account for 40 percent of denials.

Incorrect coding accounts for 35 percent of denials; 8 percent are denied for insuffi-

cient documentation; and 17 percent are denied for other reasons, including outdated fee schedules and duplicate claims. And in 4 percent of all the cases, MacKelvie added, was there an actual overpayment to the provider.

"The demonstration period of the program was abusive to providers," Wachler said. "Everyone makes coding errors. Those are simple mistakes, but they're also the low-hanging fruit."

And, often, providers thought they had some discretion in how to code procedures, for which they were later penalized, Wachler said.

"Providers need to be reimbursed to the extent that they are able, and there could be a tendency to optimize reimbursement," he said.

That will change.

"Providers who have been audited get religion," Wachler said. "They're used to documenting for treatment purposes, but now they also have to document for reimbursement purposes."

MacKelvie said the audits could have a devastating effect on some providers.

"This has the potential to recover \$30 billion a year," MacKelvie said.

Eighty-five percent of the recoveries so far have been from hospitals. In New York, the average claim adjustment was \$27,000, he added.

"It was a lot," MacKelvie said. "And theoretically if the auditors did this the same way, and they did it every 45 days, as is allowed in the program, it could cost a hospital \$545,000."

On top of that, the average hospital will have to add five full-time staffers, in administrative, accounting and legal personnel, just to stay on top of RAC audits.

"It's an incredible administrative burden," MacKelvie said.

When it came down to fighting the RAC audits, Gustafson said often her job

wasn't as difficult as she'd expected.

"The auditors really aren't very good," she said.

She didn't always win based on the merits of the medical necessity. Sometimes she prevailed as the result of a legal defense tactic.

For example, one highly contested tactic has to do with the reopening and revision of claims.

"They set forth a time frame stating that a claim can be reopened for one year, and for four years with good cause," Gustafson said. "We were overturning claims saying that the contractor did not have good cause."

But the auditors are getting savvier, and will learn how to work the audits in their favor, she added.

She also would argue the "waiver of liability" defense, stating that the provider has no reason to know that a claim would be denied.

Often the best defense, Gustafson said, is Medicare's own policy.

For example, when defending short stay charges, she argued that Medicare and Medicaid have vague criteria.

"In 100 percent of those cases, the RACs were not basing denials on Medicare policy. In 60-70 percent of the cases, the denials were based on InterQual criteria, which is a standard established by a private company, and which has not been adopted by Medicare," Gustafson said.

Others on short stays were denied on the basis that a procedure performed was not on an "inpatient-only" list of conditions and procedures.

But, conversely, there is no "outpatient-only" list.

"The inpatient-only list is an inappropriate way to deny any of these claims," Gustafson noted.

The bottom line, she said, is simple: "These things are winnable."



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