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MEDICARE OUTPATIENT THERAPY

Implementation of the 2012 Manual Medical Review Process

GAO Highlights

Highlights of GAO-13-613, a report to congressional committees

Why GAO Did This Study

In 2011, Medicare paid about $5.7 billion to provide outpatient therapy services for 48 million beneficiaries. Rising Medicare spending for outpatient therapy services—physical therapy, occupational therapy, and speech-language pathology—has long been of concern. Congress established per person spending limits, or "therapy caps," for nonhospital outpatient therapy, which took effect in 1999. In response to concerns that some beneficiaries needing extensive services might be affected adversely, Congress imposed temporary moratoria on the caps several times until 2006, when it required CMS to implement an exceptions process. The Middle Class Tax Relief and Job Creation Act of 2012, in addition to extending the exceptions process, required CMS to conduct MMRs of requests for exceptions for outpatient services provided on or after October 1, 2012, over an annual threshold of $3,700. The act also mandated that GAO report on the implementation of the MMR process.

This report describes (1) CMS's implementation of the 2012 MMR process, and (2) the number of individuals and claims subject to MMRs and the outcomes of these reviews. GAO reviewed relevant statutes, CMS policies and guidance, and CMS data on these reviews. GAO also interviewed CMS staff and officials from three MACs that accounted for almost 50 percent of the MMR workload and that processed claims for states previously determined to be at a higher risk for outpatient therapy improper payments.

View GAO-13-613. For more information, contact Kathleen M. King at (202) 512-7114 or kingk@gao.gov.

What GAO Found

The Centers for Medicare & Medicaid Services (CMS) implemented two types of manual medical reviews (MMR)—reviews of preapproval requests and reviews of claims submitted without preapproval—for all outpatient therapy services that were above a $3,700 per-beneficiary threshold provided during the last 3 months of 2012. However, CMS did not issue complete guidance on how to process preapproval requests before the implementation of the MMR process in October 2012, and the Medicare Administrative Contractors (MAC) that conducted the MMRs were unable to fully automate systems for tracking preapproval requests in the time allotted. CMS required the MACs to manually review preapproval requests within 10 business days of receipt of all supporting documentation to determine whether the services were medically necessary, and to automatically approve any requests they were unable to review within that time frame. CMS officials told GAO that the purpose of the preapproval process was to protect beneficiaries from being liable for payment for nonaffirmed services by giving the provider and beneficiary guidance as to whether Medicare would pay for the requested services. If a provider delivered services without submitting a preapproval request, the MACs were required to manually review submitted claims above the $3,700 threshold prior to payment within 60 days of receiving the needed documentation. The MACs faced particular challenges with implementing reviews of preapproval requests because CMS continued to issue new guidance on how to manage preapproval requests after the MMR process started. For example, CMS did not inform the MACs how to process incomplete requests or count the 10-day preapproval request review time frame until November 7, 2012, and the MACs initially handled requests differently. In addition, all three MACs GAO interviewed told GAO that MMRs of preapproval requests were especially challenging because they did not have time to fully automate systems for tracking and processing the requests before the start of the MMR process, although they adapted their systems to manage the requests in different ways.

CMS officials estimated that the MACs reviewed an estimated total of 167,000 preapproval requests and claims for outpatient therapy service above the $3,700 threshold provided from October 1, 2012, through December 31, 2012. Of these reviews, CMS estimated that 110,000 were for preapproval requests and 57,000 were for claims submitted without prior approval. However, due in part to the lack of automation, CMS officials reported that the total number of reviews should be considered estimates of the results of the MMR process at the time of this report. CMS estimated that the MACs affirmed about two-thirds of the preapproval requests and about one-third of the claims submitted without preapproval. Because providers can appeal denials of payment, the final outcome of the MMRs remains uncertain. CMS also estimated that by December 31, 2012, over 115,000 beneficiaries were affected by the reviews in 2012, a number that will rise as more claims subject to review are submitted throughout 2013.

In its comments on a draft of this report, HHS emphasized that CMS managed the 2012 MMR process without additional funding and within a short time frame. HHS noted that the MMR process was extended for 2013 and CMS transitioned the responsibility for these reviews to other contractors as of April 1, 2013.