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MEDICARE PROGRAM INTEGRITY

Increasing Consistency of Contractor Requirements May Improve Administrative Efficiency

GAO Highlights

Highlights of GAO-13-522, a report to congressional requesters

Why GAO Did This Study

In fiscal year 2012, CMS estimated that $32.4 billion in Medicare FFS payments were improper. CMS uses several types of contractors to conduct postpayment claims reviews to identify improper payments. Recently, questions have been raised about the efficiency and effectiveness of these contractors' efforts and the administrative burden on providers. This report (1) describes these contractors and (2) 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. GAO reviewed CMS's requirements for claims reviews in manuals and contracts, interviewed CMS officials and selected provider associations, and assessed the requirements against internal control standards and executive-agency guidance on streamlining service delivery. GAO also obtained data on numbers of claims reviewed, and appealed.

What GAO Recommends

GAO recommends that CMS (1) examine all contractor postpayment review requirements to determine those that could be made more consistent, (2) communicate its findings and time frame for taking action, and (3) reduce differences where it can be done without impeding efforts to reduce improper payments. In its comments, the Department of Health and Human Services concurred with these recommendations, agreed to reduce differences in postpayment review requirements where appropriate, and noted that CMS had begun examining these requirements.

View GAO-13-522. For more information, contact Kathleen King at (202) 512-7114 or kingk@gao.gov.

What GAO Found

The Centers for Medicare & Medicaid Services' (CMS) contractors that conduct postpayment reviews on Medicare fee-for-service (FFS) claims 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 Auditors (RA) tasked to identify improper payments on a postpayment basis; and (4) the Comprehensive Error Rate Testing (CERT) contractor that reviews a sample of claims nationwide and related 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. RAs are paid fees contingent on the amount of the claims that are found improper and recouped or adjusted, whereas the other contractors' reimbursement is not dependent on the amount of their claims reviews. The RAs conducted almost five times as many reviews as the other three contractors combined. 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.

Although postpayment claims reviews involve the same general process regardless of which type of contractor conducts them, CMS has different requirements for many aspects of the process across these four contractor types. Some of these differences may impede efficiency and effectiveness of claims reviews by increasing administrative burden for providers. 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. For example, while the CERT contractor must give a provider 75 days to respond to a request for documentation before it can find the claim improper due to lack of documentation, the ZPIC is only required to give the provider 30 days. CMS places more limits on the RAs in its requirements for reviews conducted by them than by other contractors. For example, RAs must submit the criteria that they will use to determine if a service is paid improperly to CMS for approval. The additional requirements for RAs are due in part to CMS's experience during an initial demonstration testing the use of RAs. CMS officials indicated that other requirement differences across contractors generally developed due to setting requirements at different times by staff in different parts of the agency. Providers indicated that some differences hindered their understanding of and compliance with the claims review process. 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. 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.