



JUL 01 2009

Administrator
Washington, DC 20201

Ms. Mari Savickis
Division of Federal Affairs
American Medical Association
25 Massachusetts Ave, NW, Suite 600
Washington, DC 20001

Dear Ms. Savickis:

Thank you for your letter regarding the Recovery Audit Contractor (RAC) program. The Centers for Medicare & Medicaid Services (CMS) welcomes feedback from the provider community as the nationwide program rollout continues.

The CMS is required to protect the Medicare Trust Funds from improper payments. We prevent billing errors through active outreach and education to providers. Retroactive claims review is an appropriate way to assess compliance and to promote greater accuracy of future claim submissions.

RACs have a valuable and unique role in the efficient detection and collection of overpayments – as well as in the identification and reparation of underpayments. They are compensated solely on the basis of performance.

We acknowledge that the way the RACs are funded is relatively uncommon in Government, and that many in the provider community are concerned the RACs may sacrifice accuracy for efficiency. CMS has taken a number of steps to protect against overly aggressive reviews, most notably by: (1) creating a New Issue Review board that must first approve any issues a RAC intends to pursue; (2) retaining a RAC Validation Contractor to review RAC findings and issue annual accuracy scores; and (3) requiring that RACs refund their fees if their determinations are overturned at any level of appeal.

The overall goal in Medicare claims processing is to ensure claims accurately reflect the services provided the first time they are submitted for payment. CMS is in agreement with the AMA that provider education is the ideal method to prevent common billing errors by physicians. By educating the physician about correct billing, we can increase the extent to which claims are processed and paid accurately the first time they are submitted.

CMS shares all vulnerabilities identified by the RACs with the Medicare claim processing contractors so that local edits and/or provider education can occur. In addition to existing education efforts by the claim processing contractors, we intend to publicize RAC program results and newly identified vulnerabilities as widely as possible (findings will be aggregated, not reported at the individual provider level). This will allow physicians to complete their own quality assurance reviews and will help them to determine if they are billing accurately.

The CMS is also currently conducting intensive provider outreach in all 50 States, along with representatives of the RACs themselves. CMS is contacting each State medical association to schedule outreach with its membership. CMS is making the outreach available through on-site visits, conference calls, Webinars, and open door forums. These sessions are an opportunity for providers to learn more about the history of the RAC program, to meet members of the contractor's leadership teams and the CMS staff that will be monitoring their work, and to ask questions about how the program may affect their practices.

While the review of evaluation and management (E&M) coding is now available for RAC review, any issue the RAC identifies would still be required to be approved through the CMS New Issue Review (NIR) process and/or by the validation contractor. CMS is aware of the discussions regarding the levels of visits as well as the discussions and potential confusion surrounding consultation services. Members of the NIR team include staff from the policy areas who are knowledgeable on the discussions and will be able to help direct the RACs in their review process. CMS does not intend to have the RACs begin reviewing the levels of an office visit and/or consultation services without advance notice to the AMA and to the physician community. However, CMS does believe there are some situations such as duplicate claims, unbundling, and/or the correct choice of new or established patient codes that are self-explanatory and may be areas suitable for RAC review.

The RACs may only request records and conduct reviews on 10 pilot cases before requesting approval through the CMS New Issue Review process and (if approved) posting the issue on its Web site. The RACs are prohibited from recovering any overpayments identified in those 10 reviews without CMS approval, and the 10 cases are per an issue/topic – not just per provider. By posting the new issue to the Web site, physicians will be able to determine what types of claims the RACs may be reviewing. Since it may be burdensome to some physicians to remember to check a particular Web site on a regular basis, CMS is working with the RACs to implement a subscription system to update the provider community when a new issue has been approved for widespread review.

Although statistically valid random sampling is a valid and legitimate benefit integrity tool, we agree that allowing widespread extrapolation of E&M level error findings could be problematic. The RACs are allowed to apply the sampling methodology outlined in section 3.10 of the CMS Program Integrity Manual, but only after conducting the initial 10 pilot reviews and obtaining explicit CMS approval of both the underlying issue and the methodology with which they intend to pursue it. We will carefully weigh the historical concerns related to E&M coding when considering requests to extrapolate, and we will likely only allow it in limited, highly focused situations. In addition, the use of any extrapolation would have to be approved during the NIR process.

We similarly recognize providers' concerns about medical record request limits; the limits are subject to change annually, and we welcome feedback from the provider community. The Practicing Physicians Advisory Council (PPAC) recommendation to limit requests to 3 medical records in 45 days for solo practitioners has been taken under advisement and we will carefully monitor the effects of the existing limits in the remainder of the current fiscal year. We want to ensure the limits are fair and that they represent a reasonable balance between the need to identify/correct improper payments and the need to protect providers from undue administrative burden.

The CMS also appreciates the direct financial burden on providers in responding to RAC requests for medical records. The practice expense relative value unit component of the physician fee schedule is intended in part to compensate providers for supplies and staff time involved in copying records.

Although our goal is to minimize the burden on providers in responding to record requests for relatively low-value claims, CMS is concerned about the negative consequences that could result from establishing a higher minimum claim amount. RACs are not permitted to identify claims for review solely by value. They must have a reasonable suspicion that improper payments exist before requesting records for pilot reviews; those findings must be presented to CMS in order to obtain approval for collection and/or widespread review.

A member of PPAC recently expressed an interest in knowing whether RACs were reviewing particularly low- or high-value claims. We have subsequently developed a reporting mechanism for both initial claim values and any amounts ultimately collected or restored. This tool will help us monitor RACs' claims identification practices.

We value our relationship with the American Medical Association and its specialty/State partners, and look forward to working with you and the provider community to continuously refine and improve the RAC program.

Sincerely,



Charlene Frizzera
Acting Administrator