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

Re: **Revised RAC Statement of Work**

Dear Administrator Tavenner:

On behalf of the physician and medical student members of the American Medical Association (AMA), I offer our comments regarding the Centers for Medicare & Medicaid Services Recovery Auditor (RAC) program. **We strongly oppose the RAC program, as we believe that the contingency fee compensation structure incentivizes RAC "fishing expeditions" that are exceedingly burdensome for physicians, and often lead to erroneous overpayment determinations.** Furthermore, the RAC program has become an exceedingly burdensome program at a time when physicians already face myriad Medicare regulatory requirements, such as complying with the Physician Quality Reporting System (PQRS), the implementation of ICD-10, the adoption of electronic health records and Meaningful Use, as well as other numerous and duplicative audit programs. It is our understanding that the guidelines for the RAC program, as encompassed in the Statement of Work (SOW), are currently undergoing review and will be reissued in a revised SOW for the new contract period. We offer below our specific recommendations on how the SOW should be improved.

Audit Duplication

As a threshold matter, we strongly urge CMS to consolidate its audit system into a more balanced, transparent, and fair system which does not increase administrative burden on physicians. CMS employs numerous contractors—RACs, Zone Program Integrity Contractors (ZPICs), Comprehensive Error Rate Testing (CERT) contractors, Payment Error Rate Measurement (PERM) contractors, and Medicare Administrative Contractors (MACs)—to review and audit the medical care delivered by physicians and other providers. Physicians are often confused about which auditor is auditing them and why. This confusion is due to both the number of auditors and poor communication to physicians undergoing audits. In the RAC program in particular, a physician may be contacted by both the RAC and the MAC. Physicians spend time that could otherwise be devoted to patient care trying to discern the nature of the review and who to contact for follow-up. At a

minimum, CMS should improve its audit contractors' communications to physicians, including ongoing education and outreach regarding known billing, coding, and documentation vulnerabilities.

Penalties

RACs should be subject to a penalty determined by CMS for erroneous overpayment determinations, and should be required to reimburse physicians for the costs incurred in defending against RACs whenever an appeal against them is won. In CMS' 2011 RAC Report to Congress, CMS made clear that 43 percent of the time when a health care provider appeals a RAC overpayment determination, the health care provider wins.[1] The report also stated that CMS spends $47.5 million in administrative costs annually for the RAC program, including the cost of hearing appeals. This error rate and appeal cost are too high, and physicians should not bear the cost of legal and administrative fees to pursue such appeals, especially when they prevail. CMS should ensure that RACs are carefully proceeding in initial overpayment determinations and recoupments by imposing a meaningful financial penalty on RACs who lose on appeal or have a sustained rate of error, and by requiring repayment of physicians' legal fees.

CMS should also apply a penalty to the RACs when they fail to timely perform administrative duties, such as processing communications to physicians or responding to physician inquiries. Because the timelines for document production, discussion, and appeal are short, timely communication and response is required to safeguard the RAC program from inefficiency and inaccuracy.

Look Back Period

The AMA has strong policy that RAC reviews should be limited to less than one year from payment of claims. Since Congress promulgated the RAC program, a new one-year claim timely filing requirement has come into effect which precludes physicians from rebilling past one year after the date of service. It is therefore inequitable that RACs have up to three years to identify overpayments due to incorrect documentation or coding, without any physician recourse but appeal after the first year. **At a minimum, CMS should retain its current three-year look back period in the revised SOW.** Lengthy look back periods result in additional burdens for both CMS and physician practices, as revised policies and archived medical records must be reviewed and evaluated. **CMS should also permit physicians to rebill any denied claim if appropriate services were rendered.**

Prepayment Review

We strongly urge CMS to retain its current SOW language which limits RAC activity to post-payment reviews. The current SOW provides "the Recovery Auditor shall identify Medicare improper payments using the post payment claims review process. Any other source of identification of a Medicare overpayment or underpayment (such as prepayment review) is not included in the scope of this contract." (Pg. 12) We urge CMS to consider that RACs have a very poor record on appeal, losing 43 percent of the time when a provider appeals an overpayment determination, and are ill equipped to make such determinations on a prepayment basis. We expressed these reservations

[1] Centers for Medicare & Medicaid Services report entitled *Recovery Auditing in the Medicare and Medicaid Programs for Fiscal Year 2011*, available at http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Recovery-Audit-Program/Downloads/FY2011-Report-To-Congress.pdf.

during CMS' consideration of a RAC prepayment review demonstration program, and continue to believe that RACs should be precluded from performing prepayment review. **Should CMS seek to allow RACs to perform prepayment review beyond the scope of the demonstration, which is authorized to take place only in 11 states and has heretofore been limited to a set of hospital diagnosis-related groups (DRGs), we strongly urge CMS to propose this policy change through the formal rulemaking process, and not as part of a revised SOW.**

Extrapolation

We oppose the use of extrapolation in the RAC program. Many RAC reviews are conducted by personnel with little to no expertise in medical care, and RAC overpayment determinations are overturned on appeal at an alarming rate. Extrapolation of RAC auditors' findings will exacerbate these problems. We therefore strongly advise CMS to preclude the RACs from utilizing extrapolation.

At a minimum, CMS should ensure that the revised SOW requires that RAC extrapolation reviews conform to section 1893(f)(3) of the Social Security Act (SSA). The amended SOW should state that when a RAC initially contacts a physician, the RAC is not permitted to use extrapolation to determine overpayment amounts to be recovered from that physician by recoupment, offset, or otherwise unless (per section 1893 of the SSA) the Secretary of the Department of Health and Human Services (HHS) has determined, before the RAC audit, either that previous, routine pre- or post-payment audits of the physician's claims by the Medicare Administrative Contractor (MAC) have found a sustained or high level of previous payment errors, or that documented educational intervention has failed to correct those payment errors.

Physician Reviews

Physician audits should be performed by a physician of the same specialty or subspecialty licensed in the same jurisdiction. The current SOW only requires that a registered nurse or therapist perform coverage or medical necessity determinations, and that certified coders make coding determinations. In many cases, these individuals do not have the training or experience to make determinations regarding complex medical care. A physician, not a lower level provider, should review and approve any RAC claim against physicians or physician decision-making. Physicians of the same specialty should also review edits that are utilized for automated review.

Medical Record Reimbursement

CMS should require RACs to pay for the medical records of physicians. Currently, the SOW provides that RACs will pay for the medical records related to acute care hospital claims, long term care hospital claims, HMOs, dialysis facilities, etc., at a rate of $0.12 per page. Physicians often have to contact and compensate off-site facilities to store, locate, and retrieve medical records. To reduce the financial burden that many physician practices face in responding to RAC audits, and to provide equity among the provider types affected by RAC audits, we urge CMS to include RAC reimbursement for physician production of medical records. We also urge CMS to revise the SOW to require that physicians be reimbursed for records submitted pursuant to semi-automated review.

On-Site Reviews

CMS should require that the RACs provide notice of at least 10 business days prior to conducting on-site reviews. The current SOW provides that "the Recovery Auditor may obtain medical records by going onsite to the provider's location to view/copy the records…" (Pg. 13) The SOW does not require any advance notice of such onsite reviews. RAC reviews are meant to identify improper payments, not fraud. We believe strongly that patient care in the physician's office must not be interrupted during the course of the audit. There is no basis for unannounced site visits for RAC audits, and CMS should make clear in the revised SOW that RACs must provide advance notice.

Contractor Errors

Physicians should be held harmless from overpayment recoupment when the overpayment is due to an incorrect action by a payment contractor. The current SOW provides "the Recovery Auditor may determine that an overpayment exists if the claim was paid twice (i.e. a duplicate claim), was priced incorrectly, or the claims processing contractor did not apply a payment policy." (Pg. 19) Physicians should not be subject to the financial strain of the review and recoupment process for errors that are beyond their control.

Guideline Oversight

AMA policy is that all Medicare contractors should disclose any medical decision making tool or score sheet used in audits. **To ensure that the internal guidelines developed by the RACs are appropriate, CMS should review and approve such internal guidelines prior to their implementation. In addition, CMS should require that the RACs make their internal guidelines available to physicians so that physicians may understand and avoid common billing errors.**

Semi-Automated Review

The records requested by CMS for semi-automated review should fall within the medical record request limits. Our understanding is that when a physician receives an "informational" letter informing them that a RAC is conducting a semi-complex review, which "gives them the option" to submit medical records pursuant to that review, those medical records do not fall within the medical record request limit. It is our impression that CMS has made some effort to carefully tailor the medical record request limits for physicians to ensure that such requests are not exceedingly burdensome. We believe that leaving the semi-automated review record requests outside the bounds of these limits is contrary to CMS' goal in this regard, and therefore urge CMS to include them in the revised SOW.

Discussion Period

To ensure that the discussion period is a meaningful avenue for physicians to address RAC overpayment determinations, CMS should: 1) explicitly allow voluntary electronic submission (fax, email) of physician requests to engage in the discussion period; 2) require the RACs to create a pathway (email address, portal) for that submission; and 3) require the RACs to respond to such requests within 10 days. The current SOW provides that "discussion requests should be in writing and shall be responded to by the recovery auditor within 30 days of receipt, unless the recovery auditor is notified by the affiliated contractor of a provider initiated appeal." (Pgs.

24, 44) Our understanding is that the discussion period closes on the 41st day following the receipt of the demand letter. Further, physicians are generally advised to appeal by the 30th day following the date of the demand letter to avoid recoupment on the 41st day. We are concerned that some physicians may wish or attempt to engage in the discussion period, but because the RACs are not required to timely respond to such requests and the timelines for appeal are short, that the discussion period may in some cases not be a viable option.

Admissions

CMS should make clear in the SOW that RACs are precluded from making recoupments associated with "inappropriate admissions" and/or discrepancies between the hospital and physician's site of service. Auditing these claims when the physician payment would be the same whether the service was provided on an inpatient or an outpatient basis is particularly inequitable. This is consistent with current language in the SOW that provides: 1) "The recovery auditor can only collect the difference between the paid amount and the amount that should have been paid." (pg. 29); 2) "Situations where the provider submits a claim containing an incorrect code but the mistake does not change the payment amount are NOT considered to be improper payments" (pg. 2); and 3) "The Recovery Auditor shall not forward claims to the FI/Carrier/MAC/DME MAC/for adjustment if the claims are incorrectly coded, but the coding error is not expected to equate to a difference in the payment amount" (pg. 35). Given CMS' recent attention to issues related to hospital admissions, we strongly urge CMS not to audit physician practices for discrepancies between physician and hospital records, particularly with respect to admissions designations.

Transitions

The RAC SOW includes provisions on how to best transition a geographic area from one RAC contractor to another. **We recommend that during a time of transition from one RAC to another, RAC work should be suspended for a minimum of 90 days, and providers should be notified at least 90 days in advance.** The current SOW provides that "the impact may vary from little to no impact to a work stoppage in a particular area for a 3-6 month period of time (or more dependent on the transition)," and "the transition plan will be communicated to all affected parties (including providers) by CMS within 60 days of its enactment." (Pgs. 2, 3) To best avoid confusion in the physician community and to allow RACs time to gain a familiarity with their region (and the LCDs that they may utilize), RACs should be required to pause work during a transition, and providers should be notified of such transition at least 90 days prior to the date on which RACs commence audits.

Already-Returned Overpayments

Prior to instituting an audit of a physician practice, RACs should make a good faith effort to ascertain whether the practice has already self-identified any billing irregularities that may have resulted in overpayments (including any such overpayment that may have been reported to the RAC), and has satisfactorily cured the irregularities by returning the overpayments and making any needed changes in their billing procedures, and where such self-identification and rectification has already occurred, that the audit not be initiated. **To avoid duplicative overpayment recovery efforts, CMS should require the RACs to ensure that overpayments have not already been returned or recouped prior to initiating a medical records request or recoupment.**

Customer Service

CMS should strengthen the language in the SOW related to customer service and should penalize the RACs for failure to comply with these requirements. Currently, the SOW provides, "The staff answering the customer service lines shall be knowledgeable of the CMS recovery audit program. The staff shall have access to all identified improper payments and shall be knowledgeable of all possible recovery methods and the appeal rights of the provider. If need be, the staff person that identified that the improper payment shall return the call within 1 business day." (Pg. 43) This language could be strengthened by providing that "If need be *or requested*, the staff person that identified the improper payment, *and/or the physician medical director*, shall return the call within one business day." In addition, CMS should require that any follow-up resulting from customer service calls take place within one business day. Lastly, CMS should penalize the RACs for failure to comply with the customer service requirements outlined in the SOW.

RAC Data Warehouse

CMS should require RACs to input essential data elements into the RAC Data Warehouse within 10 business days following their availability. CMS states in the current SOW that "the Recovery Audit Data Warehouse can only be successful if the data input into it by the Recovery Auditors is reliable, timely and valid." (Pg. 47) Timelines for submission of information are required to ensure that such information is timely. **We also recommend that CMS explore how it may require the other contractors to timely and completely update the RAC Data Warehouse to prevent audit overlap and duplication.** The current SOW only provides that MACs, ZPICs and others "may input claims" for exclusion. (Pg. 12)

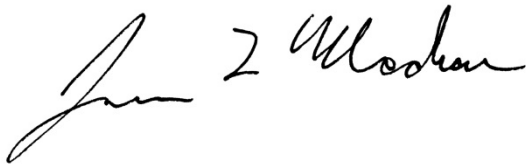
Limitation on Recoupment

We urge CMS to make clear in the revised SOW that Section 935 of the Medicare Modernization Act (MMA) applies to RAC audits and allows physicians who appeal an audit determination to stay recoupment through the audit process. We have received inquiries regarding the timelines for recoupment and appeals, and believe that greater outreach regarding such timelines would be useful for both the RACs and physicians.

Conclusion

Thank you for the opportunity to provide our views on the RAC SOW. We look forward to ongoing engagement with CMS as the revised SOW is finalized. Should you have any questions regarding this letter, please contact Carol Vargo, Assistant Director, Federal Affairs, at 202-789-7492 or carol.vargo@ama-assn.org.

Sincerely,



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