



Statement

of the

American Medical Association

to the

**Committee on Small Business
Subcommittee on Regulations, Health Care
and Trade
United States House of Representatives**

**RE: The Impact of the Centers for Medicare
and Medicaid Services (CMS)
Regulations and Programs on Small
Health Care Providers**

Presented by: William A. Dolan, MD

May 14, 2008

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The American Medical Association (AMA) appreciates the opportunity to present testimony to the Committee on Small Business Subcommittee on Regulations, Health Care and Trade on the impact of the Centers for Medicare and Medicaid Services (CMS) regulations and programs on small health care providers. We commend Chairman Gonzalez, Ranking Member Westmoreland, and Members of the Subcommittee for your leadership in recognizing the effect of often-burdensome regulations on small physician practices.

Approximately 53 percent of physician practices are comprised of fewer than three physicians and 75 percent of physician practices are comprised of fewer than eight physicians. For the majority of these small physician practices, burdensome regulations can take valuable time away from patient care. We believe that in some circumstances the worthy goals of CMS regulations could be better served through less onerous means. Specifically, we have significant concerns with the Recovery Audit Contractor (RAC) program and the transition to ICD-10.

THE RECOVERY AUDIT CONTRACTOR (RAC) PROGRAM

The RAC Demonstration Program was instituted under Section 306 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA). It mandated pilot projects that employed RACs to analyze and audit physician reimbursement claims and rewarded them for identifying billing errors made by physicians and other providers. The program began in 2005 and was initially implemented in Florida, New York, and California and subsequently expanded to include Massachusetts, South Carolina, and

Arizona. The RAC pilot (hereinafter the Demonstration) terminated in March of this year. Under Section 302 of the Tax Relief and Health Care Act of 2006, however, the program was made permanent and will be expanded nationwide beginning later this year. The AMA is pleased that throughout the program, we were able to work in cooperation with CMS on several issues of concern to the physician community. We continue, however, to harbor significant concerns with the burdensome and punitive nature of the program.

We firmly believe that the best way to reduce common billing and coding mistakes is through targeted education and outreach, rather than onerous audits performed by outside contractors provided with incentives to deny claims. RACs are not compensated by CMS. Instead, they receive a share of the funds recovered from alleged overpayments, otherwise known as “contingency fees.” At best, this type of compensation system provides an incentive to RACs to deny aggressively “borderline” claims. At worst, it effectively forces physicians, whose time is better spent caring for patients than reviewing old documents and pursuing appeals, to simply yield to unproven RAC claims. We believe that RACs should be paid a contractual amount unrelated to collections. Any collections should go to educating physicians about common billing errors and supporting desperately needed health care services for America’s seniors and disabled in the Medicare program rather than the RACs’ bottom line.

In addition, given the burden on physicians associated with a RAC review, the ends do not appear to justify the means. Some physicians have seen upwards of 50 RAC audits over the course of a few weeks, overwhelming them and requiring many to either close their offices or devote significant staff resources to gathering the requested medical records. And although little data has been released by CMS concerning the average alleged overpayments RACs collected from physicians, the 2006 data suggests that the average was as little as \$135 per provider in Florida and \$216 per provider in California. These collections are nominal compared to the time and effort required to process them. Moreover, it must be taken into account that during the Demonstration there was an emphasis on identifying overpayments rather than underpayments, and that many physicians did not challenge RAC claims due to the nominal amount of the claim, the burden of the appeal, or general confusion about the process.

Challenging or appealing RAC claims requires physicians to reallocate valuable resources to provide data that could be several years old. The RACs typically require physicians to collect and send myriad documents, including physician orders and progress notes, diagnostic test results, history, operative reports, and certificates of medical necessity, even when the requested documentation is housed or archived in a multitude of different locations or facilities.

In addition to costing countless patient hours, this program is redundant. Other audit processes such as the Comprehensive Error Rate Testing Program (CERT), employment of fiscal intermediaries (FIs), carriers, Medicare administrative contractors (MACs), and Quality Improvement Organizations (QIOs) already oversee Medicare payments. Rather

than add another Medicare contractor to the system, we believe current contractors could address any gaps in the review process.

As stated above, the AMA believes that the RAC program is seriously flawed. The Demonstration was incredibly laborious and failed to address the need to educate and communicate with physicians in order to avoid billing mistakes. For this reason, the AMA supports the passage of H.R. 4105, the “Medicare Recovery Audit Contractor Program Moratorium Act,” which would impose a one-year moratorium on the RAC program. This legislation, sponsored by Representative Lois Capps (D-CA), would allow policy makers needed time to re-evaluate the program and would allow CMS to focus its efforts on education and outreach.

Given, however, that the planned expansion of the RAC program is currently set to proceed, we sincerely hope that CMS will make every effort to continue to work with the AMA to mitigate the burdens and confusion that expansion of the program will undoubtedly bring. In addition, CMS should resolve outstanding issues, discussed below, prior to the nationwide rollout of the RAC program.

AMA/CMS Coordination

The AMA has been working closely with CMS on the RAC program implementation in an effort to mitigate the harmful effects we believe the program will have on the nations’ physicians. We are pleased with CMS’ cooperation to date and look forward to continuing to work with them. There are numerous issues related to the rollout of the RAC program that we believe would be best implemented with coordinated effort and input from the AMA.

Specifically, we understand that CMS plans to use RAC validation contractors to measure the accuracy of RAC claim determinations and to ensure that the RACs are not denying Medicare claims that were properly paid. Given the AMA’s coding expertise, we believe it is particularly important that we be involved with the validation contractors. We would like CMS to use the AMA as a resource should CMS and/or the validation contractors require Current Procedural Terminologies (CPT) coding clarification, as confusion with coding resulted in inappropriate recoupments during the Demonstration.

In addition, we would like CMS to involve the AMA in matters relating to physician communication. We would appreciate CMS sharing any proposed letters associated with RAC audits with the AMA for feedback. Specifically, we understand that CMS will be developing standardized demand letters, which the RACs will be required to use. The AMA is pleased that CMS recognized the need for standardized language in the overpayment letters for the expanded program. If developed correctly, this should decrease physician confusion by more clearly and accurately explaining the audit and appeals process. We look forward to providing meaningful input on these letters and we hope that CMS will utilize language developed as part of earlier coordinated efforts.

We are satisfied with CMS' plans to increase reporting requirements for RACs. We support this increased oversight and believe that the monthly financial reports outlining all work accomplished by the RACs should be available to the public as they contain crucial data (i.e., overpayments and underpayments collected and number of medical records requested) that is of significant interest to the physician community. During the Demonstration, this data was very difficult to obtain and was not provided in a timely manner.

While CMS has consistently noted that RACs will not be involved in proactive provider education, the agency has committed to ensuring provider education for those areas identified as vulnerable to errors. It is vital that CMS follow through on this commitment through meetings, conference calls, and written guidance. Furthermore, CMS should clarify which of its contractors is responsible for education and outreach and ensure that such education and contractor practices are consistent. We strongly encourage CMS to share any information related to provider outreach and education with the AMA in a timely fashion so that we can remain informed and help alert physicians to contractor educational efforts. CMS should also make available online, in an easily understandable format, an up-to-date list of procedures that have been the subject of audits as this will promote transparency and assist in physician education. And CMS should evaluate whether it is appropriate to make systems changes to improve payment accuracy upfront, reducing the need for retrospective audits.

RAC Program Concerns

While we appreciate CMS' willingness to work with the AMA thus far, we believe there are several problems with the current proposed program. Most immediately, we do not think that the RACs should be permitted to review claims from the previous 12 months. If the RACs are intended to catch improper payments missed by the carriers and Fiscal Intermediaries (FIs), RACs beginning work this year run the risk of reviewing claims that are still under review by such carriers and FIs. Therefore, we believe that CMS should preclude RACs from reviewing any claims within the past 12 months and only authorize reviews for claims processed in the past 12 - 24 months. Prohibiting RAC reviews for the first fiscal year gives the carriers and FIs the opportunity to educate physicians when billing errors are detected, adequately explain to the physician how to correct future errors, and monitor the physician's billing practices for a period of time before taking recoupment action.

We are also concerned that CMS decided to allow RACs to review Evaluation & Management (E&M) services. We do not believe that E&M services are appropriate for RAC review as the broad parameters for reporting E&M codes do not lend themselves to basic review. The various levels of E&M services pertain to wide variations in skill, effort, time, responsibility, and medical knowledge, applied to the prevention or diagnosis and treatment of illness or injury, and the promotion of optimal health. A review of E&M codes requires that all factors including mixed diagnoses, variations in age, and decision-making, be taken into consideration and carefully evaluated. Similarly, we believe CMS should remove medical necessity determinations from the RACs purview. We do not believe that medical necessity determinations are appropriate for the

RAC program. Medical necessity determinations are highly subjective and require extensive clinical review. They are not “mistakes,” that can be identified using automated software. Rather, they are individualized clinical assessments of compliance with Medicare coverage policy. Medical necessity reviews should involve a comprehensive assessment of the medical record by a physician of the same specialty, licensed in the same state who reviews the physician’s orders, the patient’s history, execution of the patient’s plan of care, and other details to determine whether the care provided satisfied Medicare coverage criteria. If this type of review is only performed at the appellate level, countless patient care hours and already dwindling practice resources will already have been wasted. Should medical necessity reviews be included in the expanded program, however, they should be limited to no more than one year past the date of the original determination.

The RAC Demonstration has shown how incredibly burdensome a RAC audit can be for a physician, particularly a single practitioner or small group practice. Many physicians have had to close their offices for a day or more to retrieve requested records. Thus, we appreciate that CMS is considering raising the minimum claim amount and limiting the number of medical records requested. The minimum claim amount should be \$25 rather than \$10. \$10 is simply too low and will likely result in many physicians simply paying the alleged overpayment rather than expending the time and resources required for an appeal. In addition, CMS should require that physicians are reimbursed for the copying expenses associated with documents produced in response to overpayment claims.

In the hopes of ensuring that the program causes as little anxiety and confusion as possible, we believe CMS should shorten the timeframe within which RACs must respond to physician inquiries. Currently, CMS requires RACs to respond to written correspondence from audited physicians within 30 days. We believe that this timeframe is unnecessarily long. For physicians contacted about a RAC audit, there are immediate questions and concerns. These physicians are entitled to a prompt response. CMS should require RACs to respond to written physician inquiries within 15 days and to respond to physician phone inquiries within 48 hours.

Furthermore, CMS should clarify the appeals process under the RAC program. The appeals process for the RAC program is supposed to mimic the Medicare appeals process. However, CMS has yet to publish a final rule related to Section 935 of the MMA, calling for a limitation on recoupment, which halts the recoupment process once a physician properly appeals. Consistent with Congressional intent, the limitation on recoupment should be triggered at the first level of appeal. Although CMS has begun to implement this policy, it has not been finalized and is being applied inconsistently. Thus, we strongly encourage CMS to clarify and finalize the Medicare appeals regulations, ensuring the policy is applied at the first level of appeal, as they will greatly affect all physicians who are subjected to a RAC audit.

Though statutory language and the demonstration Statement of Work that govern the RAC program provide the RAC with authority to pursue underpayments as well as overpayments, underpayments were not pursued vigorously during the Demonstration. CMS must provide the oversight necessary to ensure that inaccurate payments are

pursued by RAC contractors in an equitable manner. Specifically, CMS should reverse their decision not to include, for the purposes of underpayments, situations where a physician mistakenly neglects to report a service they delivered. If a physician has delivered appropriate care to a patient, they should be reimbursed for the care. Services omitted from claims should be treated as underpayments. Additionally, CMS should require that RACs accept case files from providers for an underpayment case review. At the very least, CMS must permit national, state, local, and specialty medical societies to share information with CMS and the RACs about underpayments. Finally, CMS should include underpayments in its online list of incorrect billing issues.

Physicians strive for payment accuracy and are committed to continuing to work with CMS and its contractors to ensure the validity of physician payments. We believe that the best way to promote these worthy goals is through education. Given that expansion of the program appears imminent, however, we hope that CMS will address our concerns and resolve these issues prior to nationwide rollout of the program. The AMA is dedicated to working with CMS and we look forward to ongoing efforts to address our concerns and improve the RAC program.

ICD-10

Physicians value the transformative power that the adoption of new technology promises for patient care, including advances in the electronic transmission of claims and other transactions. The International Classification of Diseases, Ninth Revision, Clinical Modification, (ICD-9-CM) is used for diagnosis coding in both the inpatient and outpatient settings, as well as for procedure coding in the inpatient setting pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA), which called for using standardized transactions and code sets.

While the AMA recognizes the importance of updating the current coding scheme, ICD-9, with ICD-10, we realize that the transition process will be a complex and costly undertaking. As physicians experienced with the transition to the HIPAA standard electronic transactions environment, an effort that continues even 12 years after the passage of HIPAA, we believe a well-defined and executed transition plan is critical to ensuring the success of a migration of this magnitude. The drawn-out, costly process that the health care industry experienced with electronic transactions could be avoided if an appropriate transition plan to move to ICD-10 is fully developed through a consensus process that involves multiple stakeholders, including physicians.

The transition to the ICD-10 system will increase the number of possible codes ten fold. Physicians, and other stakeholders, including health plans and payers, clearinghouses, and software vendors, need adequate time to successfully plan the move to a new diagnostic coding system. In addition to incurring significant costs for implementing a new coding system, physician practices will also face additional challenges transforming their practices, including upgrades or replacements of practice management and billing systems and software, adjustments to current operational protocols, and staff education and training costs. Private and public payers will also have to upgrade or replace their

own payment processing and data management systems to accommodate the significant body of data generated by this extensive transition. Therefore, the AMA recommends pursuing a realistic transition time period to ICD-10 to ensure that the delivery of health care, claims and payment processing, and acquisition of critical health information technologies are not adversely impacted due to this substantial coding migration.

It is important to keep in mind that physicians are currently struggling to implement existing HIPAA requirements, including the ongoing transition to the National Provider Identifier. Also, physicians must comply with Medicare and other public and private payer mandates while facing shrinking payer revenues, that have failed to keep pace with the cost of practices, and even steeper Medicare payment cuts. Unlike other professionals and businesses, physicians are limited in their ability to pass on the costs or practice investments in the form of higher charges for their services. These costs are especially difficult to absorb for small physician practices. The costs that will be incurred due to system upgrades or replacements are more demanding for smaller practices that face greater technological, operational, and financial challenges.

On April 1, 2008, the AMA, along with multiple specialty groups, the BlueCross BlueShield Association, as well as other key health care stakeholders sent a letter to the Department of Health and Human Services (HHS) recommending the following process and timeline for moving to the ICD-10:

Adoption, Testing, and Verification of Version 5010 of HIPAA Electronic Transactions Standard Prior to Moving to ICD-10

The current HIPAA electronic transactions standard version 4010 is not compatible with ICD-10. Moreover, version 5010 significantly differs from 4010. As the National Committee on Vital and Health Statistics (NCVHS), an advisory body to the HHS on health data, statistics and national health information policy, recommended in their September 26, 2007, letter to HHS Secretary Leavitt, implementation of ICD-10 should not take place simultaneously with the adoption of the version 5010.

Implementation of a Comprehensive Pilot Testing of ICD-10 Prior to National Roll-Out

HHS should pilot test ICD-10 in order to identify potential issues and problems early on, allow time to develop solutions, and gather feedback from pilot participants that will assist in the national transition process.

Incorporation of Adequate Time in the Transition Process and Timeline to Train Coders

A transition from ICD-9 to ICD-10 will require an appropriate supply of coders. Training coders for ICD-10 will require the development of a new curriculum, publication of curriculum materials, and most importantly, adequate workforce training

to support the providers and billers under ICD-10; a system with approximately 10 times more codes than are in ICD-9.

Pursuit of an Aggressive Outreach Strategy to Covered Entities and Vendors

An important lesson from the transition to version 4010 and the current transition to the NPI is the essential need to begin educating the covered entities and vendors—especially the smallest practices and software vendors—as early and as often as possible.

Given the significant resources, administrative complexities, and advance planning that are required to retool or replace systems and processes that depend on ICD-9 logic, the AMA recommends that HHS work collaboratively with all health care industry stakeholders, especially physicians, in order to develop an effective transition plan to use ICD-10.

CONCLUSION

We appreciate the opportunity to provide input on the RAC program and the critical transition to ICD-10. The AMA looks forward to working closely with the Small Business Committee to ensure that physician practices, especially smaller practices, are able to manage the RAC audit process and prepare for the ICD-10 transition without compromising the delivery of health care.