

December 3, 2014

Marilyn B. Tavenner
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Hubert H. Humphrey Building, Room 445-G
200 Independence Avenue, SW
Washington, DC 20201

Dear Administrator Tavenner:

On behalf of the physician and medical student members of the American Medical Association (AMA), I strongly urge you to rectify the two-year backlog of Medicare and Medicaid appeals. While we appreciate the efforts of the Office of Medicare Hearings and Appeals (OMHA) to address this issue, and have enclosed our specific recommendations to that office under separate cover here, the problem does not lie with OMHA. Instead, the Centers for Medicare & Medicaid Services (CMS) has failed to address the fundamental issue driving the appeals backlog: the Recovery Audit Contractor (RAC) program.

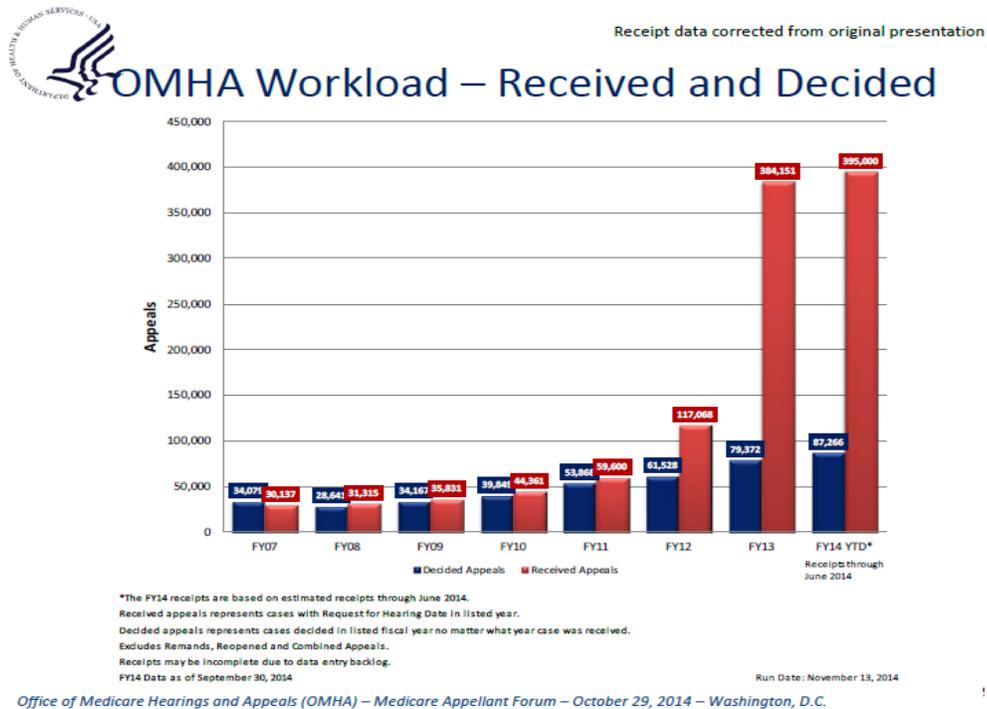
In 2013, more than 60 percent of RAC determinations appealed by physicians were overturned.¹ Based on CMS' data and the experience of our members, RAC auditors are often wrong and their bounty hunter-like tactics have caused physician practices undue hardship and expense. As CMS considers awarding new RAC contracts, we strongly urge the following changes to the program:

- **RACs should be subject to financial penalties for inaccurate audit findings and physicians should receive interest when they win on appeal of a RAC audit.**
- **Physicians should be permitted to rebill for recouped claims for a year following recoupment.**
- **CMS should provide an optional appeals settlement to physicians similar to that provided to hospitals for short-term care.**
- **CMS should retain the current medical record request limits and allow medical record reimbursement for physicians.**
- **RAC audits of physicians should be performed by a physician of the same specialty or subspecialty licensed in the same jurisdiction.**

¹Centers for Medicare & Medicaid Services. Recovery Auditing in Medicare for Fiscal Year 2013. Available at <http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Recovery-Audit-Program/Downloads/FY-2013-Report-To-Congress.pdf> Note that this percentage included both Part B and DME claims.

RACs Largely Contribute to Appeals Backlog

The volume of provider appeals has grown to such a level that the system is overloaded, causing at least a two-year delay for appeals to be heard at the Administrative Law Judge (ALJ) level. Despite efforts by the OMHA to mitigate this backlog, current delays exceed statutory deadlines and are failing to provide due process for physicians. One of the key contributing sources to this growing backlog is the RAC program. As shown in the chart below, appeals from the RACs began in 2011 and entered the ALJ level in 2012. Not surprisingly, the backlog of appeals also began in 2012, as OMHA experienced a 42 percent increase in the number of claims appealed compared to 2011. As confirmed by OMHA, “[i]n fiscal year 2013, the number of claims appealed to OMHA more than doubled from fiscal year 2012, with a 123% increase...the increase in appealed claims from the RA [or RAC] program was particularly high in fiscal year 2013, with a 506% increase in appealed RA program claims compared to fiscal year 2012 appealed claims from the RA program, versus a 77% increase in appealed claims not related to the RA program during that same period of time.” Overall, this data demonstrates that the RAC program must be reformed in order to resolve the appeal backlog.



RAC Determinations Are Often Inaccurate

The RAC contingency fee structure encourages RACs to find overpayments with little regard for the accuracy of their findings. Indeed, RACs are paid a sizeable commission of approximately 9.0-12.5 percent for denied claims. Only if a claim is later overturned on appeal must the RAC pay back their contingency fee, providing little incentive for RACs to ensure that they limit their audits. Due to this payment structure and the lack of financial repercussions, RACs are conducting burdensome fishing expeditions that are inaccurate and often overturned on appeal. The most recent data from the program

confirms that RAC decisions are frequently appealed and wrong in a majority of cases, resulting in over 60 percent of overturned decisions for Part B claims, as shown in the graph below.

Appendix K5: FY 2013 Total Appeal Decisions by Claim Type – All Levels

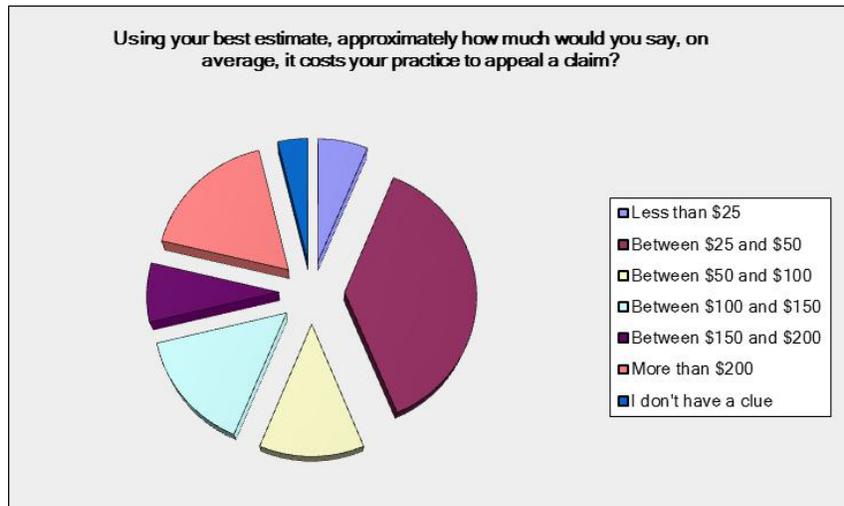
<u>Claim Type</u>	<u>Total Appeal Decisions</u>	<u>% Total Overturn Decisions</u>	<u>% of Overpayment Determinations Overturned on Appeal</u>
Part A	720,416	11.3%	10.0%
Part B/DME	116,433	60.2%	8.5%
Total	836,849	18.1%	9.3%

Source: Centers for Medicare & Medicaid Services. Recovery Auditing in Medicare for Fiscal Year 2013.

Without clear safeguards, such as enlisting physician medical reviewers, repealing the contingency fee basis and enacting financial penalties for incorrect RAC determinations, these inaccuracies and the growing appeal delays will continue to persist.

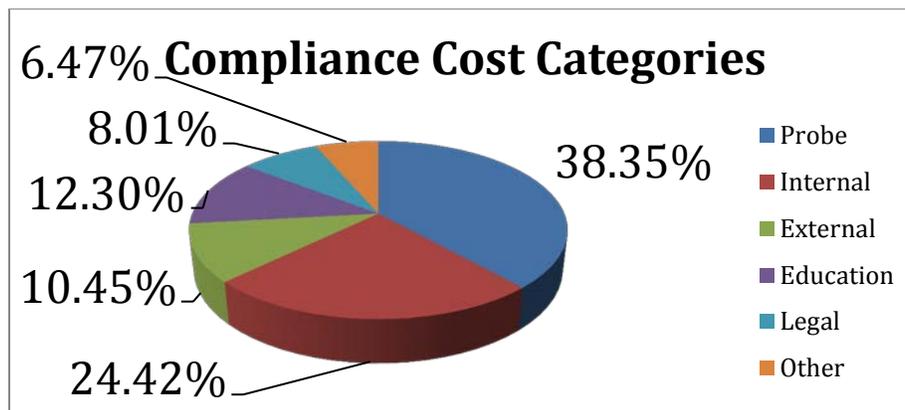
Significant Cost of RAC Appeals

Appeals are not cheap and require significant resources, time, and expense. Based on a recent survey of providers, the average cost to appeal a RAC audit was approximately \$110 per claim. In contrast, the average value of the claim being audited was only \$86, suggesting that in many cases, even if the physician wins on appeal, they will face a net loss. Multiply the average cost of an appeal by the total number of claims appealed by survey respondents, and the total cost on appeals was just under half a million dollars (\$455,468) in 2012. Note that this survey only reached a portion of physicians; the actual cost of RAC appeals across all physicians is much higher.



Source: Frank D. Cohen, MPA, MBB Senior Analyst. The Frank Cohen Group, LLC. Survey on Recoupment. March 2012.

Beyond this direct cost of RAC appeals, physicians also spend significant financial resources on compliance efforts to ensure they meet payment rules and regulations. Cost estimate of these efforts, which include probe audits, internal and external chart reviews, legal and educational expenses, have been estimated at approximately \$1,622 per physician per year, although this amount varies depending on practice size. The following graph outlines how this \$1,622 is typically spent based on a survey of physicians. Overall, this suggests that physicians are also dedicating significant expenses to ensure they are compliant to avoid RAC audits, funding which is not used to directly improve patient care.



Source: Frank D. Cohen, MPA, MBB Senior Analyst. The Frank Cohen Group, LLC. The Everyday Cost of Compliance Survey. October 2014.

Needed Changes to the RAC Program

Without action by Congress and CMS to relieve the burden on physicians, RACs will continue to operate under their current financial incentives and resist changes that would improve audit accuracy, reduce the number of appeals, and mitigate the burden on physicians. The AMA therefore urges for the following program changes:

- **RACs should be subject to financial penalties for inaccurate audit findings, and physicians should receive interest when they win on appeal of a RAC audit.**
The program's contingency fee structure encourages RACs to perform as many audits as possible with little regard to accuracy or the burden imposed on physician practices. CMS has reported that the RAC "error rate" is not significant, but this is directly contradicted by the percentage of RAC claims overturned on appeal. Moreover, CMS fails to consider that many physicians choose not to appeal erroneous RAC determinations due to the significant expense and time in seeking an appeal, not to mention the current backlog in cases. Financial penalties on RACs would ensure they target audits, make accurate decisions, and comply with program requirements, including appropriately informing and notifying physicians. In turn, physicians who are successful in appeals should be compensated, at a minimum, for the time spent going through the time consuming appeals process.
- **Physicians should be permitted to rebill for recouped claims for a year following recoupment.**

The timely filing rule requires that certain services be filed within one year from the date of service. However, RACs currently operate under a three year look-back period. Denied claims are likely to be ineligible for rebilling given the broader RAC review period and the time it takes for an audit to be completed. We urge CMS to allow physicians to rebill claims for the year following recoupment.

- **CMS should provide an optional appeals settlement to physicians similar to that provided to hospitals for appeals related to short-term care.**

As outlined in more detail in our comments to OMHA, CMS has taken steps to mitigate the appeals backlog by offering a settlement agreement on certain hospital claims. We urge CMS to consider a similar settlement offer for physician claims that are pending appeal. Such a program could mitigate the appeals backlog by quickly resolving cases. We, however, urge that any settlement offer provide appropriate reimbursement for the claims at issue.

- **CMS should retain the current medical record request limits and allow medical record reimbursement for physicians.**

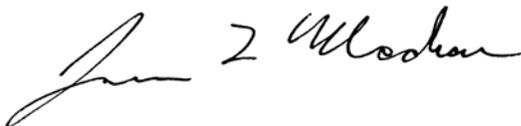
The AMA understands that CMS is considering revising existing RAC medical record request limits. Given the existing administrative burden and cost of RAC audits, the high denial rate, and the two-year appeals backlog, which has been largely attributed to the RAC program, we urge that these limits not be increased. In addition, hospitals are partially reimbursed for their medical records. We believe that physicians, as a matter of equity, should also be reimbursed for this significant expense.

- **RAC audits of physicians should be performed by a physician of the same specialty or subspecialty licensed in the same jurisdiction.**

Most RAC audits are evaluated by a certified coder or nurse rather than a physician. Given that treatment decisions often require a high level of expertise and familiarity with specialty areas, the AMA believes physicians of the same specialty or subspecialty and in the same jurisdiction would be best equipped to accurately perform these reviews. Including physicians would also improve RAC accuracy and promote communication with the physician community.

The AMA is committed to working closely with CMS to ensure appropriate coding and billing of physician services. We appreciate the agency's ongoing effort to listen to our suggestions and make reasonable changes to the RAC program. Should you have any questions regarding this letter, please contact Cybil Roehrenbeck, Assistant Director, Federal Affairs, at cybil.roehrenbeck@ama-assn.org or 202-789-8510.

Sincerely,



James L. Madara, MD

Enclosure