COLORADO
Department of Health Care Policy & Financing

303 E. 17th Avenue
Denver, CO 80203

November 17th, 2023

RE: Recovery Audit Contract (RAC) Audit "Excessive use of Initial Hospital Care Codes"

Dear Colorado Hospital Association and Colorado Medical Society Representatives:

In response to both of your requests for a review of the RAC audit entitled "Excessively billed Evaluation and Management Initial Hospital Care Codes" and the concerns you shared in your communications, the Department is providing a detailed response below. We have addressed the issues you raised including provider types included in the audit; the restart of the audit; informal reconsideration and appeals rates; audit methodology and examples; claims limits; and regulatory authority from different payors. The Department appreciates your ongoing efforts and we continue to welcome ongoing dialogue to collaboratively work together to ensure the Department meets our compliance requirements as the Medicaid single state agency for Colorado while mitigating unnecessary administrative burden.

The RAC audit is founded on documented historical coding standards and federal and state authorities. This RAC audit entitled "Excessively billed Evaluation and Management Initial Hospital Care Codes" has identified a need for expanded provider education and clarification related to correct coding practices related to Medicare or Medicaid programs. The below information provides additional clarification. Further, the Department will publish an audit fact sheet that will detail more in-depth information to help with transparency and educational opportunities that we have identified through your engagement and partnership with us. At its core, these audits are a feedback resource on the accuracy of provider coding activities. Reducing these findings, through more accurate billing submissions, is a goal we hope is shared among all parties.

After you have reviewed this information, we will schedule a follow up discussion to include me, Executive Director Bimestefer, HCPF COO Ralph Choate, and leaders from both of your organizations. We look forward to that discussion and to more opportunities to improve both the RAC program and the billing performance of care providers, in collaboration with you.

Sincerely,

Bart Armstrong

Bart Armstrong
Fraud, Waste, and Abuse Division Director
Medicaid Operations Office

cc: Kim Bimestefer, Executive Director
Ralph Choate, Chief Operations Officer

RAC Audit: Excessive Use of Initial Hospital Care Codes

Association Concern: Provider Types in the Audit

Your requests stated that this audit was targeting consulting specialty physicians; to clarify, the audit was put in place to identify specific medical billing codes and billed professional claims that were paid to providers. The audit reviewed claims data from 152 provider types and specialties across the spectrum of care and resulted in 997 RAC cases/notices mailed over the last year. This audit did capture billed claims that included, but was not exclusive to, consultations and hospitalists. To help with transparency, we have enclosed "Attachment A: Specialty Provider Types" which includes additional detail on the 152 provider types identified through the audit as billing the initial hospital care codes incorrectly.

Association Concern: Restart of the Audit

The basis for restarting the audit was based on further clarifications from policy, including multiple states Medicaid staff and RAC program contract managers, reports from the Office of Inspector General (OIG), reports from the Government Accountability Office (GAO), reviews of medical documentation and informal reconsideration requests submitted by providers, and the Centers for Medicare and Medicaid Services (CMS) audit clarifications.

The CMS clarifications, starting February of 2023, were initially requested by the Colorado Medical Society, which reached out to a Medicare Regional Medical Director at CMS, Dr. Sean Michael, to help clarify rules and regulatory guidance in regard to this audit. While Dr. Michael did respond, he based his response on Medicare rules. The Department asked that we send the audit clarification to someone who can speak about Medicaid/CMS policies since Medicare rules were not at issue in this audit. Dr. Michael was kind enough to send information through different areas of CMS and they responded by stating that:

"This is an issue between the providers, the hospital billers, the state, and the RAC auditors. There is no way for CMS to get involved in a state-specific, provider-level claims billing discussion when to me, the letter to providers (Department Memo) is extremely detailed and even provides examples of what the state (and RAC) is seeing and why the claims are being denied. It appears to be the hospital billers not understanding how to appropriately bill for initial services. The RAC conducted an audit and found specific issues with billing patterns on the same day. Please look at the letter under "Claim Examples", there are specific examples of the billing issues. It appears the providers need to review their claims submitted by the hospital on the same day to confirm the examples to better understand why the state and RACs needed to take action. This appears to be an "education issue" where providers and their hospital billers need a better understanding of how to bill for initial hospital services so that as mentioned below in the letter "providers should bill the most appropriate code that describes the service, which for CPT would include subsequent care codes"."

Based on the feedback from different states, agencies, and the documentation from providers, the audit was not in question any longer and the Department chose to resume the audit as there were no

further clarifications that were needed. Providers who dispute the methodology in audits should utilize their rights and submit documentation and rebuttals through the audit process so they have documented responses and the ability to challenge any findings they believe are not correct. Using the audit process is the best way to ensure that the requests, outcomes, and details from the provider and the RAC vendor are clarified and that each clarification is timely.

Association Concern: Informal Reconsideration and Appeal Rate

Your requests stated that there was a high appeal and informal reconsideration rate. To help with transparency in this audit, we can assure all providers that the Department did extensive research, worked with policy, and medical coders, and reviewed available historic regulatory documents before approval of the audit. The Department also approved each notice, reviewed medical claims data and medical records, and approved all informal reconsideration notices and language. We can confirm that we have metrics in place to identify issues when there is cause for concern for any audit. **The rate of formal appeal for this audit is 1.3% and the Informal Reconsideration rate is 15%,** both of which are below metrics and risks that would result in a halt of an audit.

Association Concern: Audit Methodology and Examples

Your requests also asked for us to give guidance for a specific code to be used for consults and clarification on the methodology used in the audit. Given the billing patterns found within this audit, which can be unique to each provider, and knowing that this audit spans more than just consultants, we do not want to craft any guidance that would not follow CPT coding guidelines, which can change annually. Additionally, we cannot post AMA guidelines specifically. Those are considered licensed materials and providers are required to have access to those materials as outlined in 45 CFR 162.1000, 10 CCR 2505-10 8.000, in our provider billing manuals, and as required in the signed provider agreement.

We do want to clarify a point on the methodology. While we do not review medical records for automated audits for the initial notice, we do review all records and provider rebuttals that are submitted for informal reconsideration. We also use claims data to identify admitting physicians on hospital claims for this audit. We want to ensure that our reviews, whether automated or medical record reviews, are sound, and we hope this helps with transparency of the level of detail in which we audit claims.

To help clarify what we have seen, we are providing examples of the claims billing issues we have found in this audit. As we have done throughout these audits historically, we continue to invite discussions and reviews of these sometimes-complex examples. While many of our providers have found clarity in those discussions, we invite further conversation on how we can expand our education efforts.

Example 1: Provider is not the admitting physician, but billed initial hospital care codes which is not allowed per AMA guidelines.

Example 2: Provider is not the admitting physician but also bills using the admitting physician indicator from Medicare (-AI) violating both Medicare and Medicaid coding policies.

Example 3: Provider is from the same medical group practice but is not the admitting physician and sees the same patient for the same specialty and then multiple providers from that same practice bill duplicative initial hospital care codes violating both Medicare and Medicaid coding policies.

Example 4: Provider is from the same medical group practice and is not the admitting physician but sees the same patient for the same specialty and multiple providers from that same practice bill duplicative initial hospital care codes and also bills using the admitting physician indicator from Medicare (-AI) the violating both Medicare and Medicaid coding policies.

Example 5: Provider is from the same specialty as another provider who already has seen the patient for the same condition and the same consultation and is not the admitting physician and multiple providers bill duplicative initial hospital care codes violating both Medicare and Medicaid coding policies.

Example 6: Provider is from the same specialty as another provider who already has seen the patient for the same condition and the same consultation and is not the admitting physician and multiple providers bill duplicative initial hospital care codes while using the admitting physician indicator from Medicare (-AI) violating both Medicare and Medicaid coding policies.

Example 7: Provider is not an outside physician and is affiliated with the hospital as a non-consult physician with the same tax ID as the hospital and bills outside of the DRG for professional services violating both Medicare and Medicaid coding policies.

Example 8: Provider is an outside physician consultant and both the group practice and the hospital are owned by the same corporation, but the professional claims are billed in violation of unbundling of the DRG payments.

For more information about physician and hospital relationships, OIG has published guidance for physicians.

Association Concern: Claims Tiers & Limits

Some concerns that have been brought by you include the amount of medical claims in each notice. We have listened to the provider community, and we have put new limits in place for automated audits as of September of 2023. This change was to ensure that not just hospitals, but all providers, had equitable access to utilize their rights to request an informal reconsideration and/or to request a formal appeal. The claims tiers and limits are based on CMS guidance; however, this approach is unique to the Colorado RAC program as we want to ensure we are balanced in the number of claims being audited for each provider. This change resulted in fewer claims being identified as overpayments in notices, compared to the billing patterns of the provider; instead of 100-400 claims being audited in a single notice, now we only allow for a smaller amount; providers who had gotten notices for 300 claims in the 1st cycle of this audit (October 2022) are now seeing a reduction down to 4-50 claims per notice.

This is one of the many RAC program enhancements that we have made to give providers more time to leverage their right for informal reconsideration or appeal. At the same time, we have reduced the number or amount of claims we are auditing to reduce provider administrative burden. The updated tiers for automated audits are posted on the HMS Colorado RAC website and also detailed below:

- Claim limits are based on the Provider's Total Health First Colorado Payments received in the prior State Fiscal Year, ensuring “like” providers are treated equitably.
- Limits are applied at the Colorado Medicaid Provider ID level. Providers may receive more than one Automated Finding letter a month. The below limit is applied across all Automated Finding Letters for that month.
- All Automated Findings will be mailed within the 3rd or 4th week of every month.

Provider Reimbursement (Previous SFY)	Monthly Maximum Claims Limit
$50 Million+	3.33%
$10 Million - $50 Million	2.92%
$4 Million - $10 Million	2.50%
$1 Million - $4 Million	2.08%
< $1 Million	1.67%

Association Concern: Medicare vs. Medicaid & Changes in Payment Policies

Lastly, you stated you had concerns regarding the rules we had applied and who is the regulatory authority when there are conflicting rules from different payors. We do want to make it clear that Medicare is a separate payor with its own reimbursement regulations; as such, Medicare coding standards may differ from those of Health First Colorado. The RAC audit is a shared responsibility across the federal and state governments, with specific roles and responsibilities related to oversight of different public health assistance programs. Each has distinct authorities and standards.

States may have differing benefits that they cover based on their population’s needs, and no two states are alike. However, the standards to deviate from Federal State Medical Assistance rules (42 CFR Part 4 Subchapter C) and a state-approved plan are the same for all states.

All payors must recognize standard coding practices as defined in the Administrative Simplification Act (HIPAA) 45 CFR 162.1000. All Health Plans, including state Medicaid Agencies, are required to follow the code sets (American Medical Association "AMA" Medical Coding guidelines) pursuant to 45 CFR 162.925(c). If a Health plan, including Medicare or Medicaid, deviates from the AMA coding medical coding standards, the CFR, or CMS guidelines, we are required to give notice in billing manuals, bulletins, transmittals, and as the State Medicaid Plan. We also are required to get approval from our regional CMS representatives and get approval from CMS on a State Plan Amendment.

Because Medicare did deviate from the AMA coding standards, they posted the rule changes as detailed below. However, the Department did not deviate from the AMA coding rules, which are shown in our published materials in provider bulletins and manuals from 2010 forward.

To help illustrate the timeline of historical regulatory changes surrounding consultant medical codes and why the Department did not deviate from the AMA coding rules, we have detailed the published rules, laws, and regulations related to the changes that were made.

March 2006
The Office of Inspector General (OIG) published the report "Consultations in Medicare: Coding and Reimbursement". This report identified the abuse and overutilization of consultation codes and recommended that CMS discontinue reimbursement for these medical code sets.

November 25th, 2009
The Centers for Medicare and Medicaid Services (CMS) communicated that it would be discontinuing the use of consultation codes as of January 1st, 2010 in the Federal Register (FR-61768). This communication was for reimbursement and coding standard changes for Medicare only. They did not yet have a methodology to pay specialty providers as the specialty providers who commented stated there was continued overutilization of improper codes being billed for those services (consults); however, they recommended following the AMA coding standards which are the standards we use for this audit today. Use the subsequent hospital care codes as these best define the services that are being rendered. The guidance for the use of a modifier (Admitting Indicator "AI) or certain rules for claims processing had not yet been created. This document contains the entire history of the OIG audit and the changes from 1990-current consultation codes (page 30-end "4. Consultation Services a. Background")

December 18th, 2009
CMS issued a transmittal related to Medicare claims processing for telehealth consultation codes, again, stating that they would discontinue consultation codes for Medicare effective January 1st, 2010. They made note that there was no formal guidance on how to bill those codes at that time, other than to follow AMA coding standards, as noted in the Federal Register from November 25th, 2009.

January 1st, 2010
CMS Discontinues payment of consultation code sets.

March 1st, 2010
The Department issues a provider bulletin stating the following:

"Discontinuation of CPT Consultation Codes Effective April 1, 2010, CPT consultation codes (ranges 99241-99245 for office/outpatient consultations and 99251-99255 for inpatient consultations) will no longer be recognized for payment. This change is being implemented to be consistent with Medicare policy. Please submit claims for consultation services using another Evaluation and Management (E/M) code that most appropriately represents where the visit occurred and that identifies the complexity of the visit performed." This is the same language that was published by CMS for Medicare guidance at that time. Provider billing manuals are also updated to reflect this change as well as to reiterate the use of federal coding standards as defined by the AMA.

We did not provide guidance to deviate from the AMA rules, to use the Medicare-only -AI modifier to identify the admitting physician, or to bill using codes that are defined as "admitting physician codes" to replace the consultation codes that we no longer paid on. The Medicare claims processing that has been cited in our communications from you had not been published at this time, so there would be no training or guidance from CMS that would have been available to allow for the billing practices you have defended.

August 26th, 2011
CMS published a transmittal for their claims processing contractors which allows for the use of the Medicare-only – AI modifier and what standards of reimbursement should be followed. Providers who are consulting still can use other codes, but this publication was to ensure that the claims processing contractor did not deny claims based on specific criteria.

December 1st, 2022
The Department's policy re-publishes the guidance to use the correct coding for consultations in a provider bulletin to help with clarity on what provider billers should do to bill correctly.