

September 25, 2012

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

Re: Medicare Recovery Auditors auditing Evaluation and Management Services

Dear Administrator Tavenner:

On behalf of the Medical Group Management Association (MGMA), we are writing to express our strong opposition to the Centers for Medicare & Medicaid Services' (CMS') recent decision to allow Connolly, its Recovery Auditors (or RACs) for Region C, to audit Evaluation and Management (E/M) Services and to allow it to extrapolate its findings to project incorrectly paid claims.

MGMA-ACMPE, founded in 1926, is the nation's principal voice for medical group practices. Our nearly 22,500 members manage and lead 13,200 organizations, in which 280,000 physicians provide more than 40 percent of the healthcare services delivered in the United States. The Association's core purpose is to improve the effectiveness of medical group practices and the knowledge and skills of the individuals who manage and lead them. Individual members, including practice managers, clinic administrators and physician executives, work on a daily basis to ensure that the financial and administrative mechanisms within group practices operate efficiently so that patient care remains the focus of physicians' time and resources.

Our members often respond directly or supervise those who respond to inquiries from Medicare auditors, including RACs. As the RAC program has expanded to include more Medicare Part B audits, we have worked with our members to identify problems with the process and have brought those concerns to CMS' attention. Unfortunately, a number of problems still remain, particularly in the Connolly region. We do not believe the RAC program – and Connolly in particular - is equipped to appropriately evaluate physician E/M coding accurately.

E/M services are paid on a complex scale, based on the history of the patient being seen, the type of examination, and the medical decision-making required. Determining which code to bill relies on a physician's professional judgment. Reviewing such determinations likewise requires significant expertise. Yet the RACs are not required to have physicians in the same medical specialty conduct medical reviews. It is also our understanding that the RACs' physician specialty information is not always accurate, which could further complicate review by incorrectly flagging a physician as an outlier.

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The RACs have not proven that they have the skill and expertise to address much more straightforward issues. CMS' most recent data to date for Fiscal Year 2011 shows that providers successfully appeal RAC audits 43.4 percent of the time. The Fiscal Year 2010 rate was 46.2 percent. The appeal rates are unacceptable and must be addressed before auditors who are paid a percentage of the money they collect are allowed to second guess the judgment of physicians treating Medicare beneficiaries.

In the course of the past year, we have heard from many members who have had frustrating requests from RACs, particularly from Connolly. In one instance, Connolly sought return of recalculated reimbursements as a result of Congress reinstating the geographic pricing cost index (or GPCI) floor in the Affordable Care Act. In another instance, several of our members received overpayment demand letters as a result of place of service discrepancies where the physician payment rate would not have changed (e.g., the patient's status was changed from inpatient to outpatient, both settings that pay physicians at the "facility" rate). Demanding repayment in those instances is contrary to the RAC Statement of Work, which states that "[s]ituations 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." (emphasis in original). Most of these requests were resolved during the discussion period but required significant time and expense and caused great concern for our members. Members of Congress have even joined in the chorus of those concerned about RAC audits and the effect they have on healthcare providers. A bicameral, bipartisan group of leaders asked the Government Accountability Office to investigate Medicare auditors. In addition, Rep. Dan Boren (D-Okla.), in a press release, said Connolly used "overzealous predatory tactics" and called for a federal investigation of Connolly and other RACs. Based on the experience of our members and CMS' appeals data, it is clear that the RAC program, especially in Region C, needs to address systemic problems with interpreting Medicare payment criteria. They should not be empowered to review much more complex issues, like billing for E/M services.

We are aware that billing for E/M services has been a focus of the Department of Health and Human Services Office of Inspector General (OIG), which found an increase in higher level, more expensive and more complex E/M services from 2001-2010, including identifying approximately 1,700 physicians who billed higher level E/M codes in 2010. Despite its findings, the OIG did not determine that these physicians billed inappropriately. Indeed, these physicians may have just been statistical "outliers" because of the specialty or subspecialty services provided to an increasingly complex patient population. We appreciate CMS' response to this report, released in May, which committed to providing greater education on billing for E/M services to the physician community. We are also aware that CMS informed its Medicare Administrative Contractors (MACs) of the OIG's findings to prioritize the MACs' efforts and directed the MACs to focus on the top 10 billers in each jurisdiction. Additionally, in May, CMS released comparative billing reports to 5,000 primary care providers who have consistently billed high level E/M codes to assist physicians in self-audits to assess conformity with Medicare billing requirements. The agency's education efforts surrounding E/M billing are just getting underway. At a time when the Medicare program is focused on ensuring proper access to and payment for primary care services, we think it will be counter-productive to allow the RACs to begin reviewing these services and extrapolating their findings.

At the very least, should CMS allow its contractors to proceed with E/M medical reviews,

we urge CMS to make the following changes to reduce the negative impact it will have on physicians and their group practices.

- ***Eliminate the approval to extrapolate.*** Though CMS has the authority to allow RACs to extrapolate, to the best of our knowledge, CMS has not approved any other issue for extrapolation. Extrapolation is a severe measure that can turn modest errors into overpayment demands that have the potential to bankrupt a practice. The evidence clearly indicates that the RAC program is not sophisticated enough to review E/M services. Moreover, billing for E/M services is dependent on many factors and varies based on the patient. Applying the results of a review of one patient to make assumptions about an examination of another patient is not appropriate.
- ***Allow resubmission of claims.*** Where a RAC determines, appropriately, that an E/M service was billed at a higher level than justified based on its records review, CMS should allow the physician to resubmit the claim at a lower level, allowing him/her to receive some reimbursement for services rendered. If CMS wants to educate physicians and nonphysician practitioners and encourage participation in the Medicare program, it should allow them to receive some level of reimbursement for services performed, even if they were provided outside of the 12-month filing deadline.
- ***Limit the look back period.*** In 2010, CMS eliminated the use of consult codes for Medicare patients. As a result, services that were previously billed as consults are now billed as E/M services. The transition has been difficult, with physicians having to change their billing and charting patterns. MGMA repeatedly asked CMS to provide a crosswalk and other guidance to assist with this process. CMS has not provided a crosswalk and physicians struggled as a result. If CMS proceeds in allowing Connolly or other RACs to review E/M services, we urge you to exclude services provided during the first year of the transition and begin with claims no earlier than Jan. 1, 2011. We are particularly concerned that the approval listing on Connolly's website indicates that its review will be for dates of service from "10/1/2007-Open." The RACs are limited to reviewing claims no more than three years past the date of the initial determination, making the RAC listing confusing at best.

We urge CMS to reconsider and promptly reverse its decision to authorize the review of E/M services by Connolly and extrapolation of its findings. Thank you for your attention to this matter. Should you have any questions, please contact Amy Nordeng at anordeng@mgma.com or 202-293-3450.

Sincerely,

A handwritten signature in black ink that reads "Susan Turney". The signature is written in a cursive, flowing style.

Susan Turney, MD, MS, FACP, FACMPE
President and CEO