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Via Overnight Courier

November 29, 2007

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS1399
GNC Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, Maryland 21244-1850

Re: Medicare Program; Criteria and Standards for Evaluating
Intermediary and Carrier Performance During Fiscal Year 2008,
CMS 1399-GNC, RIN 0938-ZB02

Ladies & Gentlemen:

As the Chief Medical Officer for RehabCare Group, Inc., I appreciate having the opportunity to comment on the criteria to be used for evaluating the performance of fiscal intermediaries (FIs) and carriers who assist the Centers for Medicare and Medicaid Services (CMS) in administering the Medicare program.

RehabCare Group, Inc., is a leading provider of rehabilitation therapy services, and treats more than 22,000 patients every day. The company manages Medicare claims, denials, and appeals for its own account and on behalf of certain of its program management clients. In the past couple of years, we have successfully appealed over 400 denied claims, a 90.5% success rate, and we are currently managing a caseload of over 1,200 denied claims. I have personally been involved in over 150 hearings before Administrative Law Judges. I feel I am qualified to offer these comments on the criteria and standards for evaluating FI performance.

The FY 2008 Contractor Performance Evaluation for FIs is structured around five criteria designed to meet the stated objectives of CMS. The first criterion, aimed at claims processing, measures contractual performance against accuracy and timeliness requirements, as well as activities in handling appeals. Within the claims processing criterion, we have identified those performance standards that are mandated by legislation, regulation, or judicial decision. These standards include claims processing timeliness, the accuracy of Medicare Summary Notices (MSNs), the timeliness of FI and carrier redeterminations, and the appropriateness of the reading level and content of FI and carrier redetermination letters. Further evaluation in the claims processing criterion may include the accuracy of claims processing, the percent of claims paid with interest, the accuracy of redeterminations, timeliness of forwarding

cases to and effectuation of Qualified Independent Contractor (QIC) decisions, and effectuation of administrative law judge (ALJ) decisions.

The second criterion, going to customer service, assesses the adequacy of the service provided to customers by FIs in their administration of the Medicare program. Functions to be evaluated under this criterion include: (1) timeliness and accuracy of all correspondence to providers; (2) monitoring the quality of replies provided by the contractor's provider telephone customer service representatives (quality call monitoring); and (3) provider outreach and education activities.

The third criterion, concerning payment safeguards, evaluates whether the Medicare Trust Fund is safeguarded against inappropriate program expenditures. FI performance may be evaluated in the areas of Medical Review (MR), Medicare Secondary payer (MSP), Overpayments (OP), and Provider Enrollment (PE). In addition, FI performance may be evaluated in the area of Audit and Reimbursement (A&R).

We would like to offer our comments on these three criteria.

The first criterion involves the accuracy of claims processing. CMS designed a system where there are multiple FIs across the United States. Each FI interprets for itself the Medicare Federal Register. Each FI may have its own Local Coverage Determination (LCD) plan or a medical director who may interpret the Federal Register differently than another FI's medical director. All of this leads to a high degree of variability in results between the FIs. Our company operates a very large number of facilities in virtually every region of the country. As a result, we have seen denied claims and the accompanying reasons for denial from all of the FIs. In our experience, there is an inexplicable lack of consistency in the review and treatment of similar claims among the various FIs. In fact, we have observed significant inconsistencies where a city or region is split between FIs and the allowance of a claim may just depend on which FI responsible for processing the claim. In Puerto Rico, where we manage an Inpatient Rehabilitation Facility ("IRF") under COSVI, we saw a significant number of denials that were ultimately overturned while other IRFs in Puerto Rico under different FIs did not even receive requests for chart reviews.

The first criterion also looks at the accuracy of redeterminations. In most of the redeterminations that we have seen based on medical necessity, there has been no involvement or oversight by qualified physicians who have the type of specialized training and experience necessary to evaluate unique patients, diagnoses, treatment alternatives, and plans of care. This has led to a significant number of claims being denied on redetermination but which, subsequently, were overturned at the QIC or ALJ level when it was

determined that the treatment or plan of care was, in fact, medically necessary. (Even at the QIC level where there is supposed to be a guarantee of physician review, we have seen claims that are denied for lack of medical necessity where the reviewer was a nurse or a physical therapist lacking the necessary qualifications.) The inefficiencies and costs associated with this pattern of results- for all parties concerned- are very significant.

The second criterion involves the need for FIs to provide outreach and education activities. Consistently we have found that FIs may provide full or half day education courses with a view towards improving documentation relating to medical necessity or improving understanding of the 75% Rule. When the FI staffs are queried, however, for specific patient examples or clinical vignettes, the usual response is that such information cannot be provided and must be determined retrospectively on a case by case basis. Notably, Mutual of Omaha has been asked at multiple education forums if it can provide an example of a total joint replacement patient that would be appropriate for admission to inpatient rehabilitation. Mutual of Omaha claims that specific information cannot be provided and that determinations must be made retrospectively on a case by case basis.

The third criterion speaks to payment safeguards and an evaluation of whether the Medicare Trust Funds is being properly protected. Currently, there is no requirement that FIs review decisions by the QICs or ALJs and then adjust their claims processing accordingly. TriSpan, for example, has had over 90% of its denials overturned at the QIC or ALJ levels but it is still denying claims at the same rate, on the same bases, and using the same procedures and the same personnel. The costs, to the FIs, the Medicare Trust Fund, and the providers, of this sort of performance are huge. FI performance should be evaluated, at least in part, on conformity with QIC and ALJ decisions and on the percentage of denials that are subsequently overturned at higher levels.

There is a considerable degree of economic inefficiency resulting from the manner in which FIs are performing their functions. Patient access to care and the quality of care delivered to patients are also being compromised as a result.

The current denials and appeals system has numerous problems with far reaching ramifications:

- There is an inappropriate "sentinel effect" caused by denials. When a medically complex total knee replacement claim (that meets medical necessity) is denied by the FI review team, then all future medically complex total knee replacement patients are denied access to appropriate inpatient rehabilitation care by the admitting facility for the next 18 months until the

case is overturned by the ALJ. During that time period all complicated total knee replacement patients are sent to a less appropriate setting and do not receive the intensity of care nor the amount of therapy they are entitled to or that they need. In our experience, it takes a minimum of six months after the denial is overturned to re-establish referral patterns so that facilities once again appropriately refer those patients to an IRF.

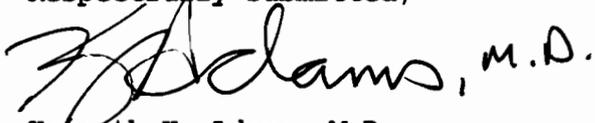
- The cost to providers in appealing wrongfully denied claims is significant. In our experience, rectifying an improper denial at the QIC or ALJ level can cost as much as \$3,000 in staff time. At RehabCare, we have conservatively spent over \$750,000 this year appealing claims that were ultimately overturned in favour of the beneficiary.
- FI's are required to notify beneficiaries of a denial and the way in which that's being done is creating a significant amount of undue stress for these mostly elderly patients. Denial letters should be written at the educational level of the person receiving the letter. This is not occurring. Denial letters are too often written in an incomprehensible style that confuses the patients. We've seen cases where patients have been lead to believe that Medicare is not picking up any of their covered expenses. Despite constant reassurance during the process, patients will frequently call to find out if "we've taken care of their hospital bill or will they still have to payback Medicare?"

The FI performance and evaluation criteria should include unambiguous metrics by which the kinds of problems outlined above are captured and corrected. To that end, we offer the following recommendations:

- 1) FI error and overturn rates should be calculated and published when denials are taken to the ALJ level.
- 2) Further audits in a facility should be abated until a final decision on initial denials is made at ALJ level and if the decision of the FI is overturned then the audits should be terminated.
- 3) FIs should be required to have competent and qualified reviewers who have the professional training and clinical experience necessary for unique patients, diagnoses, and plans of care.
- 4) FI LCD's should be required to conform strictly with the Medicare Benefits Policy Manual and there should be no inconsistencies between the LCDs of the various FIs.

- 5) A study should be done on the economic impact to patients, providers, FIs, and the Medicare Trust Fund associated with cost of rectifying improperly denied claims.
- 6) FIs should be required to give specific examples of de-identified patient charts of cases that meet FI approval.
- 7) FIs need to write denial letters to beneficiaries that are intelligible; specifically delineate that the letter is a courtesy letter; and that the patient is not responsible for the denied claim unless the patient signed a letter accepting such responsibility.
- 8) FIs should have report cards that are rated by the providers as to the customer service levels that the FI's provide.

Respectfully submitted,



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November 30, 2007

Ms. Lee Ann Crochunis
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7500 Security Boulevard
Mail Stop C4-26-05
Baltimore, Maryland 21244-1850

RE: File Code: CMS-1399-GNC
Medicare Program; Criteria and Standards for Evaluating Intermediary and
Carrier Performance During Fiscal Year 2008

Dear Ms Crochunis:

This letter presents the comments and recommendations of the Federation of American Hospitals ("FAH") on the Centers for Medicare & Medicaid Services' (CMS) Criteria and Standards for Evaluating Intermediary and Carrier Performance During Fiscal Year 2008. The Federation of American Hospitals is the national representative of investor owned or operated community hospitals and health systems throughout the United States. Our members include teaching and non-teaching, acute, rehabilitation, psychiatric, cancer, and long-term care hospitals in urban and rural America, and provide a wide range of ambulatory, acute and post-acute services.

I.C. Development and Publication of Criteria and Standards

Medicare contractor evaluation is a critical component of CMS' ability to promote good provider relations. Providers must have a mechanism for submitting input regarding the criteria and standards used to evaluate Medicare contractors. CMS states the standards and criteria for evaluating the performance of fiscal intermediaries and carriers will continue to be developed as long as those types of contractors exist. Although the notice references the replacement of fiscal intermediaries and carriers by Medicare Administrative Contractors (MACs), FAH believes additional clarification regarding future contractor performance should be included.

We recognize that the MAC Statements of Work include the same type of criteria and standards for evaluation as this notice does for current contractors. However, we recommend CMS utilize on an annual basis the current format in the Federal Register to

propose changes to MAC evaluations for an upcoming fiscal year. Such a process is more transparent, and would afford providers and others more appropriate and timely notification of proposed changes and allow ample opportunity for the submission of comments.

Thank you for your consideration of this comment. If you have any questions, please feel free to contact me at 202-624-1529 or sspeil@fah.org.

Sincerely,

A handwritten signature in black ink that reads "Steve Speil". The signature is written in a cursive, slightly slanted style.

Steve Speil
Senior Vice President
Health Finance and Policy