Alliance of Specialty Medicine

Sound Policy. Quality Care.

Improving Medicare's Program Integrity Initiatives

Key Takeaway: *The Alliance is increasingly concerned with Medicare's various program integrity initiatives, including the Recovery Auditor Contactor (RAC) program, and supports a comprehensive review of the Centers for Medicare and Medicaid Services' (CMS) program integrity activities, as well as subsequent improvements that would address efforts to curb fraud and abuse without burdening physician practices with inappropriate audits that may unfairly limit beneficiary access to care.*

The Alliance urges Congress to:

- **Improve transparency in Medicare audit initiatives**, by requiring the Secretary of HHS to clarify the function and scope of authority of the various Medicare program integrity auditors; establish a new web portal for consolidating information on program integrity efforts and information/education on various program integrity contractors, including contractor sampling and extrapolation methodologies; and require CMS to annually publish key data related to various audits, including the number of denials and appeals, net denials (defined as total denials minus denials overturned on appeal) and each auditor's appeal rate. Medicare auditors should also be required to submit potential audits for review and approval by the Secretary, and approved audits should be made public. In addition, Medicare auditors should face a financial penalty when their denials are overturned on appeal.
- **Require public reporting of common coding and billing errors and omissions** using various metrics (e.g., error type, omission type, physician specialty, contractor, and region, among others). Congress should also require the Secretary to enhance educational offerings to physician practices on how to avoid common coding and billing mistakes, especially given the impending move to ICD-10.
- **Replace financial penalties with Corrective Action Plans (CAPs),** as well as institute a program that would provide technical assistance to physician practices while they work to address internal deficiencies that may have led to a high volume of coding and billing errors and inappropriate payments that have not been deemed fraudulent. CMS' Quality Improvement Organizations (QIOs) could administer such a program through an expanded scope of work.
- **Enforce transparency in the development of local coverage and payment policies**, by requiring contractors to adhere to CMS' established requirements for soliciting comments, recommendations, and obtaining input from representatives of relevant specialty societies, as part of the contractor's notice and comment period for new or revised local coverage determinations (LCDs). Local contractors must also be required to provide a formal notice and comment process for any and *all changes* it intends to implement that would revise coverage and payment policies.
- **Mandate physician review for Medicare denials**, by requiring a physician practicing in the same specialty or sub-specialty and with clinical expertise or knowledge of the service in question, to validate whether a medical necessity denial is warranted.