COSMOS
Navigate the Compliance Universe

Compliance Today - July 2019
Using a backbone audit and denials management solution

By Stewart M. Presser and Bryan Exner

Stewart M. Presser (stewartp@bluemark.net) is Senior Strategic Advisor and **Bryan Exner** (bryane@bluemark.net) is Chief Operating Officer with Bluemark in New Paltz, New York.

Due to the complexities of regulations and billing requirements, providers are faced with rapidly increasing volumes of audits and claim denials from all types of insurance carriers. Although initially only government payers, such as Medicare and Medicaid, were auditing and denying healthcare claims, now commercial insurance carriers also have instituted broad-based claim audits and regularly issue both technical and medical review denials. Today, hospitals and other caregivers are faced with a myriad of challenges to their claim dollars, including both prepayment and post-payment reviews.

With this barrage of audits and denials, providers need viable tools and processes to efficiently and effectively support the claim defense process and, ultimately, protect at-risk reimbursement dollars. At the foundation of an organization's strategy, healthcare providers must establish a cross-functional audit and denial department dedicated to managing the impending wave of audit requests. A state-of-the-art technology solution to automate and facilitate the claim defense process across multiple departments is also a critical component for success.

Less than a decade ago, providers received an unmanageable volume of audit requests from payers, specifically Medicare audit contractors. At that time, manual processes and disparate, rudimentary systems—including simple spreadsheets and basic audit tracking software—were the only tools used to manage this process. It did not take long for providers to become overwhelmed with the volume. As a result, many audits turned into technical denials due to providers' inability to submit initial record requests in a timely manner or manage the overall denial time frames. Over the years, the Centers for Medicare & Medicaid Services (CMS) realized that providers needed relief from these tremendously high request volumes.

This was a welcome change, but it still did not resolve the issue of audit and denials management or help ensure that providers never sustained a denial due to internal audit tracking issues. Other payers increased audits without regard to providers' abilities to handle high volumes of requests. Providers are now faced with a whole new set of challenges, including:

- How to respond to the now thousands of record requests from all payers on a regular basis,
- Millions of dollars in prepay and post-pay reimbursement at risk, and
- High rates of denials.

In its fiscal year 2016 Report to Congress, CMS stated:

> Medicare FFS RACs collectively identified and corrected 380,229 claims with improper payments that resulted in $473.92 million in improper payments being adjusted. The total corrections identified include $404.46 million in

> overpayments collected and $69.46 million in underpayments repaid to providers. This represents a 7.5% increase from program corrections in FY 2015, which were $440.69 million. In FY 2016, the Medicare FFS Recovery Audit Program returned a net of $214.09 million to the Medicare Trust Funds. This represents a 50% increase from returned dollars in FY 2015, which were $141.87 million. These savings take into consideration the costs of the program, including contingency fees, administrative costs, and amounts overturned on appeal.[1]

State Medicaid and private insurance payers historically look to Medicare results to hone their audits on providers, which leads to increased audit volumes. The assumption is, if the provider codes incorrectly for Medicare, they will likely have a certain coding error on all payer claims. The Health and Human Services Office of the Inspector General (OIG) consistently monitors federal agency audit results, and then embarks on their own audits, oftentimes duplicating what other federal audits have already done. Unfortunately, the OIG is not exempt from duplicating what other Medicare audits have done, so it's possible that providers can experience duplicate audits by the OIG.