

April 3, 2012

Marilyn B. Tavenner  
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

RE: CMS' Improper Payments Initiatives [CMS-10421]

Dear Acting Administrator Tavenner,

The undersigned organizations appreciate the opportunity to provide our comments in response to the Federal Register notice entitled *Agency Information Collection Activities: Proposed Collection; Comment Request* [CMS-10421]. We are cognizant that as part of the Administration's Campaign to Cut Waste, the Centers for Medicare and Medicaid Services (CMS) is swiftly formulating strategies to meet the President's goal of reducing improper payments in the federal health care programs by \$50 billion by the end of 2012. We seek to engage with CMS on an ongoing basis as the agency strives to meet this goal. We believe that a fluid dialogue with the medical community will best inform CMS' emerging efforts in this area. Below we offer our views on the Recovery Audit Prepayment Review Demonstration and the Prior Authorization Demonstration for power mobility devices, as well as our specific recommendations on how CMS may reduce the improper payment rate going forward.

### **Recovery Audit Prepayment Review Demonstration**

We strongly urge CMS to rescind the proposed Recovery Audit Prepayment Review Demonstration. For the reasons set forth below, this demonstration would threaten patient access to care and inappropriately utilize the Recovery Auditors.

#### *Patient Access to Care*

CMS proposes to initially employ the Recovery Audit Prepayment Review Demonstration to perform admission necessity and correct coding prepayment review for eight Medical Severity-Diagnosis Related Groups (MS-DRGs). After this first code set, CMS intends to move forward with others. The preliminary MS-DRGs are: syncope and collapse (MS-DRG 312); transient ischemia (MS-DRG 069); gastrointestinal hemorrhage with complications and comorbidities (MS-DRG 378); gastrointestinal hemorrhage with major CC (MS-DRG 377); gastrointestinal hemorrhage without CC/MCC (MS-DRG 379); diabetes with MCC (MS-DRG 637); diabetes with CC (MS-DRG 638); and diabetes without CC/MCC (MS-DRG 639). The effect of prepayment review of these MS-DRGs is certain: patients who present with these conditions may be inappropriately turned away. Hospital policy and procedure will dictate that care for these patients undergo a high level of scrutiny related to cost, rather than need. While this would be troubling for any patient presenting at a hospital, it is especially alarming considering the MS-DRGs that CMS has chosen.

Take, for example, syncope and collapse (fainting). A patient may faint for a wide variety of reasons with varying degrees of severity, ranging from an ear infection to a heart attack or stroke. Similarly, transient ischemia is a highly complex clinical diagnosis: it is a “mini-stroke,” which has the same etiology as a more serious stroke. In addition, the review of gastrointestinal hemorrhage with complications and comorbidities, gastrointestinal hemorrhage with major CC, and gastrointestinal hemorrhage without CC/MCC gives us serious pause; the cause of internal bleeding is a complex clinical determination, as internal bleeding may be a symptom of a chronic or acute condition, and treatment should be free from reservation.<sup>1</sup>

It is hard to imagine a more clinically-obtuse code set for CMS to have chosen for prepayment review. While a physician may make an informed judgment about the ultimate diagnosis in any of these clinical scenarios, conservatism may be the best option when dealing with such potentially life-threatening diagnoses, as there is no room for error. When making such determinations, which are not often clear-cut, physicians should not have to consider hospital reticence to treat such patients due to increased government scrutiny and the attendant risk of lost payment.

#### *Recovery Auditors*

We strongly oppose the use of the Recovery Auditors (or RACs) to perform prepayment review. We believe that the program’s contingency fee structure inappropriately incentivizes the Recovery Auditors to conduct “fishing expeditions” that are exceedingly burdensome for physician practices. The Recovery Audit Prepayment Review Demonstration expands the reach of the Recovery Auditors by incentivizing them to perform prepayment review, a task for which they have neither experience nor expertise.

Based on our members’ experience with the Recovery Auditors, we believe that they are incapable of efficiently or accurately conducting prepayment review. As a threshold matter, the Recovery Auditors are grossly inefficient in providing timely resolution of, and correspondence regarding, post-payment audit activities. This is evidenced by CMS’ recent decision to transfer the responsibility for sending Recovery Auditor demand letters from the Recovery Auditors to the Medicare Administrative Contractors (MACs) because the Recovery Auditors’ performance in sending demand letters was poor.<sup>2</sup> In fact, according to the American Hospital Association’s RACTrac Survey, 42 percent of hospitals report a long lag time (more than 30 days) between the date on the review results letter and receipt of the demand letter,<sup>3</sup> which does little to effectively reduce the improper payment rate.

Unfortunately, the Recovery Auditors’ poor administrative capabilities are not limited to issuance of demand letters. According to the same RACTrac Survey, 39 percent of hospitals report that

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<sup>1</sup> Ralph Weubker. “MS-DRGs Targeted in RAC Prepayment Demo Raise Red Flags Despite Delay.” *Report on Medicare Compliance*. Volume 21, Number 1, January 9, 2012. Available at [http://www.ehrdocs.com/pdf/news/rmc010912\\_a.pdf](http://www.ehrdocs.com/pdf/news/rmc010912_a.pdf).

<sup>2</sup> MM7436 Revised: Recovery Audit Program: Medicare Administrative Contractor (MAC)-Issued Demand Letters. January 9, 2012. Available at <https://www.cms.gov/MLN+MattersArticles/downloads/MM7436.pdf>

<sup>3</sup> American Hospital Association. Exploring the Impact of the RAC Program on Hospitals Nationwide: Results of AHA RACTrac Survey, 2<sup>nd</sup> Quarter 2011. August 29, 2011.

Recovery Auditors did not meet the 60-day deadline to make a determination on a claim, 35 percent of hospitals report that they received a demand letter announcing a Recovery Auditor denial and pending recoupment *after* the denial had been reported on the remittance, and 32 percent of hospitals report not receiving a demand letter informing the hospital of the Recovery Auditor denial.<sup>4</sup> These issues have been problematic in the context of retrospective review and will be even more burdensome in the context of prepayment review.

Recovery Auditors also have a poor record on appeal, which calls into question their ability to make accurate prepayment determinations. According to CMS' FY2010 Recovery Auditor Report to Congress, 46.2 percent of the claims appealed were decided in the provider's favor.<sup>5</sup> This number is far too high. In the context of prepayment review, this means that physicians may have to fight for months or years to rectify an erroneous improper payment determination by a Recovery Auditor. The cost of retaining legal counsel and internal staff to navigate Recovery Auditor appeals is also high, taking away dollars that physicians could be putting toward innovative care coordination initiatives, quality improvement, and other efforts to better medical care for patients.

Even though a primary purpose of the Recovery Auditor program is to educate providers regarding vulnerabilities, there are widespread reports that providers are unable to engage with the Recovery Auditors directly. Physicians report calling the Recovery Auditors numerous times without receipt of a response. Hospitals report that only 39 percent received Recovery Auditor responses to hospital inquiries within 3 days, 17 percent received a response after at least 14 days, and 15 percent never received a response.<sup>6</sup> We also note that the activity of the Recovery Auditors is often not transparent, and the Recovery Auditors largely fail to take a proactive approach to educating providers. While CMS does require that Recovery Auditors list approved issues on their websites, the listing of related information, such as Medicare policy citations, is inconsistent among the Recovery Auditors. At best, physicians are tasked with proactively combing the Recovery Auditor websites to trove for updates and new issue approvals. While we appreciate that CMS does do some national outreach on specific issues that the Recovery Auditors have identified, the lackadaisical posture of the Recovery Auditors in regard to physician education does not effectively reduce the improper payment rate. In the context of the Recovery Audit Prepayment Review Demonstration, the disconnect between the Recovery Auditors and the provider community will undoubtedly result in extensive payment errors.

It is our understanding that CMS proposes to employ the Recovery Auditors for this demonstration for budgetary reasons rather than because the Recovery Auditors are the appropriate contractors to conduct prepayment review. Namely, CMS does not have to pay the Recovery Auditors to conduct these reviews on a contract basis because the Recovery Auditors are compensated on a contingency fee basis. We fundamentally disagree with this approach to contractor selection. Prepayment review should not be undertaken by novice contractors, especially contractors whose incentives are perverse. We strongly urge CMS to consider the operational challenges and adverse consequences for providers and patients that this approach

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<sup>4</sup> Id.

<sup>5</sup> Centers for Medicare and Medicaid Services. Implementation of the Recovery Auditing at the Centers for Medicare and Medicaid Services: FY2010 Report to Congress, as required by Section 6411 of Affordable Care Act. Available at <https://www.cms.gov/Recovery-Audit-Program/Downloads/FY2010ReportCongress.pdf>.

<sup>6</sup> American Hospital Association. Exploring the Impact of the RAC Program on Hospitals Nationwide: Results of AHA RACTrac Survey, 2<sup>nd</sup> Quarter 2011. August 29, 2011.

Marilyn B. Tavenner  
April 3, 2012  
CMS—10421

will produce, and request that CMS rescind the proposed Recovery Audit Prepayment Review Demonstration.

### **Prior Authorization Demonstration for Power Mobility Devices**

We strongly urge CMS to revise the Prior Authorization Demonstration to focus on extreme statistical outliers, rather than on every provider who orders power mobility devices in each of the chosen states. While we appreciate the changes that CMS has already made to the demonstration to alleviate physician burden—especially the designation of a nominal G code to partially reimburse the physician for administrative cost—we urge CMS to take a common sense approach to this demonstration and exclude physicians who do not present as extreme statistical outliers.

We understand that CMS means to take a measured approach by choosing several states that CMS believes have had aberrant power mobility device billing patterns. However, by only narrowing the field of affected physicians at the state level, CMS is inequitably including physicians that do not present as outliers. While we have noted reports of numerous commercial durable medical equipment supplier improper payments, we are unaware of any widespread vulnerability in regard to physicians who order power mobility devices. We ask CMS to consider that many of the physicians who will be impacted by the proposed demonstration infrequently order power mobility devices. We do not believe that those physicians, or physicians who order power mobility devices regularly because of their specialty or patient population, should have to undergo the administrative burden of seeking prior authorization simply because they happen to practice in a target state.

CMS should also consider the impact of this demonstration on beneficiaries, as the prior authorization process can have detrimental health consequences for patients. Delays in treatment and interruptions of the patient-physician relationship due to the preauthorization process can result in adverse effects on patient health. Lengthy preauthorizations can interfere with patient follow-through if patients fail to return for needed treatment. We ask that CMS carefully consider the implications—for both patients and physicians—of the blunt approach that it is proposing, and strongly urge CMS to focus its efforts solely on extreme statistical outliers.

### **Burden Estimate and Respondent Cost**

We disagree with CMS' estimate that prior authorization and prepayment review consume, on average, 0.5 hours of provider time. In our experience, glitches in the prior authorization and prepayment review process can often take more than 0.5 hours of physician and administrative personnel time. For example, according to a recent study, the average physician practice devotes 1 hour of physician time, 13.1 hours of nursing time, and 6.3 hours of clerical time to the prior authorization process each week.<sup>7</sup> We ask that CMS provide its methodology for determining the burden estimate it sets forth in its request, as we believe that it is artificially low.

We also dispute CMS' respondent cost estimate. In many cases, the cost of mailing medical records can be in excess of CMS' stated estimate of \$5.00. While we appreciate that CMS has launched esMD, which will allow physicians to submit records electronically to CMS contractors,

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<sup>7</sup> Lawrence P. Casalino, Sean Nicholson, David N. Gans, Terry Hammons, Dante Morra, Theodore Karrison and Wendy Levinson. "What Does it Cost Physician Practices to Interact with Health Insurance Plans?" *Health Affairs*, 28, No.4 (2009). Available at <http://content.healthaffairs.org/content/28/4/w533.full.pdf+html>.

the program is still in its infancy and has not been adopted by the majority of physicians. Furthermore, it is unclear whether esMD is, in fact, a “less expensive alternative,” as physicians must contract with a Health Information Handler (HIH) to utilize esMD, and CMS does not oversee this cost. We ask that CMS provide its methodology for determining the respondent cost. We also request that CMS conduct a review of other audit response costs, such as the cost to a physician to respond to a Medicare Recovery Auditor audit, for example, when developing its respondent cost estimate for the demonstrations.

Lastly, we ask that CMS contemplate the additional cost of erroneous determinations, and subsequent appeals, that the demonstrations will impose on physicians and patients. Physicians whose claims are rejected on prepayment review will face prohibitive legal and administrative costs to appeal those determinations. According to a recent survey conducted by the American Medical Association, more than half (52 percent) of physicians report appealing 80 percent or more of insurer rejections on first-time preauthorization requests for tests and procedures. Nearly two-fifths (39 percent) of physicians report appealing 80 percent or more of insurer rejections on first-time preauthorization requests for drugs.<sup>8</sup> Also troubling, patients whose claims are erroneously rejected through the prior authorization process will likely incur additional medical care costs, ultimately raising the total outlays from the federal health care programs. We ask that as CMS develops its burden estimate and respondent cost, that it take a more global view of the cost of its proposals to the federal health care programs overall.

#### **Recommendation: Engage with the Center for Program Integrity (CPI)**

Throughout CMS’ supporting materials for the Recovery Audit Prepayment Review Demonstration and Prior Authorization Demonstration for power mobility devices, CMS cites the identification and reduction of fraud as a reason for the demonstrations. For example, CMS says in the ‘Supporting Statement Part A’ of the proposed collection:

These proposed demonstrations seek to protect the Medicare Trust Fund from fraudulent actions and the resulting improper payments by developing methods to investigate and prosecute fraud. In fact, these demonstrations would add to the efforts that CMS and its partners have taken in implementing a series of anti-fraud initiatives in high-risk fraud states.

Furthermore, CMS cites Section 402(a)(1)(J) of the Social Security Act, which may be used by CMS to develop or demonstrate improved methods for fraud investigation in the federal health care programs, as the statutory basis for the demonstrations.

As a general matter, we object to the conflation of improper payments unrelated to fraud and fraudulent activity; these are two distinct types of improper payments, and should be approached differently. However, because the proposal cites fraud identification as its main purpose, we are unclear as to why there appears to be little to no input from CMS’ Center for Program Integrity (CPI), the center within CMS that is charged with overseeing fraud prevention and detection in the federal health care programs. Instead, the Office of Financial Management (OFM) appears to be solely responsible for the development and implementation of the demonstrations. We ask that CMS: (1) Clarify the objective of these demonstrations, namely, are they meant to identify improper payments unrelated to fraud, or fraud, or both; and (2) If these demonstrations are

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<sup>8</sup> American Medical Association. AMA Survey of Physicians on Preauthorization Requirements. May 2010. Available at <http://www.ama-assn.org/ama1/pub/upload/mm/399/preauthorization-survey-highlights.pdf>.

aimed at fraud, work in concert with CPI on every element of the demonstrations, from development to implementation.

**Recommendation: Require Demonstration Contractors to operate under Existing Guidelines**

We urge CMS to consider that the agency has put in place numerous operational guidelines, both in the Code of Federal Regulations and as part of the programs' Statements of Work, for audit contractors. For example, Medicare Recovery Auditors have a three-year look back period, limits on medical record requests by provider type, and a process for independent validation of issues approved for audits. Should CMS decide to proceed with the demonstrations discussed above, we strongly urge CMS to expressly apply existing contractor guidelines to the Recovery Audit Prepayment Review Demonstration, the Prior Authorization Demonstration for power mobility devices, and to other new CMS demonstrations. We have long worked with CMS to develop the parameters of these contractor guidelines, and believe that applying them in the context of CMS' demonstrations to curb the improper payment rate will help CMS and the medical community avoid previously-experienced pitfalls and challenges.

**Recommendation: Hire a Full Time Medical Director at OFM**

As previously noted, it is our understanding that OFM has been tasked with developing new initiatives to reduce the improper payment rate, including the Recovery Audit Prepayment Review Demonstration and Prior Authorization Demonstration for power mobility devices. As discussed, these demonstrations target clinically complex codes and diagnoses. It is our strong belief that such initiatives should not proceed without in-depth clinical input and oversight. However, it is our understanding that OFM does not currently employ a full time medical director, and instead is relying on—at best—the expertise of contractor medical directors. We strongly urge OFM to halt the demonstrations and any other improper payment initiatives until a full time board certified physician is hired as a medical director. While we believe that an audit should only take place under the review of a medical director of the same specialty as the physician undergoing an audit, a full time medical director at OFM is required at a minimum.

**Recommendation: Publish Contact Information for MAC Medical Directors**

We strongly urge CMS to publish MAC Medical Director contact information, including direct phone numbers and email addresses. While CMS has published a list of MAC Medical Directors, the listing only provides the name and address of the MAC and the name of the Medical Director.<sup>9</sup> We think that a direct line of communication between physicians and physician medical directors would facilitate a productive dialogue regarding improper payment vulnerabilities and common errors. However, our members report an inability to locate their physician medical director due to a lack of transparency on the part of the MACs and CMS. We remind CMS that since the transition from carriers and fiscal intermediaries to the MACs, and the subsequent reduction of the number of MACs nationwide, the number of physician medical directors at the MAC-level has also decreased, leading to confusion in the medical community. An easily-identifiable listing on CMS' website of each MAC medical director's contact

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<sup>9</sup> Centers for Medicare and Medicaid Services. Contacts for Part B – Medicare Administrative Contractor (MAC – Part B) Alphabetical Index. Available at <https://www.cms.gov/medicare-coverage-database/indexes/contacts-part-b-medicare-administrative-contractor-index.aspx?bc=AgAAAAAAAAAA&>.

information, including phone numbers and email addresses, would help CMS reduce the improper payment rate by allowing MAC medical directors to maintain an open and productive dialogue with physicians.

**Recommendation: Publish CERT Reports in their Entirety**

We understand that the Comprehensive Error Rate Testing (CERT) program produces a national Medicare fee-for-service (FFS) improper payment rate, and publishes a report to describe such findings. We strongly urge CMS to publish and widely disseminate the CERT reports in their entirety, as we understand that their findings are the genesis of many of CMS' initiatives on improper payments, and are distributed in full to CMS contractors. Without access to the full report, physicians are unaware of emerging improper payment errors and vulnerabilities. To prevent such improper payments upfront, medical societies seek to partner with CMS to educate physicians, but are stymied from doing so because they do not have access to the complete findings of the CERT reports.

As part of the Department of Health and Human Services *FY 2011 Agency Financial Report*, Ernst & Young conducted and issued an independent auditor report. That report concluded in part that CMS' efforts to reduce improper payments should be supplemented by analyses or reports that describe identified vulnerabilities or common errors to the public. Specifically, the Ernest & Young report concluded:

The processes designed to prevent errors should be supplemented by controls and analyses that highlight any material errors that may or could occur. In this regard, errors or abuses within the Medicare claims data, if material, should be detected in the annual Comprehensive Error Rate Testing (CERT) process and in the Payment Error Rate Measurement (PERM) process for Medicaid...*To be fully effective in compensating for inherent risks in the programs, the monitoring activities must be well understood, susceptible to replication and highly credible. Timeliness of the availability of the error rate reports to the public is critical to the Agency's efforts to provide transparency and accountability.*<sup>10</sup>

As Ernest & Young suggest above, the CERT reports should also be issued in a more timely manner. This past year, the incomplete FY 2010 CERT report was published on November 22, 2011—nearly a year following the reporting time period. As we seek to educate our members about improper payments and correct coding, timely receipt of this information is invaluable to medical societies and to CMS' goal of reducing the improper payment rate.

**Recommendation: Utilize the OIG's Evaluation of the CERT Program**

The Office of Inspector General of the Department of Health and Human Services (OIG), recently published a report entitled *Pilot Project to Obtain Missing Documentation Identified in the Fiscal Year 2010 CERT Program (A-01-11-00502)*.<sup>11</sup> In that report, OIG evaluated whether additional documentation was available to enable the CERT contractor to overturn its claim payment denials and reduce the estimate of improper payments in the Medicare FFS program in 2010. OIG concluded that it was able to obtain additional documentation that allowed the CERT

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<sup>10</sup> U.S. Department of Health and Human Services. *FY 2011 Agency Financial Report*. November 15, 2011. Page 78. Available at <http://www.hhs.gov/afr/2011afr.pdf>.

<sup>11</sup> Office of Inspector General, U.S. Department of Health and Human Services. *Pilot Project to Obtain Missing Documentation Identified in the Fiscal Year 2010 CERT Program (A-01-11-00502)*. Available at <http://oig.hhs.gov/oas/reports/region10/11100502.asp>.

Marilyn B. Tavenner  
April 3, 2012  
CMS—10421

review contractor to overturn, or partially overturn, its claims payment denials for 46 of 136 claims (or 34 percent).

The OIG report showed that the CERT documentation contractor did not initially obtain all the necessary documentation for these 46 claims because it did not always: (1) contact referring providers directly to obtain documentation to support the medical necessity of the billing providers' claims; (2) redirect follow up documentation requests to compliance or reimbursement personnel; and (3) seek signature attestations when signatures on clinicians' notes were illegible or were missing. OIG issued recommendations to improve the program that corresponded with each of its findings.

While we understand that CMS has made improvements to the CERT program to more accurately depict the improper payment rate, CMS disagreed with most of OIG's recommendations in its response letter dated November 23, 2011. We ask that CMS reevaluate the OIG's recommendations and report on CMS' improvements to the program. Specifically, we request that the CERT contractors—and all CMS auditors—increase their efforts to contact and work directly with physicians during the audit process. The improper payment rate should not be artificially high because the CERT contractors are not conducting the appropriate follow up with physicians and other providers.

## **Conclusion**

Thank you for your consideration of our comments and recommendations. We seek to be CMS' partner in identifying clinically-sound, non-burdensome, and effective means of reducing the improper payment rate. Should you have any questions regarding this letter, please contact Carol Vargo, Assistant Director, Federal Affairs, American Medical Association at [carol.vargo@ama-assn.org](mailto:carol.vargo@ama-assn.org).

Sincerely,

American Medical Association  
American Academy of Dermatology Association  
American Academy of Home Care Physicians  
American Academy of Neurology  
American Academy of Ophthalmology  
American Academy of Otolaryngology—Head and Neck Surgery  
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 Osteopathic Surgeons  
American College of Physicians  
American College of Radiology  
American College of Rheumatology  
American College of Surgeons  
American Congress of Obstetricians and Gynecologists  
American Gastroenterological Association

Marilyn B. Tavenner  
April 3, 2012  
CMS—10421

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 Transplant Surgeons  
American Urological Association  
College of American Pathologists  
Congress of Neurological Surgeons  
Heart Rhythm Society  
Medical Group Management Association  
Renal Physicians Association  
Society for Cardiovascular Angiography and Interventions

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