



AMERICAN ACADEMY OF
FAMILY PHYSICIANS

STRONG MEDICINE FOR AMERICA

Statement of the American Academy of Family Physicians

Submitted to the
U. S. House of Representatives

Committee on Small Business
Subcommittee on Regulations, Healthcare and Trade

Concerning

Postpayment Review Conducted by
AdvanceMed
Under the CMS Recovery Audit Contractor Program

Presented By

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Good afternoon, Chairman Gonzalez and ranking member Westmoreland and members of the committee. I am Dr. Karen Smith a family physician and owner of a solo private practice in Raeford, NC.

On Monday morning October 24, 2005 two representatives from AdvanceMed presented to my office with badges identifying themselves as authorized subcontractors for Cigna/Medicare and requested 72 charts for review of clinical documentation of services rendered from July 1, 2004 through June 30, 2005. My staff extracted the requested information from the electronic records system and I personally provided the walking tour of the building including inspection of state and federal licenses for medical business operations. The care of my patients was disrupted in our open access rural family practice as patients, pharmaceutical vendors, and other visitors of the practice observed the unannounced review.

Five months later on March 16, 2006, I received notification that 72 claims with 154 services submitted were reviewed and 91 (of the 154) disallowed for payment. This translated to Medicare overpayment of \$48,245.00 based upon CMS extrapolation calculation with a sampling frame size¹ of 2,935 patients. The actual amount paid to the practice for the services questioned was \$1,551.11. The practice management system noted 1,287 Cigna/Medicare patients in our practice on March 27, 2006 (list is part of supporting information). This discrepancy was not acknowledged nor corrected in the final calculations.

The reasons for denial included incomplete or no documentation, services incorrectly coded, services not covered by Medicare, lack of documentation for drugs administered, services not medically necessary in the judgment of the reviewer (who was not a physician).

When my staff and I reviewed the summary, we noticed that several items of documentation the reviewer cited as being non-existent, were indeed present in our electronic record system. I called AdvanceMed in an effort to notify them of the discrepancy and request instructions for sending this information. The response was this information could be submitted only in an appeal. This answer was communicated in such an intimidating and aggressive manner, prompting me to call a well-known independent auditor. I participated in several of her coding workshops and quickly recognized additional professional assistance was going to be needed. At my request, the auditor immediately contacted an attorney who also called AdvanceMed only to receive the same answer.

The appeal process was initiated and then delayed due to AdvanceMed sending letters to the wrong medical office and which neither I nor my counsel ever received. Documentation was finally accepted by CMS and forwarded to Q2 Administrators as hired by CMS to review the file and make an independent decision.

The outcome from the CMS review was partially favorable but still translated to a new overpayment with extrapolation calculation of

\$18,158.00 and it was still based upon the sampling frame size¹ of 2,935 (a difference of 1,648 patients).

The monetary difference from the findings noted by AdvanceMed, the CMS subcontractor, and Q2 auditor was \$30,087.00 (even with the incorrect patient population number as noted in my data base). Our attorney reviewed additional options including an Administrative Law hearing for services performed but required additional appeal presentation. The practice, my family, and myself were at a point of stress never imagined. We were exhausted and emotionally distressed after countless hours and days of preparation and review during the third to fourth year of our new business existence.

This led to the decision to halt further appeals and review. We were financially drained and feeling the pressure to make payroll, pay mortgage, as well as the other expenses. A loan was acquired from my personal home equity and the check sent to CMS to satisfy the calculated obligation. Ninety days later I received notification from the U.S. attorneys office for a possible levy of assets due to nonpayment of the CMS recoupment. After two attempts of providing documentation it was clarified that the payment had not been applied to our debt.

I recognize that every medical office is responsible for providing access to efficient and high quality healthcare. I established a technologically advanced practice in one of the poorest counties in North

Carolina. We implemented a plan in accordance to guidelines for the Future of Family Medicine as outlined by the American Academy of Family Physicians. This is a state-of-the art, primary care practice in rural North Carolina that adheres to the highest standard of care and participates in quality-based projects with the goal of decreasing medical errors, eliminating redundancy in services by using tracking systems and the use of intercommunication tools with the hospitals located about 25 miles away. We also strive to provide same day acute care, and we emphasize disease prevention. We are one of five doctors, who serve 39,000 patients, and we are part of the socioeconomic structure of the community adding to the financial stabilization of our small town. Our practice is the only solo physician-owned practice and we receive no support from the hospital systems which generate revenue from our market area but are located in and subsidize neighboring counties.

The “guilty until proven innocent” audit we endured used sampling and extrapolation calculations which are not properly verified for validity. In addition to the disruption to patient care and possible reputation damage by the surprise and abrupt visit of badge-bearing authorities, the process quickly exhausted our financial reserves.

It defies common business sense to run a high-quality practice that utilizes electronic health records in a financial environment where Medicare does not recognize the true total costs for caring for individual patients with many medical problems, who is, in other words, the typical Medicare

patient. In addition, the refusal of the CMS Recovery Audit Contractor to recognize the presence of appropriate and pertinent documentation in our electronic health record is at best discouraging. In this case, that judgment proved costly to my practice.

The escalating cost of healthcare cannot be subsidized from monies taken out of the businesses of small physician practices. We have the compassion and the desire to remain in operation but will be unable to endure in a world of uncontrolled costs and diminished payment.

Thank you for holding this hearing and seeking this input.

¹ "Sampling Frame: The sampling frame of sampling units was created by first obtaining a universe of claim lines for claims meeting the above criteria² and then identifying the list of unique Claim Control Numbers (CCNs) (i.e., unique claims) within the universe of claim lines. The frame was sorted by CCN and then auto-numbered.

²"Above criteria" refers to: Sample Design: Simple Random Sampling
"Sampling Unit Claim submitted by the provider with at least one service line Paid > 0. Furthermore, the date of service must fall within the Time Period of interest."