



AMERICAN ACADEMY OF
FAMILY PHYSICIANS
STRONG MEDICINE FOR AMERICA

December 16, 2010

Donald Berwick, M.D.
Administrator
Centers for Medicare & Medicaid Services
Department of Health & Human Services
Attention: CMS-6034-P
P. O. Box 8016
Baltimore, MD 21244-8016

Dear Dr. Berwick:

I am writing on behalf of the American Academy of Family Physicians (AAFP), which represents more than 94,700 family physicians and medical students nationwide. Specifically, I am writing to offer our comments on the *Medicaid Program; Recovery Audit Contractors; Proposed Rule* as was published in the November 10, 2010, *Federal Register*.

This proposed rule provides guidance and outlines requirements related to state implementation of recovery audit contractors (RACs) for the purposes of identifying underpayments and overpayments made through the Medicaid program and recouping overpayments. As required by the Affordable Care Act, states must enter into contracts consistent with State law and in the same manner as the Secretary enters into contracts with RACs under Section 1893(h).

The AAFP recognizes and regrets the short timeline under which these contracts must be effected and the complexity of adapting a national program to the states and territories. We are concerned that additional guidance is necessary to take advantage of lessons learned from the Medicare RACs and early findings of the Medicaid Integrity Program (MIP) contractors, and to provide for Medicaid RAC programs that have a well-defined statement of work, including methods for consistent application of specific state program requirements.

Section 1893(h) contains some important safeguards regarding RACs, such as the requirement that the contractor has staff that has the appropriate clinical knowledge of, and experience with, the payment rules and regulations under this title or the contractor has, or will contract with, another entity that has such knowledgeable and experienced staff. However, it does not contain many of the specifications contained in the Statement of Work for the Recovery Audit Contractor Program as posted at <http://www.cms.gov/rac/downloads/Final%20RAC%20SOW.pdf>. These specifications are essential to a program that is both effective and fair.

The proposed implementation date of April 01, 2011, allows little time for states to develop statements of work (SOW) with their contractors that provide for consistency with state laws and regulations or to provide

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education to physicians and providers about the RACs. As noted in the proposed rule and as seen in the Medicare RAC program, there are many entities conducting audit activities, such that physicians receive requests for records and refund requests based on automated claims review from a variety of sources. There must be time for careful consideration of how duplication of audit activity will be avoided and to provide education and introduction of the RAC contractors to physicians and providers, including what their requests for records or refunds will look like, the time period for responding to such requests, and opportunities for rebuttal and appeal. We urge CMS to survey states regarding their awareness of necessary SOW provisions and their progress/expected timelines to accomplish an effective implementation of RAC contracts, and we urge CMS, if necessary, to allow states additional time to accomplish these tasks.

Appreciating that state laws and differences in Medicaid programs require some flexibility in implementation of RAC contracts, we still feel that many elements should be standardized to promote quality and reduce the burden on those physicians who provide care to Medicaid recipients in more than one state. Some specific provisions that States should address in the RAC SOW are:

Staff Qualifications & Responsibilities

The RAC shall operate under direction of a currently licensed Contractor Medical Director (CMD) who is actively involved in examining all evidence used in making individual claim determinations that are not directly supported by published Medicaid program policy or guidance (e.g., those based on medical literature and clinical judgment) and who acts as a resource to all reviewers making individual claim determinations. If a physician or provider requests to speak to the CMD regarding a claim(s) denial, the RAC shall ensure the CMD participates in the discussion.

Each RAC will employ registered nurses, physical therapists, and other healthcare professionals with clinical knowledge and practice experience in their fields. In addition, certified coders with credentials and experience appropriate to coding of the types of services under review will be employed to make correct coding determinations. All staff conducting automated or complex reviews must demonstrate knowledge of the state's published Medicaid guidelines and coding criteria for the dates and types of service under review. (This is more important in the Medicaid RAC program than Medicare due to lack of standardized coding and payment policy across Medicaid programs.)

Establishment of Review Criteria

Before a RAC begins to operate, there must be development of internal guidelines for what information should be reviewed by automated or complex review and appropriate processes for determination of results. Determinations should be supported by published program guidance (e.g., web site materials, manuals, newsletters) in effect at the time of service. There should be a defined and published look back period and minimum dollar value for which claims are subject to review.

When performing complex coverage or coding reviews (i.e., reviews involving the medical record), the RAC shall ensure that initial coverage/medical necessity determinations are made by RNs or therapists subject to final determination by the CMD and that coding determinations are made by certified coders. Determinations should not be based on minor omissions such as missing dates or signatures when physicians separately attest to the accuracy of the record.

The SOW should exclude from review the level of service billed for Evaluation and Management Services. As noted in the 2007-2009 Improper Medicare Fee-for-Service Payments Reports, "A common error involved 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." Such provision would not exclude review of Evaluation and Management Services for

inclusion in a global period or accuracy of code selection based on place of service, patient type, or age of patient.

Requests for Records

RACs shall establish a method for physicians to provide customized address information to direct RAC correspondence to a specified person and address. The state shall establish limits on the number of medical records requested per physician or provider in a specified time period and require that RACs adhere to such limits. We are particularly concerned that small and solo practice physicians are already overwhelmed with requests for records related to other review programs (e.g., Medicare Advantage & Medicaid Managed Care plans) and cannot bear another significant increase in administrative burdens.

An established time period for submission of records requested by the RAC shall be included in requests for records. RACs will not use bulk mailing when requesting records due to extended delivery time that may deny physicians adequate response time. RACs shall accept medical records electronically (e.g., by encrypted DVD or CD), by fax, or mail. RACs will pay physicians for the per page costs of copying and for first class postage when records are mailed.

Disaster Relief

Relief in the presence of a disaster whether widespread or to an individual location shall include extension of deadlines for receipt of records or refunds, acceptance of reconstructed records or exemption from review for records that were completely destroyed, and/or delay of reviews for up to six months.

Notifications, Rebuttals, & Appeals

RACs shall notify physicians of findings no later than 60 days following receipt of records, including the rationale for the determination. This rationale shall list the review findings, including a detailed description of the Medicaid policy or rule that was violated and a statement as to whether the violation resulted in an improper payment.

Notification of findings of overpayment or underpayment shall include information on how overpayments may be repaid/offset, time limits for repayment without interest, and information on timeliness of additional payment and method of additional payment. Information on the right to rebuttal should include a defined period in which physicians may contact the RAC with rebuttal of findings and allow a defined period in which the RAC must respond to rebuttal. Additionally, notification should explain the right to appeal, specific requirements for appealing, and the effect of an appeal on the timing of repayment/offset and applicable interest. Contact information should be provided for both rebuttal and appeal inquiries.

Underpayments

RACs exist to identify improper payments, therefore equal emphasis and fees must be applied to the discovery of underpayments as that applied to overpayments. If the charge to the RAC is truly to “fulfill the state’s obligation to ensure that it pays the right amount to the right provider for the right service at the right time for the right recipient,” there should be no difference in the contingency fee for an underpayment than that of an overpayment. In the proposed rule, the agency admits to the substantial 9:1 ratio between Medicare RAC recoveries of overpaid vs. underpaid claims. AAFP strongly urges CMS to address this blatant discrepancy and modify the SOW for both the Medicare and Medicaid RACs so that all RACs expend their resources equally in identifying both types of improper payments. Furthermore, AAFP recommends all RACs are required to disclose quarterly the number of requests that have been submitted by the RACs for permission to review suspected underpayments. It is unreasonable to conclude that RACs would expend their resources on finding underpayments when the profit is so significantly less.

Validation of Accuracy

States will contract with a validation contractor to determine the accuracy of the RAC determinations and require in the SOW that RACs cooperate with validation contractors. RACs will develop corrective action plans to address errors found by the validation contractor. Any RAC found to have an error rate in excess of 10% or greater based on validation contractor findings and/or findings overturned on appeal should be subject to a monetary penalty.

Education & Outreach

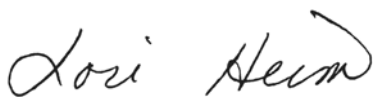
As noted to CMS in a joint letter from numerous physician organizations and medical societies dated March 09, 2009, physicians firmly believe that the best way to reduce common billing and coding mistakes is through targeted education and outreach, rather than onerous audits performed by outside contractors with incentives to deny claims. Education and outreach are insufficient across Medicare and Medicaid programs. The sheer volume of applicable and varying rules across the numerous programs is daunting, with frequent changes and differing interpretations among contractors making correct coding and billing a moving target. Streamlined and easily accessible guidance is needed, especially for those policies and procedures unique to a state's Medicaid program. We urge CMS to designate a percentage of recovered program dollars to improve education, increase prepayment claims edits to eliminate payment of duplicate claims and those obviously submitted in error (e.g., age-specific services provided to a patient outside the designated age range), and to provide continuous outreach with information on newly discovered and commonly occurring billing errors in both the Medicare and Medicaid programs.

In addition to concerns regarding the statement of work for Medicaid RACs, we note reference to concerns of the Office of the Inspector General regarding the low number of referrals from the Medicare RACs to fraud investigators and CMS's proposal that whenever Medicaid RACs have reasonable grounds to believe that fraud or criminal activity has occurred, they must report it to the appropriate law enforcement officials. Physicians as healthcare providers and as taxpayers have invested in the Medicaid program to provide payment for the healthcare services of those eligible to receive benefits under the program and as such, expect that program oversight will be rigorous and judicious.

However as it is not within the scope of work or the expertise of the RACs to distinguish fraud or criminal activity from erroneous billing, we ask that CMS reconsider. We feel that suspicions of fraud and criminal activity should be referred for further investigation by other Medicaid integrity contractors (e.g., an audit MIC) with expertise to determine whether or not referral to law enforcement is appropriate. This implication that RAC reviews for incorrectly paid claims should result in suspicions of fraud and criminal activity does not appear to have any basis other than an OIG report on the lack of referrals by RACs and could have ominous implications for physicians and other healthcare providers for whom "credible allegations" could lead to suspended payments, increased enrollment burdens, and eventually, no capacity to continue to provide care to patients of government-funded programs. This may be especially true for the Medicaid programs that typically pay only a percentage of the already low Medicare Physician Fee Schedule rate.

Thank you for this opportunity to comment on this matter. If we may be of further assistance in this regard, please contact Robert Bennett at rbennett@aafp.org.

Sincerely,



Lori J. Heim, MD, FAAFP
Board Chair