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Although Audits Restart Aug. 3, CMS Will Roll Them Out in Stages; TPE Is On Ice for Now

By Nina Youngstrom

Although CMS's website says it's resuming Medicare audits Aug. 3, this will happen in stages. Hospitals and other providers won't be hit with a flurry of documentation requests at the same time from CMS medical reviewers and program integrity contractors, and Targeted Probe and Educate is on hold for now, a CMS spokesperson said.

The perception that an audit blitz was imminent came from answers to frequently asked questions (FAQ) on provider burden relief,[1] which said CMS expected to "discontinue exercising enforcement discretion beginning on August 3." But CMS has explained that it won't happen all at once.

"Please know that the posted FAQ documents provided a high-level overview to participating health care providers," a spokesperson said. "CMS will restart its prior authorization processes on August 3, 2020. After that, medical review will begin with the Medicare Administrative Contractors, followed by reviews by the Supplemental Medical Review Contractor (SMRC) and the Recovery Audit Program Contractor (RAC). To ensure provider burden is adequately addressed, the MACs will conduct post payment review. This will allow for extensions as needed. CMS will determine when it may be appropriate to begin Targeted Probe and Educate (TPE), which typically consists of prepayment review. These combined efforts are focused at lowering improper payment rates and increasing operational efficiencies. CMS is committed to resuming these program integrity activities while not negatively impacting provider burden."

In an existential way, it's anybody's guess how the audits will play out, said attorney David Glaser, with Fredrikson & Byron in Minneapolis. When 2021 rolls around, people may look back at 2020 as the darkest time in recent history, depending on whether the country starts to get the pandemic under control or it spirals even further, and depending on a hospital's experience with it, he said. "If things get worse, I don't think [auditors] will want to pick on people about documentation. It depends on how things go," Glaser said. Meanwhile, providers should document to the extent reasonable, and if they can't explain something, they shouldn't be cagey, he said. "Acknowledge the things that are missing. If you don't have the patient's signature because of COVID-19, say that in there so you can try to tell the story the best you can." For example, the hospital can document it's not getting patient signatures because it's not using pens, or the physician didn't perform the usual patient exam because the evaluation and management service was delivered via telehealth, with audio only (a telephone call).

Glaser also urged providers to print CMS guidance weekly, including FAQs and waivers. When CMS updates them, it often removes earlier versions, and they vanish from the internet. Having proof of compliance with a waiver, FAQ or other guidance at a particular moment in time will be critical when providers are audited because a Medicare auditor may base a denial on a policy that wasn't in effect at the time, he said. "CMS is doing a good job of saying when they add [a waiver or FAQ], but you don't know if the week before there was nothing about it or the guidance was different," Glaser said. "It's really hard…to recreate it."

For the same reason, he recommends keeping transcripts of CMS's weekly stakeholder engagement calls on COVID-19, which address billing and documentation for the most part.

The delay in the audits "is not a 'free pass' to ignore regulations; compliance remains required. I doubt any auditor is going to accept 'We were too busy to comply' unless you were truly overwhelmed with COVID-19 patients and can prove that," said Ronald Hirsch, M.D., vice president of R1RCM.

"It's important to note that CMS administrator Seema Verma hinted that data mining has found doctors billing for more telehealth hours than there are in a day, so I cannot see CMS allowing such activities to go on unchecked," he said. If data indicates outliers, it seems like they have to be looked at by some auditor or program integrity contractor—whether it's MACs with Targeted Probe and Educate or the supplemental medical review contractor "or even the Department of Justice."

Prior Auth Already Under Way

Also, although CMS said prior authorization would resume in August, it began the new prior authorization process for five hospital outpatient procedures[2] July 1, Hirsch said.

The prior authorization process, which was announced in the 2020 Outpatient Prospective Payment System/Ambulatory Surgical Center final rule, is run by the MACs. Hospitals are required to get MAC approval for five surgeries—blepharoplasty, botulinum toxin injections, panniculectomy, rhinoplasty and vein ablation—before submitting claims.

Without prior authorization, Medicare will deny claims for the procedure and "any claims associated with or related to a service that requires prior authorization," the Outpatient Prospective Payment System rule stated. That includes the professional fees for the surgeon, radiologist, pathologist and anesthesiologist.

Before surgery, hospitals submit a prior authorization request to the MACs, which spit out a unique tracking number (UTN) that's valid for 120 days. One of three (or more) things happen next:

- The MAC gives hospitals an affirmation, which means the claim will probably be covered. "A provisional affirmation decision is a preliminary finding that a future claim submitted to Medicare for the item or service likely meets Medicare's coverage, coding, and payment requirements," CMS said in answers to frequently asked questions about prior authorization.
- The MAC turns hospitals down with a non-affirmation decision, because the claim doesn't meet coverage, coding or payment requirements. However, hospitals can submit additional documentation and keep requesting prior authorization for the same procedure until hopefully it's approved. Non-affirmations are not denials with appeal rights. If hospitals are unable to satisfy the MAC, that's the end of it, sort of. Hospitals can still perform the procedure, submit the claim, get a denial and appeal the usual way.
- MACs may give hospitals a provisional partial affirmation decision, which "means that one or more service(s) on the request received a provisional affirmation decision and one or more service(s) received a non-affirmation decision," the FAQs state.

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1 CMS, "Coronavirus Disease 2019 (COVID-19) Provider Burden Relief Frequently Asked Questions (FAQs)," July 2020, https://go.cms.gov/2UXXRav.
2 CMS, "Prior Authorization for Certain Hospital Outpatient Department (OPD) Services," last modified June 15,

2020, http://go.cms.gov/OPD_PA.