

REPORT OF THE BOARD OF TRUSTEES

B of T Report 31-A-19

Subject: Non-Payment and Audit Takebacks by CMS
(Resolution 704-A-18)

Presented by: Jack Resneck, Jr., MD, Chair

Referred to: Reference Committee G
(Rodney Trytko, MD, Chair)

1 At the 2018 Annual Meeting, the House of Delegates referred Resolution 704-A-18, “Non-
2 Payment and Audit Takebacks by CMS,” for report back at the 2019 Annual Meeting. This
3 resolution was introduced by the New York Delegation and asked that:

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5 Our American Medical Association (AMA) seek through legislation and/or regulation policies
6 opposing claim nonpayment due to minor wording or clinically insignificant documentation
7 inconsistencies;

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9 Our AMA seek through legislation and/or regulation policies opposing extrapolation of
10 overpayments based on minor inconsistencies; and

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12 Our AMA seek through legislation and/or regulation policies opposing bundled payment denial
13 based on minor wording or clinically insignificant documentation inconsistencies.

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15 This report discusses the broader concept of medical record documentation, the administrative
16 burden of documentation, and related AMA policy.

17 18 BACKGROUND

19
20 Medical record documentation is required to record pertinent facts, findings, and observations
21 about an individual’s health history, including past and present illnesses, examinations, tests,
22 treatments, and outcomes. The medical record is a chronological reflection of the care of the patient
23 and is an important element contributing to the quality of care.¹ In addition, the medical record
24 documentation serves as evidence of the provision of services, who provided the care, the medical
25 necessity, and the quality of care. The original medical documentation must be filed in the patient’s
26 medical record at that facility. The documentation of medical record can also be used by payers and
27 oversight entities to deny or recoup payment for inadvertent mistakes.

28
29 While Congress, federal agencies, and states have made unprecedented investments in improving
30 oversight and program integrity, significant challenges remain. Efforts to fight health care fraud or
31 identify areas of waste or abuse have a tangible impact on physician practices. To comply with the
32 federal program integrity and documentation requirements, physicians proactively conduct internal
33 audits and adopt compliance programs at their own cost.

34
35 Broad-brush requirements that impose burdens on all physicians, rather than focusing on those
36 providers who have demonstrated a propensity to commit fraud or abuse, inequitably affect

1 physicians and providers who are good actors, and result in unnecessary costs to the health care
2 system. This fact is especially true in pre- and post-payment review. The number of reviews and
3 types of reviewers are confusing, add unwarranted physician burden and unnecessary costs, and
4 disrupt and distract from delivering patient-centered care.² Furthermore, some contractors audit and
5 attempt to recoup against services that Medicare does not require, do not adhere to CMS
6 requirements surrounding the approval of Local Coverage Determinations (LCD), or are for minor,
7 clinically insignificant errors.

8

9 The regulatory burden placed on physicians is also a major component of physician burnout.
10 Physicians often must spend too much of their time on administrative tasks rather than providing
11 care to patients. The evolving health care system needs easier enrollment, more rational program
12 integrity rules, and fewer reporting requirements.

13

14 RELATED POLICIES

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16 Our AMA has extensive policy opposing the imposition of inappropriate actions for minor
17 documentation errors by the federal government and private payers. Physicians must be protected
18 from allegations of fraud, waste and abuse, and penalties and sanctions due to the differences in
19 interpretation and or inadvertent errors in coding.³ Moreover, AMA policy directs our AMA to
20 oppose efforts to punish or harass physicians for unintentional errors in Medicare claims
21 submissions and the legitimate exercise of professional judgment in determining medically
22 necessary services.⁴

23

24 AMA policy also already directs our AMA to pursue legislative, regulatory, or other avenues to
25 eliminate fines for inadvertent Medicare billing errors⁵ and to remove a physician from a potential
26 review if there is proof that the error is only related to a clerical mistake.⁶ It is also AMA policy
27 that insufficient documentation or inadvertent errors in the patient record do not constitute fraud or
28 abuse⁷ and that there should be no medical documentation requirements for the inclusion of any
29 items unrelated to the care provided.⁸ Furthermore, our AMA policy supports the elimination or
30 improvement on the use of extrapolation in Medicare post-payment audits⁹ including RAC audits.¹⁰

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32 DISCUSSION

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34 Our AMA has strong existing policy (see appendix) regarding the opposing of claim nonpayment
35 for inadvertent, unintentional, or clerical errors. Our AMA is already working with the federal
36 government to reduce administrative burden through regulatory relief efforts including areas
37 involving inadvertent, unintentional, or clerical errors in documentation. Moreover, our AMA has
38 stated multiple times that unnecessary administrative tasks undercut the patient-physician
39 relationship.¹¹ For example, studies have documented lower patient satisfaction when physicians
40 spend more time looking at the computer and performing clerical tasks.¹² Moreover, for every hour
41 of face-to-face time with patients, physicians spend nearly two additional hours on administrative
42 tasks throughout the day.¹³ The increase in administrative tasks is unsustainable, diverts time and
43 focus away from patient care, and leads to additional stress and burnout among physicians.
44 Furthermore, our AMA has already stated that CMS should review sub-regulatory guidelines,
45 which create additional burdens on physicians, and reduce the number of sub-regulatory guidance
46 documents that are issued.

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48 While our AMA has policies, and has taken action in regard to inadvertent errors, the Board of
49 Trustees believes that AMA policy could be more specific in addressing the concerns surrounding
50 minor wording errors or clinically insignificant inconsistencies and their relationship to potential
51 nonpayment, extrapolation of overpayments, and bundled payment denials. Although the original

1 resolves of Resolution 704-A-18 call for our AMA to “seek through legislation and/or regulation,”
2 the Board of Trustees believes that our AMA should have flexibility in addressing this issue and
3 not be required to only seek reform through legislation or regulation. Instead, in addition to these
4 avenues, our AMA should also be seeking reform through sub-regulatory guidance and other payer
5 policies.

6
7 Our AMA believes that eliminating and/or streamlining reporting, monitoring, and documentation
8 requirements will improve the health care delivery system and make the health care system more
9 effective, simple, and accessible. By reducing administrative burden, CMS can support the patient-
10 physician relationship and allow physicians to focus on an individual patient’s welfare and, more
11 broadly, on protecting public health.

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13 RECOMMENDATION:

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15 The Board of Trustees recommends that the following recommendation be adopted in lieu of
16 Resolution 704-A-18 and the remainder of the report be filed:

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18 That our American Medical Association advocate to oppose claim nonpayment, extrapolation
19 of overpayments, and bundled payment denials based on minor wording or clinically
20 insignificant documentation inconsistencies. (New HOD Policy)

Fiscal Note: Less than \$500

REFERENCES

¹ E.g., CMS, *Medicare Learning Network Fact Sheet: Complying with Medical Record Documentation Requirements*, (2017), <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/CERTMedRecDoc-FactSheet-ICN909160.pdf>; MSSNY, *Basics of E/M Coding: A Handbook for Physician Offices* (2009),

https://www.mssny.org/Documents/2016/Practice%20Resources/Coding_Handbook.doc_6-16-09-Revised_8-14-09-add.pdf.

² Physicians face pre-payment and postpayment scrutiny from a variety of government entities and contractors including CMS, Medicare Administrative Contractors (MAC), Recovery Audit Contractors (RAC), Unified Program Integrity Contractors (UPIC) (combining program safeguard, zone program integrity, and Medicaid integrity contractors), Quality Improvement Organizations (QIO), Comprehensive Error Rate Testing (CERT), and Supplemental Medical Review Contractors (SMRC).

³ Fraud and Abuse Within the Medicare System, (H-175.981).

⁴ Kennedy-Kassebaum: Fraud and Abuse, H-175.985.

⁵ Due Process for Physicians, H-175.982.

⁶ Expedited Review for Clerical Errors on Medicare Enrollment Applications, D-330.905.

⁷ Medicare Guidelines for Evaluation and Management Codes, H-70.952.

⁸ *Id.*

⁹ Medicare Prepayment and Postpayment Audits, H-330.921; Medical Office Screens, H-335.981.

¹⁰ Creating a Fair and Balanced Medicare and Medicaid RAC Program D-320.991.

¹¹ E.g., AMA Letter to CMS, *Medicare and Medicaid Programs: Regulatory Provisions To Promote Program Efficiency, Transparency, and Burden Reduction* (CMS-3346-P) (Nov. 19, 2018).

¹² Street RL et al., Provider Interaction with the Electronic Health Record: The Effects on Patient-Centered Communication in Medical Encounters. Patient Educ. Couns., 2014; Kazmi Z, Effects of Exam Room EHR Use on Doctor-Patient Communication: A Systematic Literature Review. Inform Prim Care, 2013; Farber NJ et al., EHR Use and Patient Satisfaction: What We Learned. J Fam Pract 2015.

¹³ Colligan L, Sinsky C, Goeders L, Schmidt-Bowman M, Tutty M. *Sources of physician satisfaction and dissatisfaction and review of administrative tasks in ambulatory practice: A qualitative analysis of physician and staff interviews*, Oct. 2016.

APPENDIX: AMA POLICIES

Policy H-175.981, “Fraud and Abuse Within the Medicare System”

(1) Our AMA stands firmly committed to eradicate true fraud and abuse from within the Medicare system. Furthermore, the AMA calls upon the DOJ, OIG, and CMS to establish truly effective working relationships where the AMA can effectively assist in identifying, policing, and deterring true fraud and abuse.

(2) Physicians must be protected from allegations of fraud and abuse and criminal and civil penalties and/or sanctions due to differences in interpretation and or inadvertent errors in coding of the E&M documentation guidelines by public or private payers or law enforcement agencies.

(3) The burden of proof for proving fraud and abuse should rest with the government at all times.

(4) Congressional action should be sought to enact a "knowing and willful" standard in the law for civil fraud and abuse penalties as it already applies to criminal fraud and abuse penalties with regard to coding and billing errors and insufficient documentation.

(5) Physicians must be accorded the same due process protections under the Medicare audit system or Department of Justice investigations, that are afforded all US citizens.

Sub. Res. 801, A-98 Reaffirmed: Res. 804, I-98 Reaffirmed: BOT Rep. 6, A-00 Reaffirmation I-01 Modified: CMS Rep. 7, A-11

Policy H-175.982, “Due Process for Physicians”

It is the policy of the AMA to review current legislation governing fraud and abuse investigations and propose additional legislation and/or regulations as necessary and be prepared to take legal action in order to assure physicians due process in the conduct of fraud and abuse investigations. Our AMA requests the United States Department of Justice to establish a specific procedure for audit of a physician's office records which includes, but is not limited to, the following:

(1) Patient care in the physician's office must not be interrupted during the course of the audit;

(2) Patient ingress and egress must not be hindered during the course of an audit;

(3) Normal telephonic communication must not be interrupted during the course of an audit; and

(4) Normal routine of physician's care of patients in hospital or at home must not be interrupted.

AMA policy is to pursue legislative, regulatory or other avenues to eliminate fines for inadvertent Medicare billing errors.

Sub. Res. 229, I-97 Reaffirmation A-99 Reaffirmation I-00 Reaffirmation I-01 Reaffirmed: Res. 12, A-06 Reaffirmation I-07 Reaffirmed: BOT Rep. 22, A-17

Policy H-175.985, “Kennedy-Kassebaum: Fraud and Abuse”

Our AMA: (1) will work to alleviate the oppressive, burdensome effects on physicians of the Health Insurance Portability and Accountability Act of 1996 (HIPAA);

(2) opposes efforts to repeal provisions in Health Insurance Portability and Accountability Act of 1996 (HIPAA) that would alter the standard of proof in criminal and civil fraud cases or that would eliminate the ability of physicians to obtain advisory opinions regarding anti-kickback issues; and thoroughly evaluate and oppose other fraud and abuse proposals that are inappropriately punitive to physicians;

(3) will ensure that any proposed criminal fraud and abuse proposals retain the current intent standard of "willfully and knowingly" to be actionable fraud; and that the AMA oppose any effort to lower this evidentiary standard;

(4) will vigorously oppose efforts by the Department of Justice to punish and harass physicians for unintentional errors in Medicare claims submissions and the legitimate exercise of professional judgment in determining medically necessary services;

(5) continues its efforts to educate the entire Federation about the AMA's successful amendment of the Health Insurance Portability and Accountability Act (also commonly referred to as the Kassebaum-Kennedy bill) which resulted in language being added so that physicians cannot be

prosecuted or fined for inadvertent billing errors, absent an intent to "knowingly and willfully" defraud;

(6) educates the public and government officials about the distinction under the law, between inadvertent billing errors and fraud and abuse; and

(7) responds vigorously to any public statements that fail to distinguish between inadvertent billing errors and fraud and abuse.

Sub. Res. 222, A-97 Appended: Res. 202, I-98 Reaffirmation A-99 Reaffirmation A-01
Reaffirmation I-01 Reaffirmation A-02 Reaffirmed: BOT Rep. 19, A-12

Policy H-175.979, "Medicare "Fraud and Abuse" Update"

Our AMA seeks congressional intervention to halt abusive practices by the federal government and refocus enforcement activities on traditional definitions of fraud rather than inadvertent billing errors.

BOT Rep. 34, I-98 Reaffirmation A-99 Reaffirmation A-00 Reaffirmation I-00 Reaffirmation I-01
Reaffirmed: BOT Rep. 22, A-11

Policy H-70.952, "Medicare Guidelines for Evaluation and Management Codes"

Our AMA (1) seeks Federal regulatory changes to reduce the burden of documentation for evaluation and management services;

(2) will use all available means, including development of new Federal legislation and/or legal measures, if necessary, to ensure appropriate safeguards for physicians, so that insufficient documentation or inadvertent errors in the patient record, that does not meet evaluation and management coding guidelines in and of itself, does not constitute fraud or abuse;

(3) urges CMS to adequately fund Medicare Carrier distribution of any documentation guidelines and provide funding to Carriers to sponsor educational efforts for physicians;

(4) will work to ensure that the additional expense and time involved in complying with documentation requirements be appropriately reflected in the Resource Based Relative Value Scale (RBRVS);

(5) will facilitate review and corrective action regarding the excessive content of the evaluation and management documentation guidelines in collaboration with the national medical specialty societies and to work to suspend implementation of all single system examination guidelines until approved by the national medical specialty societies affected by such guidelines,

(6) continues to advise and educate physicians about the guidelines, any revisions, and their implementation by CMS,

(7) urges CMS to establish a test period in a specific geographic region for these new guidelines to determine any effect their implementation will have on quality patient care, cost effectiveness and efficiency of delivery prior to enforcement of these mandated regulations;

(8) opposes adoption of the Medicare evaluation and management documentation guidelines for inclusion in the CPT; and

(9) AMA policy is that in medical documentation the inclusion of any items unrelated to the care provided (e.g., irrelevant negatives) not be required.

Sub. Res. 801, I-97 Reaffirmation I-00 Reaffirmed: CMS Rep. 6, A-10

Policy D-330.905, "Expedited Review for Clerical Errors on Medicare Enrollment Applications"

1. Our AMA will urge the Centers for Medicare and Medicaid Services (CMS) to create an expedited process to review minor clerical errors on enrollment applications that result in CMS deactivating the physician's billing privileges.

2. Our AMA will urge CMS to remove a physician from a potential fraud and abuse review if there is proof that the error is only related to a clerical mistake.

3. Our AMA will urge CMS to create a process that not only reactivates a physician's billing privileges but also retroactively applies the effective date to the initial date when the minor clerical error occurred and applies no penalty to payments due for care provided to Medicare beneficiaries during this time frame.

Res. 222, A-16

Policy D-320.991, "Creating a Fair and Balanced Medicare and Medicaid RAC Program"

1. Our AMA will continue to monitor Medicare and Medicaid Recovery Audit Contractor (RAC) practices and recovery statistics and continue to encourage the Centers for Medicare and Medicaid Services (CMS) to adopt new regulations which will impose penalties against RACs for abusive practices.

2. Our AMA will continue to encourage CMS to adopt new regulations which require physician review of all medical necessity cases in post-payment audits, as medical necessity is quintessentially a physician determination and judgment.

3. Our AMA will assist states by providing recommendations regarding state implementation of Medicaid RAC rules and regulations in order to lessen confusion among physicians and to ensure that states properly balance the interest in overpayment and underpayment audit corrections for Recovery Contractors.

4. Our AMA will petition CMS to amend CMS' rules governing the use of extrapolation in the RAC audit process, so that the amended CMS rules conform to Section 1893 of the Social Security Act Subsection (f) (3) - Limitation on Use of Extrapolation; and insists that the amended rules state that when an 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 (as per Section 1893 of the Social Security Act) the Secretary of Health and Human Services has already determined, before the RAC audit, either that (a) previous, routine pre- or post-payment audits of the physician's claims by the Medicare Administrative Contractor have found a sustained or high level of previous payment errors, or that (b) documented educational intervention has failed to correct those payment errors.

5. Our AMA, in coordination with other stakeholders such as the American Hospital Association, will seek to influence Congress to eliminate the current RAC system and ask CMS to consolidate its audit systems into a more balanced, transparent, and fair system, which does not increase administrative burdens on physicians.

6. Our AMA will: (A) seek to influence CMS and Congress to require that a physician, and not a lower level provider, review and approve any RAC claim against physicians or physician-decision making, (B) seek to influence CMS and Congress to allow physicians to be paid any denied claim if appropriate services are rendered, and (C) seek the enactment of fines, penalties and the recovery of costs incurred in defending against RACs whenever an appeal against them is won in order to discourage inappropriate and illegitimate audit work by RACs.

7. Our AMA will advocate for penalties and interest to be imposed on the auditor and payable to the physician when a RAC audit or appeal for a claim has been found in favor of the physician.

Citation: Res. 215, I-11; Appended: Res. 209, A-13; Appended: Res. 229, A-13; Appended: Res. 216, I13; Reaffirmed: Res. 223, I-13