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Medicare Advantage Regulatory Scrutiny Keeps Pace with Growth: OIG Report Examines Prior Authorization and Payment Denial Errors

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Introduction

On April 28, 2022, the United States Department of Health and Human Services' Office of Inspector General ("OIG") issued a report finding that 15 of the largest Medicare Advantage Organizations ("MAOs") in the United States have at times denied or delayed beneficiary access to care and provider payment requests for services that met Medicare coverage and MAO billing rules (the "Report"). The OIG based its findings on a stratified random sample of 250 prior authorization and 250 payment denials selected from June 1–7, 2019, and determined that several factors impacted denials, including the imposition of MAO clinical criteria that are not contained in Medicare coverage rules, MAO requests for supplemental documentation despite sufficient showings of medical necessity, and both human and system errors.[1] The Report follows OIG's prior review of a stratified random sample of prior authorization denials in 2018, which found that 75% of prior authorizations reviewed and denied by the nation's largest MAOs were ultimately approved through the MAO appeal process.[2] Amidst heightened scrutiny of MAO chart review and health risk assessment practices, and continued accelerated growth of the Medicare Advantage program, the Report reiterates OIG's concern that capitated payments under the Medicare Advantage program may create incentives to limit access to necessary services and restrict or delay provider reimbursement.[3,4]

I. OIG's Findings: Prior Authorization and Payment Denials

The Report cited Medicare guidance and both human and software error in the sample reviewed as primary reasons for MAO prior authorization and payment request denials that met Medicare coverage rules and MAO reimbursement requirements. The Report first focused on prior authorization denial practices, and found that among those prior authorization requests reviewed that MAOs denied, 13 percent met Medicare coverage rules. OIG cited two primary reasons for these denials. First, the Centers for Medicare and Medicaid Services ("CMS") permits MAOs to impose additional clinical criteria as conditions for prior authorization to those typically required by traditional Medicare, provided such criteria are no more restrictive than, and do not contradict, Medicare's Local Coverage Determination ("LCD") or National Coverage Determination ("NCD") standard policies.[5] The Report cited as examples of MAO clinical criteria reviewed but not otherwise required by Medicare coverage rules: (i) restricting access to follow-up MRIs based on the size of a beneficiary's lesion (providing that a legion smaller than 2 cm is not eligible for follow-up before one year); and (ii) requiring a beneficiary to receive an X-ray prior to covering a CT scan. OIG remarked that existing guidance is "not sufficiently detailed" to indicate whether CMS would consider the denials in OIG's sample to be inappropriate, and guidance is otherwise lacking as to what types of clinical criteria would be deemed no more "restrictive" than Medicare coverage rules provided that they are evidence-based and do not contradict LCD or NCD standards.[6]

The Report identified MAO requests for supplemental medical documentation, despite OIG reviewers finding sufficient documentation in the sample records provided, as a second reason for prior authorization denials for services meeting Medicare coverage requirements. OIG cited human and software system errors as the primary reasons for these denials, but also noted that CMS permits MAOs to impose heightened payment verification standards through their billing and payment procedures provided that providers are paid accurately, timely and with an audit trail.[7] Nonetheless, OIG cited examples of erroneous documentation requests in the Report, including requests (a) for beneficiary health status (e.g., previous medication use or ability to use wheelchair in home) even though such documentation was on file with the MAO; and (b) documentation of beneficiary's primary insurance carrier even though such documentation was already included in the original claim submission.[8]

Finally, OIG found that erroneous payment denials reviewed were primarily caused by human error during manual claims-processing reviews (e.g., overlooking a document) and system processing errors (e.g., the MAO's system was not programmed or updated correctly). In particular, MAOs often rely on staff to review manually requests for payments before approval; however, OIG noted that manual reviews are susceptible to human error (e.g., overlooking a document in the case file or inaccurately interpreting Medicare or MAO coverage rules). For example, in one instance OIG found that an MAO misclassified an in-network SNF provider as an out-of-network provider for payment purposes, and that in another, an MAO denied a payment request for a service requiring prior authorization even though such prior authorization had been submitted.[9] Additionally, the Report warned that system processing errors may generate a larger volume of incorrect denials. OIG cited an instance in its review where an MAO's system assigned an incorrect provider tax identification number to a provider, which incorrectly classified the provider as out-of-network; the MAO reported that the same error may have affected 163 additional claims.

Of note, OIG acknowledged that for three percent of prior authorization denials and six percent of payment denials reviewed, MAOs ultimately reversed their denials. It nonetheless warned that relying on beneficiary appeals to preserve access to necessary services can create a substantial burden and barrier to access to care, and delays related to payment appeals may create administrative burdens for MAOs, beneficiaries, and providers alike.[10]

II. OIG's Recommendations

In light of the above findings, OIG issued three recommendations to CMS, each of which CMS accepted:[11]

1. OIG recommended that CMS issue additional guidance on the requirement that MAO clinical criteria must not be "more restrictive" than Medicare coverage rules, and that the guidance should include specific examples of criteria that would be considered allowable and unallowable. OIG also recommended CMS to instruct MAOs to examine and revise their procedures for making coverage determinations, as needed, considering CMS's new guidance. CMS confirmed its intent to issue new guidance on the appropriate use of MAO clinical criteria for medical necessity reviews.[12]
2. OIG recommended that CMS closely scrutinize MAOs using more restrictive clinical criteria than required by Medicare or requesting unnecessary documentation in connection with prior authorizations, follow its standard enforcement process to determine culpability and penalties, as applicable, and consider aggravating factors in civil money penalty calculations if prior authorization denials limited beneficiary access to care. OIG also recommended close audits of prior authorization denials related to imaging, post-acute facility stays, and injections, as the Report identified disparate denial rates for these services in the course of OIG's review. CMS accepted this recommendation and agreed to update its audit protocol and auditor training materials, as needed, to align with the guidance that it plans to issue under the first recommendation.[13]
3. OIG recommended that CMS work with MAOs to improve their internal systems to prevent the types of errors identified in the Report. To avoid system errors, OIG recommended that CMS direct MAOs to take additional steps to ensure that any changes affecting coverage or payment are properly coded in their systems. OIG also recommended that CMS direct MAOs to consider additional staff training on documentation verification. CMS agreed to direct MAOs to take additional steps to identify and address vulnerabilities, and to examine their manual review and system programming processes and to address vulnerabilities that may result in inappropriate denials.[14]

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Ropes & Gray will continue to monitor developments in this area. If you have any questions, please do not hesitate to contact the authors or your usual Ropes & Gray advisor.

1. OIG, Some Medicare Advantage Organization Denials of Prior Authorization Requests Raise Concerns About Beneficiary Access to Medically Necessary Care, April 2022 at 5, *available at* https://oig.hhs.gov/oei/reports/oei-09-16-00410.asp. The 15 MAOs reviewed accounted for nearly 80 percent of beneficiaries enrolled in Medicare Advantage as of June 2019, ranging in size from about 165,000 to nearly 6 million beneficiaries. To conduct the case file reviews, OIG contracted with health care coding and billing professionals with expertise in Medicare coverage rules and with physicians to assist in medical necessity reviews. OIG reviewed the Medicare Advantage Independent Review Entity contractor (which reviews appeals that were upheld by MAOs), physicians, and health care coding experts. OIG also reviewed CMS policy documents such as the Medicare Managed Care Manual. For administrative coverage reviews health care coding experts determined whether the prior authorization (utilization management tool whereby MAO clinical staff determine whether services are medically necessary prior to care) or payment requests (provider request for reimbursement for services that have already been delivered to beneficiaries) met the Medicare coverage rules and/or MAO billing rules that the MAO cited as support for its denial decision. For example, MAOs often cited NCDs and LCDs, the Medicare Managed Care Manual, the beneficiary's Evidence of Coverage Document, and other MAO billing rules. A physician was consulted for those denial cases that warranted a medical necessity review.
2. OIG, Medicare Advantage Appeal Outcomes and Audit Findings Raise Concerns About Service and Payment Denials, September 2018 *available at* https://oig.hhs.gov/oei/reports/oei-09-16-00410.asp. The September 2018 report further raised concerns the MAO appeals processes are rarely utilized by beneficiaries (*e.g.*, 1% of denials made it to the first live appeal). CMS responded to that report by increasing the penalties for MAO violations that prevent beneficiaries from accessing medically necessary services.
3. OIG, Some Medicare Advantage Organization Denials of Prior Authorization Requests Raise Concerns About Beneficiary Access to Medically Necessary Care, April 2022 at 1. Of all Medicare beneficiaries in 2021, 42 percent (26.4 million) were enrolled in a Medicare Advantage plan. The Congressional Budget Office projects that the share of all Medicare beneficiaries enrolled in Medicare Advantage plans will rise to about 51 percent by 2030. Kaiser Family Foundation, Medicare Advantage in 2021: Enrollment Update and Key Trends, June 2021, *available at* https://www.kff.org/medicare/issue-brief/medicare-advantage-in-2021-enrollment-update-and-key-trends/.
4. OIG, Some Medicare Advantage Companies Leveraged Chart Reviews and Health Risk Assessments To Disproportionately Drive Payments, September 2021, *available at* https://oig.hhs.gov/oei/reports/OEI-03-17-00474.pdf.
5. CMS, Medicare Managed Care Manual, ch. 4, sec. 10.16, *available at* https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/mc86c04.pdf.
6. OIG, Some Medicare Advantage Organization Denials of Prior Authorization Requests Raise Concerns About Beneficiary Access to Medically Necessary Care, April 2022 at 10.
7. CMS, Medicare Managed Care Manual, ch. 4, sec. 10.2, *available at* https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/mc86c04.pdf.
8. OIG, Some Medicare Advantage Organization Denials of Prior Authorization Requests Raise Concerns About Beneficiary Access to Medically Necessary Care, April 2022 at Appendix B.
9. *Id.* at 13.
10. *Id.* at 18.
11. *Id*. at Appendix D.
12. *Id*. at 20.
13. *Id*. at 21.
14. *Id.* at 22.