

May 26, 1998

Nancy-Ann Min DeParle, Administrator
Health Care Financing Administration
Department of Health and Human Services
Hubert H. Humphrey Building, Room 309-G
200 Independence Avenue, SW
Washington, DC 20201

Attention: HCF A-1719-P

Dear Ms. DeParle:

The American Society of Internal Medicine (ASIM), representing the nation's largest medical specialty, is pleased to provide the following comments on the Health Care Financing Administration's (HCFA) "Medicare Program; 'Without Fault' and Waiver of Recovery from an Individual as it Applies to Medicare Overpayment Liability" notice of proposed rulemaking (NPRM) that appeared in the March 25, 1998 Federal Register.

42 Code of Federal Regulations (CFR) Section 401.323: Determining Without Fault for a Provider or Supplier

ASIM agrees that physicians should be without fault if they fail to receive a response from their carrier after sending it a written inquiry questioning a suspected overpayment. ASIM recommends that proposed section 401.323(ii) be amended to state that physicians who suspect that their carrier has made an overpayment send a written inquiry to the carrier within 120 days of the payment. Section 401.323(ii)(B) should be changed to state that physicians who are aware of a potential overpayment are without fault if they fail to receive a response from their carrier within 60 days after the carrier receives the inquiry. The current proposal, which gives carriers 120 days to respond to physician inquiries and physicians only 60 days to notify the carrier that they were potentially overpaid, is inappropriate. Providing carriers more time to respond to inquiries than physicians have to report them is illogical as carrier resources greatly exceed those of a typical physician practice. These two time standards should be reversed. At minimum, carriers should be required to respond within the same amount of time that physicians are given to report an overpayment.

ASIM has concerns regarding the proposed criteria for determining that a physician knew that a carrier made an excessive payment, contained in section 401.323(c). The sections that spell out the criteria for determining that a provider knew a carrier payment was excessive, section 401.323(c)(1) through (c)(3), must be modified to acknowledge mistakes made by the entities that physicians depend on for payment and coverage information. Section 401.323(c)(1) states that physicians are at fault if they fail to recognize an overpayment based on "experience, actual notice, or constructive notice," which includes *Federal Register* notices, instructions from HCFA, guidance from carriers, and instructions from Peer Review Organizations (PRO). If notices from these entities impose liability on physicians, incorrect instructions should absolve physicians from that liability unless the misguided advice or excessive payment is glaring enough that the physician can reasonably be expected to notice. For example, we would not expect HCFA to absolve a physician of liability for following the guidance of a carrier bulletin that mistakenly reads that Medicare "pays for services that are not medically necessary" instead of correctly reading that Medicare "does not pay" for medically unnecessary services or when the carrier incorrectly issues a check for \$1,000 when the correct payment for the services rendered was \$100.

ASIM opposes the notion that physicians should be aware of an overpayment, and are therefore at fault, if the amount of reimbursement exceeds payment amounts that appear in "an official source document, such as the *Federal Register*." Section 401.323(c)(1)(i) would effectively require all physicians to review the *Federal Register* for Medicare payment and coverage information. Physicians rely on their carrier to provide them with payment information; HCFA should also rely on its carriers to perform these activities--

activities that it pays its carriers to perform. This section should be deleted from the rule as it is unreasonable to expect physicians to monitor and adhere to policies that appear only in the *Federal Register*.

Section 401.323(c)(1)(ii) establishes that physicians are at fault if they receive payments that are in excess of HCFA policies that are disseminated by carriers. ASIM agrees that it is reasonable to hold physicians accountable to carrier bulletins and other communications. However, physicians cannot be held accountable for carrier errors that go uncorrected. As previously stated, physicians typically depend on their carrier for Medicare payment and coverage information. Physicians should not be liable for carrier errors that they cannot be reasonably expected to detect.

HCFA national policies or carrier-specific local policies regarding coverage issues that are published in carrier bulletins and reinforced through explanation of Medicare benefits (EOMB) forms are less clear than Medicare Fee Schedule (MFS) payment rates that are clearly defined and disseminated to physicians. Physicians often contact their carrier's "provider line" when they have questions regarding payment and coverage policies or questions pertaining to EOMBs they receive from the carrier. Vague EOMB language requires physicians to rely on the provider line for explanations regarding payment and coverage issues. ASIM members frequently complain that they receive conflicting advice from carrier personnel when they contact the provider line. Physicians should be absolved of liability if they keep an overpayment that resulted from billing and payment advice provided by carrier personnel.

Ensuring that the instructions issued by carrier personnel are correct is in the best interest of the Medicare program. HCFA must take advantage of the increased funding provided by Congress through the Medicare Integrity Program (MIP) to assure that carrier personnel have the skills to provide accurate information to physicians regarding payment and coverage issues. In fact, the "Medicare Integrity Program" heading in the "Background" section of HCFA's MIP NPRM, published in the March 20, 1998 Federal Register, states the agency's belief that fluctuations in Congressional funding from one year to the next made it difficult for the agency (and its contractors) to "attract, train, and retain qualified professional staff, including auditors and fraud investigators." ASIM agrees with HCFA that the stable, increased funding of MIP will allow it to maintain qualified professionals with the expertise necessary to adequately handle physician payment and coverage questions pertaining to the claims submitted for services to beneficiaries. ASIM believes that HCFA should use a portion of this increased funding to improve the skill level of carrier (contractor) personnel under MIP. Upgrading the quality of service provided by carrier personnel will permit physicians to feel confident in the advice they are receiving from their carrier and reduce the ambiguity of who is at fault when a carrier issues an overpayment.

Section 401.323(c)(1)(iii) is troubling because it states physicians should know that their carrier made an excessive payment if they have had "experience with Medicare payment amounts for similar or reasonably comparable items or services." Section 401.323(c)(1)(iii) should be altered to read "experience with the same item or service." It is inappropriate to hold physicians accountable to this standard when there is no established definition of what constitutes a "similar or comparable" item or service.

Section 401.323(d) should be revised to indicate that carriers are at fault and physicians are without fault if the carrier provides erroneous information to physicians that physicians cannot be reasonably expected to detect and cannot reasonably be expected to get from another source.

ASIM believes that section 401.323(f) is too broad in defining when physicians are not without fault, stating that there are even "some circumstances when a provider or supplier will never be without fault." Stating that a physicians are at fault if they accept payment that they know or should know was excessive under Medicare statutes and regulations is all encompassing. This standard fails to acknowledge that Medicare regulations are ever-changing and that Medicare fee schedule payment rates are updated annually. The amount of the overpayment for each services must be considered on a case-by-case basis. It is unreasonable to expect physicians to notice slight overpayments for specific services when numerous factors can affect the total payment received. For example, Medicare pays for laboratory

chemistry tests based on the number and combination of “automated” and non-automated tests that are billed. Physicians who bill for an “automated” chemistry test will notice that their EOMB form shows a different payment amount for the same test depending on which other tests were performed and billed together. Physicians will not always receive the same payment each time they perform a service. Section 401.323(f)(2) should be modified to indicate that a determination on whether a physician is at fault for an overpayment based on information provided by the carrier should be decided on a case-by-case basis to acknowledge the complexity of Medicare billing.

Section 401.323(h) presumes that physicians obtain and reference the issue of the *Federal Register* that contains the annual MFS. ASIM believes it is unreasonable to expect physicians to be aware of payment rates that are published in the Federal Register. Physicians, who are paid under the MFS, receive the payment amount for each physician service directly from their carrier. The information supplied by the carrier, usually in the form of a special MFS bulletin, is limited to the payment rate for their geographic area for each procedure code. The number of requests ASIM gets from its members who are interested in the relative value units HCFA assigns to each service illustrates how little information physicians actually receive regarding payment rates. Carriers provide only a fraction of the payment information included in the Federal Register, yet physicians cannot be reasonably expected to access the MFS through the *Federal Register*. HCFA must acknowledge this by adding language in section 401.323(h)(1) that states physicians are without fault if they can prove that an error was published their local carrier bulletin that provides the local MFS payment rates. ASIM is discouraged that HCFA does not trust its carriers to relay payment rate information from the MFS that appears in the *Federal Register* accurately to physicians.

ASIM believes that the “without fault presumption--three year rule” that is proposed in section 401.323(i) does virtually nothing to prohibit carriers from seeking to recoup overpayments that they have identified three or more years after it issued the payment(s). The without fault presumption is gutted by a list of circumstances indicating physician fault beyond the three year exception that is virtually the same as the list of reasons that a physician is at fault for overpayment within three years of the payment date. ASIM recognizes HCFA’s need to establish criteria for when a physician is never without fault. However, we believe that those instances should be limited to situations in which physician obtain payments fraudulently or when a carrier error is so glaring that a physician reasonably should detect it. Section 401.323(i) should also reflect the changes we recommended regarding when a physician is never without fault under proposed section 401.323(f).

HCFA must avoid holding physicians indefinitely liable for overpayments. Although ASIM is encouraged that physicians are presumed to be without fault after three years, HCFA must amend section 401.323(i) to accurately reflect the shift from an assumption of fault to a presumption of without fault. Further, ASIM recommends that HCFA establish a standard in which physicians are relieved of liability barring evidence of fraud when seven years elapses past the payment date. A seven-year absolution is necessary because physicians cannot reasonably be expected to maintain the payment records necessary to ascertain whether the carrier, in fact, did issue an overpayment. An incident involving an ASIM member illustrates the need to establish a cut off point in which physicians can no longer be at fault. This member, who is retired from private practice, received a request for repayment of an excessive payment nine years after the date of service. The internist retired a year after the he provided the service in question so he had no means for proving that he received proper payment. Not only did he fail to possess the billing records for this patient, which would have been nine years old, he did not have the patient’s medical record to prove that he actually performed the service. He lacked access to the patient’s current record, which presumably resided with the patient’s current physician, and he already destroyed his records as state law only required that he keep them for seven years. ASIM believes that a seven-year absolution is reasonable as it is consistent with most states’ requirements for maintaining inactive medical records.

ASIM commends HCFA's decision to afford physicians the ability to appeal not without fault initial determinations, spelled out in section 405.803(b). We concur that physicians' due process right to an appeal should be specifically included in Medicare regulations. ASIM recommends that Medicare regulations prohibit carriers from seeking recoupment of an overpayment until the physician has exhausted all appeal rights. At minimum, carriers should be obligated to pay interest to a physician for any recouped overpayment that had to be returned to the physician because physician fault was overturned on appeal.

Thank you for full consideration of these comments. If you have any questions regarding our comments, please contact our Third Party Relations Specialist, Brett Baker, by phone at (202) 466-0295, or by e-mail at <bbaker@asim.org>.

Sincerely,

Alan Nelson, MD
Executive Vice President