# Statement

of the

American Medical Association

to the

Practicing Physicians Advisory Council

RE: Recovery Audit Contractors
National Provider Identifier

May 19, 2008

**Division of Legislative Counsel**
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The American Medical Association (AMA) appreciates the opportunity to submit this statement to the Practicing Physicians Advisory Council (PPAC or the Council) concerning recovery audit contractors and the national provider identifier.

We would also like to advise the Council concerning the status of the pending cuts to the Medicare physician payment rates due to the fatally flawed sustainable growth rate (SGR) payment formula. Despite well-intentioned congressional efforts to avert Medicare physician cuts due to the SGR, Medicare physician payment rates are scheduled to be cut 10.6% on July 1, 2008, and an additional cut of 5% or more is projected for January 1, 2009. These will be part of a series of cuts totaling about 40% in the coming decade. Yet, even by the government's own conservative estimate, physician practice costs will increase nearly 20% during this time period. Further, these shortfalls are forecast despite that Medicare payment rates for physicians in 2008 are about the same today as they were in 2001. Physicians cannot absorb these steep losses.

**As of May 19, there are only 42 calendar days (and substantially fewer legislative days) remaining for Congress to address this problem before the 10.6% Medicare physician payment cut goes into effect. Congress must act now to enact 18 months of positive Medicare physician payment updates that reflect medical practice cost increases. Rapidly eroding margins are threatening the viability of medical practices, putting health information technology and other high-capital intensive purchases out of reach, and forcing the large cohort of practicing physicians over 55 years of age to weigh retirement.**

The steep cuts that are yielded by what is ironically called the "sustainable growth rate," would be unsustainable for any business, especially small businesses such as physician practices. Further, once Medicare implements a payment rate cut, it has a ripple effect and other payers that tie their rates to Medicare (including Medicaid, TRICARE, and various private payers) follow suit. In fact, the Military Officers Association of America (MOAA), which represents 5.5 million members of TRICARE (the government's health insurance for military families), recently sent a letter to Congress calling for positive Medicare physician payment updates. MOAA stated that "since TRICARE payment rates are tied to Medicare's rates, any such reductions will significantly deter more doctors from seeing any uniformed service beneficiaries – not just those over age 65." MOAA further added that when "our service members are sent in harm's way, the last thing they should have to worry about is whether their families will be able to find a TRICARE doctor."

Numerous surveys project a crisis in patient access if Medicare payments fall further behind practice cost increases:

- In an AMA survey of almost 9,000 physicians, 60% said they would have to limit the number of new Medicare patients they treat if this year's pay cut is not stopped. Further, more than half of the surveyed physicians said they could not meet their current payroll with a 10% Medicare pay cut and would be forced to reduce their staff.

- The Medicare Payment Advisory Commission reports that 30% of Medicare patients looking for a new primary care physician already have trouble finding one.

- The Medical Group Management Association found that 24% of group practices already limit their acceptance of new Medicare patients.

- The Council on Graduate Medical Education is predicting the country will face a shortage of 85,000 physicians by 2020.

- An Association of American Medical Colleges workforce study found that 51% of physicians over 50 cite "insufficient reimbursement" as a "very important" factor in retirement decisions.

Although physicians want to continue providing care to all their patients, continued Medicare payment cuts make it difficult to do so, and thus the Medicare physician payment rate cuts threaten the foundation of our health care delivery system. The Medicare physician payment formula must be addressed now to preserve care for our seniors and disabled patients. **We urge CMS to support immediate Congressional action to avert the pending Medicare physician payment rate cut scheduled for July 1 and replace it with a positive update of a 0.5% update for the remainder of 2008, followed by a 2009 update that adequately reflects increases in medical practice costs. Further, these updates should not increase the size or duration of Medicare physician payment cuts in future years. Eighteen months of positive updates would allow Congress the time**

**needed to pave the way for longer-term reform of the Medicare physician update formula.**

Immediate legislative action is also needed to avoid extensive administrative costs and related problems that 11th-hour Congressional interventions cause for both the Medicare carriers and physicians. If CMS does not have adequate time to implement physician payment rate changes by July 1, 2008, then its Medicare carriers as well as physician practices must implement such changes on a retroactive basis, which becomes administratively confusing and costly.

If Congress fails to act to prevent the 10.6% cut scheduled for July 1, we urge CMS to provide physicians a period of time during which they are permitted time to change their Medicare participation or non-participation status. If physicians' rates are cut they may no longer be able to cover the cost of delivering care, and thus they need ample opportunity to determine the terms on which they can accept Medicare patients.

## 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 to 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 urge PPAC to recommend that CMS 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 urge PPAC to recommend that CMS involve the AMA in matters relating to physician communication, and 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 urge PPAC to recommend that CMS: (i) 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; (ii) 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 (iii) 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 FIs, RACs beginning work this year run the risk of reviewing claims that are still under review by such carriers and FIs. **Therefore, we urge PPAC to recommend that CMS 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 also urge PPAC to recommend that CMS not 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 urge PPAC to recommend that CMS 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 no less than $25 rather than $10, which is 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, we urge PPAC to recommend that CMS require physicians to be 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. **We urge PPAC to recommend that CMS 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 urge PPAC to recommend that CMS 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.

## NATIONAL PROVIDER IDENTIFIER

The Health Insurance Portability and Accountability Act (HIPAA) requires implementation of the national provider identifier (NPI) as a unique national identifier for physicians and other health care providers starting May 23, 2007. However, due to lack of industry readiness, CMS issued an NPI contingency plan that allows physicians and others to continue using "legacy" numbers on claims and other health care transactions while they prepare to transition to the NPI. CMS has said that all NPI contingency plans must end by no later than May 23, 2008, and Medicare has announced it will also terminate its contingency plan at this time. In the meantime, as a step toward the May 23, 2008, deadline, Medicare announced that as of March 1, 2008, all claims must contain at least an NPI number and may not contain only legacy numbers.

The AMA remains deeply concerned about progress on the transition to the NPI. The NPI compliance deadline, May 23, is only days away. After May 23, physicians must submit claims to all public and commercial payers using just their NPI number. Given the concerns the AMA has heard from physicians and other industry stakeholders, there remain several issues that must be resolved before May 23. **The AMA and 35 specialty societies recently sent a letter urging Secretary Leavitt to continue allowing physicians to send claims with both numbers for at least six months past the May deadline to allow more time to prepare for those who need it, including payers and clearinghouses. To date, however, the NPI deadline has not been extended.**

The AMA is extremely concerned that significant claims processing and payment problems could result if physicians are no longer permitted to include their legacy identifiers when conducting standard transactions after May 23rd. Based on input we have received across the health care industry, while significant progress has been made to meet the NPI deadline, particularly over the last year, there remain entities that are still resolving implementation issues. **Therefore, we urge PPAC to recommend that CMS: (i) allow physician practices and others to continue to submit transactions that contain both legacy and NPI numbers for a minimum of six additional months after May 23; and (ii) closely monitor the readiness level of covered entities and take all appropriate steps necessary to ensure that the industry does not experience wide-scale disruption in claims processing and payment during this time.**

According to program officials, Medicare Part B claims are now processing at a rate of more than 99 percent following March 1, 2008, the date when the program began accepting claims with just the NPI or the NPI accompanied by a legacy number. However, Medicare has acknowledged that a relatively small subset—approximately 20 percent—of these claims are being submitted with just an NPI. Furthermore, the number of claims that have been submitted with just an NPI has risen only slightly in the past month. It is also unclear what percentage of claims physicians are holding while they work through any matching problems. With the May 23 deadline just days away, it is highly unlikely that the volume of claims being sent successfully with just an NPI will reach an acceptable level. Also, aside from claims transactions, the rate at which the NPI only is being included on other HIPAA transactions is likely even lower. On May 7, several clearinghouses conducted a "legacy

free day" exercise with Medicare, where they stripped legacy numbers from claims and forwarded claims to the carriers only containing the NPI. Although this was deemed a success by CMS, concerns continue to persist. Physicians who have been unable to bill as of March 1 due to Medicare NPI/legacy matching problems, continue to sit on hundreds of thousands of dollars worth of claims and remain unable to submit test claims with the NPI.

Following the March 1 deadline, physician practices that experienced reimbursement problems as a result of Medicare's inability to match their old legacy number(s) to their new NPI number(s) were in most cases instructed to re-enroll. The AMA is especially concerned about the pending May 23 deadline and the impact this could have on physicians still in the midst of the enrollment process. We also continue to hear from our members that carriers are providing conflicting or inaccurate information, with some members just recently learning that they must re-enroll. While these issues may represent a small percentage of overall providers, in many cases these are small practices that simply cannot afford a cash flow interruption spanning a month or more. Once they have re-enrolled, they will also need time to send test claims to Medicare with just their NPI. We were pleased that Medicare has instructed the carriers to process any enrollment applications associated with NPI problems first, and believe that this practice should continue.

In addition to our concerns with Medicare, we are concerned about the readiness of clearinghouses and commercial payers. It is our understanding that the rate of claims that are being processed successfully with just the NPI by commercial payers is comparable to Medicare and thus is still very low. We have also heard that the readiness level among state Medicaid programs varies. For instance, it is our understanding that New York State Medicaid has said they will not be ready to accept claims with just an NPI after the May deadline. In addition, some clearinghouses may be waiting until the May 23 deadline before beginning to submit claims with NPI only. This lack of testing could result in significant processing problems. The rate of claims that are being submitted to payers with just an NPI may also be masking other readiness issues that may only come to light after May 23—problems that could be averted if the rate of claims with just an NPI is substantially increased. For instance, some physician practices, especially the smallest ones, may have practice management systems that do not have the ability to submit claims with an NPI only to a payer(s) and claims with NPI plus the legacy number to another payer(s). This could present a real challenge for some practices if some payers are not ready by May 23. Practices that have not been using a clearinghouse would need to employ one or revert back to submitting paper claims if permitted.

**With the above concerns in mind, we strongly urge PPAC to recommend to CMS that:**

1. **CMS delay enforcing use of just the NPI on claims and other HIPAA standard transactions and permit these transactions to be conducted with both legacy and NPI numbers for a minimum of six months following May 23 (until November 23);**

2. **Medicare continue accepting claims and other transactions with an NPI number(s) accompanied by a legacy number(s) for at least six months following May 23;**

3. **CMS review and assess the rate of claims and other transactions being submitted successfully with just the NPI by Medicare, commercial payers and other public payers (and the rate of claims sent with the NPI only which are rejected) during the six month period following May 23;**

4. **CMS terminate any contingency plan if and only if it is apparent that the vast majority of claims are processing successfully with the NPI only; and**

5. **If the contingency timeframe terminates on May 23 as currently planned, that Medicare closely monitor the rejection rates and claims processing interruptions immediately following the deadline and be prepared to allow claims to be resubmitted with the NPI and legacy numbers together if there are significant interruptions.**

The low volume of claims being processed with just an NPI number, as well as the industry readiness feedback the AMA has received, point to the need for more time to continue to facilitate Medicare's ability to appropriately match a physician's old legacy identifier(s) to their new NPI number(s). Without extension of the May 23 deadline, we continue to be very concerned about interruption to the processing of claims and the impact this could have on patient access to care. We urge PPAC to make the above recommendations to CMS in order to avoid such problems.

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The AMA appreciates the opportunity to comment on the foregoing, and we look forward to continuing to work with PPAC and CMS in addressing these important matters.