Statement

of the

American Medical Association

to the

Practicing Physicians Advisory Council

RE: Recovery audit contractors/
inappropriate admissions
Risk adjustment review
Physician resource use reports

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The American Medical Association (AMA) appreciates the opportunity to submit this statement to the Practicing Physicians Advisory Council (PPAC) concerning recovery audit contractors/inappropriate admissions, Medicare Advantage risk adjustment review, and physician resource use reports.

RECOVERY AUDIT CONTRACTORS/INAPPROPRIATE ADMISSIONS

Under the Recovery Audit Contractor (RAC) pilot, many hospital recoupments were the result of RAC determinations of "inappropriate admissions" that were based on screening criteria in proprietary databases, such as the Interqual software. Similarly, contractors have been using these systems to deny claims. In an attempt to avoid denials and recoupments, hospitals have increasingly been employing these same proprietary databases, and preemptively editing and down-coding claims. There are several problems with this practice and with the databases themselves.

We have significant concerns with the use of these proprietary databases to make automatic edits and down codes. Based upon these database edits, hospitals have been changing patients' status from "admitted" to "observation," often times without the admitting physician's knowledge or input. Similarly, some hospitals have elected not to bill for certain inpatient services at all, or have billed inpatient services as outpatient. Not only are these changes often inappropriate, but they can have serious negative consequences for both physicians and patients. For physicians who are not informed of status changes, there is the distinct possibility that their claims could be denied and/or the subject of a future audit either because their Part B place of service does not match that claimed by the hospital, or where the hospital opts not to bill Medicare, there is simply no link with any Part A service. For patients, a reclassification from "admitted" to "observation" can result in unanticipated patient co-payments, and in the case of skilled nursing facilities, which require a prior three-day hospital admission, a significant financial burden. **We believe that when hospitals make reclassifications based on screening criteria in proprietary databases, both the admitting physicians and the patients must be immediately notified. In addition, we believe that RACs should be precluded from making recoupments associated with "inappropriate admissions" and/or discrepancies between the hospital and physician's site of service. We urge PPAC to make these recommendations to CMS.**

In addition to being concerned about how these data systems are being used, we remain concerned about the actual software and the data it employs. We believe the criteria being used by these proprietary databases is in some cases flawed. In addition, the software does not allow for circumstances that require that an admitting physician use his or her medical judgment, and perhaps most troubling, it provides no transparency into how or why edits are being made.

We believe that these data programs must be based upon accurate and supportable data sources that have been developed with physician input**.** Currently, this is not the case. For example**,** according to the Society for Cardiovascular Angiography and Interventions (SCAI), in 2007, the current standard of care for a patient who has undergone an uncomplicated elective Percutaneous Coronary Intervention (PCI) is an overnight stay in the

facility in which the PCI was performed. The Interqual data program, however, dictates that all elective patients have to be treated as outpatients. While PCI has become safer, the randomized clinical trials defining level of care and length of stay for patients following PCI are limited and the majority of them have been conducted outside the United States and therefore reflect differing practice patterns. **Thus, we believe it is essential that physicians are intimately involved in the development of the data being used by these proprietary databases, and we urge PPAC to make this recommendation to CMS.**

In addition, these programs must provide for consideration and evaluation of a physician's medical judgment should it be in conflict with the software. Currently, in an effort to avoid denials and audits, hospitals simply default to the screening criteria in the proprietary databases and as a result make reclassifications and status changes that impact physician billing and patient costs. Although hospitals must get a physician to sign off on the change, the physician need not be the same one who admitted the patient. This is not appropriate. Instead, hospitals should confer with the admitting physician and then defer to the physician's judgment on whether an admission is justified with some confidence that contractors and auditors will individually review physician decisions that differ from the data program results. **Thus, there must be a process whereby the admitting physician is consulted and can override the software program with his or her medical judgment with some assurance that contractors and auditors will ensure that the judgment is considered and evaluated by physicians in the same geographic area and specialty. We urge PPAC to make this recommendation to CMS.**

Finally, any software used to detect and reduce payments should be completely transparent. Such transparency will promote accountability, clarity, and consistency. Everyone involved in medical decision making and payment should have access to the clinical criteria being used to review claims. It is crucial that physicians know exactly why claims are being denied or audited and what those decisions are being based upon. **We recommend that PPAC urge CMS to ensure that the evidence underlying these data programs and the processes being employed are completely transparent. This is the only way to ensure collaboration, trust, and the best possible patient care.**

MEDICARE ADVANTAGE RISK ADJUSTMENT REVIEW

In it 2010 Call Letter to Medicare Advantage (MA) plan sponsors, the Centers for Medicare and Medicaid Services (CMS) indicated that beginning in 2010 the agency will conduct "more targeted, data-driven and risk-based audits," instead of focusing on routine plan audits. To conduct these more focused audits, CMS plans to use existing data to create "performance profiles" of MA plan sponsors and to identify poorly performing plans. The audits will also focus on what CMS considers the highest risk areas for beneficiary harm (*e.g.*, enrollment operations, appeals, and grievances). The AMA generally supports these provisions, which will ensure greater oversight and accountability.

As part of its new audit strategy, CMS may require MA plan sponsors to perform self-audits and report the results back to CMS. In addition, plan sponsors will be required in 2010 to audit the data that they are required to report to CMS, using audit technical specifications

that CMS has indicated it will publish in late 2009. The AMA generally supports this requirement.

In brief, the AMA supports audits to ensure MA plans are in compliance with all federal requirements. Over the past year, however, physician offices have made numerous complaints to the AMA about extremely burdensome audits of their patients' charts that are conducted by MA plans. The number of claim record requests have skyrocketed. One cardiology practice was sent a letter asking for over 750 charts. In another case, United Healthcare's Secure Horizons MA plan contracted with a company called "The Coding Source" which requested a Texas medical group with eight physicians for 2,359 charts. The Coding Source acknowledged that the request involved "a large amount of charts" and that a review would take several weeks to complete. The Coding Source indicated that it would be reviewing "all consult notes, progress notes, pathology, radiology, surgical records, and hospital visits." In many cases, the correspondence that MA plans send to physician offices imply that the chart reviews are mandated by CMS. Given the very small percentage of charts that are actually included in CMS-required risk validation audits, it appears that the great majority of the chart reviews that are the subject of these complaints are self-initiated by the plans and not required by CMS. The correspondence is misleading in this respect. In addition, it appears that the purpose of the audits is less to assure compliance with MA regulatory requirements and more of a fishing expedition to find data that would support increased risk scores and attendant increased payments to the plan. Finally, many MA organizations utilize third parties to obtain the information from medical practices and in some cases the physician office has no idea what plan is doing the audit.

Accordingly, the AMA urges PPAC to recommend that CMS prohibit MA organizations from explicitly stating or implying in their communications and correspondence with physicians that they are obligated to submit to large scale medical chart reviews as part of a CMS regulatory oversight and payment requirement when that is not in fact the case. PPAC should recommend that the agency require MA organizations to clearly distinguish between requests that are prompted by Medicare regulatory requirements and those that are designed to secure additional payment and reimbursement for the plan.

In addition, the AMA strongly urges PPAC to recommend that CMS take into account the potential impacts of more aggressive program integrity efforts on the medical practices that provide care to the plan's subscribers.

Finally, the AMA urges PPAC to recommend that to the extent these medical chart reviews continue, that at a minimum:

- **Office staff time required to pull, review, copy, and re-file medical records should be compensated.**
- **Methods should be employed to ensure that physicians can identify the entity that is requesting information, the reason for the request, and the reason for any deadline that is given for responding to the request.**

- **The same practices are not required to comply with audit demands from a multitude of plans.**

PHYSICIAN RESOURCE USE REPORTS

CMS is currently in the process of implementing the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) provision requiring confidential feedback reports to physicians on their resource utilization.

The AMA appreciates that CMS is implementing this program on a phased-in basis and has reached out for physician input on several occasions. We agree with a recommendation from the Medicare Payment Advisory Commission that rather than relying on proprietary episode grouper software to develop the reports, Medicare should ultimately use software that is in the public domain. We are pleased that CMS made a sample feedback report available for review and sought initial input from the medical community at a recent meeting with the AMA and the medical specialty societies. We look forward to continuing to work with CMS to provide recommendations for further refining these reports to achieve actionable and meaningful results that educate physicians about any needed corrections in practice patterns.

The AMA appreciates the opportunity to comment on the foregoing, and we look forward to continuing to work with PPAC and CMS to resolve these important matters.