AMA
AMERICAN MEDICAL ASSOCIATION

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Marilyn B. Tavenner
Acting 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

Re: RAC Audits of E&M Codes

Dear Acting Administrator Tavenner:

On behalf of the physician and medical student members of the American Medical Association (AMA), I write to you regarding the recent decision by the Centers for Medicare & Medicaid Services (CMS) to approve Recovery Auditor (RAC) review of certain Evaluation and Management (E&M) services. We have been informed that in the next several weeks, Connolly, the RAC contractor for Medicare Region C, will begin complex medical review of CPT code 99215 for a Level 5 office visit, and will be permitted to extrapolate their findings based on a statistical sample of such claims. **The AMA strongly opposes RAC review of E&M codes, including CPT code 99215, and strongly urges CMS to rescind its approval of RAC review of CPT code 99215 and reject any other pending RAC requests to audit E&M codes.**

The AMA devotes significant resources toward educating physicians about correct coding and documentation. However, in the context of E&M coding, physician choices regarding appropriate code designation can be a subjective matter based on the complexity of the patient visit. Physicians who provide E&M care apply complex decision-making based on myriad clinical approaches, including research and review of patient medical history, analyses regarding appropriate medication, discussion of home situation and prescription distribution plan, preventive care planning, and many other variables. Because of the complexity of this type of care, it does not lend itself easily to medical review. In particular, based on our historical experience with the RACs, and in light of the fact that the RACs are not required to have same-specialty physicians review RAC determinations, we have no confidence that the RACs will be up to the task of understanding these variables or their clinical relevance. We note that the RACs have a low accuracy rate as it is: CMS' FY2010 Recovery Auditor Report to Congress reported that 46 percent of the Medicare RAC determinations appealed were decided in the provider's favor. **RAC review of E&M codes will undoubtedly lead to erroneous recoupments and lengthy, expensive appeals for both physicians and CMS.**

Moreover, CMS' approval of RAC extrapolation of their findings based on a sample of CPT code 99215 claims is misguided and should be rescinded. Each E&M visit is different based on the unique needs of the patient. Assignment of levels of E&M services is based on six components to encompass description and define the level of the provided E&M service. These components are history, examination, medical decision making, counseling, coordination of care, and the nature of the presenting problem. A seventh component, time, is used to capture the additional physician effort when this service dominates the visit. Due to the variability and balance of these components from one visit to the next based on the needs of each patient, the use of the extrapolation method in an audit for comparison of visits among different patients has a high outcome probability of error and should not be used. **We do not believe that CMS intends this result, and we**

therefore strongly urge CMS to revoke its approval of RAC extrapolation of sample CPT code 99215 determinations and reject extrapolation for any other pending E&M code reviews.

We are concerned that inaccurate or incomplete data regarding physician specialties or subspecialties may also lead to needless RAC audits of E&M services. In our ongoing discussions with state medical societies, we have been informed that there are significant problems with inaccurate information concerning physicians' specialty designations. For example, several physicians reported that the specialty that the RAC had listed for that physician did not match the specialty that Medicare had on file, resulting in demand letters that were vacated in the discussion period. Other physicians reported that a RAC did not have any listing of physician specialties. In the context of medical review of CPT code 99215, accurate data regarding physician specialty and subspecialty is essential upfront to determine whether a physician who frequently bills that E&M code is doing so properly. For example, a senior subspecialist in a practice may consistently see the most complex patients who visit the practice. The lack of accurate specialty designation data regarding that physician may lead a RAC to the erroneous conclusion that the physician is an outlier, or billing improperly, and cause the RAC to request medical records for that physician—a time consuming, expensive, and burdensome process for the practice. **Inaccurate specialty and subspecialty data will result in erroneous RAC outlier determinations and waste CMS resources.**

Lastly, we strongly urge CMS to review this decision in light of the increasingly complex nature of medical care. From reporting of quality measures to electronic health record Meaningful Use adoption, physicians are being asked to provide more complex care for more complex patients. Physicians who earnestly seek to comply with these requirements may now be spending more time with each patient and delivering E&M care with a more global, comprehensive approach. It is logical, therefore, that such physicians would bill for the additional time, review, input, and collaborative care that they are now giving to their patients. For example, an E&M visit with a patient who is comorbid, seeking treatment for hypertension, diabetes, and heart disease, will be longer and more comprehensive than it would have been just 10 years ago. This intensity of patient-centered care is consistent with CMS' goals to encourage and support physicians who are treating patients with multiple chronic conditions, and to encourage better coordination of care. To penalize these same physicians for billing at the CPT code that often best reflects the care that these patients require is short-sided and inequitable. **We strongly urge CMS to reevaluate their approval of RAC review of CPT code 99215 in light of CMS' other robust efforts to encourage comprehensive, complex care, as the approval of this RAC review is incongruous with CMS' stated priority to strengthen and support high quality, patient-centered care.**

For the forgoing reasons, the AMA strongly opposes RAC review of E&M codes, including CPT code 99215, and strongly urges CMS to rescind its approval of RAC review of CPT code 99215 and to reject any other pending RAC requests to audit E&M codes. At a minimum, because of the subjective nature of E&M coding, CMS should specifically exclude one-level code differences between CPT code 99215 and CPT code 99214 from recoupment. Thank you for your attention to this matter. Should you have any questions on this letter, please contact Margaret Garikes, Director, Federal Affairs at (202) 789-7409 or margaret.garikes@ama-assn.org.

Sincerely,

James L. Madara, MD