CMS Action to Better Manage Medicare Contractors Doing Postpayment Review of Claims Can Improve Efficiency, Reduce Provider Burden

Why GAO Did the Study

CMS uses several types of contractors to conduct postpayment claims reviews of Medicare fee-for-service (FFS) claims to identify improper payments. These contractors were established by different legislative actions; are managed by different offices within CMS; and serve different functions in the program. These contractors include:

(1) Medicare Administrative Contractors that process and pay claims and are responsible for taking actions to reduce payment errors in their jurisdictions
(2) Zone Program Integrity Contractors (ZPIC) that investigate potential fraud, which can result in referrals to law enforcement or administrative actions
(3) Recovery Auditor contractors (RACs) tasked to identify improper payments on a postpayment basis
(4) The Comprehensive Error Rate Testing (CERT) contractor that reviews a sample of claims nationwide and documentation to determine a national Medicare FFS improper payment rate.

All four types of contractors conduct complex reviews, in which the contractor examines medical records and other documentation sent by providers to determine if the claims meet Medicare coverage and payment requirements. Overall, compared to over one 1 billion claims processed in 2012, *all four types of contractors combined reviewed less than one 1 percent of claims*, about 1.4 million reviews, for which providers might be contacted to send in medical records or other documentation.

Recently, questions have been raised about the efficiency and effectiveness of these contractors' efforts and the administrative burden on providers. In the report, GAO assesses the extent to which requirements for postpayment claims reviews differ across the contractors and whether differences, if any, could impede effective and efficient claims reviews.

What GAO Found

- **The Status Quo Can Be Confusing and Inefficient.** CMS has different requirements for many aspects of the process across these four contractor types. There are differences in oversight of claims selection, time frames for providers to send in documentation, communications to providers about the reviews, reviewer staffing, and processes to ensure the quality of claims reviews. GAO cautioned that "some of these differences may impede efficiency and effectiveness of claims reviews by increasing administrative burden for providers." As GAO explained, "having inefficient processes that complicate compliance can reduce effectiveness of claims reviews, and is inconsistent with executive-agency guidelines to streamline service delivery and with having a strong internal control environment."

- **The Status Quo Add Unnecessary Costs to the System.** GAO warned that "ineffective or inefficient claims reviews present the risk of generating false findings of improper payments and an unnecessary administrative and financial burden related to provider appeals for Medicare-participating providers and the Medicare program."

- **The Use of Contractors Has Evolved and May Not Be Strategically Aligned With CMS Goals.** As GAO summarized, "according to CMS officials, differences in requirements generally developed because the contracts or requirements were written at different times by staff within different parts of CMS, or the contractors' functions and activities have changed over time."

What GAO Recommends

GAO recommends that CMS:
(1) examine contractor review requirements to determine what could be made more consistent
(2) communicate its findings and time frame for taking action
(3) reduce differences where it can be done without impeding efforts to reduce improper payments.
CMS has begun to examine differences in requirements across contractors, *but did not provide information on any specific changes being considered or a time frame for action*.

A broad array of stakeholder comments were reviewed and considered. As part of its study, GAO reviewed white papers sent by health care stakeholders in response to the Senate Committee on Finance's May 2, 2012, letter requesting suggestions to improve efforts to address Medicare and Medicaid fraud, waste, and abuse.

Postpayment claims reviews may be automated, semiautomated, or complex.
- Automated reviews use computer programming logic to check claims for evidence of improper coding or other mistakes.
- Semiautomated reviews use computer programming logic to check for possible improper payments, but allow providers to send in information to rebut the claim denial before it is implemented.
- Complex reviews are conducted if additional documentation is needed to determine whether a payment was made in error. Complex reviews involve manual examinations of each claim and any related documentation requested and received from the provider, including paper files, to determine whether the service was billed properly, and was covered, reasonable, and necessary.

Each contractor establishes its own claims selection criteria. A contractor may use data analyses, knowledge of Medicare billing requirements, and clinical expertise to develop its claims selection criteria to focus on claims with a high likelihood of being improper.

The number of postpayment reviews has significantly increased in recent years. The analysis of data from CMS indicates that from 2011 to 2012, the RAC's complex postpayment reviews increased 77 percent. Except for the CERT contractor, which reviews a randomly selected sample of claims each year to estimate the error rates, all contractors increased their postpayment claims reviews by 16 percent or more. However, the 2.3 million reviews performed by these contractors accounted for less than 1 percent of the over 1 billion FFS claims paid annually, and about 1.4 million were complex reviews.

The RACs have stringent requirements from CMS, but conduct more reviews than all the other postpayment contractors combined. GAO noted that "CMS sets more limits through claims review requirements on [RACs] than on other contractors," yet the RACs "conducted nearly five times as many complex reviews in fiscal year 2012 as the other three contractors combined—over 1.1 million complex postpayment claims reviews and nearly 1 million automated review denials.

CMS has begun an effort to examine whether its activities add administrative burden for providers. In 2011, CMS established an internal work group known as the Provider Burden Reduction Work Group to inventory CMS and contractor activities that may create administrative burden for providers, to assess providers' complaints, and identify areas for improving efficiency of processes. As of November 2012, CMS officials told us that the work group had briefed CMS senior management about its work, but this effort was still in progress. CMS has not publicly announced the results of the work group's efforts, whether it would make any requirements more consistent, or a time frame for any changes.

(1) **Use RAC requirements as a model.** GAO said representatives of provider associations believe that if certain RAC requirements were applied to the other contractors, "this could reduce administrative burden and improve claims reviews efficiency."

(2) **Streamline deadlines to be uniform.** GAO explained representatives also noted that "some of the differences in the contractors' postpayment claims review requirements can impede effectiveness and efficiency of the claims reviews by complicating providers' responses to [additional documentation requests] or their understanding of claims review decisions." Others "stated that having different timeframes makes responding to [additional documentation requests] more challenging." As GAO noted, "ensuring consistency in common processes is consistent with OMB guidance on streamlining service delivery and a strong control environment."

(3) **Modify incentives.** Several provider associations GAO interviewed indicated that is sometimes "difficult for the providers whose claims were being reviewed to obtain the needed documentation from third parties in a timely manner." GAO explained "there is no financial incentive for the third parties to forward requested documentation to the service providers because the third parties' claims are not denied as improper if the documents are not submitted to the contractor."

(4) **Accept electronic submissions.** Different types of contractors are subject to different requirements regarding the formats in which they will accept providers' documentation, whether paper, fax, or electronic submission. GAO concluded that "making electronic submission acceptable across all contractors would be consistent with OMB guidance on streamlining service delivery."

(5) **Update staffing requirements.** CMS requirements for staffing, including claims reviewers' qualifications, vary depending on the type of contractor, but CMS specifies the minimum number of physicians serving as medical directors that each contractor must have on staff. CMS requires that medical directors serve as a readily available source of medical expertise to provide guidance on claims reviews for all of the contactors, but their scopes of responsibility vary across contractors. CMS officials also indicated that they have not required similar numbers of medical directors or required a certain number of medical directors to be responsible for oversight of a specific number of claims reviews because of cost issues. CMS officials indicated that they do not want to incur additional costs that could be involved in establishing consistent minimum staffing requirements for conducting claims reviews, if that would increase the number of medical directors that contractors would have to hire. However, CMS's current requirements for medical may be inadequate for two reasons.

  o **The proportion of medically-trained reviewers for the volume of claims may be inadequate.** For example, MACs must have at least three full-time equivalent (FTE) medical directors on staff, RACs are required to have one FTE medical director on staff, ZPICs are required to have at least one part-time medical director, and the CERT contractor is required to have two FTE medical directors. However the contractors reviewed 2.3 million claims in 2012.

  o **CMS's requirements are inconsistent across postpayment contractors.** CMS requires RACs and the CERT contractor to employ certified coders to determine compliance with Medicare coding requirements, but does not require MACs or ZPICs to do so. CMS has a requirement for ZPICs, that when Medicare policy for a given service is not clearly articulated, the ZPICs must involve a medical specialist trained and experienced in providing the type of service being reviewed. There is no similar requirement for the other contractors.

  Unsurprisingly, GAO notes that representatives from numerous provider associations indicated that "on the basis of some of the claims review results, their members had questioned whether some reviewers were qualified to review claims, and several associations indicated that erroneous claims reviews led to appeals that would not have been needed had the determination been correct."