

# Medicare audits could take less punitive approach in 2018

JAN 17, 2018

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One thing physicians may notice in 2018 is the government taking a less punitive and more educational approach to correcting Medicare billing errors.

The AMA and the Centers for Medicaid and Medicare Services (CMS) have been holding monthly meetings to discuss issues concerning Medicare Administrative Contractors (MACs) and Recovery Audit Contractors (RACs)—and the effort appears to be bearing fruit.

CMS describes MACs as private health insurers who review clinical documentation and process Medicare fee-for-service medical or durable medical equipment (DME) claims. RACs are private entities paid on commission to identify and correct Medicare over or underpayments.

## CMS acts on improvement suggestions

Previous AMA-advocated improvements included requiring RACs to have medical directors, certified coders and a web presence on which physicians can look up the status of audits. Also, RAC contingency fees must be paid back if an appeal is lost.

More recent improvements have also been made.

Before sending audit results directly to CMS, a RAC must first send results to the providers included in the audit. Physicians have 30 days to send the RAC a request to discuss the audit results and can also submit additional documentation or information supporting their interpretation of Medicare's requirements.

Physicians may also request to speak to the RAC's medical director, to the physician who reviewed the file, and to consult with a RAC physician in their same specialty. Having this discussion is beneficial for physicians because it could avoid the time, effort and expense of going through a formal appeal process. Furthermore, through these discussions, CMS may identify patterns of RAC issues

and help fix the overall RAC process.

While positive steps have been taken as a result of the AMA's advocacy, the Association continues to push for more changes that would reduce physicians' audit-related administrative burdens.

AMA letters to CMS include a set of physician "asks," and it appears several of these requests will likely be granted. These include requests for CMS to:

- | Clarify contractors' function and scope of authority.
- | Establish an internet portal for consolidating information on program integrity efforts, including contractor sampling and extrapolation methodologies.
- | Increase physician education efforts on how to avoid common coding and billing mistakes.
- | Work with practices to address deficiencies that may lead to a high volume of coding and billing errors.
- | Refine reviews using predictive analytics to focus on claims that are at high risk for improper payments.
- | Consider replacing financial penalties with corrective action plans.

Some of these recommended changes have already been implemented by CMS.

CMS piloted its Targeted Probe and Educate (TPE) process in 2016. It involved MACs using data analytics to identify home health and durable medical equipment providers who may have received improper payments, had a high error rate or posed "the greatest risk to the Medicare trust fund," according to the new CMS TPE webpage.

TPE was expanded to all MAC reviews—including physicians—on Oct. 1, 2017. CMS pledged to "focus only on providers/suppliers who have the highest claim error rates or billing practices that vary significantly out from their peers."

This is how TPE works. After the provider is "targeted" using data analytics, the MAC performs up to three rounds of "probe and Educate." Each round takes about 90 days—30 days for MAC to review the claims, a few days to schedule an educational call, 45 days for providers to show improvement—and is centered around a one-on-one educational phone call with the provider.

"This eliminates burden to providers who, based on data analysis, are already submitting claims that are compliant with Medicare policy," according to CMS. "MACs also educate providers throughout the probe review process, when easily resolved errors are identified, helping the provider to avoid additional similar errors later in the process."

Providers and suppliers who continue with high error rates after three rounds of TPE are referred to CMS for additional action.

## Advocacy for RAC reform continues

The AMA continues to push for similar RAC reforms. The AMA opposes the congressionally-mandated contingency fee structure used to pay the RACs. In June 13 and Sept. 11 letters to CMS Administrator Seema Verma, the AMA described RAC contingency fee payments as a “pay and chase model.”

In the Sept. 11 letter, the Association cited CMS statistics showing that out of the nearly 47,000 RAC Medicare Part B determinations that were appealed in fiscal 2015, 70 percent were overturned in the provider’s favor.

The letter followed by recommending that:

- | RACs on the losing end of appeals reimburse physicians for the cost of the appeal plus interest.
- | Meaningful financial penalties be implemented for RACs that make errors.
- | The RAC contingency payment structure be repealed.

The AMA also told CMS that doctors are committed partners in the agency’s effort to eliminate healthcare fraud and waste, but “broad brush requirements” create a regulatory burden that is a major component of physician burnout and results in unnecessary costs to the health care system. Instead, the AMA urged CMS to focus on “those providers who have demonstrated a propensity to commit fraud or abuse.”

“AMA recommends that CMS work with both public and private stakeholders, including the AMA, to determine and discuss how to develop a framework that properly balances eliminating fraud and abuse while not negatively impacting honest providers with burdensome and unnecessary requirements,” AMA Executive Vice President and CEO James L. Madara, MD, wrote in the letter.