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MEDICARE

Claim Review Programs Could Be Improved with Additional Prepayment Reviews and Better Data

GAO Highlights

Highlights of GAO-16-394, a report to the Chairman, Committee on Finance, U.S. Senate

Why GAO Did This Study

CMS uses several types of claim review contractors to help reduce improper payments and protect the integrity of the Medicare program. CMS pays its contractors differently—the agency is required by law to pay RAs contingency fees from recovered overpayments, while other contractors are paid based on cost. Questions have been raised about the focus of RA reviews because of the incentives associated with the contingency fees.

GAO was asked to examine the review activities of the different Medicare claim review contractors. This report examines (1) differences between prepayment and postpayment reviews and the extent to which contractors use them; (2) the extent to which the claim review contractors focus their reviews on different types of claims; and (3) CMS's cost per review and amount of improper payments identified by the claim review contractors per dollar paid by CMS. GAO reviewed CMS documents; analyzed CMS and contractor claim review and funding data for 2013 and 2014; interviewed CMS officials, claim review contractors, and health care provider organizations; and assessed CMS's oversight against federal internal control standards.

What GAO Recommends

GAO recommends that CMS (1) request legislation to allow the RAs to conduct prepayment claim reviews, and (2) provide written guidance on calculating savings from prepayment reviews. The Department of Health and Human Services disagreed with the first recommendation, but concurred with the second. GAO continues to believe the first recommendation is valid as discussed in the report.

View GAO-16-394. 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) uses different types of contractors to conduct prepayment and postpayment reviews of Medicare fee-for-service claims at high risk for improper payments. Medicare Administrative Contractors (MAC) conduct prepayment and postpayment reviews; Recovery Auditors (RA) generally conduct postpayment reviews; and the Supplemental Medical Review Contractor (SMRC) conducts postpayment reviews as part of studies directed by CMS. CMS, its contractors, and provider organizations identified few significant differences between conducting and responding to prepayment and postpayment reviews. Using prepayment reviews to deny improper claims and prevent overpayments is consistent with CMS's goal to pay claims correctly the first time and can better protect Medicare funds because not all overpayments can be collected. In 2013 and 2014, 98 percent of MAC claim reviews were prepayment, and 85 percent of RA claim reviews and 100 percent of SMRC reviews were postpayment. Because CMS is required by law to pay RAs contingency fees from recovered overpayments, the RAs can only conduct prepayment reviews under a demonstration. From 2012 through 2014, CMS conducted a demonstration in which the RAs conducted prepayment reviews and were paid contingency fees based on claim denial amounts. CMS officials considered the demonstration a success. However, CMS has not requested legislation that would allow for RA prepayment reviews by amending existing payment requirements and thus may be missing an opportunity to better protect Medicare funds.

The contractors focused their reviews on different types of claims. In 2013 and 2014, the RAs focused their reviews on inpatient claims, which represented about 30 percent of Medicare improper payments. In 2013 and 2014, inpatient claim reviews accounted for 78 and 47 percent, respectively, of all RA claim reviews. Inpatient claims had high average identified improper payment amounts, reflecting the costs of the services. The RAs' focus on inpatient claims was consistent with the financial incentives from their contingency fees, which are based on the amount of identified overpayments, but the focus was not consistent with CMS's expectations that RAs review all claim types. CMS has since taken steps to limit the RAs' focus on inpatient claims and broaden the types of claims being reviewed. The MACs focused their reviews on physician and durable medical equipment claims, the latter of which had the highest rate of improper payments. The focus of the SMRC's claim reviews varied.

In 2013 and 2014, the RAs had an average cost per review to CMS of $158 and identified $14 in improper payments per dollar paid by CMS to the RAs. The SMRC had an average cost per review of $256 and identified $7 in improper payments per dollar paid by CMS. GAO was unable to determine the cost per review and amount of improper payments identified by the MACs per dollar paid by CMS because of unreliable data on costs and claim review savings. Inconsistent with federal internal control standards, CMS has not provided written guidance on how the MACs should calculate savings from prepayment reviews. Without reliable savings data, CMS does not have the information it needs to evaluate the MACs' performance and cost effectiveness in preventing improper payments, and CMS cannot compare performance across contractors.