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Written Testimony of Ellen R. Evans, MD Corporate Medical Officer HDI

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Subcommittee on Health

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Chairman Brady, Ranking Member McDermott, Members of the Committee, thank you very much for the opportunity to testify before you today. My name is Dr. Ellen Evans and I serve as the Corporate Medical Officer for Health DataInsights (HDI), a technology driven healthcare services company that specializes in claims integrity and the correction of improper payments for the Medicare Trust Fund, government and private payors. HDI currently serves as the CMS Recovery Auditor for Region D which is comprised of 17 western states and 3 US territories.

As background, I am a graduate of the University of Texas Medical School at Houston and a residency-trained, Board-certified licensed Family Physician with a Certification of Added Qualifications in Geriatric Medicine. My clinical practice experience has included hospital care and geriatric inpatient and outpatient consultation services as well as rehab, nursing home, home care, and Critical Access Hospital coverage. Leading the Creighton University Geriatric Education Program and Geriatric Consultation Services in Omaha, Nebraska, I served as the Medical Director of community and hospital-based Skilled Nursing Facilities (SNFs) and Long Term Care facilities. A past President of the Nebraska Medical Directors Association, I joined HDI after serving as the Contractor Medical Director for the Medicare Division of Mutual of Omaha—one of the largest Medicare fiscal intermediaries. In my current role, as Corporate Medical Officer of HDI, I oversee all of our medical and clinical activities, which include clinically-intelligent claim selection, well-documented new issue submission, accurate and precise medical record review, and quality assurance throughout every clinical aspect of HDI's recovery audit work.

Evolution of the Recovery Audit Program

The Recovery Audit program is an innovative approach to recovering improperly paid Medicare claims. Unlike other contractors in the Medicare program integrity field, our work is not focused on fraudulent payments, but instead we review paid claims to ensure that providers who participate in the Medicare program are complying with Medicare billing policies and guidelines. These are the most prevalent types of Medicare improper payments: payment made for services that do not meet Medicare's coverage and medical necessity criteria; payment made for services that are incorrectly coded; and payment made for services where the submitted documentation does not support the services as billed. The funds we recoup from improperly paid Medicare payments are returned directly back to the Medicare Trust Fund. In addition to identifying overpayments, Recovery Auditors also identify underpayments that are returned to providers.

I joined HDI during the Medicare Recovery Audit Demonstration Program. Unlike many other Federal healthcare program integrity contracts, the Recovery Audit program was first piloted in three states—New York, Florida and California, with a few additional states added mid pilot. During this three year period, over $1 billion of improper payments were corrected for the Medicare Trust Fund. As a result of the success of the program, in 2006, Congress mandated that the Department of Health and Human Services institute a permanent and national Recovery Audit program.

The Recovery Audit demonstration served as an important tool to help CMS prepare and shape the permanent Recovery Audit Program that is in place today. As a result of lessons learned and feedback from Medicare providers and suppliers during and after the demonstration period, CMS adopted numerous changes to improve the permanent Recovery Audit program. These changes included:

- Limiting the number of medical records that are requested for review;
- Requiring each Recovery Auditor to employ a full-time medical director who is a licensed physician, as well as licensed RNs and certified coders to ensure the reviews are completed accurately;
- Requiring the Recovery Auditor to return its contingency fee if a provider contests an audit and the Recovery Auditor loses at any level of the appeal;
- Posting new issues targeted by the audits on the Recovery Auditor's website to provide more transparency;
- Changing the look back period from four years to three years; and
- Accepting imaged medical records from providers on CD/DVDs in lieu of paper records.

In addition to general contract oversight, CMS has specific requirements that include:

1. Complying with an established approval process for all new review issues,
2. Requiring approved new issues are posted to the Recovery Auditor's website,
3. Requiring the specific audit issue is detailed in each request for medical records,
4. Following the CMS established medical record request limits,
5. Reimbursing certain providers for medical records,
6. Applying restrictions on findings of improper payment for minor omissions that other CMS review contractors deny,
7. Providing written notification to providers on all determinations, finding or not,
8. Affording providers opportunity to have a discussion with a Recovery Auditor's physician,
9. Affording providers a discussion period with the Recovery Auditor prior to initiating a formal appeal with the Medicare Administrative Contractors (MAC), and
10. Comply with monthly accuracy sampling conducted by an independent CMS contractor to confirm Recovery Audit findings.

These CMS requirements are unique to Recovery Auditors when compared to other Medicare Program Integrity contractors. The result is to ensure enviable accuracy and precision of Recovery Audit work.

CMS Requirements on Postpayment Reviews Unique to Recovery Auditors, Compared to Other Contractor Types, as of May 7, 2013

Requirement	Contractor Type			
	Medicare Administrative Contractors (MAC)	Zone Programs Integrity Contractors (ZPIC)	Comprehensive Error Rate Testing (CERT) Contractor	Recovery Auditors (RA)
Selection of claims for postpayment review				
CMS approval of criteria for selecting billing issues prior to widespread use	No	No	n/a	Yes
Provider notice of issues targeted for review				
Provider notice (on website) of billing issues targeted for postpayment review	No	No	n/a	Yes
Additional documentation requests (ADR)				
Provider reimbursement for copies of medical records	No	No	No	In some cases
Limits on number of ADRs contractor can request from provider	No	No	No	Yes
Reviews				
Authority to deny claim for minor omissions	Yes	Yes	Yes	No
Provider communication				
Provider notification regardless of review outcome	No	No	No	Yes
Reviewer's credentials available upon provider request	No	No	No	Yes
Access to contractor's medical director to discuss claim denials upon request	No	No	No	Yes
40 days to discuss any revision to initial determination informally prior to having to file an appeal	No	No	No	Yes
Quality assurance				
External validation of randomly selected claims by independent contractor	No	No	No	Yes

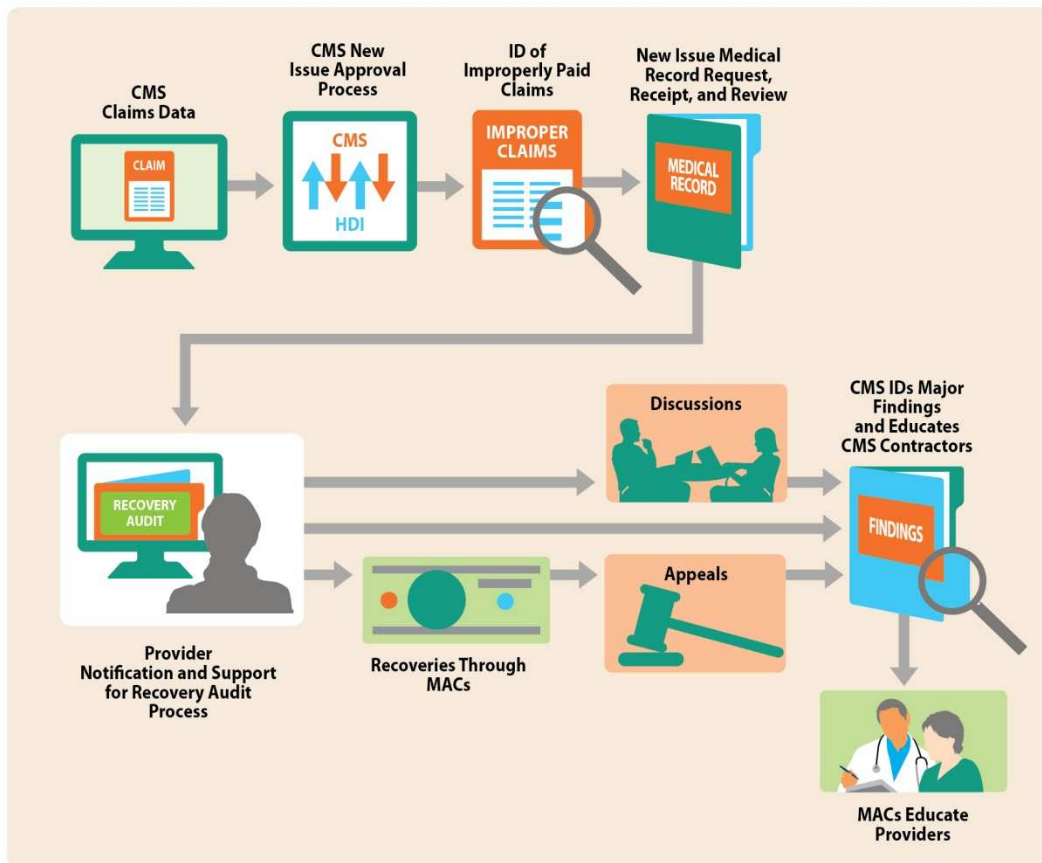
Source: GAO: Medicare Program Integrity: Increasing Consistency of Contractor Requirements May Improve Administrative Efficiency, July 2013

The Recovery Audit Program Today

Billions of Medicare dollars are paid improperly by the Medicare program every year. The improper payment rate for Medicare recently increased from 8.5% in FY2012 to 10.1% in FY2013. Medicare pays over $300 billion in claims each year, which means that over $30 billion in taxpayer dollars is lost to waste and billing errors each year.

Recovery Auditors serve an important role in correcting improper Medicare payments. Over $8 billion of improperly paid Medicare dollars have been recovered under the Recovery Audit program since 2006.

How Recovery Auditors Identify Improper Payments



CMS designed the Recovery Audit program to identify improper payments and return funds to the Medicare Trust Fund. Recovery Auditors identify the types of claims that are most at risk for improper payment by employing vast auditor experience, data mining, and use of Federal publications such as HHS OIG, GAO and CERT reports. In order to ensure Recovery Auditors are making accurate claim determinations, every issue that a Recovery Auditor seeks to review must be submitted first to CMS for a rigorous evaluation and approval process. In submitting new issues, the Recovery Auditor must describe the CMS rationale for identification of the improper payment including federal reports, statutory references and CMS rules and regulations. Furthermore, new issue submissions must provide methodology for claim selection and identification of medical record review guidelines based on identified medical record elements in support of a submitted claim. Issues which are approved are then posted to the Recovery Auditor's Provider Portal in advance of any audit activity.

Recovery Auditors use three methods to review claims:

- Automated – improper payments identified based on claims payment data
- Semi-Automated – Improper payments based on claims payment data and provider has opportunity to submit record prior to improper payment determination
- Complex – review of medical records with higher probability of improper payment

Medical records are only requested for complex review claims and CMS has limited the amount of medical records (ADRs) a Recovery Auditor can request to less than 2% of Medicare claims for any given provider.

Medical reviews are conducted by licensed and experienced clinicians who undergo extensive screening and comprehensive training, and meet specific education requirements. HDI's team includes licensed physicians, licensed RNs, certified coders and registered pharmacists with oversight of all provided by the Medical Director. In addition, HDI has established Quality Review and Assessment programs that drive audit review accuracy and precision in real time to generate the most accurate and precise provider audit results possible.

HDI's goal is to generate quality determinations that are accurate, precise and well documented. These determinations are clearly and concisely communicated to the provider. Within the provider communication, Recovery Auditors cite the specific sections of CMS manuals, guidelines, rules and regulations which are associated with the audit finding. CMS appeal instructions are also included in the provider communication should the provider disagree with the review determination.

How the Appeals Process Works for Audited Claims

In cases in which a provider disagrees with a finding by the Recovery Auditor, the provider has an opportunity to initiate a "discussion period" before formally appealing the denial. This offers providers an opportunity to submit supporting documentation for their original billing. It is also an additional opportunity for the Recovery Auditor to explain the rationale behind an

overpayment decision. Upon review of all provider information, the Recovery Auditor notifies the provider of its final determination.

The provider also can utilize the normal CMS appeals process, the five-level Medicare claims appeal process through which fee-for-service providers appeal reimbursement decisions.

There are five levels of appeal –note that appeals rarely reach the last two levels These are as follows:

1. Redetermination by the Fiscal Intermediary (ie Medicare Administrative Contractor)
2. Reconsideration by a Qualified Independent Contractor;
3. Administrative Law Judge Hearing;
4. Medicare Appeals Council Review; and
5. Judicial Review in U.S. District Court.

In November 2012, HHS OIG reported that certain improvements could be employed at the Administrative Law Judge (ALJ) level of Medicare Appeals. Currently, there is a large backlog of cases at the Administrative Law Judge level that is causing concern for all stakeholders. It has been documented that a number of factors have driven the backlog. This includes increased numbers of appeals by providers and limited ALJ resources. I will speak to the appeals process later in my testimony, but I think all stakeholders agree that this stage of the Recovery Audit process needs closer attention. We look forward to collaborating with stakeholders to focus on long term reforms to the Recovery Audit appeals process which will allow the ALJ's to effectively manage incoming appeals.

Beyond the correction of improper Medicare payments, Recovery Auditors also work together with CMS to evaluate recovery audit results and identify major findings and possible corrective action steps. CMS corrective actions include installing national claims edits, generating provider education materials, refining billing and medical necessity requirements to improve improper payment rates, and clarifying or changing policy. Regular Major Finding discussions among CMS and its contractors are held to understand Recovery Audit findings and identify corrective interventions with MACs and CMS, including the identification of provider outreach, education opportunities and instruction.

Success of the Recovery Audit Program

From FY 2012 to FY 2013, the Recovery Auditors returned more money to the Medicare Trust Fund than any other healthcare integrity initiative, earning the distinction by the HHS OIG as the "most improved" program. Since 2006, the Recovery Auditors have recovered over $8.9 billion in improper payments to the Medicare Trust Fund as well as returned over $700 million in underpayments to providers. Based on the return on investment that the Recovery Audit program yields, the program is a cost effective means of identifying underpayments and overpayments in the Medicare fee-for-service program. Because of the program's success, the projected life of the Medicare Trust Fund has been extended by two additional years.

This high level of recovery has occurred notwithstanding the fact that Recovery Auditors are limited to reviewing less than two percent of providers' Medicare claims volume. In fact, in 2012, the OIG report stated that despite all of CMS' program integrity programs, the Agency still reviews less than 1% of the over one billion fee-for-service claims paid annually. Controls such as these have been put into place to ensure there is a balance between oversight of Medicare spending and provider burden. As outlined earlier, these types of safeguards along with efforts to maximize transparency and provide vital data to the Medicare Administrative Contractors for provider education are unique to the Recovery Audit program and have played a part in the overall success of the program.

New Changes to the Recovery Audit Program

CMS has played an integral role in the Recovery Audit program since the demo began in 2006. The agency has made continual advancements to enhance the program and ensure minimal provider burden, high levels of accuracy, and transparency. The Medicare provider community and the Recovery Auditors played a distinct role in developing and encouraging the numerous changes made to the Recovery Audit program after the demonstration. Additionally, in February 2014, CMS announced it would be making a number of new changes to the Recovery Audit program, which would be effective with the new contractor awards. These changes were made to enhance the program, as well as address provider concerns.

Concern	Program Change
Upon notification of an appeal by a provider, the Recovery Auditor is required to stop the discussion period.	Recovery Auditors must wait 30 days to allow for a discussion before sending the claim to the MAC for adjustment. Providers will not have to choose between initiating a discussion and an appeal.
Providers do not receive confirmation that their discussion request has been received.	Recovery Auditors must confirm receipt of a discussion request within three days.
Recovery Auditors are paid their contingency fee after recoupment of improper payments, even if the provider chooses to appeal.	Recovery Auditors must wait until the second level of appeal is exhausted before they receive their contingency fee.
Additional documentation request (ADR) limits are based on the entire facility, without regard to the differences in department within the facility.	CMS is establishing revised ADR limits that will be diversified across different claim types (e.g., inpatient, outpatient).
ADR limits are the same for all providers of similar size and are not adjusted based on a provider's compliance with Medicare rules.	CMS will require Recovery Auditors to adjust the ADR limits in accordance with a provider's denial rate. Providers with low denial rates will have lower ADR limits while providers with high denial rates will have higher ADR limits.

Source: CMS

Current Status

Even though the Recovery Audit program has proven to be a success, the program has recently been subject to external constraints that have resulted in a significant decrease in recovery audit reviews.

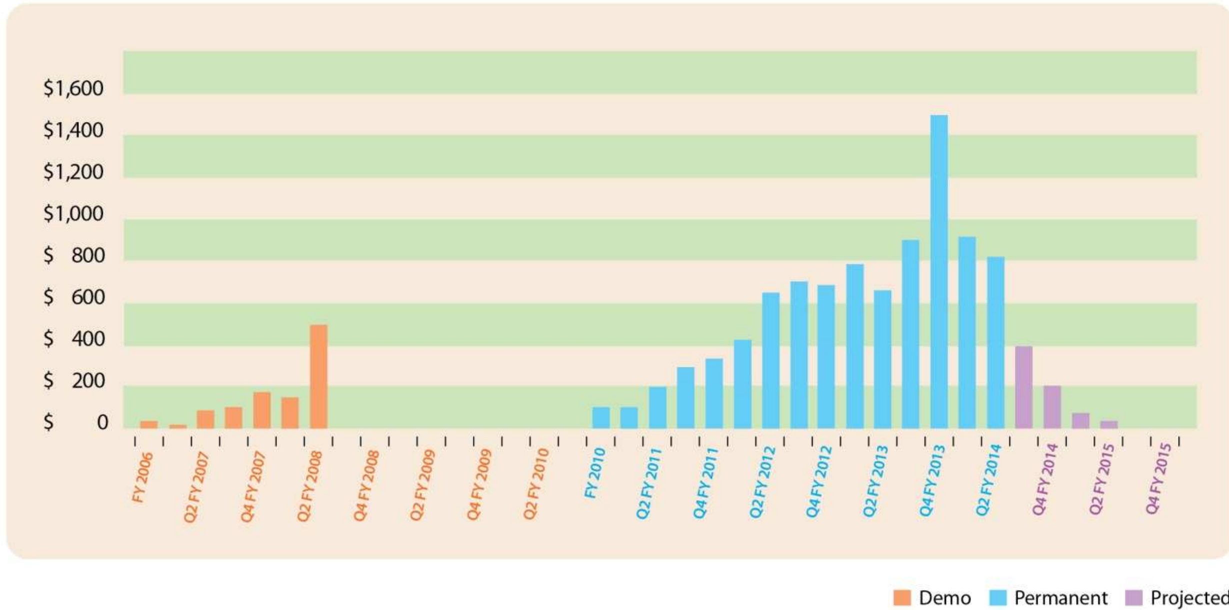
First, as part of the implementation of the 2 midnight rule, a moratorium was placed on the Recovery Auditors, preventing auditing of short-stay hospital claims from October 2013-March 2015. As of now, these short-stay claims will never be subject to review by a Recovery Auditor. CERT reports have documented that short-stay inpatient claims historically have a high probability of improper payment. As such, Members of Congress and taxpayers should be concerned that Medicare providers will be shielded from Recovery Audit review of these types of claims for 18 months. Based on years of historical Recovery Audit data, it is estimated that the audit moratorium will result in over $5 billion in lost savings to the Medicare Trust fund.

The second significant change to the program is the current program "pause" until the new Recovery Auditor contracts are finalized. In February 2013, CMS began the procurement process for the next round of Recovery Audit contracts. At that time, CMS announced the Recovery Audit program would continue during the transition, with some decline in the number of audits allowed. As of today, the new Recovery Audit contracts have not been awarded. In February 2014, CMS announced the Recovery Audit program would be suspended until the new contracts are in place, but it is currently unknown when the awards will occur.

The audit moratorium and the program "pause" have scaled back the essential scope and effectiveness of the Recovery Audit program. The result is billions of dollars of improper

payments are not being recovered and restored to the Medicare Trust Fund, contributing to Medicare’s long term solvency challenges. Recent Recovery Audit corrections quarterly reports already show that recoveries have declined significantly over the past two quarters.

Recovery Audit Collection by Quarter



Recovery Audit Program Myths: Setting the Record Straight

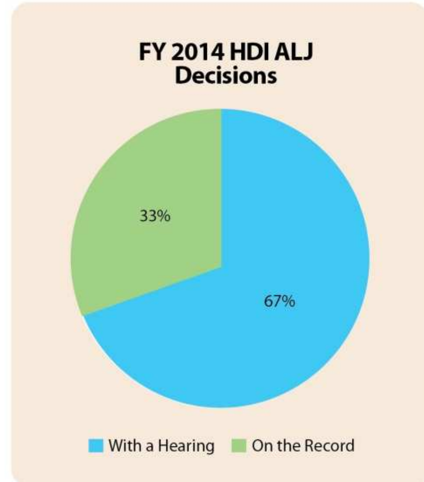
Despite the success of the Recovery Audit program, misconceptions about how the program works and how Recovery Auditors carry out their audits remain. The Recovery Audit program administered by CMS is relatively simple and is very similar in its scope and structure to audit programs carried out in other government programs, such as Medicaid and TRICARE, and in the commercial sector by insurers and other payers. However, because the program is relatively new, some confusion about the program remains. I would like to take this opportunity to dispel some common myths about the program:

Myth #1: Recovery Auditors are Bounty Hunters because they receive a fee on every claim they deny. A Recovery Auditor is required to return all of its fees when a finding is reversed at any level of provider appeal. This means Recovery Auditors are incentivized to work accurately and precisely. In actuality, Recovery Auditors are paid through performance-based contracts in which they are only paid for overpayments and underpayments that are accurately identified and corrected. This type of fee structure requires Recovery Auditors to absorb the front end cost of auditing. Unlike cost-plus contractors, the federal government does not provide any funding for hiring and training of experienced clinicians, claims analysts, and other experts to run the program. This incentivizes Recovery Audit contractors only to pursue claims which are

improperly paid. Contingency-based contracting protects taxpayer dollars by only paying for results.

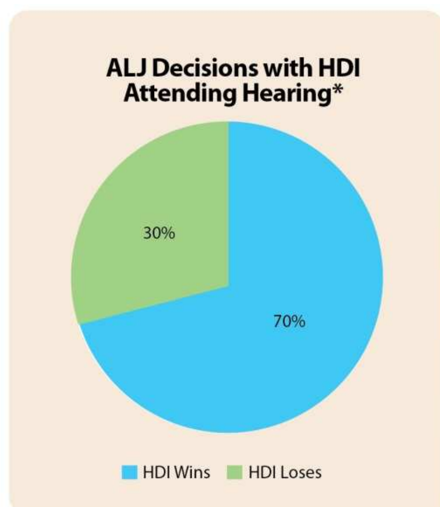
Myth #2: Over 70% of appeals before an ALJ are overturned in favor of the hospital.

According to CMS' most recent Recovery Audit program Report to Congress, in FY 2012, only seven percent of all Recovery Auditors' determinations have been challenged and later overturned on appeal. Specifically, Medicare providers appealed 373,259 claims, which constitute 26.3 percent of all Medicare claims with overpayment collections. Of those claims appealed to the ALJ, 99,476 claims were overturned with decisions in the provider's favor (26.7 percent). For HDI specifically, we can report that in FY 2014 when HDI attends a hearing, 77.3% of our improper payment denials have been upheld at the ALJ level.

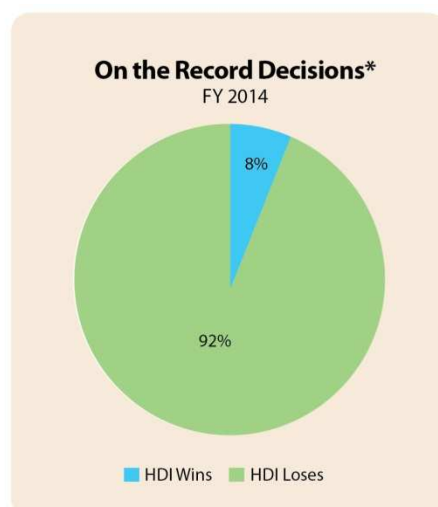


In its March 2014 Recovery Audit report to Congress, CMS notes that "the receipt and an appeal and the reversal of a Recovery Auditor decision does not necessarily mean the Recovery Auditor was wrong in its determination." For example, providers are often given the opportunity to reopen their claims to correct their billing during the appeals process. Additionally, the report notes inconsistencies also occur between the Recovery Auditor decision and ALJ decision due to the fact that Recovery Auditors are required to make their claims decision based on all CMS policies including manuals and Local Coverage Determinations (LCDS), while ALJs provide deference to but are not bound by these same CMS requirements.

There also has been an increasing number of ALJs appeal decisions occurring "on the record," which are decisions based solely on the review of relevant documents without a hearing. Decisions made on the record do not afford Medicare Recovery Audit Contractors an



* HDI receives only 11% of notices to attend hearings



* HDI has no opportunity to participate for CMS

opportunity to participate, providing legal arguments and clinical testimony discussing the merits of the review and the Medicare regulations that resulted in the claim denial. Our data support the fact that when decisions are made by ALJ's on the record and HDI does not participate in a hearing, the overturn rate significantly increases.

Myth #3: Recovery Auditors are often inaccurate and inflict avoidable legal and administrative costs on hospitals. Another program safeguard that is unique to the Recovery Audit program is the use of an independent validation contractor to review random samples of claims of which a Recovery Auditor has made an improper payment determination. These samples are collected on a monthly basis and scored on an annual basis to produce an accuracy score for each Recovery Auditor. This score represents how often Recovery Auditors are accurate in their overpayment and underpayment determinations. CMS' most recent report to Congress cites that in FY 2012 all Recovery Auditors have a cumulative accuracy score of 95.5%. I am also proud to report that in the March 2014 report, HDI's cumulative accuracy rate was reported as 97.25%.

Cumulative Accuracy Score by Recovery Auditor

Region	% of Accuracy
Region A	96.3%
Region B	96.3%
Region C	92.5%
Region D	97.2%
Average Accuracy Score	**95.5%**

Source: CMS Recovery Auditing in Medicare and Medicaid for FY 2012 Report to Congress, March 2014

Myth #4: Recovery Auditors lack clinical expertise. CMS regulations, instructions and statements of work for its contractors require every medical review be performed by a licensed clinician. Those include medical doctors, licensed RNs, certified coders, and registered pharmacists. CMS requires a licensed physician to serve full time as a Medical Director for every Recovery Audit contractor. I am pleased to tell you HDI meets or exceeds these requirements. Every medical record review completed by HDI is performed by a qualified clinician in accordance with CMS requirements. HDI employs a full-time Corporate Medical Director, a full-time Senior Medical Director, and a team of Physician Reviewers, while our parent company maintains a staff of physicians and other clinicians across every specialty who are available for consultation as needed. It is also important to note HDI's clinicians are recruited based on solid credentials backed by experience in the practice of their field and with utilization management and/ or medical review expertise. Our recruitment and hiring process brings quality clinicians to our team. The HDI training and mentoring process ensures complete familiarity with CMS Medicare manuals, guidelines, rules, regulations, and coverage resulting in demonstrated clinical expertise before any audit determinations are released.

Myth #5: Recovery Auditors impact beneficiary care. It is important to understand that Recovery Audit Contractors do not deny care, impact clinical decisions made by providers, or impact the quality of services to beneficiaries. Recovery Audit Contractors review claims after care has been provided to patients. Hospitals have already received their Medicare payments by the time a review is conducted.

Additionally, the CMS statement of work precludes recovery of claims where a beneficiary would be liable for an improperly paid claim. This means that Medicare beneficiaries are never affected financially by any recovery audit work.

Myth #6: Recovery Auditors Target Short Inpatient Stays. As already discussed here today, it is often pointed out that Recovery Auditors have focused on Short Inpatient hospital stays. There is a very compelling reason why Recovery Auditors focus on Short Inpatient hospital stays. Medicare data, such as CERT measurements, HHS OIG and PEPPER/Fathom reports have consistently noted high dollar error rates for these types of hospital claims. With persistent billing error rates for Hospital Care driven by high dollar hospital short stays, an HHS OIG study last year (2013) reported both Medicare and its Beneficiaries pay more for Hospital Care billed as Inpatient care than they pay for Hospital Care billed as Outpatient care. Based on this data, it is imperative to the longevity of the Trust Fund that Recovery Auditors focus on short inpatient stays.

That being said, as has already been indicated, we understand the frustration expressed by the hospital community surrounding the 2 midnight rule, and we want to work with CMS and the provider community to bring clarity to the rules regarding short inpatient stays. Clarity, combined with effective education and outreach, will help the system move forward in a way that addresses the legitimate concerns of providers while respecting the importance of program integrity and the interests of the taxpayers in protecting the Trust Funds. In fact, recovery audit helps bring clarity to the rules and regulations of the Medicare system by offering corrective feedback to the submission of improper claims. Without correction, the errors of improper billing are perpetuated and become entrenched.

Recovery Audit Program Recommendations

As the Committee looks to move forward on this important issue, I would like to offer the following recommendations for the Recovery Audit Program.

1. Appeals Reform as documented in the 2012 HHS OIG Report

The ALJ process, under the executive branch, is the third level of appeal for providers and has presented the CMS contractors and the Recovery Audit program with significant difficulties leading to results that are inconsistent with the goals of the Medicare program. For example, The HHS OIG documented serious issues with the ALJ process contained in their 2012 report, including:

- Medicare Regulations, Policies and Manuals are not being followed by the ALJs
- ALJ decisions are inconsistent with MAC and QIC rulings that uphold the audit approximately 90% of the time
- Many ALJ judges rule against CMS audit findings regardless of the issue presented
- Many ALJs do not have clinical expertise for reviewing clinical cases and require additional training
- An overwhelming number of ALJ decisions favorable to providers provides an incentive for providers to continue appealing
- Certain providers are "serial appellants" and are committed to appealing 100% of audits, thereby clogging the system and creating financial burden on the program

Appeals Reform would include:

- Increasing the number of ALJ judges to allow for effective management of the work load
- Implement ALJ training on Medicare policy for consistent application of CMS policy and rulings
- Review the increased use of "on the record" decisions by ALJs
- Review ALJ policy of "complete individual independence"

2. Continue to empower MACs to offer Provider Education that increases provider knowledge of Medicare policies

Consistent reinforcement of CMS policies, rules and regulations by effective educational outreach, goes a long way toward addressing many of the issues we are discussing here today. When providers fully understand Medicare rules and how to abide by them, the whole system benefits. We believe this should be an important priority for CMS and for this Committee.

3. Collaboration amongst stakeholders

Increase the dialogue between Recovery Auditors, providers, policymakers and other stakeholders to move forward in improving the direction of Recovery Audit program and protecting Medicare program and tax dollars from improper payments

4. Continuous, consistent program integrity oversight by CMS

The Recovery Auditors recommend that in order to reduce error rate where over $30billion in claims are improperly paid each year, CMS should continue to provide oversight of claim payments through continuous, consistent program integrity efforts to ensure accurate payment of claims, clear payment policies and recoupment of improper payments. We recommend that more reviews are shifted to pre-payment review for more immediate feedback to the providers.

Conclusion

In summary, we at HDI are pleased to be a part of the dialogue that is occurring today around balancing Medicare oversight with managing provider impact. The Recovery Audit program

seeks to strike this balance though its evolution from a demonstration program to a permanent program. Our quality measures have shown that we perform our workload with a high level of reproducible effectiveness and efficiency that is based in sound and experienced clinical expertise among licensed professionals with physician oversight and medical direction. Recovery Auditors maintain high accuracy; low appeals overturn rates; and steady recoveries of monies to providers and to the federal government. This success was noted by naming Recovery Audit program the "most improved" program distinction from the HHS OIG.

We believe the Recovery Audit program must continue to play a role in the Medicare program—especially in light of the recent increase in improper payments. The program is a proven success in meeting its mission to identify and correct Medicare improper payments, and return overpayments back to the Medicare Trust Fund.