The Fair Medical Audit Act of 2015
Key Points

The Center for Medicare and Medicaid Services (CMS) paid physicians approximately $64 billion in 2012. In an effort to monitor claims on an ongoing basis in the Medicare program, CMS hires Recovery Audit Contractors (RACs) to identify and prevent improper payments to Medicare providers. RACs are paid based on a percentage of the improper payments they identify and face no repercussions for inaccurate findings. There is a growing concern by many physicians that the lack of accountability has resulted in inaccurate audit findings and high volumes of appeals; in fact, the Office of Inspector General (OIG) found that nearly half of the audits that are appealed by providers are overturned by CMS judges in favor of the provider.

There is a need for Congress to strike a delicate balance between educating those providers that have committed inadvertent errors in a rapidly changing payment system and penalizing those providers who are intentionally defrauding Medicare. Providers who try in good faith to comply with Medicare rules would benefit significantly from new educational efforts and greater information before and after an audit. The current lack of transparency in the audit process hampers these “good actors” in Medicare from understanding their errors and improving their future compliance rates.

Providers are already struggling to adapt to evolving billing and payment rules in the Medicare program, and the flaws in the audit and appeals process impose additional significant administrative and financial burdens. The Fair Medical Audits Act of 2015 (FMAA) addresses this lack of transparency and due process in the RAC audit and appeal process by:

- **Enhancing Transparency in the Audit Process to Improve Compliance.** The FMAA requires pre-audit notification and post-audit reporting to physicians and other health care providers regarding specific aspects of the audit. These provisions would: (1) address confusion about the nature and scope of an audit; (2) create a more educational audit process by requiring RACs to provide information such as the number and type of errors discovered during an audit; and (3) allow physicians to better understand audit findings and reduce the risk of repeated errors.

- **Improving the Claim Review Process by Requiring RACs to Have Appropriate Knowledge and Experience Requirements.** More robust qualification standards for auditors should significantly improve audit accuracy and decrease the number of audit findings that are overturned on appeal. Currently, RAC auditors are only statutorily required to have “appropriate” clinical knowledge and experience with Medicare payment rules. The complex nature of health care audits warrants more robust experience and knowledge standards for reviewers.

- **Promoting Provider Education While Increasing RAC Accountability for Inaccurate Audit Findings.** The FMAA establishes financial penalties for RACs for inaccurate audit findings, while creating new incentive payments for RACs who voluntarily educate providers on common errors.

- **Requiring Contractors to Reimburse Certain Documentation Requests to Reduce Provider Burdens.** Physician practices currently report significant challenges in meeting the administrative and financial burdens that RAC correspondence and production requests can impose. The FMAA would help to address this by compensating providers for certain documentation requests.
Delaying Payment to RACs Until After an External Appeal. The FMAA would delay RAC payments until claims are subject to external review – currently the third level of appeal – to help ensure providers are not subject to premature and unfair recoupment.

Reducing the Appeals Backlog by Shortening the RAC “Look-Back” Period. Shortening the look-back period to 2 years would more effectively address the appeals backlog and provide much-needed administrative relief for providers.