Report in Brief
Date: August 2020
Report No. A-05-18-00024

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
OFFICE OF INSPECTOR GENERAL

Medicare Contractors Were Not Consistent in How They Reviewed Extrapolated Overpayments in the Provider Appeals Process

Why OIG Did This Audit

When an overpayment is identified in Medicare Part A or Part B, providers have the right to contest the overpayment amount using the Medicare administrative appeals process. If a statistical estimate of an overpayment (an extrapolated overpayment) is overturned during the administrative appeals process, then the provider is liable for the overpayment identified in the sample but not the extrapolated amount. Given the large difference between overpayment amounts in the sample and extrapolated amounts, it is critical that the process for reviewing extrapolations during an appeal is fair and reasonably consistent. In the first and second levels of the appeals process, such extrapolated overpayments are reviewed by Medicare administrative contractors (MACs) and qualified independent contractors (QICs), respectively.

Our objective was to determine whether the Centers for Medicare & Medicaid Services (CMS) ensured that MACs and QICs reviewed appealed extrapolated overpayments consistently and in a manner that conforms with existing CMS requirements.

How OIG Did This Audit

We surveyed the contractors about their processes for reviewing extrapolated overpayments. In addition, we interviewed the statistical groups at three contractors about their experiences with the appeals process. We audited three separate nonstatistical samples of appeals cases.

What OIG Found

Although MACs and QICs generally reviewed appealed extrapolated overpayments in a manner that conforms with existing CMS requirements, CMS did not always provide sufficient guidance and oversight to ensure that these reviews were performed in a consistent manner. The most significant inconsistency we identified involved the use of a type of simulation testing that was performed only by a subset of contractors. The test was associated with at least $42 million in extrapolated overpayments that were overturned in fiscal years 2017 and 2018. If CMS did not intend that the contractors use this procedure, these extrapolations should not have been overturned. Conversely, if CMS intended that contractors use this procedure, it is possible that other extrapolations should have been overturned but were not. In addition, CMS's ability to provide oversight over the extrapolation review process was limited because of data reliability issues in the Medicare Appeals System (MAS). Of the 39 appeals cases we reviewed that were listed in the MAS as involving extrapolation, 19 cases did not actually involve statistical sampling. Improving the accuracy of the information in the MAS would potentially assist CMS with ensuring that extrapolated overpayments are reviewed by the MACs and QICs in a consistent manner.

What OIG Recommends and CMS Comments

We recommend that CMS: (1) provide additional guidance to contractors to ensure reasonable consistency in procedures used to review extrapolated overpayments during the first two levels of the Medicare Parts A and B appeals process; (2) take steps to identify and resolve discrepancies in the procedures contractors use to review extrapolations during the appeals process; (3) provide guidance regarding the organization of extrapolation-related files that must be submitted in response to a provider appeal; (4) improve system controls to reduce the risk of contractors incorrectly marking the extrapolation flag field in the MAS; and (5) update the information in the MAS to accurately reflect extrapolation amounts challenged as part of an appeal, whether the extrapolation was reviewed by a contractor, and the outcome of any extrapolation review.

In written comments on our draft report, CMS concurred with our recommendations and described the actions that it has taken or plans to take to address them.