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CMS Budget Justification Requests Increased Audit and Appeals Funding

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The Centers for Medicare & Medicaid Services' (CMS) FY 2022 Budget Justification request to Congress suggests an increased focus on Medicare claim reviews and an effort to decrease the number of claim denials overturned through the Medicare appeals process. CMS specifically proposes to "conduct greater levels of medical review in FY 2022" while seeking a $50.5 million increase in funding for these activities, essentially doubling the FY 2021 enacted amount. Medical review activities include pre- and post-payment audits and encompass the Targeted Probe and Educate (TPE) process. CMS also requests additional funding for modeling and analytic tools aimed at identifying fraud, waste, and abuse.

In line with these requests, CMS announced in June that the Medicare Administrative Contractors (MACs) were authorized to begin conducting post-payment medical review on dates of service on or after March 2020. MAC post-payment audits were paused during the beginning of the COVID Public Health Emergency (PHE) as part of an effort to reduce provider burden. While MAC medical reviews were previously permitted to resume in August 2020, at that time such reviews were limited to dates of service before March 2020. With CMS's announcement, we will now start seeing the first round of audits of claims submitted during the PHE.

The FY 2022 Budget Justification also includes a request for funding of "appeals initiatives" aimed at reducing the number of claim denials that are reversed at the Administrative Law Judge (ALJ) level of the Medicare appeals process. The ALJs operate under the U.S. Health and Human Services' (HHS) Office of Medicare Hearings and Appeals (OMHA), which represents the third level of review in the Medicare appeals process. The five levels of appeal are:

- Redetermination
- Reconsideration by a Qualified Independent Contractor (QIC)
- Hearing before an ALJ
- Medicare Appeals Council Review
- Judicial Review by a Federal Court

The agency indicates that the requested "appeal initiatives" funds would permit the QICs to participate as a party in approximately 2,150 ALJ cases, which CMS states "affords the QICs additional rights to successfully defend a claim denial." CMS asserts that, based on its experience, "invoking party status in hearings" would reduce the "ALJ reversal rate" and lower Medicare Trust Fund expenditures.

Tasking the QIC with defending claim denials raises questions in light of the QIC's statutory role as an independent reviewer at the Reconsideration level of appeal. Further, contractor participation as a party in ALJ hearings typically draws out the appeals process. HHS was sued in 2018 because of a backlog of appeals at OMHA. While recent efforts to reduce the backlog appear to have been largely successful, with the pending workload and appeal receipts significantly decreasing, the average processing time has continued to increase each FY, with the largest delay in OMHA's history reported for FY 2020.

Key Takeaways

The CMS proposals give insight into the agency's priorities. After a significant pause in audit and medical review activity due to the PHE, it is not surprising that CMS is seeking to ramp up these activities. However, auditing of claims submitted during the PHE will be complicated due to the multiple policy changes, waivers and flexibilities CMS issued in response to COVID. Providers and suppliers should be vigilant during audits and medical reviews and not assume that Medicare contractors are applying the correct policies and coverage standards.

While it is not yet clear whether CMS's desire to reduce reversals at the ALJ level will fundamentally change appeal results, increased contractor participation will increase the burden associated with presenting appeals at the ALJ level. However, contractor participation, particularly as a party, can also open up more opportunities to directly challenge the contractors on their lower level determinations. Regardless, CMS's proposal serves as a reminder that detailed arguments and evidence should be raised early in the appeals process. For further information, please contact Katie Salsbury, Steve Azia or any member of Baker Donelson's Reimbursement Team.