

March 9, 2009

Ms. Charlene Frizzera
Acting Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Room 445-G, Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Dear Acting Administrator Frizzera:

The undersigned organizations are writing to share our ongoing concerns about the Recovery Audit Contractor (RAC) program, which has been expanded nationwide. We want to reiterate our concerns now that the contested contract award decisions have been resolved, and the program is moving forward.

While we are pleased that throughout the program, physicians have been able to work in cooperation with the Centers for Medicare and Medicaid Services (CMS) on several issues of concern to the physician community, we believe the program is an enormous burden on the affected physicians and has failed to further the worthy goal of eradicating frequent billing mistakes. **We strongly believe that problems with over and/or underpayments of Medicare claims would be most effectively resolved through physician outreach and education.**

We remain concerned with the prospect of the RACs reviewing Evaluation and 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, are considered and carefully evaluated. Despite detailed Medicare guidelines that specify the documentation required for each level of E&M service, knowledgeable individuals often reach different conclusions regarding the E&M level of service justified by the documentation.¹ These problems are further exacerbated by the fact that the people performing the audits are not physicians of the same specialty and state as the physicians being audited.

CMS has acknowledged the legitimate differences of opinion in determining how documentation aligns with the E&M level of service billed in other review programs. The discussion of the “incorrect coding” errors in the November 2007 “Improper Fee-for-Service Payments Report” makes this clear:

¹ King MS, Lipsky MS, Sharp L., *Expert Agreement in Current Procedural Terminology Evaluation and Management Coding*, Arch Int Med 162:316-320, 2002; Chao J et al. *Billing for Physician Services: a Comparison of Actual Billing with CPT Codes Assigned by Direct Observation*, J Fam Pract 47:28-32, 1998; Kikano GE, Goodwin MA, Stange KC, *Evaluation and Management Services: A Comparison of Medical Record Documentation with Actual Billing in a Community Family Practice*, Arch Fam Med 9:68-71, 2000; Zuber TJ et al., *Variability in Code Selection Using the 1995 and 1998 HCFA Documentation Guidelines for Office Services*, J Fam Pract 49:642-645, 2000.

A common error involved is overcoding or undercoding E&M codes by one level on a scale of five code levels. Published studies suggest that under certain circumstances, experienced reviewers may disagree on the most appropriate code to describe a particular service. This may explain some of the incorrect coding errors in this report. CMS is investigating procedures to minimize the occurrence of this type of error in the future.

Congress and CMS have also addressed the related compounding problem of extrapolating results from a limited medical review of E&M services to a broader universe of claims billed.

- CMS instituted the Progressive Corrective Action (PCA) program in 2002 to govern Medicare medical review. The PCA program's guiding principle is that medical review activities be proportional to the extent of the perceived problem.
- Congress, through the Medicare Prescription Drug and Modernization Act of 2003 (MMA), limited the agency's use of extrapolation to cases where a physician has a sustained payment error level or when documented educational intervention has failed to correct the error.
- CMS considers the complexity associated with validating E&M levels of service in determining the results derived from its agency's Comprehensive Error Rate Testing (CERT) program, which the agency employs to determine the extent to which its contractors are accurately making fee-for-service payments.

E&M services are already subject to medical review by the Medicare Administrative Contractors (MACs), who are able to refer cases to Program Safeguard Contractors (PSCs), and they are included in the CERT program. These programs have evolved because of the well-documented, widely-acknowledged imprecision associated with determining the extent to which documentation aligns with the level of service billed. Allowing the RAC program to review E&M service claims—including enabling them to extrapolate their findings—will upset this balance. It will recreate the same problem—large unsubstantiated overpayments that are minimized or overturned after additional review of complex E&M scenarios, at great cost to all parties—that initially led Congress and CMS to make improvements through the PCA program and the MMA.

Moreover, auditing E&M services threatens to overburden physicians at a time when many specialties are in increasingly short supply and impending baby boomer retirements will exacerbate existing shortages. While audits of E&M services will create yet another unfunded mandate for all physicians, the burden will be particularly heavy for primary care physicians because nearly all primary care services fall into the E&M category and the majority of these practices are solo or small practices with little ability to deal with the administrative burden imposed by a RAC audit. Currently, almost 30 percent of patients seeking a new primary care physician have trouble finding one, 30 percent of group practices already limit Medicare patients, and by 2020 there will be an estimated 85,000 physician shortage in this country. Inflicting audits of E&M services would come at the very time an aging population is putting additional strains on the health care system and physician office visits are up. **Thus, we strongly urge CMS not to allow RACs to perform E&M audits.**

The shifting Medicare rules pertaining to the billing of one specific type of E&M service, consultations, is particularly concerning. Our significant, ongoing concerns with the consultations policy have been brought to CMS' attention and, while we continue to work with them the problems have yet to be resolved. Specifically, CMS' current policies on split-shared billing, transfer of care, and documentation for consultations are unclear and physicians remain

confused about their implementation. **Therefore, we believe it is unreasonable for CMS to allow the RACs to review consultations.** Allowing contractors to perform audits on consultations would exploit physician confusion over these policies.

Finally, we continue to be concerned that resources are not being put toward educating physicians on billing mistakes. 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 with incentives to deny claims. Thus far, we have been extremely disappointed by the focus on punitive measures instead of physician education and communication. This is particularly egregious given that the funding provided to the new MACs is insufficient to sustain the level of outreach that has existed under the carrier contracts. It is our understanding that in some cases funding is as much as 30 percent less than what was previously provided. We have already received numerous reports from physicians that they are unable to get through to a customer service representative at the MAC unless they remain on hold for hours. In addition, we have heard from several physicians that their efforts to bill correctly are often thwarted by inconsistent and/or incorrect coding advice from the carriers and MACs. Educating physicians and providing them with accurate information regarding common coding and billing mistakes is critical to reducing onerous RAC audits of physicians and is consistent with numerous CMS comments stressing their preference for ensuring that initial payments are correct rather than trying to collect overpayments after the fact. **Therefore, we strongly urge CMS to ensure that physicians are sufficiently educated regarding Medicare billing policies.**

While we remain concerned by these issues, we are grateful that CMS has made a number of changes, including limiting the number of medical records that can be requested by a RAC, installing RAC Medical Directors, and implementing a validation process. We request, however, that CMS consider the recommendation by the Practicing Physicians Advisory Council (PPAC) on December 8, 2008, that CMS revise the request for records limits established for solo practitioners from 10 requests to three requests per 45 days. This revision would, as noted by PPAC, make the number of records requests more "linear relative to the number of physicians in a practice, and not skewed toward small groups and solo practitioners bearing a heavier burden." **Thus, we urge CMS to limit medical record requests to three in a 45 day period for solo practitioners.**

Similarly, we appreciate CMS' willingness to increase the minimum claim amount from 10 dollars to 25; however, additional input from physicians suggests this amount is still too low. **Given the administrative burden RAC audits pose on physicians, we believe that the minimum claim amount should be raised to at least 100 dollars.** Finally, we are pleased that CMS is considering reimbursing physicians for the costs associated with copying records in response to audits. **We strongly urge CMS to implement a provision requiring RACs to reimburse physicians for copies of requested medical records prior to the commencement of the RAC audits.**

The undersigned organizations continue to believe that the RAC program is not the appropriate vehicle for achieving payment accuracy and will continue to advocate for its elimination and the redirection of incentive payments to physician outreach and education. Given that expansion of the program is underway, however, we urge CMS to address our concerns and resolve these issues before the RACs begin to audit physicians. We look forward to working with CMS on efforts to improve the RAC program.

American Academy of Dermatology Association
American Academy of Facial Plastic and Reconstructive Surgery

American Academy of Family Physicians
American Academy of Home Care Physicians
American Academy of Hospice and Palliative Medicine
American Academy of Neurology Professional Association
American Academy of Otolaryngology – Head and Neck Surgery
American Academy of Ophthalmology
American Academy of Physical Medicine and Rehabilitation
American Association of Clinical Endocrinologists
American Association of Clinical Urologists
American Association of Neurological Surgeons
American Association of Orthopaedic Surgeons
American College of Cardiology
American College of Chest Physicians
American College of Emergency Physicians
American College of Gastroenterology
American College of Mohs Surgery
American College of Obstetricians and Gynecologists
American College of Osteopathic Surgeons
American College of Physicians
American College of Radiology
American College of Rheumatology
American College of Surgeons
American Gastroenterological Association
American Geriatrics Society
American Medical Association
American Osteopathic Academy of Orthopedics
American Osteopathic Association
American Psychiatric Association
American Society for Gastrointestinal Endoscopy
American Society for Radiation Oncology
American Society of Anesthesiologists
American Society of Cataract and Refractive Surgery
American Society of Clinical Oncology
American Society of Hematology
American Society of Nephrology
American Society of Plastic Surgeons
American Society of Transplant Surgeons
American Thoracic Society
American Urological Association
Association of American Medical Colleges
Congress of Neurological Surgeons
Heart Rhythm Society
Infectious Diseases Society of America
Joint Council of Allergy, Asthma and Immunology
Medical Group Management Association
Renal Physicians Association
Society for Cardiovascular Angiography and Interventions
Society of Hospital Medicine
The Endocrine Society

Medical Association of the State of Alabama

Alaska State Medical Association
Arizona Medical Association
Arkansas Medical Society
California Medical Association
Colorado Medical Society
Connecticut State Medical Society
Medical Society of Delaware
Medical Society of the District of Columbia
Florida Medical Association Inc
Medical Association of Georgia
Hawaii Medical Association
Idaho Medical Association
Illinois State Medical Society
Indiana State Medical Association
Iowa Medical Society
Kansas Medical Society
Kentucky Medical Association
Louisiana State Medical Society
Maine Medical Association
MedChi, The Maryland State Medical Society
Massachusetts Medical Society
Michigan State Medical Society
Minnesota Medical Association
Mississippi State Medical Association
Missouri State Medical Association
Montana Medical Association
Nebraska Medical Association
Nevada State Medical Association
New Hampshire Medical Society
Medical Society of New Jersey
New Mexico Medical Society
Medical Society of the State of New York
North Carolina Medical Society
North Dakota Medical Association
Ohio State Medical Association
Oklahoma State Medical Association
Oregon Medical Association
Pennsylvania Medical Society
Rhode Island Medical Society
South Carolina Medical Association
South Dakota State Medical Association
Tennessee Medical Association
Texas Medical Association
Utah Medical Association
Vermont Medical Society
Medical Society of Virginia
Washington State Medical Association
West Virginia State Medical Association
Wisconsin Medical Society
Wyoming Medical Society