Michael D. Maves, MD, MBA, Executive Vice President, CEO

November 28, 2007

Mr. Kerry Weems
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 Administrator Weems:

The American Medical Association (AMA) appreciates the opportunity to comment on the revised Statement of Work (SOW) (J-1 RAC SOW – Amendment 1, V.11072007) for the Recovery Audit Contractor program (RAC) (RFP-CMS-2007-0022). The AMA continues to harbor significant concerns about the burdensome and punitive nature of the RAC program and firmly believes that the best way to reduce improper coding is through targeted education and outreach.

The RAC Demonstration, which began in 2005 and is expected to terminate in early 2008, when an expanded national RAC program takes its place, is a program that rewards companies contracted by Medicare for locating billing errors made by physicians and other providers. The RAC Demonstration has been exceedingly punitive. Rather than focusing on educating physicians about billing mistakes, it has incentivized private contractors to serve as bounty hunters. Little data has been released by the Centers for Medicare and Medicaid Services (CMS) concerning improper payments collected by RACs from physicians. However, we have information indicating that that a very small sum—on average $135—was collected from physicians in Florida in 2006.

The AMA supports correct coding and payment, but feels that given the burden on physicians associated with a RAC review, that the ends do not justify the means. Some physicians have seen upwards of 50 RAC audits in a few weeks time, overwhelming them and requiring many to either close their offices or devote significant staff resources in order to gather the requested medical records. Many practices in California spent countless hours complying with RAC audits that were outside the scope of the RAC's SOW. RAC audits

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have demanded physician time that would have been better spent on patient care. Furthermore, the emphasis to date has been largely on overpayments, not underpayments. The AMA firmly believes that the answer to correcting improper payments lies with dedicated outreach and education, not audits.

Below you will find our specific comments labeled by the pertinent section of the SOW.

I. Purpose

On page 1, under "NOTE" CMS indicates that the RACs are not tasked with "proactive education of providers;" rather, this is delegated to the Fiscal Intermediaries (FIs) and carriers. The AMA agrees with this; given that physicians are accustomed to interfacing with carriers and carriers are better suited to explain payment policy. It is also critical that responsibility rest with a specific organization, whether the RAC or the carrier, to educate physicians regarding the billing problems identified in the RAC audits. On page 3 the SOW calls for the RAC's project plan to include a "provider outreach plan." **The AMA strongly urges CMS to ensure that the RAC evaluation contractor (page 45) closely monitor the communication required between carriers and physicians resulting from RAC initiated audits and matters pertaining to educating physicians on improper payments. The AMA also strongly encourages CMS to involve the AMA in all communication efforts related to education.**

IV. Specific Tasks

Task 1 – General Requirements

On pages 3-4, under A.1.3, "RAC Organizational Chart," the SOW states, "while CMS is not dictating the number of key personnel, it is CMS' opinion that one key personnel is not adequate for an entire region." The AMA agrees. Given that there are four multi-state regions, in many cases it is unlikely that a single individual will be able to cover more than one state adequately. **Therefore, the AMA recommends CMS consult the state medical societies in each region to determine what would be the most appropriate number of Contractor Medical Directors (CMDs) per RAC.**

On page 3, under section A.1, the SOW calls for a "[D]etailed quarterly projection by vulnerability issue." Based upon the description that follows this item, it appears to apply only to overpayments. We are unclear if that is the case and therefore, request clarification from CMS. **We urge CMS to consider including underpayments in the definition of "vulnerability issues" in the event that there are underpayments that have been identified and due to "ineffective policies" (page 5) cannot be repaid to physicians.**

On page 4, under C.3., the SOW calls for monthly progress reports that include among other things, "Upcoming Provider Outreach Efforts." **We strongly urge CMS to share this information with the AMA in a timely fashion so that we can remain informed and help alert physicians to RAC educational efforts.**

On page 5, under section B.2, the SOW requires the RAC to "submit monthly financial reports outlining all work accomplished during the previous month." **The AMA strongly urges CMS to make these reports available to the public as they contain crucial data (i.e. overpayments and underpayments collected and number of medical records requested) that is of significant interest to the physician community.** During the Demonstration, this data was very difficult to obtain and was not provided in a timely manner.

Task 2 – Identification of Improper Payments

While the RAC demonstration SOW allows for a four year look back period for claims reviews, under the expanded program CMS calls for a three year look back period. On page 7 under subsection B.3 the SOW states, "[T]he RAC shall not attempt to identify any overpayment or underpayment more than 3 years past the date of the initial determination made on the claim." In reading this provision closely, it appears as though CMS has further limited the initial look back period for some RACs depending upon when their contract begins. For example, both a RAC that begins operations in March 2008 and a RAC that begins operations in March 2009 would be able to review claims only as far back as October 1, 2007.

The AMA appreciates that CMS has reduced the amount of time a RAC may go back and review claims, however, we have strong concerns about permitting a RAC to review claims from the previous twelve months. If the RACs are intended to catch improper payments missed by the carriers and FIs, RACs beginning work in March 2008 run the risk of reviewing claims that are still under review by carriers and FIs. **Therefore, we strongly urge CMS to preclude RACs from reviewing any claims within the past twelve months and only authorize reviews for claims processed one year prior to the last twelve months.** Prohibiting RAC reviews for the first fiscal year gives the carriers and FIs the opportunity to educate physicians when billing errors are detected, adequately explain to the physician how to correct future errors, and monitor the physician's billing practices for a period of time before taking recoupment action.

We are also concerned that CMS decided to remove certain provisions regarding areas which the RACs are precluded from reviewing – items which appeared in earlier draft SOWs. Specifically, we are troubled that CMS chose to omit the provision that would have precluded a RAC from reviewing Evaluation & Management (E&M) services that are incorrectly coded. **We strongly oppose this and urge CMS to reinstate this provision. If CMS decides to permit reviews of incorrectly coded E&M services it should be permitted for both underpayments as well as overpayments.** Finally, we are concerned that CMS chose to omit a provision concerning medical necessity. **We urge CMS to retain the provision that would preclude a RAC from reviewing claims involving medical necessity more than one year past the date of the original determination.**

On page 9, under subsection B.6, with respect to how RACs may identify claims most likely to contain overpayments (referred to as "targeted reviews"), CMS has included new language that reads, "NOTE: The above paragraph does not preclude the RAC from utilizing extrapolation techniques for targeted providers." Extrapolation techniques have been used with great frequency by Medicare carriers in the past and generated a huge volume of complaints from physicians. Often the extrapolation was not statistically valid and was used to magnify overpayment demands based on very small samples of claims to recoup hundreds of thousands of dollars. **AMA policy strongly opposes the extrapolation method unless it is used solely to develop educational or compliance program interventions.**

On page 11, under subsection D concerning, "Obtaining and Storing Medical Records for Reviews," there is a discussion of limiting the number of medical records requested of different providers based upon location and type. As CMS is aware, the RAC Demonstration has shown how incredibly burdensome a RAC audit can be for a physician, particularly a single practitioner or small group practice. Many physicians have had to close their offices for a day or more in order to retrieve the requested records. **We urge CMS to work with the AMA to come up with reasonable limits surrounding medical records requests made of physicians.**

Also under this section, there is mention of Medical Request Letters. On page 33 CMS indicates that standardized demand letters will be developed, which the RACs will be required to use. The AMA greatly appreciates that CMS has recognized the need for standardized language. If developed correctly, we believe this will limit physician confusion and better explain why the physician is being contacted. **We urge CMS to provide meaningful opportunities to the AMA to review and comment on the development of standardized language for these letters pursuant to earlier efforts in this area, and on the standardized language for the request for medical records letters.**

On page 10, under subsection D.1.a, is a provision that addresses payment for medical records. The AMA is deeply concerned that CMS has chosen to require reimbursement for some medical records (i.e. acute inpatient and acute long-term care hospital claims) but has not done so for medical records requested from physicians. **While we appreciate that CMS requires RACs to reimburse physicians for medical records requests associated with an underpayment (page 28) we strongly urge CMS to require RACs to reimburse physicians for any and all medical records requests.**

On page 16, under subsection E.1.b, "Coding Determinations," concerning types of determinations a RAC may make, **we, again, urge CMS to preclude E&M services that are incorrectly coded.**

Also on page 16, under subsection E.3, "Medicare Policies and Articles," we urge CMS to monitor directly and/or through the RAC evaluation contractor, the policies used by the RACs in making review determinations. Related, we are unclear about the language in the SOW that reads, "…except in the case of a retroactively liberalized LCDs (sic) or CMS National policy." We remain significantly concerned about the way payment policy was applied in California related to Local Coverage Decisions (LCD) on reimbursement for

Lupron and Zolodex. The AMA does, however, appreciate that CMS has included language that requires CMS involvement in any matter involving a RAC's interpretation of any policy and/or regulation. We look forward to continuing to work with CMS to address our concerns with the current California RAC's request for repayment concerning claims involving Zolodex and Lupron.

On page 19, under subsection E.9, on "Staff Performing Complex Coverage/Coding Reviews," coverage/medical necessity determinations are made by RNs or therapists, and coding decisions are made by certified coders. The AMA has strong policy concerning medical necessity reviews. **The AMA strongly urges CMS to revise this section to state that medical necessity denials within the Medicare program should be reviewed by a physician of the same specialty and licensed in the same state.**

Subsection F.3 on page 21 is confusing and the AMA requests clarification from CMS. It is unclear why the RACs are instructed to send a single letter with the results of a claims review involving medical necessity and correct coding but separate letters are required when "the RAC identifies two different reasons for a denial."

On page 22, under subsection F.3.c, "Contents of Notification of RAC Complex Review Findings Letter," appeal information must be included in the letter. **We urge CMS to work with the AMA to develop a one page fact sheet that describes the appeals process and includes a link to the fact sheet in the letter.**

Task 3 - Underpayments

Missing from Task 3 is any mention of interest. This concerns us given that under Task 4, which addresses overpayments, interest requirements are included in subsection H (page 37). **The AMA urges CMS to include language on interest under Task 3.**

Also, on page 27 there is mention of an "Underpayment Notification Letter." As noted earlier, the **AMA urges CMS to work with us on standardized language for this letter.**

We are also concerned that on page 27 CMS has chosen not to include, for the purposes of underpayments, situations where a physician fails to report a service they delivered. If a physician has delivered medically necessary and appropriate care to a patient, they should be reimbursed for the care. **We urge CMS to treat services omitted from claims as underpayments.**

On page 26, under Task 2, subsection K.2, CMS notes that," the RAC may receive referrals or "tips" on potential overpayments from CMS, ACs, and OIG or law enforcement." However, on page 28 under Task 3 concerning underpayments, CMS says, "The RAC will have no responsibility to accept case files from providers for an underpayment case review." This is inequitable. If RACs can be rewarded for locating overpayments and underpayments, physicians should be able to flag areas where underpayments may be

occurring. Furthermore, on page 36 under Task 4, the SOW allows for voluntary/self-reported overpayments by physicians. **The AMA urges CMS to, at the very least; include language in the SOW that permits national, state, local, and specialty medical societies to share information with CMS and the RACs about underpayments.**

Task 4 – Recoupment of Overpayments

The AMA requests clarification from CMS on what constitutes "legally supportable" recovery techniques, as described on page 29. **The AMA recommends CMS provide some examples of what these recovery techniques are.**

On page 29, under the heading "Adjustment Process," the SOW dictates that RACs may attempt recoupment for claims less than $10. The time and effort required on the part of physicians for a RAC audit is tremendous. A RAC audit frequently takes physicians away from their patients and can represent significant losses for them if they have to close their practices or devote significant resources to dealing with audit requests. **The AMA urges CMS to change the minimum amount to $25, consistent with the minimum amount of debt eligible for referral to the Department of Treasury (page 35).**

On pages 31-32 there are two graphical depictions of the "Adjustment Process." Missing however, is any mention of underpayments. **The AMA urges CMS to include underpayments in these depictions.**

On pages 37-38, under subsection I, "Customer Service," the SOW calls for the RAC to respond to written correspondence within 30 days. The AMA believes that 30 days is too long of a time period. Being contacted about a RAC audit is extremely disconcerting, and physicians who contact the RAC should receive a relatively quick response. **The AMA recommends CMS require RACs to respond to written physician inquiries within 15 days and to respond to physician phone inquiries within 48 hours.**

Also included in the SOW on page 45, under Task 7, subsection J, the "Support Evaluation Contractor," is a provision concerning a provider survey. **The AMA urges CMS to do the following: include a more robust description of this survey; include physicians' experiences with RAC customer service; and use the outcomes of the survey for evaluating the performance of the RACs and future contract awards.**

Task 5 – Supporting Identification of Overpayments in the Medicare Appeal Process and/or in the DCIA Process

On page 39, under the heading, "Data Warehouse Reporting of Possible/Identified Improper Payments," there is no mention of underpayments. **The AMA requests clarification concerning whether the Warehouse is only intended for overpayments.**

On page 43 under subsection 7.C, the AMA strongly supports the inclusion of a provision that states, "[I]f a provider files an appeal disputing the overpayment determination and the appeal is adjudicated in the provider's favor at ANY level, the RAC shall repay Medicare the contingency payment for that recovery. Repayment to Medicare will occur on the next applicable invoice." This provision will help remove the perverse incentive RACs have to go after overpayments unjustly, only to have them overturned on appeal without any responsibility to return the contingency fee paid by CMS for locating them. **Similarly, the AMA supports the related provision on page 44 under subsection 7.F on "Recalled Cases," which states, "[T]he RAC shall receive no payment, except for monies already recouped, for recalled cases."**

Finally, on page 45, under subsection K, "Public Relations & Outreach," the SOW requires the RACs to develop and maintain a web page by January 1, 2010. **The AMA strongly urges CMS to change this to the date on which the contract for each RAC begins, given that by 2010 RAC operations will have already begun in a number of states and timely information to physicians on this program is critical.**

Appendix 3: RAC Expansion Schedule

CMS did not provide any explanation regarding their decisions about which States would have RAC operations beginning in March 2008, October 2008, and January 2009 or later, although we understand from conversations with CMS that the intent is to ensure that they do not interfere with the transition to the Medicare Contracting Reforms (MAC) already underway. After reviewing the map contained in the appendix, however, the AMA is unclear about the rationale behind the planned RAC expansion schedule and how it comports with the MAC plans. For example, RAC Jurisdiction D comprises California, Oregon, Washington, Idaho, Montana, North Dakota, South Dakota, Wyoming, Nevada, Utah, Arizona, Nebraska, Kansas, Iowa, and Missouri. This same area, however, also contains MAC Jurisdictions 1, 2, 3, and 5, which have various MAC implementation dates. MAC Jurisdictions 1 and 5 were recently awarded to Palmetto (though this was recently contested and could be delayed) and WPS and are expected to be operational no later than June 2008 and September 2008. Jurisdiction 3 was awarded to Noridian last year and is already operational and it appears as though CMS will be announcing the award of Jurisdiction 2 shortly. Also, the States that comprise J-12 (Delaware, District of Columbia, Maryland, New Jersey and Pennsylvania) for which a contract was recently awarded to Highmark and which should be operational no later than September 2008, is scheduled to begin RAC operations in January 2009, or later, according to the SOW. The RAC expansion schedule for the states in MAC J-12 appears logical given that the two implementation timeframes are staggered. Yet, other MAC jurisdictions like J-5 that will be in the midst of a MAC transition will have just begun operations at almost the same time the RAC is expected to start operations—October 2008. **The AMA urges CMS to communicate its rationale for the RAC expansion more clearly before moving ahead with expansionist plans.**

The AMA appreciates the chance to share these comments and concerns with CMS. Should you have any questions about this letter please contact Mari Savickis at mari.savickis@ama-assn.org or at 202-789-7414.

Sincerely,

Michael D. Maves, MD, MBA