Testimony of Sandy Coston, CEO and President, Diversified Service Options, Inc.

United States Senate Committee on Finance Hearing

"Creating a More Efficient and Level Playing Field: Appeals Issues in Medicare"

Chairman Hatch, Ranking Member Wyden, and distinguished members of the Committee. It is an honor to testify before you today. I am Sandy Coston, CEO and President of Diversified Service Options, Inc. (Diversified) and its wholly owned subsidiaries, First Coast Service Options, Inc. (First Coast) and Novitas Solutions, Inc. (Novitas). With over 20 years of experience in the Medicare program, I am very grateful for the opportunity to share my thoughts on how to improve the Medicare appeals process.

First Coast and Novitas contract with the Centers for Medicare & Medicaid Services (CMS) to provide quality Medicare administrative services throughout the United States to approximately five hundred thousand health care providers who care for more than eleven million Medicare beneficiaries. The services we provide include claims processing, customer service, appeals adjudication, education and outreach activities, and functions that help ensure the integrity of Medicare Program payments.

We are proud to serve as the Part A and Part B Medicare Administrative Contractor (MAC) for Florida, Puerto Rico, and U.S. Virgin Islands (Jurisdiction N), Delaware, District of Columbia, Maryland, New Jersey, and Pennsylvania (Jurisdiction L), and Arkansas, Colorado, Louisiana, Mississippi, New Mexico, Oklahoma and Texas (Jurisdiction H). Collectively, these three contracts represent approximately 32% of the national Part A and Part B Medicare workload. We take our responsibility of protecting the Medicare Trust Fund seriously and we have approximately 3,400 staff located in Florida, Georgia, Maryland, Pennsylvania, Texas, and Wisconsin that carry out these responsibilities on a daily basis. Our headquarters are in Florida and Pennsylvania and we have proudly served the Medicare Program since its inception.

We applaud the Committee for holding this hearing to highlight the need to improve appeals processes. We also appreciate the work of Senator Hatch and Senator Wyden for their work focusing attention on making improvements with input from Medicare contractors such as ours and other key stakeholders who care about the Medicare program and are committed to making improvements.

The focus of my testimony today will be on ways to streamline the appeals process and lower the appeals backlog; specifically, our role in the appeals process, a description of what we believe generated significant increases in appeals resulting in the current backlogs, efforts that currently take place to alleviate these backlogs, and provide our expertise on additional recommendations to improve the process and further reduce additional appeals backlogs.

Current Appeals Process

Medicare claims are submitted to a MAC for processing. Approximately 95% of Medicare Part A and Part B claims are processed by CMS claims systems without human intervention. Should the claim determination result in a decision that differs from the expectation of the physician, provider, supplier or beneficiary, they have a right to appeal the decision. Currently there are five different levels of appeal.

As referenced in the attached Exhibit I - Claims Appeal Process, the MAC handles the first level of appeal, also referred to as a redetermination. When submitted within the 120 day time limit, the MAC reviews both its initial claim determination as well as any and all information submitted on or with the initial claim and/or the appeal request. This may include information regarding the claim provided to the MAC for the first time. The MAC then either modifies or affirms its original decision and effectuates any changes.

It is important to understand that appeals are not all related to whether or not a particular service was or was not medically necessary (i.e. clinical reviews). In fact a significant number of submissions for appeals are non-clinical in nature (i.e. approximately 40%). In addition, there are a number of other factors that complicate the provider's decision to request an appeal as opposed to taking some other type of action. For example, rather than requesting an appeal, a provider might simply have made a clerical error and in fact needs to request a clerical error claim reopening. In this case, the provider would indicate what was missed or keyed wrong for example, and request that the MAC correct the claim and reprocess. Unfortunately, providers do not always understand when this can be done, nor do they make a clear distinction as to what they are asking the MAC to do (i.e. appeal or reopening) leaving it up to the MAC to review each request and determine the most appropriate course of action to take that will address the provider's request.

Another common problem is that some providers deal with multiple MACs. This can lead to confusion as to which MAC should be sent the appeal for the claim at hand. MACs also must upon appeal receipt, sort out those appeals that belong to other MACs and reroute them for the providers.

There are also issues that surface in appeal requests that are not “appealable issues”. These types of requests are handled as inquiries and responded to with letters of explanation rather than as an appeal. These include things such as claims that never processed initially but may have been rejected for not having contained all the needed information.

Finally, there are a number of claims actions that can occur resulting in an overpayment recovery wherein the claim was initially paid then determined to have been paid in error [e.g. probe reviews, Zone Program Integrity Contractor (ZPIC) investigations and Office of Inspector General special study results]. A letter is sent to the provider indicating the need to repay the Medicare Program; this action is eligible to be appealed. When MACs receive these types of appeals, there is an accompanying action that must be taken to cease overpayment recovery efforts within six days of receiving notification of a valid request for appeal.

These sorting type issues are generally limited to the MAC level of appeal as subsequent levels of appeal require that the first level of appeal have been completed. As a result of all these activities performed by the MAC, over the past three years we have received approximately 4 million appeal requests across our three MAC contracts. Of these, approximately 60% were completed and closed as valid appeals while the remaining 40% fell into one of several sorting categories.

The remaining levels of appeal are performed by entities separate and distinct from the MAC. The second level of appeal, termed a reconsideration, is performed by a Qualified Independent Contractor (QIC) with whom CMS contracts specifically to perform this level of appeal. Their work is limited to those claims for which a MAC redetermination has been completed and the provider remains in disagreement with the outcome. This level of appeal again involves a complete case file review of all the MAC appeal materials as well as any new materials submitted by the appellant. The findings are issued in writing to the appellant and sent back to the MAC to effectuate any changes in claims payment outlined in the appeal decision.

The third level of appeal is that conducted by the Office of Medicare Hearings and Appeals (OMHA) and is termed an Administrative Law Judge (ALJ) Hearing and results in a complete de novo review of the entire appeal case, which can also include appellant testimony, and the issuance of an ALJ decision. The decision issued is again returned to the MAC to effectuate any directed changes in claims payment.

Should the appellant disagree with the ALJ decision, the fourth level of appeal is submitted to the Medicare Appeals Council. The Health and Human Services Departmental Appeals Board (DAB) administers this review. As with the other levels, should the DAB overturn the decision in whole or in part, the MAC effectuates the decision as directed. The final level of review is that of the Judicial Review in the U.S. District Court.

Genesis of Appeals Backlog

Over the last several years, the number of entities that are involved in the evaluation of claims both pre-claim payment and post-claim payment has increased dramatically, as has the number of claims being scrutinized. In addition to the MAC, these entities include the ZPIC, the Comprehensive Error Rate Testing Program Contractor (CERT), and the Medicare Recovery Auditors (formerly Recovery Audit Contactors) (RA). Each of these entities approaches the review of claims from a slightly different perspective. The primary goal of ZPICs is to investigate instances of suspected fraud, waste, and abuse. ZPICs develop investigations early, and in a timely manner, take immediate action to ensure that Medicare Trust Fund monies are not inappropriately paid. They also identify any improper payments that are to be recouped by the MAC. CMS calculates the Medicare Fee-for-Service (FFS) improper payment rate through the CERT program. Each year, the CERT contractor evaluates a statistically valid random sample of claims to determine if they were paid properly under Medicare coverage, coding, and billing rules. Finally the RA's mission is to identify and correct Medicare improper payments through the efficient detection and collection of overpayments made on claims of health care services provided to Medicare beneficiaries, and the identification of underpayments to providers so that CMS can implement actions that will prevent future improper payments.

The most significant contributor to changes in the volume of appeals has been the RA. As demonstrated in Exhibit II – First Coast Medicare Part A Appeals Volumes, and using First Coast Part A claims as the example, the overall percent of appeals driven by RA decisions jumped from 7% in 2011 to 63% in 2013. Similarly, the overall volume of appeals went from approximately 23 thousand to over 66 thousand for the same time periods. Further, this dramatic increase in appeals was also compounded by the type of claims being reviewed. Predominately the increase involved inpatient claims which are more time consuming to review than the majority of prior appeals received by a MAC, and also require a higher level clinical skill set. Therefore, the resources available to handle these appeals at all levels were impacted by both volume and an increase in needed time to conduct a single appeal. Finally, the high dollar value of these inpatient claims being appealed made it more financially important and more likely that providers would pursue all appeal levels available.

Current Efforts to Alleviate Backlogs

To date, a number of actions have been taken to relieve the backlog that now lies primarily at the 3rd (ALJ) level which includes:

- Clarification and Standardization of Documentation Inpatient Admission Rules: CMS published the "Two Midnight Rule" in August of 2013. This rule clarified CMS's longstanding policy on how Medicare contractors review inpatient hospital claims for payment purposes. In addition to working with MACs to ensure consistent understanding of the rules, CMS also facilitated provider education in the form of probe and educate claim reviews.

- Limited RA inpatient claims review: Along with the rule above, the Protection Access to Medicare Act of 2014 signed into law on April 1, 2014, prohibited RAs from conducting any inpatient hospital status reviews on claims with dates of admission from October 1, 2013 to March 31, 2015 to give the probe and educate process time to be completed.

- Limited RA documentation requests: CMS reduced the minimum medical record requests required of RAs to reduce the administrative burdens on hospitals and other providers, as well as limited the percentage of selected claims to 75% for any one claim type. In addition, CMS carefully reviews each new claim review initiative developed by RAs.

- Hospital Appeals Settlement Project: CMS initiated a project in January of 2015 to allow all eligible hospitals to enter into an administrative agreement in exchange for withdrawing their pending inpatient status appeals. This agreement results in a timely partial payment of 68% of the net allowed amount.

- OMHA Settlement Conference Facilitation Pilot: This pilot is currently limited to Part B appeals for which an ALJ hearing was filed in calendar year 2013 and those not yet assigned to an ALJ. Following CMS and the Appellant reaching agreement, the MAC calculates the settlement amount and issues payment according to the terms of the settlement. As with the process outlined above, the provider relinquishes any right to further appeals on the claims involved.

Recommendations to Streamline the Appeals Process and Reduce Backlogs

The following is an overview of several recommendations that may effectively reduce the backlog of appeals at the ALJ level and or keep a backlog from reoccurring as well as a recommendation to improve the appeals process while gaining efficiencies.

- Remand cases to the prior level of appeal when the ALJ finds good cause for the submission of new evidence: In cases where new evidence is submitted at the ALJ level, remanding these cases back to the prior level for handling would result in a reduction in the ALJ backlog, as well as quicker resolution for the provider. Further, handling these cases at an earlier level of appeal not only preserves the ALJ level of appeal for the provider when needed, but reduces the expense of having the MAC and the QIC appeals staff prepare for and participate in cases that may indeed be able to be resolved based on the new evidence. Additionally, for reconsiderations that are favorable, there is significant cost avoided by the ALJ as well as the provider and likely the provider would receive payment sooner.

- Establish a per-claim filing fee for appeals brought by providers and suppliers which would be refunded on fully favorable decisions: This would discourage the filing of non-

meritorious appeals thereby reducing the backlog and provide a level of funding for reinvestment in program hiring and administration.

- The 1st level of appeal by the MAC could easily be modified to focus on the needed triaging of cases and the processing of cases which do not have a medical necessity component. This would modify the MAC's role from that of performing all of the 1st level appeals to that of triaging appeal requests. This triage would support the continued need to sort out the cases properly addressed as reopenings and/or inquiries, allow rerouting of misdirected appeals to the correct contractor, and timely identification of those valid appeals requiring a hold on the overpayment collection process. Additionally, by limiting the MAC appeal case work to those non-clinical cases would allow the MAC to focus its dollars on the cases most likely to be reversed at this level. The QIC would then be positioned to handle the appeals involving a more complex level of clinical decision making. Most importantly this would eliminate a back and forth of cases going into the QIC and having to be rerouted to the MAC, and the QIC having to hold its appeal receipt waiting for the MAC to prepare the documents it needs to conduct its reconsideration or 2nd level of appeal. Further and with all contractors linking the appeals process through the Medicare Appeals System (MAS), a system that CMS has already implemented, the MACs can initiate the file on the appeals and electronically initiate a case at the QIC level without having to transfer a file.

The operational savings associated with the elimination of the 1st level of clinical appeal could then be redirected into provider education on the most common claim denial findings. These topics would include claims submission accuracy and common documentation pitfalls.

As evidenced by common review findings Exhibit III - Common CERT Errors, providers frequently miss a key element of required documentation not because the patient didn't need the service being billed but because they did not add the few required elements reviewers are required to ensure are evident in the medical records. This error results in the finding of insufficient documentation. Closely related are the issues of medical necessity where the documentation lacks sufficient information to conclude that the patient needed the service billed. With additional funding, the MAC could deliver a more intensive level of training around these issues to keep these types of claim denials from occurring in the first place. Finally, by eliminating a level of appeal, the provider has fewer contractors to deal with and is able to reach the ALJ, Medicare Appeals Council and Federal District Court sooner should they chose those levels of appeal.

In closing, we appreciate the leadership of this Committee in reviewing ways to improve the appeals process and reduce backlogs. We remain supportive of the program and look forward to being part of the solution to these complex challenges. I thank you for the opportunity to testify before this Committee and I look forward to answering your questions.

Sandy Coston, CEO and President Diversified Service Options

As CEO, Coston sets the strategy and vision and provides executive leadership for the Diversified enterprise. She has accountability for government contracts administration including Part A and Part B Medicare Administrative Contractor contracts as well as managing a national provider reimbursement program for undocumented alien emergency services and a financial management services contract for the national Marketplace. Coston also serves on the Diversified, First Coast and Novitas boards of directors and on that of Diversified's affiliate, TriCenturion—a program safeguards company.

Prior to joining First Coast in 2004, Coston held several leadership positions at Blue Cross and Blue Shield of Wisconsin (BCBSWI) and then was appointed President of United Government Services, a wholly owned subsidiary of BCBSWI. In her role as President, she had responsibility for all aspects of the company's business, including providing strategic direction and executive leadership as well as administering the Medicare Part A and various Medicaid contracts.

Exhibit I

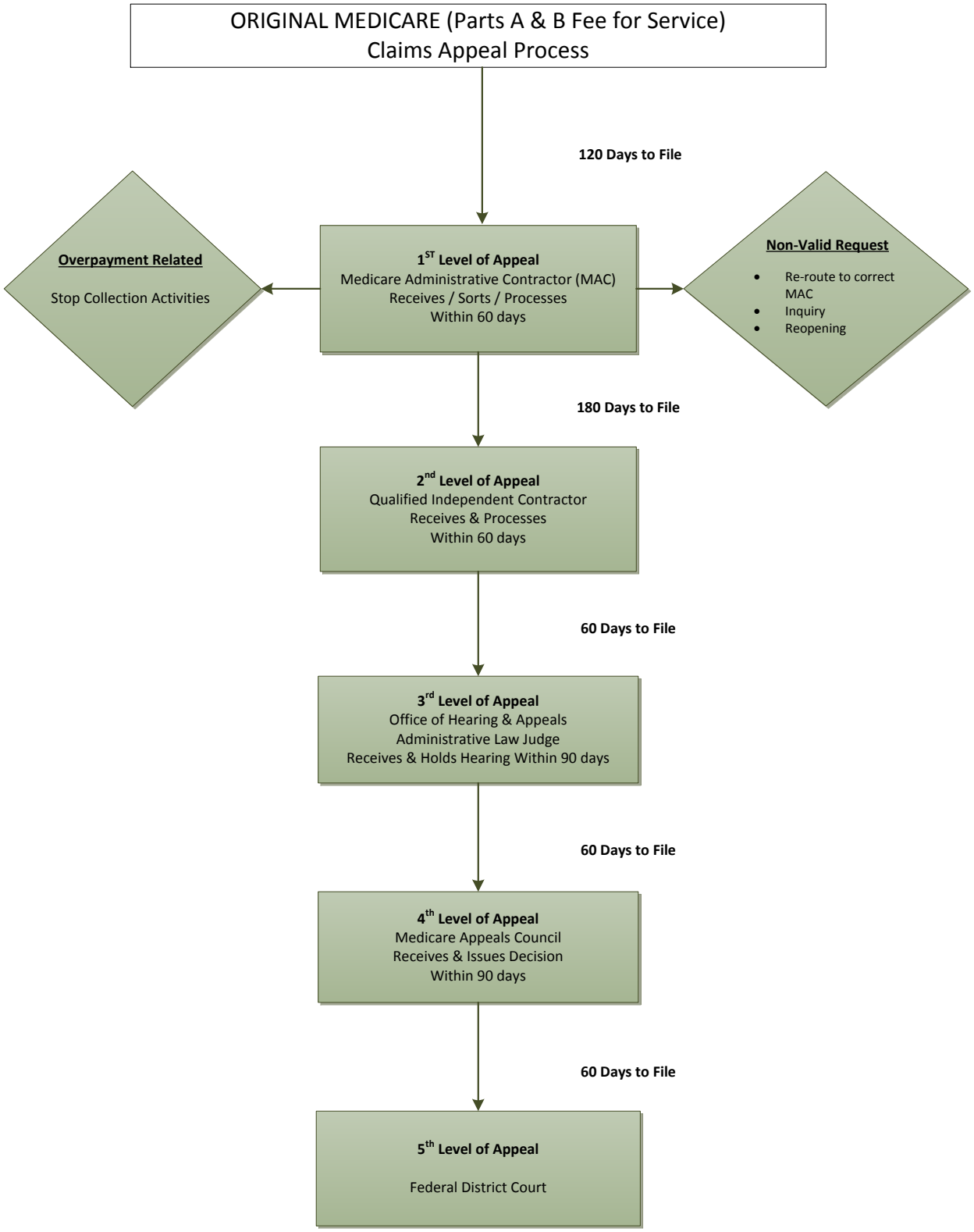

ORIGINAL MEDICARE (Parts A & B Fee for Service)
Claims Appeal Process
120 Days to File
Overpayment Related
Stop Collection Activities
1ST Level of Appeal
Medicare Administrative Contractor (MAC)
Receives / Sorts / Processes
Within 60 days
Non-Valid Request
Re-route to correct MAC
Inquiry
Reopening
180 Days to File
2nd Level of Appeal
Qualified Independent Contractor
Receives & Processes
Within 60 days
60 Days to File
3rd Level of Appeal
Office of Hearing & Appeals
Administrative Law Judge
Receives & Holds Hearing Within 90 days
60 Days to File
4th Level of Appeal
Medicare Appeals Council
Receives & Issues Decision
Within 90 days
60 Days to File
5th Level of Appeal
Federal District Court

Exhibit II

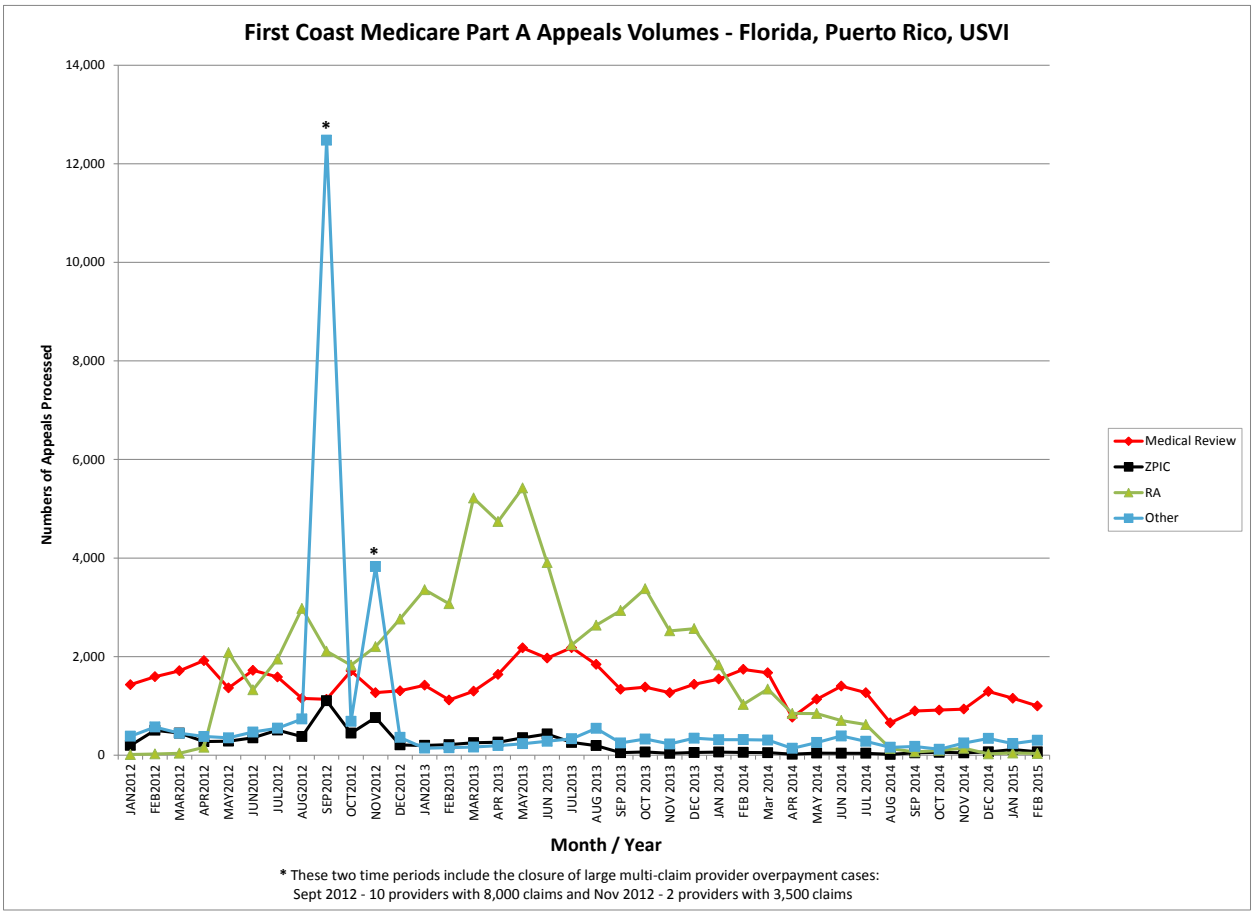
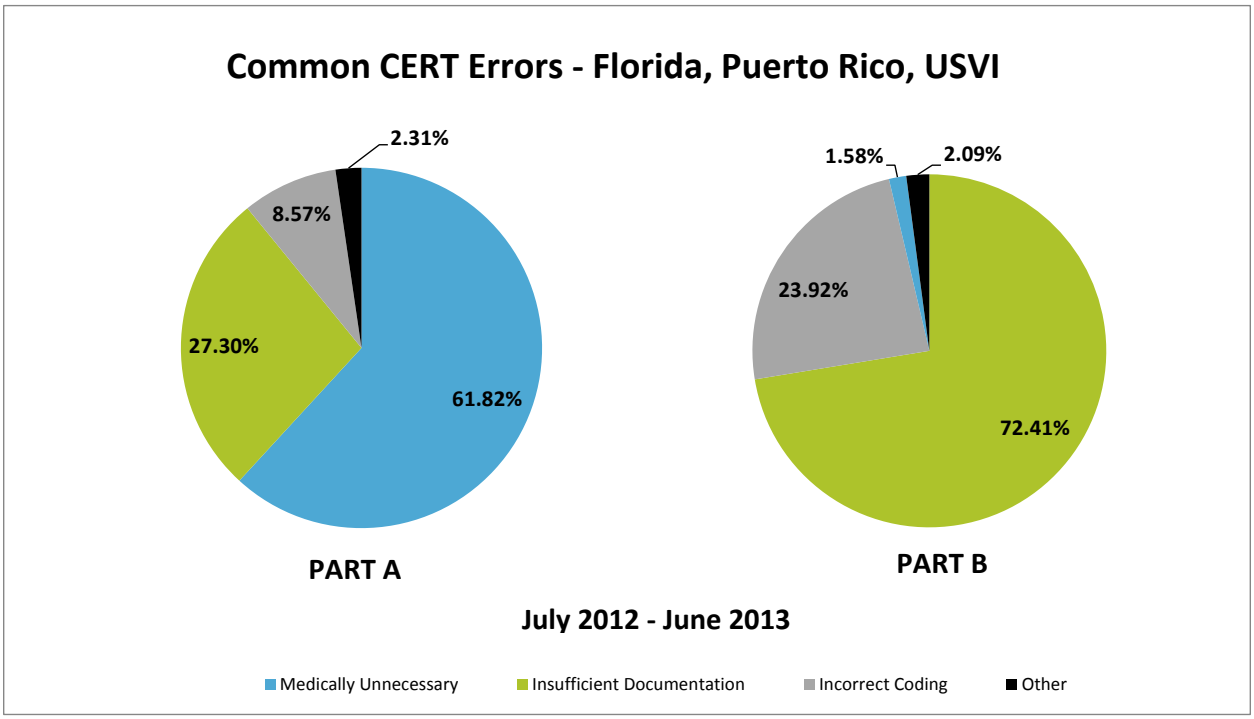

First Coast Medicare Part A Appeals Volumes - Florida, Puerto Rico, USVI
Numbers of Appeals Processed
14,000
12,000
10,000
8,000
6,000
4,000
2,000
0
*
*
JAN2012
FEB2012
MAR2012
APR2012
MAY2012
JUN2012
JUL2012
AUG2012
SEP2012
OCT2012
NOV2012
DEC2012
JAN2013
FEB2013
MAR2013
APR 2013
MAY2013
JUN 2013
JUL2013
AUG 2013
SEP 2013
OCT 2013
NOV 2013
DEC 2013
JAN 2014
FEB 2014
Mar 2014
APR 2014
MAY 2014
JUN 2014
JUL 2014
AUG 2014
SEP 2014
OCT 2014
NOV 2014
DEC 2014
JAN 2015
FEB 2015
Month / Year
Medical Review
ZPIC
RA
Other
* These two time periods include the closure of large multi-claim provider overpayment cases:
Sept 2012 - 10 providers with 8,000 claims and Nov 2012 - 2 providers with 3,500 claims

Exhibit III


Common CERT Errors - Florida, Puerto Rico, USVI
2.31%
8.57%
27.30%
61.82%
PART A
1.58%
2.09%
23.92%
72.41%
PART B
July 2012 - June 2013
Medically Unnecessary
Insufficient Documentation
Incorrect Coding
Other