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Medicare Advantage: OIG Report Finds Improper Denials

Article By:

Matthew D. Krueger

Kinal M. Patel

On April 27,2022, the Office of Inspector General of the Department of Health and Human Services (OIG), Office of Evaluations and Inspections, issued a report on the performance of Medicare Advantage Organizations (MAOs) in approving care and payment consistently with Medicare coverage rules. In its review, OIG found that 13% of MAO denials of prior authorization requests should have been approved and that 18% of payment requests from providers were improperly denied. OIG also made a number of recommendations to the Center of Medicare and Medicaid Services (CMS) with respect to its oversight of MAOs.

Purpose and Method of the Study

OIG undertook the study to assess whether MAOs are appropriately providing access to medically necessary services and making payment to providers consistently with Medicare coverage rules. Since CMS pays MAOs principally by capitation, MAOs have a potential incentive to increase their profits by denying access to care of beneficiaries or by denying payments to providers. CMS's annual audits of MAOs have indicated some persistent problems related to inappropriate denials of service and payment. As enrollment in Medicare Advantage continues to grow, OIG viewed it as important to ensure that medically necessary care is provided and that providers are paid appropriately.

OIG conducted the review by randomly selecting 250 denials of prior authorization requests and 250 payment request denials by 15 of the largest MAOs during a week in June of 2019. OIG had coding experts review the cases and had physician reviewers examine the medical records. Based on these reviews, OIG estimated the rates at which MAOs issued denials of services or payment that met Medicare coverage rules and MAO billing rules. OIG also examined the reasons for the inappropriate denials and the types of services involved.

Standards

MAOs must cover items and services included in fee-for-service Medicare, and may also elect to include additional items and services. MAOs are required to follow Medicare coverage rules that define what items and services are covered and under what circumstances. As the OIG states in the Report, MAOs “may not impose limitations – such as waiting periods or exclusions from coverage due to pre-existing conditions -- that are not present in original Medicare.” In following Medicare coverage rules, MAOs are permitted to use additional denial criteria that were not developed by Medicare when they are deciding to authorize or pay for a service, provided the clinical criteria are “no more restrictive than original Medicare national and local coverage policies.” MAOs may also have their own billing and payment procedures, provided all providers are paid accurately, timely, and with an audit trial.

MAOs utilize prior authorization requests before care is furnished to manage care and payment requests from providers to approve payment for services provided. Beneficiaries and providers may appeal such decisions, and beneficiaries and providers are successful in many of the appeals (for a one-time period, as many as 75% of the appeals were granted).

Findings

Prior Authorization Denials

In the study, OIG found that 13% of prior authorization denials were for services that met Medicare coverage rules, thus delaying or denying care that likely should have been approved. MAOs made many of the denials by applying MAO clinical criteria that are not part of Medicare coverage rules. As an example, a follow-up MRI was denied for a beneficiary who had an adrenal lesion that was 1.5 cm in size, because the MAO required the beneficiary to wait one year for such lesions that are under 2 cm in size. OIG’s experts found such a requirement was not contained in Medicare coverage rules and was therefore inappropriate. Rather, the MRI was medically necessary to determine if the lesion was malignant.

OIG also found instances where MAOs requested further documentation that led to a denial of care when it was not furnished, as such additional documentation was not required to determine medical necessity. OIG’s reviewers found that either sufficient clinical information was in the medical record to authorize the care or the documentation requested was already contained in the medical record.

Payment Denials

OIG found in the study that 18% of payment denials fully met Medicare coverage rules and MAO payment policies. As a result of these denials, payment was delayed or precluded for services that should have been paid.

OIG found that common reasons for these inappropriate payment denials were human error in conducting manual reviews (for example, the reviewer not recognizing that a skilled nursing facility (SNF) was an in-network provider), and inaccurate programming.

OIG also found that advanced imaging services (including MRIs and CT scans), stays in post-acute facilities (including SNFs and inpatient rehabilitation facilities), and injections were the services that were most prominent in the inappropriate denials that should have been authorized for care and

payment in accordance with Medicare coverage rules.

OIG Recommendations

Based on the study, OIG recommended that:

- CMS should issue new guidance on both the appropriate and inappropriate use of MAO clinical criteria that are not contained in Medicare coverage rules. In particular, OIG recommended that CMS should more clearly define what it means when it states that MAO clinical criteria may not be “more restrictive” than Medicare coverage rules.
- CMS should update its audit protocols to address issues identified in the report such as MAO use of clinical criteria and/or examine particular service types that led to more denials. OIG suggests CMS should consider enforcement actions for MAOs that demonstrate a pattern of inappropriate payment denials.
- CMS should direct MAOs to identify and address the reasons that led to human errors.

CMS reviewed the OIG report and concurred with each of OIG’s recommendations. Those recommendations can affect future coverage decisions as well as utilization of prior authorization tools. AHIP, a national association of health care insurers, challenged the OIG’s sample size as inappropriate to support the agency’s conclusions, and defended prior authorization tools.

Takeaways

Given CMS’s concurrence with the report’s findings, we recommend that MAOs track these issues over the next several months in advance of CMS’s Final Rate Announcement for CY 2024.

MAOs should also be aware of potential False Claims Act (FCA) exposure in this area. FCA exposure can arise when a company seeks and receives payments despite being out of compliance with the basic terms for its participation. If an MAO knew it was denying claims that should be paid because they would be covered under traditional Medicare, but the MAO was still collecting full capitation, it is possible that a whistleblower or the government may pursue FCA liability. This risk warrants attention because whistleblowers can bring qui tam suits under the FCA, with resulting high costs for defense and potentially high penalties if a violation is proven (or settled to avoid further litigation). That said, an FCA suit based on this theory would raise serious questions, including whether any non-payment actually met the FCA’s “knowingly” standard (which includes reckless disregard), or whether any non-payment met the materiality threshold necessary to demonstrate a violation of the FCA.

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