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Medicare Part A & Part B: Audits and auditors

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The audit landscape and the appeal backlog are part of much discussion these days, but it is important to understand how it all starts. To put things into context, there are approximately 1.5 million fee-for-service providers, and the federal government estimates that for the Fiscal Reporting Year (FY) 2016, 11% or $41.1 billion of all Medicare Fee-for-Service (FFS) claim payments were improper.[1] An improper payment has been defined by the Government Accountability Office as "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."[2]

In FY 2016, the Centers for Medicare and Medicaid (CMS) reported that the primary causes of improper payments were insufficient documentation and medical necessity errors. To combat improper payments, CMS established the CMS Integrity Program, which coordinates the Medicare and Medicaid program integrity activities under one management structure to investigate Medicare and Medicaid providers and to identify potential overpayments.[3]

CMS Integrity Program contractors (described below) screen and monitor providers and suppliers enrolling in Medicare, Medicaid, and the Children's Health Insurance program (CHIP); impose moratoria on enrollment of new providers in areas where trends indicate significant potential for healthcare fraud; coordinate with private and public health payers and other stakeholders to detect and deter fraudulent behaviors; and provide outreach and education to key stakeholders to help avoid billing errors, suspending payments in cases of suspected fraudulent conduct.

The expectation for the CMS Integrity Program was to have more consistent audits over multiple lines of business; increased oversight of government contractors; increased education of providers and beneficiaries on fraud and abuse issues; quicker responses to fraudulent activity, resulting in reduced fraud and an improved industry image; increased commitment to fighting fraud and abuse; more innovative data analysis and investigative techniques; and expanded investigations across Medicare and Medicaid.

Unfortunately, the results have been mixed, and many providers find themselves under almost impossible audit circumstances. As a result of the CMS Integrity Program, some providers have been put on 100% prepayment reviews and have also been faced with post-payment audits and extrapolated overpayment demands. Many audits recommend denials of a large percentage of providers' claims for insufficient documentation, and anecdotal evidence shows that coverage policies and government contractors' internal procedures have been applied inconsistently, with little CMS oversight. To add to the frustration, many of these decisions are

overturned only after providers undertake a time-consuming and expensive appeal of the audit decision.

The process for providers to appeal audit outcomes has been backlogged for years now, furnishing providers with few available tools to combat any unjust enforcement. In an effort to countervail this imbalance, the following is an overview of the CMS Integrity Program and its key auditors, the auditing process and, most importantly, the appeals process. We also provide a few key recommendations for dealing with any audit and repayment requests.