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Talking Points for Regulatory Fairness Hearing for Small Business, June 21, 2013 – Davenport, IA

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First off, I would like to start by thanking you for affording me the opportunity to present this information to you today.

The purpose of my testimony will focus on the Medicare audit and appeal process and the impact it has on small businesses throughout the country in the durable medical equipment, prosthetics, orthotics and supplies industry (DMEPOS). The van Halem Group is a Medicare audit and compliance consultancy based in Atlanta, GA. We work with healthcare providers throughout the country to provide assistance in responding to Medicare audits and appealing denials and overpayments. We have been in business since September 2006 and work with many types of healthcare providers. We currently have approximately 350 clients nationwide with a majority being small businesses.

The van Halem Group staff are former auditors and clinicians that previously worked for Medicare in the areas of program integrity, medical review, and appeals. Therefore, we bring a unique perspective in that we actually worked for Medicare previously performing audits of DMEPOS providers and we understand the challenges and complexities in performing these duties. Similarly, as a small business owner, I can appreciate the impact of the increasingly intense regulatory environment these businesses are currently experiencing.

Since 2006, we have seen a consistent and significant increase in the intensity and volume of audits conducted by CMS and its' contractors. The most significant increase was subsequent to the award of Zone Program Integrity Contractors (ZPICs) in 2008. These contract awards summarized below were given to companies to audit Medicare claims based on seven zones through the country. The contract awards were as follows:

- Zone 1 - $72.8 million awarded to SafeGuard Services, a subsidiary of Hewlett-Packard Enterprise Services.
- Zone 2 - $81.3 million awarded to AdvanceMed, a business unit of NCI which has more than 2000 employees operating in more than 100 locations around the globe.

- Zone 3 - $67.7 million awarded to Cahaba GBA, a subsidiary of Blue Cross and Blue Shield of Alabama.
- Zone 4 - $84.9 million awarded to Health Integrity, LLC.
- Zone 5 - $108 million awarded to AdvanceMed.
- Zone 6 - $91.7 million awarded to Cahaba GBA but the contract has not been transitioned and is currently under protest
- Zone 7 - $77 million awarded to SafeGuard Services

While these contracts are fixed-fee contracts, these large companies certainly would like to show CMS a return on their significant investments. To do so, they regularly conduct pre-payment and post-payment review of claims submitted to the Medicare program. We have seen ZPICs place companies on 100% prepayment review with no notification while simultaneously requesting documentation to support a sample of claims that were previously paid. The goal of these companies is to identify and prevent fraud, waste, and abuse. However, in our practice, we see that they are simply identify billing errors or minor issues that do not warrant a referral to law enforcement. Therefore, the ZPIC will deny a claim for payment for technical issues or identify either an actual or extrapolated overpayment based on a sample of claims reviewed. Some examples of these technical issues include a claim for oxygen equipment being denied for a patient on a lung transplant list, a claim for a ventilator for a patient in an iron-lung, prosthetic limbs for patients with traumatic amputations, or complex rehabilitative wheelchairs for quadriplegics. We have seen actual overpayments of thousands of dollars regularly extrapolated out to multimillion dollars based on these technical issues. The contractors are able to identify and calculate these denials and over-payments as cost-savings to the Medicare program, when in actuality, the services provided were reasonable and necessary and these beneficiaries needed this equipment to survive or in the minimum, to enjoy freedom and mobility, and they are often overturned in the appeal process.

While fraud does in fact exist, these contractors seem to be focused on these technical issues to boost performance numbers to show CMS a strong return. These large powerful businesses are acting with little oversight by the federal government. In a report published in November 2011[1], the Office of Inspector General (OIG) under the Department of Health and Human Services shared similar concerns over the lack of oversight by CMS of ZPIC contractors after only the first year of implementation. In June 2012, The van Halem Group, LLC, in response to a public request from the Senate Finance Committee, submitted a White Paper regarding the current audit and appeal process and its impact on providers. A full copy of this White Paper can be found on our web-site at www.vanHalemGroup.com.

The next change was regarding the implementation of the Recovery Audit Contractor (RAC) program which essentially awarded contracts to private entities to audit healthcare providers to identify overpayments and underpayments on claims that were previously paid. They divided the country into 4 regions and awarded 4 unique contracts. As part of their contract, they are eligible to received anywhere between 9 – 12.5% of the improper payments they identify. As an auditor myself, I have a hard time grasping the concept of offering incentives to auditors to identify overpayments. Auditors should always remain neutral, unbiased, and without incentives. As a result of this RAC program, we have seen significant increases in the volume of these audits as well. While there are limitations on the numbers of claims they can review in a 45 day time period, they can keep coming back to suppliers and recoup funds for claims based on minor technical issues. Originally, they were able to look back 3 years and the Affordable Care Act increased the look back period to 5 years. Additionally, the Federal Register Volume 77, Number 37 (Friday, February 24, 2012) states, “this notice will inform States that Medicare has increased the maximum contingency fee paid to Recovery Auditors by 5 percent for the recovery of overpayments only for durable medical equipment claims (DME).” This essentially provided

[1] http://www.oig.hhs.gov/oei/reports/oei-03-09-00520.pdf

an increased incentive to identify overpayments against this already beleaguered industry. Furthermore, it has been noted that CMS is encouraging RACs to use extrapolated overpayments which provides an exponential and quite honestly, frightening, incentive. As of this date, we have not seen any extrapolated RAC overpayments in our practice.

Since this time, the volume of RAC audits in the DMEPOS industry has dramatically increased and have also included items such as lower limb prosthetics and complex rehabilitative wheelchairs. While some overpayments are indeed valid, the RAC also often finds the first minor technical issue that enables them to deny the claim and do so without conducting a more comprehensive review to determine if the equipment is reasonable and necessary for the care and treatment of the beneficiaries. Even more recently, CMS announced that it will take the responsibility of DMEPOS audits away from the current RACs and will award a contract to one national RAC for DMEPOS and Home Health providers. This will certainly increase the volume. Finally, they recently awarded another contract to a Supplemental Medical Review Contractor to perform additional review in the DMEPOS industry on top of the additional contractors.

Regarding the impact on small businesses, if the audits are done on a prepayment review basis by a ZPIC, the denial of claims causes significant revenue problems because it generally takes an average of 60 - 90 days from the time the equipment is provided to process the claims. If at that point, the claim is denied, the provider must navigate through the Medicare appeals process. If an overpayment is identified as part of a post-payment review by a ZPIC or RAC, the supplier is forced to make arrangements to refund the money while navigating through the appeal process.

The problem now becomes the appeal process. Essentially, most providers utilize the first three levels of appeal. The first two, called Redetermination and Reconsideration, are conducted by additional private entities awarded contracts by CMS. Therefore, they often follow the same strict adherence to the complex policies, and unfavorable decisions are quite common. However, at third level, for the first time in the process the provider is able to communicate directly with another individual, in this instance, an Administrative Law Judge, at a federal hearing conducted via telephone in most cases. In our practice, we see a large majority of the denials previously identified by the RAC or ZPIC, overturned. Specifically, since tracking this data, we currently show receiving fully favorable or partially favorable decision 67% of the time. Even more telling, when it comes to appeals for prosthetic limbs, we have received favorable determinations 100% of the time that we have argued the denials on behalf of our clients.

Unfortunately, because of the significant increase in the volume of audits being conducted, the Administrative Law Judge dockets are extremely backed up and the process, which is mandated by federal regulations to take 90 days, is currently exceeding 1 year in some instances. So, the suppliers are required to wait during this period to receive reimbursement for expensive equipment that they have purchased or if an overpayment has been identified, they must satisfy that overpayment while the outcome of the hearing is pending. This causes a significant financial burden. In our practice, we have seen multiple companies forced to lay off employees or completely shut their doors as a result of audits and backlogged appeals. The impact on these audits is much more devastating on small businesses as they do not have the additional resources and financial ability to respond to the increased workload of responding to and defending these audits. Most DMEPOS suppliers are small businesses so the impact is felt more severely and there is seemingly no end in sight.

While the necessity of audits will never go away, what can be done is for CMS to implement more consistent and reasonable processes when auditing healthcare providers. Additionally, providing guidance and limitations on these large government contractors when auditing small businesses to lessen the impact. An audit of a provider should never result in employees being laid off and businesses closing because a “t” was not crossed or an “i” was not dotted. Unfortunately, that is currently the case. The companies who can afford to fight and defend themselves can often do so successfully, but in some instances, it may be too late.

Once again, thank you for your time and consideration today.