Arkansas Hospital is Part of RAC Appeals Lawsuit

Baxter Regional Medical Center in Mountain Home, AR joined with the American Hospital Association and two other hospitals last week in filing a lawsuit to compel the Department of Health and Human Services (HHS) to meet statutory deadlines for timely review of Medicare claims denials. There are five levels in the lengthy claims appeals process under which hospitals can seek a reversal of these denials. The first two levels combined – redetermination by a Medicare Administrative Contractor and reconsideration by a Qualified Independent Contractor (QIC) – can take up to 14 months to navigate and seldom yield changes. Then, another 60 days could lapse before the appeal gets to the third level in the process, a hearing before an Administrative Law Judge (ALJ) within the Office of Medicare Hearings and Appeals (OMHA), where hospitals have been successful in having a majority of those denials overturned.

Medicare law requires an administrative law judge to hold a hearing and render a decision within 90 days of being assigned a case by OMHA. However, in December, OMHA imposed a moratorium on assigning claims to ALJs, leaving 480,000 appeals in a type of hearing limbo. With the moratorium in place, wait times for an ALJ hearing could exceed three years delaying billions of dollars in Medicare reimbursements to hospitals, many of which are already strapped for cash. The plaintiff organizations noted in the filing that the funds being tied up otherwise could be dedicated to patient care or to sustaining the hospital infrastructure necessary to provide patient care. The two other hospitals involved in the legal action are Covenant Health (Knoxville, TN) and Rutland (VT) Regional Medical Center.

The issue also received attention during a May 20 meeting of the House Committee on Oversight and Government Reform, whose members pressed witnesses from CMS and HHS to explain and address the growing backlog of appeals at the administrative law judge level. The committee expressed frustration about the appeals backlog and impact of Medicare’s recovery auditors on hospitals and other providers, citing data from the American Hospital Association and others on the proportion of claim denials overturned on appeal.

See [http://www.aha.org/content/14/140522complaint-appeals.pdf](http://www.aha.org/content/14/140522complaint-appeals.pdf) to read the court filing.

Testimony Seeks Relief on RACs, Two-Midnight Policy

During a May 20 hearing focused on CMS’ two-midnight policy and the Recovery Audit Contractor (RAC) program, members of the House Ways and Means Health Subcommittee listened as yet more testimony was provided detailing how both the policy and the review program are draining time, resources and attention that need to be more effectively focused on patient care. Amy Deutschendorf, senior director of utilization and clinical resource management at the Johns Hopkins Health System in Baltimore, said during her testimony that the two-midnight policy has created “confusion and stress” for providers and patients, and has “taken away physicians’ judgment in the determination of hospitalization as an inpatient.” She also discussed the financial and administrative burdens of complying with RAC audits as well as the significant number of erroneous RAC denials hospitals are experiencing. Arkansas Senator Mark Pryor is a lead sponsor.
of the Medicare Audit Improvement Act (S. 1012), a comprehensive bill for reforming the RAC program. A companion bill in the House (HR. 1250) has 220 co-sponsors, including Arkansas Representatives Tom Cotton, Rick Crawford and Steve Womack. Another bill, the Two-Midnight Rule Coordination and Improvement Act (H.R. 3698/S. 2082), directs CMS to further delay enforcement of the two-midnight rule and implement a new payment methodology for short inpatient stays.

Proposal Opens Multiple Pathways to Meaningful Use

The Centers for Medicare & Medicaid Services and Office of the National Coordinator for Health Information Technology have released a proposed rule that would allow hospitals and eligible professionals multiple pathways to meet meaningful use in 2014, including using the 2011 Edition certified electronic health record technology to meet the meaningful use requirements in place for 2013. The rule is available at: https://s3.amazonaws.com/public-inspection.federalregister.gov/2014-11944.pdf.

New Bill Offers HoPE for Rural Healthcare

The Craig Thomas Rural Hospital and Provider Equity Act (R-HoPE), newly proposed legislation backed by the American Hospital Association, would extend critical rural provisions that have expired or are set to expire and implement new provisions that would benefit rural hospitals. The bill (S.2359) would remove the 96-hour physician certification requirement as a condition of payment for critical access hospitals (CAH) and would extend through 2014 the enforcement moratorium on the outpatient therapy “direct supervision” policy for CAHs and rural prospective payment system hospitals with 100 or fewer beds. It also would reinstate the outpatient hold harmless provision, increase the low-volume payment adjustment to 2,000 discharges, extend cost-based reimbursement for rural outpatient labs and implement other provisions important to CAHs. Sens. Tom Harkin (D-IA), John Barrasso (R-WY), Pat Roberts (R-KS) and Al Franken (D-MN) are the bill’s sponsors.

ICD-10 Testing on Medicare Claims a Success

In March, CMS conducted a successful ICD-10 test on more than 127,000 claims containing ICD-10 codes submitted to the Medicare fee-for-service (FFS) claims systems, with electronic acknowledgements returned confirming that the claims were accepted. Approximately 2,600 participating providers, suppliers, billing companies and clearinghouses nationwide participated in the testing, representing about 5% of all submitters. Clearinghouses, which submit claims on behalf of providers, were the largest group of testers, submitting 50% of all test claims. Other testers included large and small physician practices, small and large hospitals, labs, ambulatory surgical centers, dialysis facilities, home health providers and ambulance providers.

Nationally, CMS accepted 89% of the test claims, with some regions reporting acceptance rates as high as 99%. The normal FFS Medicare claims acceptance rates average 95-98%. Testing did not identify any issues with the Medicare FFS claims systems. In many cases, testers intentionally included such errors in their claims to make sure that the claim would be rejected, a process often referred to as negative testing. To be processed correctly, all claims must have a valid diagnosis code that matches the date of service and a valid national provider identifier. Additionally, the
claims using ICD-10 had to have an ICD-10 companion qualifier code and the claims using ICD-9 had to use the ICD-9 qualifier code. Claims that did not meet these requirements were rejected.

HHS expects to release an interim final rule in the near future that will include a new compliance date that would require the use of ICD-10 beginning October 1, 2015. The rule will also require HIPAA covered entities to continue to use ICD-9-CM through September 30, 2015. Providers, suppliers, billing companies, and clearinghouses are welcome to submit acknowledgement test claims anytime up to the anticipated October 1, 2015 implementation date. Submitters should contact their local Medicare Administrative Contractor for more information about acknowledgment testing. However, those who submit claims may want to delay acknowledgement testing until after October 6, 2014, when Medicare updates its systems. CMS will be conducting end-to-end testing in 2015. Details about this testing will be released soon.

**Immediate Ruling Sought in Two-Midnight Action**

The American Hospital Association, along with a group of joint plaintiffs, is seeking an immediate favorable ruling from a federal court on a lawsuit filed in April challenging a CMS-imposed Medicare payment cut on hospitals to account for alleged increased costs from the agency’s two-midnight rule. The motion for summary judgment states, “CMS’s 0.2% payment cut is based on the premise that a policy that makes it more difficult for a Medicare beneficiary to qualify as an inpatient will produce an increase in the number of inpatient cases.” The groups said the court “can and should” invalidate the payment cut, and “should order CMS to recalculate the Medicare [inpatient prospective payment system] amounts for federal fiscal year 2014 accordingly.” The lawsuit, filed on April 14, contends that CMS violated federal law and regulation when it adopted the 0.2% payment offset in the FY 2014 final inpatient payment rule.

**CMS to Hospital: Help Surveyors with EHR Use**

Electronic health records (EHR) are increasingly common in hospitals and critical access hospitals (CAH) and pose new challenges to the survey process. To compensate, CMS is advising hospitals and CAHs that State Survey Agency (SA) surveyors may be requesting experienced hospital/CAH EHR users with appropriate system permissions be assigned as “navigators” to assist surveyors with medical record information retrieval for survey tasks requiring detailed medical record review. Providing such assistance is analogous to the traditional expectation for paper-based records that hospitals and CAHs retrieve closed paper medical records requested by surveyors, and hospitals/CAHs are expected to provide the necessary assistance to enable surveyors to review EHRs. For more information, go to [http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/Survey-and-Cert-Letter-14-31.pdf](http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/Survey-and-Cert-Letter-14-31.pdf).

**More Care for Vets Could Come from Non-VA Facilities**

In a move related to recent allegations about excessive waits for care at a number of Veterans Affairs (VA) healthcare facilities throughout the country, the Obama Administration has agreed to expand veterans’ access to clinicians outside of the VA system. The move came amid growing pressure by some members of Congress for privatizing the care provided to millions of veterans of the U.S. armed forces. In 2013, the VA spent $56 billion providing care to 5.7 million patients.
Roughly 10% was spent at non-VA facilities. Proposals being touted to increase the use of non-VA facilities would raise that non-VA spending by an unspecified amount.

**IRS Ruling Covers Employer “Insurance Dumping”**

Fears that employers would be shoveling workers off of their group health insurance plans and into government subsidized health plans should have been diminished last month when the Internal Revenue Service (IRS) ruled that employers who replace their existing insurance coverage offerings with subsidized health insurance purchased through state insurance exchanges will not remain in compliance with provisions of the Affordable Care Act. The ruling ([http://www.irs.gov/uac/Newsroom/Employer-Health-Care-Arrangements](http://www.irs.gov/uac/Newsroom/Employer-Health-Care-Arrangements)) was given in an answer to a question posted this month on the IRS’ website. It effectively prevents employers from dumping their employees onto the new exchanges rather than providing the employee coverage themselves and underscores a November 2013 IRS Notice addressing the issue. Employers attempting the practice could face penalties of up to $100 per day per employee. Read the notice at [http://www.irs.gov/pub/irs-drop/n-13-54.pdf](http://www.irs.gov/pub/irs-drop/n-13-54.pdf).

**Hospitals Appealing Half of RAC Denials**

The latest results from the American Hospital Association’s (AHA) quarterly RACTrac survey shows that hospitals continue to proactively fight to reverse denials of Medicare claim payments by Recovery Auditor groups, better known as RACs. Hospitals responding to the survey report appealing 50% of all RAC denials; about half had an appeal overturned in their favor through use of the discussion period before a formal appeal. AHA will host a free webinar on June 24 to review recent RAC policy developments and results from the survey, which help hospitals monitor the impact of RACs and advocate for needed changes to the program. For more information, visit [www.aha.org/rac](http://www.aha.org/rac).

**The AHA Calendar**

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<tr>
<td>June 10</td>
<td>Pharmacist-Led Collaborative to Reduce Adverse Drug Events, Crowne Plaza, Little Rock</td>
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<tr>
<td>June 11-13</td>
<td>AHA and AHEF Hospital Executive Leadership Conference, Chateau on the Lake, Branson, MO</td>
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<tr>
<td>June 12</td>
<td>Understanding Health Exchanges – Webinar T2908</td>
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<td>June 17</td>
<td>Ambulatory Payment Classifications: Assessing Financial Impact – Webinar T2909</td>
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<td>June 17</td>
<td>From Volume to Value: The Changing Payment Landscape – Webinar</td>
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<td>June 18</td>
<td>2014 Governor’s Quality Award Health Care Seminar “Improving Quality Through Patient-Centeredness,” Embassy Suites, Little Rock</td>
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<td>June 19</td>
<td>The Power of Empowerment: Strategies to Energize Your Team – Webinar T2910</td>
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<td>June 19</td>
<td>Healthcare Finance: An Introductory Course For Healthcare Managers – Webinar T2911</td>
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<td>June 24</td>
<td>Restraint and Seclusion: Complying with CMS CoPs and The Joint Commission Standards – Webinar T2912</td>
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Information on all AHA educational programs and activities is available at [http://www.arkhospitals.org/events](http://www.arkhospitals.org/events).