Background and Summary

The Centers for Medicare & Medicaid Services (CMS) and the Office of Medicare Hearings and Appeals (OMHA) have made several significant announcements concerning Medicare claims auditing and appeals that impact hospitals.

First, in July 2013, OMHA announced a “temporary suspension” of the assignment of new requests for an Administrative Law Judge (ALJ), or third-level appeal, hearing to allow the office to work through some 357,000 claims currently in the queue. OMHA estimates the suspension could last 2 years.

Next, as part of the 2014 Inpatient Prospective Payment System (IPPS) Final Rule (CMS-1599-F), CMS made an effort to provide clarification concerning hospital inpatient admission criteria by instituting a “two-midnight” benchmark for providers and a “two-midnight” presumption for Medicare Administrative Contractors (MACs) and Recovery Audit Contractors (RACs). Following the release of the final rule, CMS instituted an enforcement delay and so-called “probe and educate” period through September 30, 2014.

Finally, CMS announced a “pause in operations” of complex medical reviews\(^1\) conducted by RACs nationwide. This is the first major public acknowledgement by CMS that the claims appeal backlog has caused administrative issues and delays and the agency noted it intends to pursue additional incremental reforms of the program.

These developments set up a variety of “good news, bad news” scenarios for hospitals. The good news is that CMS does seem to be working on solutions to address the administrative complications that are causing significant delays and burdens for providers. The bad news, however, is that an already complicated system has now become even more complicated as timelines, dates of service and varying claim types are now on several different audit and appeal tracks.

IHA continues to urge CMS and members of Congress to reform the flawed and overly complex audit and appeal programs. The increased costs and administrative burdens are overwhelming for providers and are counterintuitive the goal of reducing Medicare expenditures. The following issue brief provides more information on what is known regarding these delays and suspensions. Also included in this document is a visual timeline showing program dates, enforcement delays and impact on affected claims.

**Temporary Suspension of Level 3 Claims Adjudication**

During the suspension (effective July 15, 2013) no claims will be assigned to ALJs for review. However, Medicare beneficiary Level 3 appeals will continue to be assigned. Hospitals with a large number of pending appeals were notified by OMHA of the delay. OMHA currently employs 65 ALJs and has more than 350,000 Level 3 claims pending. The impact of this decision is not yet known, but it is anticipated that while this suspension is in effect, a new backlog of unassigned claims will develop in other areas.

\(^1\) reviews that require soliciting medical record documentation (known as Additional Documentation Requests) from providers followed by a review of records by a licensed health care professional
“Two Midnight” Rule Probe and Educate Period

Following the release of the IPPS final rule, CMS announced an enforcement moratorium and “probe and educate” period to assist claims auditors and providers in correctly identifying short-stay claims spanning 0-1 midnight. During this period, MACs will review hospital compliance with the two-midnight benchmark. The audits will be conducted for inpatient claims with dates of admission (not dates of claims submission) between October 1, 2013 and March 31, 2014 submitted by: acute care inpatient hospital facilities, long-term care hospitals and inpatient psychiatric facilities. CMS confirmed that Critical Access Hospitals (CAHs) are not subject to the probe and educate audits.

CMS guidance stated that, for most hospitals, MACs will select 10 sample claims for pre-payment review from small hospitals and 25 claims for large hospitals. Based on the results, MACs will then reach out to providers over the course of six months to provide education and guidance for better compliance. CMS states the outreach will include one-to-one phone calls to answer questions and provide detailed reasons for denials.

Following the initial probe audit, a secondary review period will be conducted for providers defined as having “moderate or significant to major” concerns, and MACs will perform additional reviews and education on a varying number of claims (based on hospital size and level of concern) with dates of admission between January 1, 2014 and March 31, 2014.

CMS indicated that “generally”, RACs will not review patient status in claims with dates of admission between October 1, 2013 and June 1, 2014. Also once a claim is reviewed by a MAC it is usually not eligible to be reviewed by a RAC.

Pause in RAC Operations for Complex Medical Reviews

CMS is in the process of awarding new contracts to RAC entities, and announced current RAC operations will be “paused” until the contracting process is complete. The agency noted that this pause will allow continued improvements to be made to the program, as well as an opportunity for existing RACs to catch up on backlogs. While the specific contracting timeline is unclear, until the process is complete, beginning on February 28, 2014 hospitals will not receive any new RAC Additional Documentation Requests (ADRs) for complex medical reviews. CMS did clarify, however, that RACs will be able to audit claims submitted during the pause following the new contracts being awarded.

Additionally, RACs can continue to conduct automated reviews\(^2\) through June 1 and will continue to complete reviews for the Additional Documentation Requests (ADR) sent on and prior to February 28, 2014.

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\(^2\) Reviews that do not require soliciting medical record documentation from providers