Improving Audits: How We Can Strengthen the Medicare Program for Future Generations

United States Senate
Special Committee on Aging

Committee Staff Report

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Introduction

The U.S. Senate Special Committee on Aging has a long track record of tackling issues which threaten the viability of the Medicare program, a program that supplied the basic health care needs of more than 51 million seniors and disabled citizens in 2013. The Government Accountability Office (GAO) considers Medicare to be a high risk program, because of its susceptibility to improper payments.[1] In FY 2013 alone, the Centers for Medicare & Medicaid Services (CMS) reported an estimated $50 billion in improper payments.[2]

Improper payments occur when claims do not comply with Medicare payment policy. For example, instead of getting one payment for a dialysis treatment, a clinic is paid for each service offered during the course of a dialysis treatment separately. An additional instance of an improper payment is when Medicare is billed for a treatment for diabetes when the patient's medical record does not show the patient has diabetes. Paying claims such as these violate Medicare payment policies and can potentially place patients at risk if they receive medically unnecessary treatments.

Congress and the current Administration have aggressively sought to reduce improper payments across the Federal government. In 2009, President Obama signed Executive Order 13520, exploring new incentives for state and local partners to reduce improper payments. On March 10, 2010, the President issued a memorandum directing agencies to intensify efforts to recover improper payments. And on July 22, 2010, the President signed into law the Improper Payments Elimination and Recovery Act (IPERA) (P.L. 111-204), requiring the Secretary of each Department to take certain steps to reduce improper payments.[3]

Partially because of these efforts, improper payments have declined across the Federal government, with a payment accuracy rate of 96.5 percent during FY 2013.[4] However, improper payment rates have actually increased in the Medicare program.

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[1] *See* U.S. Government Accountability Office 2013 High Risk Report, *High Risk: Medicare Program*, 20 May 2014 (Available at http://www.gao.gov/highrisk/medicare_program/why_did_study#t=1).

[2] *See* Kathleen M. King, U.S. Government Accountability Office Highlights, "Medicare: Further Action Could Improve Improper Payment Prevention and Recoupment Efforts," 20 May 2014 (Available at http://www.gao.gov/products/GAO-14-619T).

[3] The Improper Payments Information Act (IPIA) of 2002 (P.L. 107-300), as amended by IPERA and the Improper Payments Elimination and Recovery Improvement Act (IPERIA) of 2012 (P.L. 112-148), requires the Secretary of each Department to take certain steps to identify and reduce improper payments. It requires agencies to estimate the amount of improper payments made by certain programs, submit those estimates to Congress, and report actions the agencies are taking to reduce those payments.

[4] *See* Payment Accuracy (available at http://www.paymentaccuracy.gov/).

In FY 2013, Medicare financed health care for 51 million individuals at a cost of about $604 billion, reporting $50 billion in improper payments.[5] The Department reported that Medicare fee-for-service's improper payment rate increased from 8.5 percent in FY 2012 to 10.1 percent in FY 2013.[6] The 10.1 percent improper payment rate in Medicare fee-for-service programs represented a dramatic increase in improper payments, compared to the previous five years. [7]

The improper payment rate rose this year despite multiple efforts by the CMS and its contractors to review claims both before and after payment, and to implement automatic payment rules, or edits, which deny claims that do not comply with Medicare requirements before payment occurs. Industry stakeholders have complained that the CMS's multiple audits and claims review processes are duplicative and poorly coordinated, placing an undue burden on providers, while doing little to reduce improper payments.[8]

Aging Committee staff began to examine these issues to understand better the nature of the audit burden placed on providers and to identify areas of potential overlap between the CMS's audit and review mechanisms. During the course of this examination, we reviewed concerns from health care providers and suppliers regarding the CMS's audit and review mechanisms. We also reviewed documents from health care providers regarding the audit burden posed by audits or reviews

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[5] *See* Kathleen M. King. U.S. Government Accountability Office, "MEDICARE: Further Action Could Improve Improper Payment Prevention and Recoupment Efforts," Highlights, 20 May 2014, supra.

[6] *See* Centers for Medicare & Medicaid Services, Medicare FFS 2012 Improper Payments Report (Available at http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/CERT/Downloads/MedicareFeeforService2012ImproperPaymentsReport.pdf). There is a six-month overlap between the official 2011 and 2012 report periods (both include claims sampled between July 2010 and December 2010). Had this change in report period been applied in 2011 in place of the prospective adjustment factor, the improper payment rate would have been 9.6 percent (representing $32.4 billion in improper payments) rather than 8.6 percent (representing $28.8 billion in improper payments), as reported in the FY 2011 HHS Agency Financial Report and the Medicare FFS 2011 Improper Payments Report.

[7] The "Improper Payments Elimination and Recovery Act of 2010" (IPERA) (P.L. 111-204) establishes the definition of an improper payment. According to the Act, an improper payment "means any payment that should not have been made or that was made in an incorrect amount (including overpayments and underpayments) under statutory, contractual, administrative, or other legally applicable requirements; and includes any payment to an ineligible recipient, any payment for an ineligible good or service, any duplicate payment, any payment for a good or service not received (except for such payments where authorized by law), and any payment that does not account for credit for applicable discounts.

[8] *See* American Hospital Association, "Program Integrity and Contractor Overlap," (available at http://www.aha.org/content/12/12-ip-program-integ.pdf).

conducted by the CMS or its contractors, as well as data compiled by the American Hospital Association (AHA), and interviewed providers and their staff regarding these reviews. We consulted with multiple health care systems regarding ways to improve the audit and review processes. We also reviewed the CMS and contractor data on audits.

Committee staff examined the CMS's pre-payment and post-payment claim review programs, including the roles of its contractors, as well as the CMS and Departmental reports and documents, and Office of Inspector General (OIG), Government Accountability Office (GAO), Medicare Payment Advisory Commission (MedPAC), and private reports related to improper payments under the Medicare program. We reviewed the methodology by which CMS's improper payment rate is calculated, and conducted site visits to two Medicare Administrative Contractors (MACs) and a Recovery Audit Contractor (RAC) to understand payment processing and recovery procedures better. We also received briefings from the CMS on the Fraud Prevention System, the Health Care Fraud Prevention Partnership, the improper payment rate, and discussed the topic with a variety of experts.

In addition, we reviewed HHS's plan for reducing the 2013 improper payment rate, as published in HHS's FY2013 Agency Financial Report.[9] This plan included expansion of the Recovery Audit Contractor (RAC) program; a prior authorization pilot project for power mobility devices; changes to inpatient billing policies; provider education; and focusing medical record review activities on problematic areas.

This report examines and evaluates those actions planned by HHS within the larger context of (1) stakeholder complaints regarding the CMS's auditing and review activities; (2) the broad array of edit, audit and review mechanisms available to the CMS; and (3) areas of potential overlap in these mechanisms. Further, Committee staff suggest ways that the CMS can streamline the audit function, thereby reducing improper payments while conserving scarce resources for medical record review and auditing.

The Committee does not address improper payments in Medicare Parts C and D, where payments are made on a capitated basis, in this report. This is because improper payment rates were lower in Medicare Part C (9.5 percent or $11.8 billion,

[9] *See* Medicare Fee-for-Service, Program-Specific Reporting Information, HHS FY 2013 Financial Report, p. 167. (Available at http://www.hhs.gov/afr/2013-hhs-agency-financial-report.pdf).

with a net overpayment rate of only 5.6 percent) and Part D (3.7 percent or $2.1 billion).[10]

[10] *See Id* at 171-172.

Background

The CMS makes payments both on a fee-for-service (FFS) basis and on a capitated[11] basis, depending on what part of Medicare is providing the service. Here is a brief explanation of what each part covers:

- Medicare Part A provides hospital, skilled nursing care, home health, and certain other services;
- Medicare Part B covers outpatient services, including durable medical equipment;
- Medicare Part C allows private insurers to offer Medicare coverage to beneficiaries in a managed care environment; and
- Medicare Part D provides for prescription drug coverage.

When paying on a FFS basis, the CMS is charged for health care services actually rendered to a qualified Medicare beneficiary and reimburses health care providers or organizations for that service according to certain fee schedules and coverage decisions. These FFS reimbursements generally occur under Medicare Part A or Part B, depending on whether the service is provided on an outpatient or inpatient basis, as well as the setting (hospice, home health, skilled nursing facility, etc.).

Generally, the Department of Health and Human Services reported that improper payments made in Medicare's FFS programs declined steadily between FY 2009 through FY 2012. In FY 2012, Medicare FFS program's improper payment rate was 8.5 percent, representing $29.6 billion in improper payments.[12] This represented a significant reduction from the FY 2009 rate of 10.8 percent.[13] Yet, in FY 2013, the improper payment rate in Medicare FFS increased again to 10.1 percent, or $36 billion.[14] The FY 2013 rate reflects claims for services between July 1, 2011 and June 30, 2012.[15] This rate is calculated based on a random sample of claims reviewed by the Comprehensive Error Rate Testing (CERT) program, and it has no relationship to the amount of improper payments Medicare recovers in any given

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[11] A fixed payment remitted at regular intervals to a medical provider by a managed care organization for an enrolled patient.

[12] *See* Centers for Medicare & Medicaid Services, *Medicare FFS 2012 Improper Payments Report* (Available at http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/CERT/Downloads/MedicareFeeforService2012ImproperPaymentsReport.pdf).

[13] *See* Department of Health & Human Services, *FY 2013 Agency Financial Report*, p. 15.

[14] *See Id* at 163. This rate excludes payments made in error under Part A which should have been billed as an outpatient service under Part B. Without this adjustment, the rate would have been 10.7 percent.

[15] *See Id* at 162.

year. Instead, HHS attributed this increased error rate to new policy changes; for example, providers were reportedly confused by the new requirement, implemented in January 2011, for documentation of face-to-face encounters with physicians before providing home health services, resulting in documentation that did not support the claimed service.[16]

To address improper payments, the CMS reviews claims both before and after payment in a variety of ways. Prepayment claim review programs include the National Correct Coding Initiatives edits, including Medically Unlikely Edits, and MAC reviews.[17] Post-payment claim review programs include the CERT program, the RAC program, and post-payment review activities by other contractors, including the MACs.

An Overview of the Role of Medicare Contractors

The CMS has traditionally relied on contractors to perform many of these audit and review functions. Between 1965 and 1996, Medicare processed claims through two types of contractors, known as fiscal intermediaries and carriers. Public Law 104-191, the Health Insurance Portability and Accountability Act of 1996 (HIPAA), established the Medicare Integrity Program, which authorized CMS to contract separately for program safeguard contractors (PSCs) to identify and investigate potential fraud. With the passage of the Medicare Prescription Drug Improvement and Modernization Act (MMA) of 2003 (P.L. 108-173), the fiscal intermediaries and carriers were replaced by the Medicare Administrative Contractors (MACs). Previously, fiscal intermediaries processed Part A claims, while carriers processed Part B claims for many of the same providers. This led to a variety of communication issues, resulting in a report by GAO highlighting the need for contracting reform.[18] The same MACs now process both Part A and Part B claims, and also conduct pre-payment and post-payment claims reviews, audits of institutional providers and implementation of local coverage determinations. There

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16 *See Id* at 32.

17 *See* Centers for Medicare & Medicaid Services, *Medicare Claim Review Programs: MR, NCCI Edits, CERT, and Recovery Audit Program* (Available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/mcrp_booklet.pdf).

18 *See* Leslie G. Aronovitz, Testimony Before the Subcommittee on Health, Committee on Ways and Means, House of Representatives, 25 September 2001 (Available at http://www.gao.gov/new.items/d011141t.pdf).

are currently 12 MACs processing Part A and Part B claims, and four MACs processing Durable Medical Equipment (DME) claims.[19] [20]

The CMS also transitioned fraud investigation activities from the 18 PSCs to six Zone Program Integrity Contractors (ZPICs).[21] ZPICs aid in the identification and investigation of potentially fraudulent activities. The MMA also established a demonstration project to assess the use of recovery audit contractors (RACs) in the Medicare program. Subsequently, the Tax Relief and Health Care Act of 2006 (P.L. 109-432) required implementation of a permanent RAC program. RACs identify and aid in the recovery of improper payments made on behalf of the Medicare program.

Each of these contractors reports to a different part of the CMS. The Center for Medicare oversees the MACs, while the Office of Financial Management oversees the RACs and the CERT program. The CERT program audits providers both to estimate Medicare's improper payment rate and to categorize errors contributing to those rates. The Office of Financial Management has overall responsibility for oversight of claims review activities by MACs, RACs, and the CERT program and for the measurement of the improper payment rate. The Center for Program Integrity oversees the ZPICs and has responsibility for program activities involving the investigation of fraud.[22]

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[19] *See* Centers for Medicare & Medicaid Services, "Medicare Administrative Contractors," 10 July 2013 (Available at http://www.cms.gov/Medicare/Medicare-Contracting/Medicare-Administrative-Contractors/MedicareAdministrativeContractors.html).

[20] *See* Centers for Medicare & Medicaid Services, "Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Jurisdictions," 16 Aug 2013 (Available at http://www.cms.gov/Medicare/Medicare-Contracting/Medicare-Administrative-Contractors/DME-MAC-Jurisdictions.html).

[21] Due to contract protests, a seventh ZPIC was not fully operational. In this area, a PSC continued to perform these duties. *See* U.S. Government Accountability Office, *Medicare Program Integrity: Contractors Reported Generating Savings, but CMS Could Improve Its Oversight*, Report to Congressional Requesters, October 2013 (Available at http://www.gao.gov/assets/660/658565.pdf).

[22] *See* U.S. Government Accountability Office, "Medicare Program Integrity: Increasing Consistency of Contractor Requirements May Improve Administrative Efficiency," Report Highlights (Available at http://www.gao.gov/products/gao-13-522).

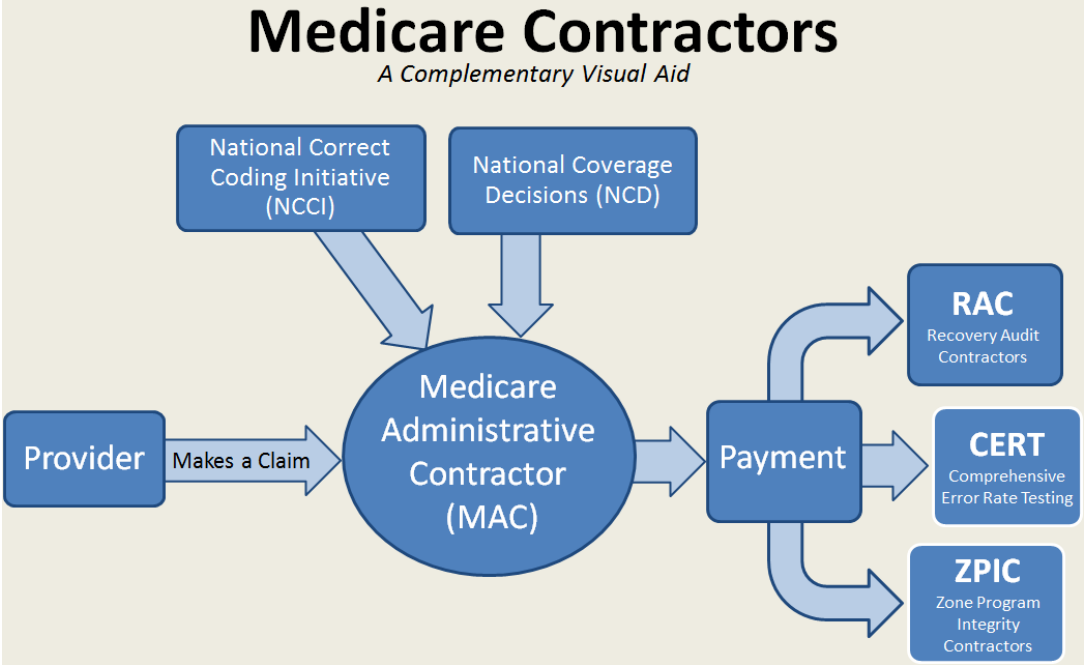

Figure 1: A Diagram of Program Integrity Contractor Functions.

As Figure 1 illustrates, the MACs pay the claims based on a variety of inputs from pre-payment review processes, and those payments are reviewed by different post-payment review contractors. MACs are required to have error rate reduction plans in place for reducing improper payments made in their jurisdiction.[23] These plans are required to contain the reasons for error in the contractor's jurisdiction, corrective actions in place and new corrective actions planned for the future, adjustments that the contractor has made or will make to its Medical Review Strategy, coordination activities among components within the contractor, and the ways in which the contractor will use the CERT results to develop and implement provider outreach and education efforts.[24]

RACs were created to identify and recover overpayments and underpayments made on behalf of the Medicare program.[25] Their mission statement also included taking action to reduce future improper payments.[26] However, RACs are paid on a

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[23] *See* Centers for Medicare & Medicaid Services, *Medicare Program Integrity Manual*, ch.1, § 1.3.1.

[24] *See* Centers for Medicare & Medicaid Services, Medicare Program Integrity Manual, ch.12, § 12.3.9.

[25] *See* Centers for Medicare & Medicaid Services, *Statement of Work for the Recovery Audit Program*, (Available at https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/recovery-audit-program/downloads/090111RACFinSOW.pdf).

[26] *See Id*.

contingency fee basis, earning between 9 percent and 12.5 percent in contingency fees in FY 2009 and FY 2010 based on the amount of improper payments identified.[27]

The primary function of ZPICs is to investigate and identify potentially fraudulent FFS claims. The CMS uses its fraud prevention system to prioritize investigative leads based on analysis and development of predictive analytics models.[28]

As of the date of this report, the CMS had also created a new contractor, known as the Supplemental Medical Record Review Contractor. According to the CMS's website, this contractor will conduct medical record reviews for the Provider Compliance Group, the same group within the Office of Financial Management that manages the RAC program.[29] [30]

How CMS Intends to Use These Contractors to Reduce Its Improper Payment Rate

In addition to individual contractor error rate reduction plans, the CMS and HHS also submit global error rate reduction plans. In accordance with IPERA, HHS included in its FY 2013 Agency Financial Report a plan for how its contractors would reduce the CMS's improper payment rate. HHS specified that the rate would be reduced by:

- Expanding the role of RACs;
- Instituting a prior authorization pilot program for power mobility devices;
- Changing payment policies relating to inpatient hospital claims;
- Reducing administrative and documentation errors by building the health care fraud prevention partnership; educating providers; and focusing Medicare contractor's medical review efforts;
- Reducing authentication and medical necessity errors by hiring a supplemental medical review contractor to focus on vulnerabilities identified;

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[27] *See* Centers for Medicare & Medicaid Services, *Medicare Fee-for-Service Recovery Audit Program Myths*, 17 December 2012, (Available at http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Recovery-Audit-Program/Downloads/RAC-Program-Myths-12-18-12.pdf).

[28] *See* U.S. Government Accountability Office, "Medicare Program Integrity: Increasing Consistency of Contractor Requirements May Improve Administrative Efficiency," *Supra.*

[29] *See* Centers for Medicare & Medicaid Services, "Supplemental Medical Review Contractor (SMRC)," 28 December 2013 (Available at http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Medical-Review/SMRC.html).

[30] *See* Centers for Medicare & Medicaid Services, "Office of Financial Management," 10 June 2014 (Available at http://www.cms.gov/About-CMS/Agency-Information/CMSLeadership/Office_OFM.html).

- Requiring mandatory medical review when outpatient therapy caps are exceeded; and
- Issuing comparative billing reports to providers.[31]

The Committee applauds the inclusion of the Health Care Fraud Prevention Partnership as a means of reducing improper payments. On May 20, 2014, Chairman Nelson and Ranking Member Collins, joined by Senators Carper, Casey, and Grassley, introduced the Stop Schemes and Crimes Against Medicare and Seniors (Stop SCAMS) Act of 2014 (S. 2361) to further strengthen this partnership, and its efforts to reduce improper payments. In addition, the Committee continues to advocate for provider education as an important part of reducing improper payments.

However, the plan put forth by the CMS does not place any emphasis on improving the *way* that audits are executed or on targeting problem providers or areas known to have high improper payment rates. The plan also does not describe how these activities will be coordinated with other audit and review mechanisms within the CMS, or with one another. And, following the publication of this plan, the CMS stopped further requests from RACs for additional documentation from providers as of February 21, 2014. The existing RAC contracts, however, will continue through December 31, 2015.[32] In addition, multiple stakeholders have raised concerns about the effectiveness and efficiency of the RAC program. We review stakeholder concerns below, and offer recommendations for streamlining existing audit mechanisms to reduce provider burden and achieve better reductions in improper payments.

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[31] *See Id* at 166-169.

[32] *See* Centers for Medicare & Medicaid Services, "Recent Updates," 2 June 2014 (Available at http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Recovery-Audit-Program/Recent_Updates.html).

The Impact of Current CMS Strategies to Reduce Medicare FFS Improper Payment Rate on Providers

As previously discussed, the CMS uses a combination of pre-payment and post-payment reviews to both prevent and recover improper payments. The following sections discuss the impact of those reviews on providers, as well as whether they target CERT-identified errors.

The Impact of Multiple Audits and Reviews on Providers: Case Studies

To understand the impact multiple audits and reviews can have on providers better, the experiences of hospitals and outpatient clinics are detailed below.

The Impact of Audits on Hospitals.

We describe the impact of audits on three hospitals, both urban and rural. We also comment on the impact on four health care systems, as well as on an outpatient clinic.

Hospital A – An Ascension Health Facility

Hospital A is a non-profit hospital, serving a large population of Medicare, Medicaid, and uninsured patients. According to Hospital A data, RACs have audited 5,430 claims from that hospital. Of those claims, the RAC alleged 3,457 were paid improperly, resulting in $16,189,000 being assessed as overpayments. When the RAC assesses an overpayment, the CMS withholds the funds from future reimbursements. Placing the claim in an appealed status does not prevent the CMS from recovering the funds while appeals are pending. Hospital A data shows the RAC won only 506 (less than 20 percent) of those appeals, but payments were withheld for over a year.

Between January 1, 2010, and March 5, 2014, the MAC audited 2,977 claims from the RAC. The MAC confirmed that 1,972 of those claims were paid appropriately. Officials from Hospital A reported that it spends almost $3 million per year on consultants to address and respond to Medicare audits, representing approximately 20 percent or more of its bottom line. It was not clear to Hospital A how or if the CMS's contractors were coordinating their audits to prevent duplication.

This hospital is part of Ascension Health, which is the largest non-profit health care system, and third largest health care system overall (based on revenues) in the United States. It employs more than 122,000 individuals in more than 1,900

locations in 21 states and the District of Columbia.[33] RACs have audited 66,613 claims made by Ascension Health facilities, and the RACs alleged overpayments in 33,834 of those claims. This resulted in $201,810,141 being withheld from the health care system nationwide until appeals could be adjudicated. Less than one-fourth of appealed recoveries have been upheld, according to Ascension data.

Hospital B – A Catholic Health Initiative Facility

Hospital B is an acute care, not for profit referral hospital. It has more than 7100 employees, and a medical staff of more than 800 physicians and allied health providers. It is part of Catholic Health Initiatives (CHI), one of the nation's largest health care systems. CHI operates 93 hospitals, including 24 critical access facilities, and in FY 2013, provided $762 million in charity care and community service nationwide.[34]

A RAC has requested 7,231 records from Hospital B. Twenty-seven claims were requested as late as January 30, 2014 by the auditing body. Despite having to lay off dozens of other staff members, Hospital B had to employ a full-time coordinator to track and respond to these record requests. As of May 2014, 4,065 of those records, or 56 percent, were found by the RACs to have no payment deficiency. Sixteen percent of these claims were denied by the RAC, and Hospital B agreed with that decision. More than 1,764 of those claims, however, were appealed. To date, Hospital B reports a 97 percent success rate at the administrative law judge level.[35]

Correspondence between the auditors and health care providers are often still paper-based, with paper letters being sent from the RAC asking for lists of records to be submitted for auditing purposes. At Hospital B, paper copies of those letters, and follow-ups asking for additional information, are kept in binders in the RAC Coordinator's office.

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[33] *See* "Welcome to Ascension Health," Ascension Health, 2014 (Available at http://www.ascensionhealth.org/annualreport/map.html).

[34] *See* "About Us," Catholic Heath Initiatives, 2014 (Available at http://www.catholichealthinitiatives.org/about-us).

[35] *See* Data from Hospital B, RAC tracking system, provided June 5, 2014.

Figure 2. Staff photo of "pull lists" received from the CMS since the inception of the RAC program. These binders contain only the lists of records to be pulled, not the actual medical records which the Hospital submits to the CMS. Each record to be pulled averages between 50-200 pages, according to Hospital B Staff.

Figure 3. Hospital B catalogued documentation for underpayments.

The same office catalogued documentation pertaining to underpayments identified by the RACs. Based on data provided by Hospital B, 2 percent of RAC audits resulted in determinations that Hospital B was underpaid for the service provided. Figure 3 shows the Hospital's documentation pertaining to underpayments.

According to hospital staff, it is essential to keep all correspondence regarding records that have been pulled for Medicare audits because of how long the appeals process can take. They provided us with an example of a claim that was originally

paid on August 19, 2008. The RAC disputed $8,418.05 of the original claim amount. Hospital B received notification on January 26, 2012, that the money was going to be recouped. It was actually remitted on February 8, 2012. On May 15, 2014, almost six years from the date the claim was originally paid, the administrative law judge reversed the RAC decision and decided in favor of Hospital B. No interest was paid on this claim. The original $8418.05 was returned to Hospital B on May 20, 2014.[36] Today, Hospital B reports it has a total of $7,983,101 tied up in the RAC Appeal process.[37] Between April 2012 and April 2013, it paid $807,925 to vendors solely for the purpose of responding to Medicare reviews and audits.[38]

Hospital C

Hospital C is a non-profit community-owned hospital in a sparsely populated and rural area. The hospital supports program integrity audits but has struggled with the RAC audit process. Since November 2012, the hospital has had 425 claims audited by the RACs. Of these 425 claims, only 66 (just 15 percent) had findings. Of the 66 claims with findings, the hospital has agreed to 36 and has appealed the remaining 30 claims. The hospital was distressed to find the appeals process can take two years. Those 30 claims represent over $142,000 in billed claims, an amount that can negatively affect the financial stability of a small hospital. Due to the burdensome audit process, this hospital has had to hire a full-time staff member to simply handle correspondence and communications with the RAC. Of particular concern is that data from two separate systems (hospital and provider) must be formatted to specific RAC standards. In addition, records cannot be scanned in a routine manner and must be scanned according to very specific RAC standards – including margin size. The hospital also notes that the RAC is inefficient in its communication with the hospital and frequently sends requests to different departments as opposed to a single communication source. This can result in a costly delay of several days. Of utmost concern to this hospital is the inability to learn from billing errors. While hospital staff finds the CMS pre-pay audits process occurs efficiently and allows for education; they find the RAC process tedious, burdensome, and inefficient.

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[36] Documents provided by Hospital B, including original patient account statement, recoupment notification, actual recoupment, letter from Administrative Law Judge regarding favorable determination, notification on future payment on remittance statement; actual repayment date from patient account management system.

[37] *See* Summary of Medicare RAC Cost for Hospital B, provided June 5, 2014.

[38] *See Id*.

Health System D

Health System D is a non-profit multi-hospital system. Hospital staff support program integrity audits and have a staff of certified coders that proactively review coding issues in order to continuously improve their billing processes. They have, however, expressed concerns about the volume of Medicare audits. From 2010 to 2013, the facility had over 11,000 claims audited. At one point, a single hospital was getting an audit request to review 600 claims approximately every 45 days. This has required the health system to pull staff from multiple departments to respond. This volume of requests has continued even though almost 80 percent of their audited claims had no findings. Of those that had findings, about 30 percent were appealed. Some claims have been pending in the third level of the approval process for over a year. This health system also reported that the RAC has requested claims previously audited by CMS (in another type of audit), but the duplication has been minimal and they have been able to resolve duplicate audit requests with the RAC and CMS. The primary concern of this health system has been the volume of audits

National Data from Providers

According to the American Hospital Association's (AHA) RACTrac Survey[39] results, these providers' experiences are not atypical.

Nationally, the survey found that two-thirds of records reviewed by RACs did not involve an improper payment. Fifty-five percent of hospitals reported spending more than $10,000 in the first quarter of 2012 to manage the RAC process alone, with 33 percent spending more than $25,000 and nine percent spending more than $100,000.[40]

It should be noted that RACTrac data is self-reported. Committee staff was provided with data from one RAC, relying on CMS data, which reported a 26.5 percent overturn rate on appeal. In general, statistics compiled by the RACs do not appear to be consistent with AHA data. But it is clear from our case examples that opportunities exist to improve the way in which audits are done, and potentially reduce problems of duplication and excessive numbers of audits while ensuring providers have opportunities to learn from those audits.

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[39] The RACTrac survey is a survey conducted by the American Hospital Association, which collects data from hospitals on a quarterly basis for the purpose of measuring the impact of Medicare's RAC program on hospitals nationwide. *See* American Hospital Association RACTrac (Available at: https://www.aharactrac.com/).

[40] *See* Letter to Daniel Levinson, Inspector General, Department of Health & Human Services, October 24, 2012. (Pg. 3)

A Provider's Experiences with CMS Audits[41]

Unfortunately, these experiences are not limited to hospitals. Part B providers experience the same type of difficulties with audits that hospitals do. We provide one example below.

On March 13, 2013, a RAC issued a letter requesting additional documentation to a provider (hereinafter Provider). Provider sent in the documentation, and was informed on April 29 that the payment was improper. In this case, the CMS had *underpaid* Provider based on an incorrectly reported number of units of a medication.

In April, Provider received another notification of improper payment, again an underpayment because Provider incorrectly reported the number of units of a medication that was actually used.

In May, the RAC requested more records, and Provider faxed an additional 14 pages of documentation on July 11.

In July, Provider received a notification from the RAC that **previous payments would be fully reversed** due to non-receipt of documentation requested in the March 13 letter. Provider responded to this letter with fax transmittal confirmations for 30 pages of records sent in response to the previous request, re-sent the records, and requested that the RAC cease recovery efforts.

In August, the RAC notified Provider of an overpayment in the amount of $625.80, and later that month, the Provider was notified of another overpayment in the amount of $175.92 and asked that those funds be immediately repaid. The justification was that services were not rendered on the dates billed, because documentation of services had not been provided in response to the March letter. Provider again informed the RAC that records had been sent. The RAC determined in September that an overpayment did not occur.

Later, Provider received another request for records. Provider forwarded a total of 25 pages of documents, including previous fax transmittal confirmations, to the RAC. In October, another letter from the RAC indicated a claim was going to be sent to the claims processor based on non-receipt of documentation. Provider

[41] This is based on documentation provided to Committee staff by a single Part B provider. The name of that provider is not disclosed for privacy purposes.

again explained the situation. In December, the RAC responded that, while they had received medical records, it was not within the required 45 day time period, so the claims were denied. They included their requirements for submission of medical records, shown below:

Provider Additional Documentation Submission Requirements

Medical Record (MR) Submission Requirements (Paper/CDs or DVDs)
Record Requirements

If you would like to download a copy of the CDs or DVDs instructions please click here.

- Please note that the additional documentation and medical records for ***Prepay audits are due within 30 days, Post pay audits are due within 45 days*** from the date of the additional documentation request letter.
- Please be sure all documentation submitted is **legible.**
- Please submit only requested documentation as identified in the letter and documentation that specifically supports the procedures/codes billed for all dates of services related to the claim. If not requested please omit before sending.
- **All Blank pages should be OMITTED** (Note: Provider will not be paid for blank pages)
- The metadata excel file must be included with each submission
  - Requested claim number
  - Begin date of service
  - End date of service
  - Patient name (first and last name)
  - Patient DOB
  - Patient HIC number
  - Patient account/control number
  - Medical record number
  - Provider name (full name)
  - Provider number
  - Provider NPI
  - Number of pages or the file size of the image submitted for acknowledgement purposes

CDs or DVDs Medical Records:

- **Scanned image resolution must be clear and legible. 300 dpi and in black and white.**
- Image format must be in either PDF or TIFF format though **PDF is preferred**
  - o For PDF format, DO NOT password protect the individual PDF files. Instead, zip all PDFs into a WinZip file and encrypt it.
  - o CD/DVDs do not require encryption but it is recommended for security purposes. If encryption/password protection is desired, the following common WinZip options are accepted:
    - Zip 2.0 compatible encryption
    - 256-Bit AES encryption
    - PGP Encryption
- If a password is required to open a zipped CD/DVD please submit that password to Performant Recovery , **Prior to shipment**, via one of the methods below. Must include a record identification reference (reference number/claim number/audit number) for identification.
  1. **Call** [redacted] and provide password to a Provider Service Representative
  2. E-mail password to [redacted]

Figure 4. List of Additional Document Request Submission Requirements from a Medicare contractor's website.

The RAC correspondence contained a detailed description of the appeals process should the Provider want to dispute its findings. Providers can appeal RAC decisions through a process described in Medicare regulations and policy. Nationwide, providers appealed 6 percent of overpayments in FYs 2010 and 2011.[42]

When a provider appeals a RAC decision, however, this does not delay or prevent the CMS from withholding the amount of the alleged overpayment from current claims due to the provider. The HHS OIG found that nearly half (44 percent) of RAC decisions appealed were overturned in the providers' favor during FY 2010 and FY 2011[43], and the CMS's own data shows that 26.7 percent of RAC determinations for overpayment were overturned on appeal in FY 2012.[44] By some estimates, the backlog of Medicare appeals is such that providers in some cases would be waiting two years or more to recover the money originally owed to them.

As this case demonstrates, a number of audit characteristics contribute to provider burden, including:

- Extensive technical requirements for document submission, which may vary from contractor to contractor;
- Inadequate tracking mechanisms to ensure a contractor knows what documentation they have received; and
- Limited options outside the formal appeal process to reverse audit decisions.

On July 3, 2015, the CMS announced a new pilot program called Settlement Conference Facilitation in an effort to alleviate some of the appeals backlog. This is an alternate dispute resolution process designed to bring CMS together with providers to agree on a resolution to claims pending at the ALJ level. If a resolution is reached, a settlement document is drafted and the request for ALJ review is dismissed. This pilot program is currently only open to Medicare Part B

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[42] *See* Department of Health and Human Services, Office of Inspector General, *Medicare Recovery Audit Contractors and CMS's Actions to Address Improper Payments, Referrals of Potential Fraud, and Performance* August 2013, p. 11 (Available at http://oig.hhs.gov/oei/reports/oei-04-11-00680.pdf).

[43] *See* Office of Inspector General Report, *Medicare Recovery Audit Contractors and CMS's Actions to Address Improper Payments, Referrals of Potential Fraud, and Performance,* August 2013. (Available at http://oig.hhs.gov/oei/reports/oei-04-11-00680.pdf).

[44] *See* Centers for Medicare & Medicaid Services, *Recovery Auditing in Medicare and Medicaid for Fiscal Year 2012,* p. 11.

providers, so is not expected to have a direct impact on the backlog of Part A claims.[45]

In this case, the Provider was subject to multiple requests for information already submitted. The Provider supplied the Committee staff with fax confirmations proving that records were received which related to these RAC-identified issues. The RAC denied payment for these services, stating they had not received the records within the proscribed time frames. At last report, the Provider was still working with the RAC in an effort to prevent the identified overpayment amount from being withheld from future claims.

Assessments of Provider Burden, as Well as Audit Accuracy, Are Complicated by Inconsistent and Potentially Incomplete Data on Provider Appeals

Despite these and other challenges, RACs are estimated to have returned significant amounts of money to the Medicare Trust Fund—by some estimates, $8.9 billion since the inception of the program—with $700 million being returned to providers as a result of underpayments.[46] However, because of the pending appeal backlog, money returned to the Trust Fund because of RAC re-determinations may have to be paid back to providers, with interest. Data on how often RAC re-determinations are overturned on appeal is at times conflicting. The CMS and the AHA, for example, report what appear to be vastly conflicting numbers. OIG reports provide a third data set. We provide the following analysis of available data.

In FY 2012, the CMS reports that providers appeal 26.3 percent of all claims with RAC overpayment determinations, with 26.7 percent of those determinations being overturned on appeal.[47] They note that the same claim may be counted as having more than one appeal, since claims are appealed at different levels. This, along with the different years reviewed, may account for discrepancies with OIG data. The OIG found, in FY 2010 and FY 2011, that providers appealed 65,198 (6 percent) of overpayments (not counting appeals at different levels, but only if a claim was appealed once at any level), and that of those appealed, about 44 percent

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45 *See* Department of Health and Human Services, "Settlement Conference Facilitation Pilot" (available at: http://www.hhs.gov/omha/settlement_conference_facilitation_pilot.html).

46 Data provided by RACs, 2014.

47 *See* Centers for Medicare & Medicaid Services, *Recovery Auditing in Medicare and Medicaid for Fiscal Year 2012*

were overturned in the providers' favor.[48] Previous OIG work had found that 56 percent of all appeals were overturned at the Administrative Law Judge (ALJ) level regardless of whether the source was a RAC or another contractor, meaning that the rate of RAC decisions being overturned was not different than that of other contractors.[49]

A number of explanations may exist for this high overturn rate, including the complexity of Medicare payment rules; inconsistencies in interpretation of those rules at the administrative law judge level; the fact that administrative law judge decisions are not binding interpretation of Medicare policy; and contractor error. OIG offered a number of recommendations for improving appeals at the ALJ level, including a quality assurance process surrounding ALJ decisions.[50]

Of concern is that data used by the CMS and the OIG in some analyses of appeals is based upon information reported to the RAC Data Warehouse. Committee staff was provided with documentation demonstrating duplicative audits conducted by HHS's Office of Inspector General as part of its compliance reviews, despite the IG checking CMS databases to determine whether specific claims in their sample had been previously audited.[51] This raises questions about whether the data maintained by the CMS on audited claims is complete and accurate, which would affect the reliability of CMS-generated numbers regarding RAC or any other contractors' audits. And, while the AHA reports data identified through their survey, we note the limitation of this being a voluntary data collection of self-reported information.

The presence of such conflicting data sets points to the need for the CMS to develop a robust system for tracking RAC re-determinations and appeals, and to enforce reporting to that database. As long as questions remain about the reliability of CMS data on RAC re-determinations and appeals from those re-determinations, it will be difficult to assess RAC effectiveness, provider burden because of RAC appeals, and how much of the money recovered by the RAC

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48 *See* Department of Health and Human Services, Office of Inspector General, *Medicare Recovery Audit Contractors and CMS's Actions to Address Improper Payments, Referrals of Potential Fraud, and Performance*, August 2013 (Available at: http://oig.hhs.gov/oei/reports/oei-04-11-00680.pdf).

49 *See* Department of Health and Human Services, Office of Inspector General, *Improvements Are Needed at the Administrative Law Judge Level of Medicare Appeals*, November 2012 (Available at http://oig.hhs.gov/oei/reports/oei-02-10-00340.pdf).

50 *See Id.*

51 Letter to Committee staff and claims records, May 5, 2014.

program will have to be paid out to providers down the road as a result of successful appeals.

If definitive data supports audit inaccuracies of the magnitude described by AHA and other data, the CMS must also look at ways to incentivize RACs and other contractors to be accurate. At the present time, RACs do not face a penalty if their decisions are overturned on appeal, other than the loss of the contingency fee associated with that claim.

DME Providers' Experiences with Audits

The Committee has also been made aware of multiple additional concerns from durable medical equipment suppliers regarding audits. The Medical Equipment Suppliers Association (MESA) discussed these audits and their impacts on the durable medical equipment, prosthetics, and orthotics suppliers in a letter of May 15, 2014, addressed to CMS Administrator Marilyn Tavenner. Specifically, MESA discussed three different types of Medicare auditors, citing increased supplier costs, appeal backlogs, and lack of CMS oversight, among other concerns.[52]

Among six MESA members providing information to the Committee, it was reported that individual DME providers experienced between 24 and 228 RAC audits during the course of one year. Two of the six had been audited by the CERT program or a ZPIC as well. Of interest, some of these providers were under pre-payment reviews, which did not seem to affect whether or not they were also audited by other contractors for claims during the same time period. In addition, in at least one case, involvement in the CMS's prior authorization pilot program for power wheelchairs was followed by a CERT review of these claims, raising questions about whether the CERT error rate itself would be accurate if the sample included claims subject to a pilot prior authorization program not involving the entire country. [53]

[52] *See* Letter from Elizabeth Moran, Executive Director, Medical Equipment Suppliers Association, to Marilyn Tavenner, May 15, 2014.

[53] This is a pilot program requiring CMS to authorize payment for a power mobility device in advance of the company providing the device to the beneficiary. It encompasses seven states known to have a high degree of fraud. *See* Centers for Medicare & Medicaid Services, "Prior Authorization of Power Mobility Devices (PMDs) Demonstration Fact Sheet" (Available at http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/CERT/Downloads/Fact-Sheet-new-8112.pdf).

The CMS and Its Contractors' Post-payment Review Strategies Increase Provider Burden and Reduce Efficiency Through Inconsistency

In response to multiple stakeholder concerns such as those described above, the AHA recommended that the CMS streamline audit programs by channeling all improper payment audits into one program and eliminating all other auditing programs.[54] To better understand the need to streamline these programs, we discuss CMS's post-auditing processes below.

Inconsistencies in Process

The significant inconsistency in contractor requirements places additional burdens on providers to ensure compliance with these varying requirements. The GAO found that these inefficient processes reduced the effectiveness of claims reviews, and that they were inconsistent with executive-agency guidelines to streamline service delivery. The GAO recommended that the CMS increase consistency across post-payment review requirements.[55]

For example, RACs are subject to a number of post-payment requirements to which other contractors are not subject. These include requirements to submit to the CMS the basis for the billing issues they intend to address; post notice of these billing issues on their website; reimburse certain providers for the expenses associated with record production; make claims reviewers' credentials available on provider request; provide access to staff physicians for discussion of claim denials on provider request; and give providers 40 days to request an opportunity to provide additional documentation or discuss any revision prior to appeal.[56] Other contractors have different time frames for receiving documentation, and different processes for review.[57]

In an August 2013 report, the HHS Office of the Inspector General (OIG), also found inconsistencies in the way in which the CMS addressed vulnerabilities identified by the RACs. [58] In its review of actions taken to reduce improper payments based on RAC data, the OIG found that the majority of improper

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54 *See Id*.

55 *See Id*.

56 *See* U.S. Government Accountability Office, *Increasing Consistency of Contractor Requirements May Improve Administrative Efficiency*, July 2013, p. 21.

57 *See* Centers for Medicare & Medicaid Services, *Medicare Program Integrity: Increasing Consistency of Contractor Requirements May Improve Administrative Efficiency*, *Supra.*

58 *See* Department of Health and Human Services Office of Inspector General, *Medicare Recovery Audit Contractors and CMS's Actions to Address Improper Payments, Referrals of Potential Fraud, and Performance*, *Supra.*

payments resulted from services being delivered in the wrong setting, or a provider incorrectly coding Medicare claims. Further, the OIG uncovered that the CMS had, by June 2012, taken some action to address a majority of the vulnerabilities identified through analysis of RAC claims from FY 2010 and FY 2011, but had not evaluated the effectiveness of those actions.[59] Specifically, CMS had not taken action to address 18 of 46 vulnerabilities identified by RAC audits, and had not evaluated the effectiveness of the actions it did take in many instances. The OIG recommended that the CMS evaluate the effectiveness of implemented corrective actions and take appropriate action on identified payment vulnerabilities. The CMS concurred with this recommendation but noted the difficulty of measuring effectiveness for some corrective actions, such as educational efforts.

Even with greater consistency and follow-up of corrective actions, post-payment recovery efforts may not, however, be the most effective strategy to reduce improper payments. In a June 2013 OIG report, the CMS reported $543 million in debts outstanding for more than six months after the due date.[60] These payments are considered "currently not collectible" and are not reported on financial statements. The OIG reported that 97 percent of the overpayments they reviewed were not recovered.[61] These represent all identified overpayments outstanding for collection for at least 6 months, and are not just overpayments identified by RACs. CMS contractors cited inaccurate provider contract information and the need to identify providers by means other than the National Provider Identifications used by the CMS, as barriers to debt collection efforts. The OIG's recommendations are outstanding at the time of this review.

Finally, inconsistent application of methods to accurately track payments may also make post-payment review a less effective means of reducing improper payments. For instance, HHS implemented a Healthcare Integrated General Ledger Accounting System (HIGLAS) to accurately track payments. Although the CMS follows the system, this does not necessarily mean that the MACs do. Both entities rely on inefficient, labor-intensive, manual processes. The MACs covering Medicare Parts A and B record their accounts receivable balances through a manual journal voucher process, and durable medical equipment (DME) The MACs do not use HIGLAS at all. Inconsistency in reporting increases the

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[59] Vulnerabilities in this context are defined by CMS as a specific issue resulting in more than $500,000 in improper payments.

[60] *See* Department of Health and Human Services, *Medicare's Currently Not Collectible Overpayments*, June 2013 (Available at http://oig.hhs.gov/oei/reports/oei-03-11-00670.pdf).

[61] *See Id*.

possibility that incomplete or inaccurate information will be submitted to the CMS.[62]

Inconsistencies in Coverage

Inconsistent coverage requirements further increased the burden on both providers and contractors to apply different rules depending on the location of the service provided. The CMS relies on national and local coverage determinations, as well as other reviews conducted by MACs, to reduce improper payments. National Coverage Determinations (NCDs) describe the circumstances under which a particular item or service will covered under Medicare.[63] Contractors are responsible for notifying providers of new coverage decisions.[64]

MACs may also develop their own local coverage decisions.[65] Local coverage decisions are a determination of whether an item or service is reasonable and necessary, and applies this only to beneficiaries within a MAC's jurisdiction. Contractors consider a service to be reasonable and necessary if the service is:

- Safe and Effective;
- Not Experimental; and
- Appropriate, including the duration and frequency, because it is:
    - Furnished in accordance with accepted standards of medical practice;
    - Furnished in a setting appropriate to the patient's medical needs and condition;
    - Ordered and furnished by qualified personnel;
    - One that meets, but does not exceed, the patient's needs; and
    - At least as beneficial as an existing and available medically appropriate alternative.

MACs must, however, be consistent with national coverage, statutes, rulings, and regulations.[66]

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62 *See* "Medicare Program Integrity: Increasing Consistency of Contractor Requirements May Improve Administrative Efficiency," *Supra* at pp. 68-69.

63 In accordance with Section 1862(a)(1) of the Social Security Act.

64 *See* Centers for Medicare & Medicaid Services, *Medicare Program Integrity Manual*, Section 13.1, Chapter 13, Local Coverage Determinations, June 21, 2013.

65 The ability of CMS to develop local coverage decisions arises out of its statutory authority to determine what services are "medically necessary". Social Security Act §1862(a)(1)(A).

66 *See Id*.

However, the use of local coverage decisions does lead to substantial variation in service coverage nationally because the CMS does not have coverage policies specifically addressing most items and services. In a January 2014 report,[67] the OIG found that over half of Part B procedure codes were subject to one or more local coverage decisions. The local coverage decisions did not appear to be related to cost or utilization of the services. The OIG specifically noted that 49 of the 100 most costly items and services were not addressed by any local coverage decision, meaning that there was open access to these items or services. Yet, OIG noted that local coverage decisions placed some limitation on coverage for over fifty percent of items and services in some states, including California, North Carolina, South Carolina, and Georgia, but for as few as five percent in Alabama, Georgia, and Tennessee. For example, the OIG noted that a blood test used to detect inflammation was covered in 20 states, but not in three other states.[68] As another example, high dose electronic brachytherapy, a cancer treatment, was prevented in one or more MAC jurisdictions, but not in all.[69]

The OIG also noted that local coverage decisions defined similar clinical topics differently.[70] For example, for a particular type of eye surgery, 32 of the 44 states in which MACs processed claims used seven different lists of procedure costs and diagnostic codes to define the circumstances under which Medicare would cover this eye surgery.[71]

During the Committee staff's visits to two MACs (one in Florida and one in Pennsylvania), MAC staff informed us that Medical Directors of the MACs have regularly occurring phone meetings to discuss local coverage decisions. The CMS further said that it has added language to MAC performance contracts requiring their "collaboration" in developing local coverage decisions. The CMS has cited challenges to ensuring consistency across MACs in coverage decisions, including administrative challenges, implications for beneficiary appeal rights, and states' scope of practice laws.[72]

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67 *See* Department of Health and Human Services, Office of Inspector General. *OIG Local Coverate Determinations Create Inconsistency in Medicare Coverage.* (Report #OEI-01-11-00500), 07 January 2014.

68 *See Id.* This referred to the high sensitivity C-reactive protein test, which is used to measure inflammation.

69 *See Id* at 10.

70 *See* Department of Health & Human Services, Office of Inspector General, *Local Coverage Determinations Create Inconsistency in Medicare Coverage*, January 2014,

71 The eye surgery in question is blepharoplasty, a surgical procedure to correct drooping eyelids when they interfere with a person's vision.

72 *See* Response of Marilyn Tavenner to OIG Draft Report, p. 17.

Despite these challenges, the Committee staff believes that beneficiaries should have consistent access to care regardless of the state they live in, and that the CMS should use NCDs rather than local coverage decisions wherever possible. Committee staff, while recognizing the value of harnessing innovation at the MAC level, is concerned that beneficiaries may have different access to Medicare services depending on the state in which they live because of local coverage decisions. In the conclusion of this report, we recommend improved consistency and targeting of local coverage decisions.

The CMS's Pre-payment Reviews and Audits Have Limited Ability to Affect Improper Payment Rates Because They Do Not Consistently Target Problem Areas

In addition to being inconsistent in both process and coverage, we find that auditing programs do not consistently target CERT-identified areas with high improper payments, potentially limiting their overall impact on improper payment rates. CERT identifies the following categories of errors: (1) no documentation error, if providers do not supply documentation within 75 days of a request for medical records; (2) insufficient documentation error, if records submitted are inadequate to support the payment for the services billed; (3) medical necessity error, if reviewers receive enough documentation to make a decision that the services rendered were not medically necessary; or (4) incorrect coding error, if medical documentation supports a different code than that billed, the service was provided by someone other than the billing provider or supplier, the billed service was unbundled (billed for separately when it should have been included in a package of services), or a beneficiary was discharged to a site other than one coded on the claim. CERT reports do not further break down the components of incorrect coding errors.

As noted, Committee staff focused on the errors identified in Medicare FFS—that is, Medicare Parts A and B, because the highest error rates were found in these parts of the program. The following tables were assembled from data appearing in the CMS's 2013 Improper Payment Report, and include all services for which CMS projected more than $1 billion in improper payments for Part A, and more than $500 million attributable to that service for Part B.

Improper Payment Rate by Part A Service Type

Type of Part A Service	*Improper Payment Rate*	*Dollars Associated with Improper Payments*
Inpatient Hospital MS-DRG	**9.9%**	**$11.64 billion**
Home Health	**17.3%**	**$3.09 billion**
SNF Inpatient	**7.7%**	**$2.48 billion**
Hospital Outpatient	**5.3%**	**$2.44 billion**
Hospital Inpatient--Other	**11.0%**	**$0.93 billion**
Clinic ESRD	**7.8%**	**$0.81 billion**

Figure 5. All rates shown in billions of dollars and as a percentage of total payments for that service type recorded in HHS's FY 2013 Agency Report.

Among Hospital Part A costs, the highest improper payment rates were associated with chest pain (61.2 percent), medical back problems (43.4 percent), and implantation of a cardiac defibrillator (40.0 percent). Of these services, the type of error occurring most frequently was one of medical necessity. Also, 14.4 percent of home health claims were associated with insufficient documentation, while 2.7 percent were associated with medical necessity errors. The improper payment rate for skilled nursing facilities (SNFs) inpatient stays attributable to insufficient documentation was 5.8 percent, while 1.1 percent was the result of incorrect coding errors.

Improper Payment Rate by Part B Service Type

Type of Part B Service	*Improper Payment Rate*	*Dollars Associated with Improper Payments*
Oxygen Equipment/Supplies	**75.2%**	**$1.17 billion**
Hospital Visits-subsequent	**18.2%**	**$1.01 billion**
Office Visits—established	**7.1%**	**$0.96 billion**
Glucose Monitor	**74.7%**	**$0.93 billion**
Hospital Visits—initial	**28.3%**	**$0.80 billion**
Lab Tests—other	**26.1%**	**$0.72 billion**
Minor Procedures	**18.2%**	**$0.69 billion**

Figure 6. All rates shown in billions of dollars and as a percentage of total payments for that service type recorded in HHS's FY 2013 Agency Report.

Figure 5 describes those services with projected improper payments of at least $500 million. There were, however, services with higher improper payment rates than some of the services included in Table 2, but which accounted for lesser amounts of improper payments because fewer expenditures occur on that service as a whole in the Medicare program. In Medicare Part B, high improper payment rates were identified in chiropractic care (51.7 percent), followed by hospital visits and lab tests, psychiatry services and certain imaging tests. In chiropractic services, lab tests and imaging, more than 90 percent of errors were due to insufficient documentation. Incorrect coding accounted for 76 percent of initial inpatient visits coded in error, followed by 47.6 percent in critical care visits, and 37.2 percent in subsequent hospital visits. For DME, improper payment rates were highest for wheelchairs (90.7 percent for manual, 81.8 percent for motorized), hospital beds (84.3 percent), and oxygen equipment and supplies (75.2 percent).

The greatest dollar amounts associated with improper payments under Part B were seen with subsequent hospital visits ($1 billion), oxygen supplies and equipment ($1.17 billion), home health ($3.09 billion), SNF inpatient ($2.48 billion), hospital

outpatient ($2.44 billion), and nonhospital based hospice ($1.03 billion). The improper payment rate for initial hospital visits attributable to incorrect coding errors was 21.5 percent compared to subsequent visit error rates of 6.8 percent resulting from incorrect coding. Further, 67.2 percent of glucose monitors and 78.7 percent of motorized wheelchair claims, along with 47.9 percent of chiropractic claims were found to have insufficient documentation to support the claimed charges.

The CMS Does Not Consistently Target Problem Providers Or Problem Areas

The CMS's strategy for addressing CERT-identified problem areas is based on approving individual issue areas for contractors to review, rather than to ensure coverage of all CERT-identified problem areas across its contractors. An overarching plan describing how the CMS's entire contracting apparatus will come together to focus on areas identified as problematic by CERT appears lacking. Instead, certain areas are reviewed by multiple contractors, which are not always the areas identified above as having the highest amount or percentage of improper payments. For example, according to the CMS, RAC auditors' efforts are targeted as follows:

> The CMS also continues to encourage Recovery Auditors to review all claim types. In FY 2011, CMS modified the Statement of Work for the Recovery Auditors and added more emphasis on the review of all claim types with a high error rate. All four Recovery Auditors are approved to review certain Home Health and Inpatient Rehabilitation Facility topics. Other new provider types under review in FY 2012 include Skilled Nursing Facilities, Critical Access Hospitals, and Hospice. At times, CMS also refers review topics to the Recovery Auditor, including referrals from the Health and Human Services (HHS) Office of Inspector General reports.[73]

The CMS has directed MACs to target a number of the same areas.[74] We also note that there is a significant difference in a list of issues approved for review, and those which actually are reviewed. In FY 2012, Recovery Auditors identified and corrected $2.4 billion in overpayments. Over 91 percent were from inpatient hospital claims[75], despite high error rates as outlined above in many other areas.

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[73] *See* Centers for Medicare & Medicaid Services, Recovery Auditing in Medicare and Medicaid for Fiscal Year 2012.

[74] *See* Interviews of MAC Staff During Site Visits.

[75] *See* Centers for Medicare & Medicaid Services, Recovery Auditing in Medicare and Medicaid for Fiscal Year 2012, *Supra*.

Both RACs and MACs were auditing hospital observation stays, for example, leading to the possibility that the same claim could be reviewed more than once by a different contractor. Although the CMS created the RAC Data Warehouse, which other auditors are instructed to review to prevent the same claims from being reviewed by the RAC and then subsequently by another contractor, there is evidence that the RAC Data Warehouse is not up-to-date, and does not contain all claims reviewed by the RACs.[76]

In addition, there is no acknowledgement of the wide variation in error rates between individual providers. For example, OIG Medicare Hospital Compliance Reviews conducted between 2011 and 2014 demonstrated error rates that ranged from 0 to 100 percent of all claims reviewed, depending on the facility.[77] RACs do not use error rates of individual facilities to determine how frequently they should be audited.

Currently, the CMS (1) does not delegate certain contractors to review certain vulnerable areas, but instead has multiple different contractor types reviewing the same area; (2) the CMS does not ensure that its contractors address areas with the highest potential error rates; and (3) the CMS does not differentiate between providers with very high overall compliance rates from those with a history of poor compliance in determining how frequently certain providers should be audited. Changing these practices could allow the CMS to better target and coordinate contractor activities to address the improper payment rate comprehensively, across all settings and provider types.

HHS's Error Rate Reduction Plan and the CMS's Oversight of Contractor Error Rate Reduction Plans Did Not Ensure that Contractors Would Address CERT-Identified Errors

The CERT program also breaks down error rates by each MAC contract. In 2010 and 2011, the CERT program found that contract-specific error rates ranged from 1 to 76 percent, according to an OIG report. This suggests that the global error rates above may be significantly impacted by a few contractors with very high error rates. The CMS policy requires its employees to review contractor error rate reduction plans to ensure that they are reasonably related to the CERT-identified errors. However, the OIG found that there is no correlation between corrective actions described in the contractor plans and CERT-identified

[76] *See* "Supplemental Medical Review Contractor," StrategicHealthSolutions (Available at http://www.strategichs.com/wpcms/hot-topic-previously-reviewed-claims/).

[77] *See* The American Coalition for Healthcare Claims Integrity, OIG—Medicare Hospital Compliance Reviews, 2011-2014.

errors, and that most CMS staff said they did not review contractor-specific error rates when reviewing their error rate reduction plans.[78]

Similarly, the only specific services or items HHS highlighted in its error rate reduction plan did not address all areas where improper payment amounts were the most significant. HHS's error rate reduction plan addressed power wheelchairs, physical therapy, and inpatient services that should have been billed as outpatient, but primarily relied on contractor actions to address errors, despite the findings in the OIG report previously discussed.

RAC activities also were not focused on areas with the highest amounts of improper payments. Claims from two provider types accounted for 93 percent of all recovered or returned improper payments: inpatient hospitals (88 percent) and physicians or non-physician practitioners (5 percent).[79] This does not coincide with the distribution of CERT-identified errors, discussed above.

Considering the burden that these audits have placed on providers, it is troubling that they do not appear to be targeted to service types with the highest improper payment rates. The distribution of RAC audits, in particular, give the appearance that such audits are focused on high dollar claims, rather than on service areas with high error rates. Further, the wide range of error rates among contractors suggests that a few contractors with very high error rates may individually have a significant impact on the CMS's total improper payment rate. HHS suggests in its error rate reduction plan that it relies on contractor pre-payment reviews as a way to reduce errors generally, so we consider these efforts below.

National Correct Coding Initiative Actions are Not Clearly Focused on CERT-Identified Problem Areas and Performance Data is Lacking

The National Correct Coding Initiative is another program implemented by the CMS which focuses on preventing improper payments. The National Correct Coding Initiative is designed to prevent unbundling of services by comparing codes submitted on bills to ensure that Medicare is not being billed separately for services that are covered under one master code. The National Correct Coding Initiatives reviews claims from physicians, non-physician practitioners, ambulatory surgery centers, hospitals, skilled nursing facilities, home health agencies,

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[78] *See* HHS OIG, "Medicare Claims Administration Contractor Error Rate Reduction Plans," January 2014.

[79] *See* HHS OIG, "Medicare Recovery Audit Contractors and CMS's Actions to Address Improper Payments, Referrals of Potential Fraud, and Performance," August 2013, p. 11.

outpatient physical therapy and speech language pathology providers, comprehensive outpatient rehabilitation facilities.[80]

The CMS works with a contractor in implementing the National Correct Coding Initiative, which puts in place edits that automatically deny payment for: (1) services that should not be reported together; (2) extreme quantities of the same service provided on the same day; and (3) add-on codes where the required primary code is not present.[81] Although the National Correct Coding Initiative was initially developed for Part B claims, it has been applied to some extent for outpatient hospital services and physical therapy claims across multiple settings. Changes to edits used by National Correct Coding Initiative come from changes in codes, CMS policy initiatives or provider feedback.

According to CMS briefings, the National Correct Coding Initiative does not specifically target areas identified by CERT as being particularly problematic because CERT-identified errors could generally be detected only through chart review. However, the National Correct Coding Initiative stated that it is exploring ways of using the supplemental medical record review contractor recently hired by the CMS to conduct some limited chart reviews for purposes of developing edits. The effectiveness of the National Correct Coding Initiative was last reviewed by the OIG in 2003. At that time, the OIG found that the National Correct Coding Initiative prevented most errors for services it targeted in 2001.[82] Section 6507 of the Patient Protection and Affordable Care Act (P.L. 111-148) required the Department to adapt National Correct Coding Initiative methodologies to the Medicaid program. Because the scope of the program has greatly expanded since the review of its effectiveness ten years ago, and is being expanded further, we recommend that National Correct Coding Initiative develop a strategy for defining contractor success in reducing improper payments.

Medically Unlikely Edits: Effectiveness Could Be Improved

The CMS also developed Medically Unlikely Edits specifically to reduce improper payments in Part B. A Medically Unlikely Edit is the maximum number of the same service that a provider would generally report for a single beneficiary on a single date of service. Only certain types of services have these codes. The CMS

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[80] *See* Centers for Medicare & Medicaid Services, "NCCI Coding Edits," 31 March 2014 (Available at http://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/NCCI-Coding-Edits.html)

[81] Edits are defined as automated rules, which prevent payment from occurring if the claim does not meet certain rules.

[82] *See* Department of Health & Human Services, Office of Inspector General, *Medicare's National Correct Coding Initiative*, September 2003.

implemented the first of these edits on January 1, 2007, and has updated the edits quarterly since that time, increasing the number of edits. The CMS now makes the majority of edits public, withholding only those which relate to the identification of fraud. As of January 1, 2014, 9,635 codes associated with an edit are public.

In May 2013, the GAO published a report which found that less than 0.1 percent of Medicare payments were for amounts of service that exceeded these limits. The GAO also noted the CMS did not have a system for reviewing claims and determining to what extent providers who exceeded unpublished Medically Unlikely Edits limits may have received improper payments. The GAO found that, because Medically Unlikely Edits were developed for services associated with past inappropriate billing, the CMS could be missing an opportunity to reduce improper payments by not systematically examining billing information from top providers exceeding those limits.[83] Further, the GAO found that MACs applied more restrictive local limits, which could potentially further reduce improper payments if deployed nationally.[84]

Based on the GAO's conclusion that Medically Unlikely Edits are stopping only a very small percentage of improper payments, we recommend that the CMS set performance goals for the Medically Unlikely Edit program regarding its ability to prevent improper payments, and include appropriate time frames for implementation. This should be done in consultation with affected health care providers and other stakeholders.

The Impact of Ineffective Pre-payment Review Systems

While we have discussed the impact of multiple, inconsistent audits on providers, failure to refine and target pre-payment strategies also have had a significant impact on CMS resources. Targeting Medically Unlikely Edits and National Correct Coding Initiative edits, as well as other pre-payment review strategies, to areas with the greatest amounts of improper payments could result in a much more efficient and coordinated pre-payment review process. As the Kaiser Family Foundation said in its January 2013 report on Medicare policy:

> Because there is a limited number of claims a particular reviewer can handle, the goal for the CMS is to refine its pre-payment strategy—i.e., to

[83] *See* U.S. Government Accountability Office, "Few Payments in 2011 Exceeded Limits under One Kind of Prepayment Control, but Reassessing Limits Could be Helpful," May 2013.
[84] *See Id*.

identify potentially egregious claims for review while minimizing the number of "false positives" that it flags. This would reduce the burden both on providers who submit claims, and contractors who are responsible for reviewing them and making a determination about their legitimacy.

The CMS Continues to Create New Audit Programs

Rather than refine existing programs, however, the CMS recently created a new audit program, the Supplemental Medical Review Contractor. According to the CMS, this contractor is intended to review issues designated by CMS, which the CMS indicates will be based on OIG, CERT and CMS national claims data.[85] The Supplemental Medical Review Contractor is not subject to the limits on the numbers of medical records requests that the CMS has imposed on the RACs. In addition, the Committee was made aware of specific complaints regarding this new auditor, including:

(1) The auditor just started sending audit requests to hospitals, which did not recognize this auditor, so the requests did not go to the right place, resulting in missed deadlines for submitting documents. This in turn resulted in claims denials.
(2) In addition, there seems to be a lack of clarity around the standards being relied on by the Supplemental Medical Review Contractor for its reviews, and it is unclear to what extent they understand differences in coverage determinations that exist among contractors.[86]

While this new audit program may be intended to better focus on CERT identified errors, it is difficult to understand how establishing another independent contractor to address these issues is more effective than reforming existing audit mechanisms.

The Affordable Care Act also expanded the RAC program to Medicaid and began audit processes in some states in 2012. The American Dental Association (ADA) immediately began to hear concerns from its members and reached out to Members of Congress to call for transparent, fair, consistent and statistically sound audit processes in each state. The ADA's concerns primarily center around the lack of transparency in the audit process and notification procedures. Additional concerns include the statistical sampling and extrapolation methods used, the qualification of RAC auditors, and the knowledge level of those auditors regarding specific State Medicaid billing regulations.

Audited providers were also concerned that no efforts were made by either CMS or the RACs to education providers or help them learn from overpayment errors in order to avoid future audits and collections. The ADA's primary concern was that

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[85] *See* Centers for Medicare & Medicaid Services, "Supplemental Medical Review Contractor (SMRC)," 28 December 2013 (Available at: http://cms.hhs.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Medical-Review/SMRC.html).

[86] *See* April 24, 2014 email to Committee staff from AHA.

the burdensome and opaque nature of the audit process may cause providers to drop out of the Medicaid program, which already struggles to attract and maintain dental professionals willing to provide critical dental services to Medicaid patients.

In addition, the CMS is currently determining how audits might occur following implementation of the value-based payment modifier. This modifier, as required by the ACA, will tie payment to data related to the quality of services provided. The data the CMS currently receives on quality is self-reported. This suggests a continuing need to refine audit strategies to target areas most vulnerable to improper payments.

The CMS May Have Missed Opportunities to Reduce Improper Payments by Failing to Educate Stakeholders Effectively

The CMS has emphasized that it has a number of measures in place to educate providers on how to bill Medicare properly, and that this is also a primary role of MACs. For example, the CMS has issued comparative billing reports to some providers. Comparative billing reports "show individual providers how their billing patterns for various codes and procedures compare to state averages and the national average for providers within the same field."[87] These comparative studies are designed to help providers review their coding and billing practices and utilization patterns with an eye on taking proactive compliance measures.

While comparative billing reports may exist for Part B providers, 58 percent of hospitals responding to the RACTrac Survey stated they had received no education relating to avoiding payment errors.[88] In addition, according to the American Medical Association, "…physicians spend a great deal of time determining which contractor is auditing them, under what authority, and what the guidelines are for response."[89] This is because different contractors can employ different rules for response times and appeals processes, leading to confusion and misunderstandings among providers.

Effective education would involve both education on how to avoid payment errors, and basic information about the roles of the contractors which directly engage providers and suppliers in this process. On the website maintained by the CMS which provides information about Medicare, however, the only header under its Compliance and Audit Section is a reference to Part C and D audits.[90] Under this header, the CMS states:

> The goal is to provide Medicare Advantage Sponsors, Prescription Drug Plan Sponsors, other types of Medicare Plans, and the general public with

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87 *See* J. Colagiovanni and A.K. Fehn, "Comparative Billing Reports: What Providers Should Know," *RACmonitor*, 3 August 2011 (Available at http://www.racmonitor.com/news/3-feature-aritcles/625-comparative-billing-reports-what-providers-should-know.html)

88 *See* American Hospital Association Letter to Dan Levinson, October 24, 2012 (Available at: http://www.aha.org/advocacy-issues/letter/2012/121024-let-oig-audits.pdf).

89 *See* AMA, "Medicare and Medicaid Program Integrity: Recommendations for greater value and efficiency," June 2012 (Available at: https://download.ama-assn.org/resources/doc/washington/medicare-medicaid-program-integrity.pdf).

90 *See* Centers for Medicare & Medicaid Services, "Medicare" (Available at http://www.cms.gov/Medicare/Medicare.html).

useful resources that may assist them in understanding compliance requirements for participation in Part C and D of the Medicare program.

While Part C and D are beyond the scope of this report, we do note that Part C and D plans do not receive plan-specific feedback regarding the results of billing information received. There is also not a corresponding resource for Part A and B fee-for-service providers explaining the CMS's auditing mechanisms. Rather, the information available to providers tends to originate with professional organizations or trade associations, and contains varying amounts of updated information.[91]

In addition, the RAC program pays its contractors based on the amount of improper payments identified through their audits.[92] This creates an incentive to keep improper payments high, rather than to educate providers about how they can better prevent improper payments in the future. One possible solution would be to explore a payment incentive structure based on how much RACs are able to reduce improper payments within their jurisdictions, rather than solely based on the amount of improper payments that are identified.

[91] *See* AHIMA. "Understanding Governmental Audits." *Journal of AHIMA* 82, no.7, July 2011, p. 50-55 (Available at http://library.ahima.org/xpedio/groups/public/documents/ahima/bok1_049047.hcsp?dDocName=bok1_049047).

[92] *See* Tax Relief and Health Care Act of 2006, P.L. 109-432, Division B, § 302(h)(1).

Conclusions and Recommendations

The CMS today faces the highest improper payment rate of the past five years. Committee staff believes, and the CMS has expressed, that the most effective means for reducing improper payments is to prevent the payments *from occurring in the first place*, rather than to try to recover funds already paid. It is not enough that the CMS cite policy changes as the reason for its higher improper payment rate. The CMS must appropriately safeguard taxpayer dollars against improper payment, even in times of change.

Further, Committee staff is concerned that the CMS's strategy to reduce improper payments is actually a strategy aimed more at identifying and recovering improper payments that have already occurred, rather than a proactive strategy to ensure that those errors are not made in the first place. This continues a pay-and-chase model of addressing improper payments rather than a proactive focus on prevention. The CMS has developed a number of tools to audit and review providers, but we find that these audits may be duplicative and do not always serve an educational purpose. More collaboration between the CMS's prepayment review programs is needed. Contractor error rate reduction plans must be overseen more effectively by the CMS.

In follow-up to this report, Committee staff will be requesting regular updates on implementation of the OIG's recommendations for improvements in contractor error rate reduction plans from the CMS, to ensure that the CMS is providing effective oversight over the millions of dollars which are paid to its contractors.

Further, the RAC incentive structure is not based on reducing future improper payments, but on recovering past improper payments. This could be viewed as providing an incentive to keep improper payment rates high. The CERT program measures the improper payment rate based on a random sampling of claims, and we find it troubling that this rate has increased despite the advent of the RAC program. Further, we note the inclusion of pre-authorization pilot program claims data in CERT samples potentially problematic, as the CMS may not be able to accurately extrapolate CERT results nationwide. We believe that the CMS should explore ways to incorporate a RAC's effectiveness at reducing improper payment rates over time into financial incentive structures, rather than relying solely on the amount of improper payments identified by a RAC.

Overall, however, Medicare contractors have done a great deal to reduce improper payments, including implementing many local coverage decisions, and should be encouraged to continue to develop innovative ways of preventing improper payments while preserving beneficiary access. However, these local coverage decisions are applied only within the MAC's jurisdiction, which may lead to discrepancies in

access to care, and have not, in most cases, been targeted to the most costly, highly-utilized services in a consistent way. It is the CMS's responsibility to ensure that those local coverage decisions do not compromise beneficiary access to care, and that they are applied consistently so that the care a beneficiary receives does not depend on the state in which they choose to live.

Further, the CMS does not have a good way of collecting these local innovations to apply best practices nationwide. This prevents a sound correlation between contractor actions and the reduction in Medicare's improper payment rate. Also, the current variation in local coverage decisions prevents the National Correct Coding Initiative and Medically Unlikely Edit programs from addressing these issues on a national basis. While the new supplemental medical review contractor may also begin doing audits in this area, it is not clear how its efforts will do more to reduce improper payments. Rather, it appears this new contractor will be focused on recovery of improper payments after they have been made.

Aside from reviews conducted by contractors, the CMS does have a number of pre-payment checks, or edits in the system which automatically deny payments that appear to be improper. Further, the CMS should be congratulated on the development of prepayment review programs like National Correct Coding Initiative and Medically Unlikely Edits, but must ensure that it has a means of evaluating their effectiveness, and that all of their resources are brought to bear in reducing the CMS's improper payment rate. This is critical to meeting the requirements within IPIA. Citing the existence of programs, without outcomes data regarding their effectiveness in preventing improper payments, is, in the opinion of the Committee staff, inconsistent with the spirit, if not the law, of IPIA. Therefore, the Committee staff recommends:

(1) The CMS should consolidate post-payment review activities to the maximum extent possible;
(2) The CMS should consider financial incentives aimed more at the reduction of improper payment rates in a given contractor's jurisdiction, rather than solely on the amount of improper payments identified;
(3) The CMS should assess the reliability of data contained within the RAC Data Warehouse, and correct any data errors or omissions identified;
(4) Each pre-payment review program should have defined objectives and scopes of operation related to the reduction of improper payments, including how they will work together to achieve this goal;
(5) The CMS should strengthen its review of contractor error rate reduction plans to ensure they target all CERT-identified problem areas in accordance with the OIG's recommendation;

(6) The CMS should ensure that local coverage decisions target high cost, highly utilized services or items and do not create inconsistent access to care for beneficiaries; and
(7) The CMS should determine the effectiveness of the pre-payment review processes discussed in this report in terms of reducing improper payments; and
(8) The CMS should emphasize provider education as a means of reducing improper payments, to include a means of systematically gathering feedback from stakeholders to understand whether educational efforts are reaching their intended audiences.