

**American Urological Association
Comments for August 27, 2007 PPAC Meeting**

Thank you for the opportunity to address comments to the PPAC regarding the CMS Recovery Audit Contractor (RAC) program and the recent negative experience of our California urologists. We have included the specific comments of Dr. Jeffery Kaufman, a California urologist who serves as the urology representative to the NHIC Carrier Advisory Committee, is the immediate past president of the American Association of Clinical Urologists and who currently serves as Chair of the Health Policy Committee, Western Section, for the AUA.

We have summarized the major concerns of our California members below:

- Notification Letters sent to Providers Confusing and Inefficient
- HIPAA violation with Contractor requesting patient records from wrong practice
- Contractor went two years beyond Scope of Work with no immediate response or resolution of this major concern.
- Length of time to file appeal too short

As CMS is planning to expand the RAC program to all fifty states, we feel that it is crucial that CMS and the PPAC be made fully aware of what we view as egregious and illegitimate practices by PRG Schultz, the California RAC contractor. Further, we are extremely concerned that the current process does not appear to allow for quick resolution of issues with a RAC contractor. Therefore, we strongly recommend that CMS create a formal communication process where state and national medical associations would be able to notify CMS and receive a quick resolution to concerns. We deeply appreciate the time and effort expended on these issues by Melanie Combs and Dr. William Rogers.

Notification Letters sent to Providers Confusing and Inefficient

“As you know, of the three state RAC auditors, the only for-profit agent is PRG Schultz, the contractor for California who is paid a bounty for every dollar collected through the recovery program. Physicians in California have found dealing with this company difficult making the RAC process very onerous. Our initial experience regarded letters requesting medical records that vaguely suggested that the contractor already had some reason to believe we had charged or collected incorrectly for our services.

However, the issue in question was never specified in the request letters nor was it clear what or how much supporting material would be necessary to submit for review to support our claims. In fact, the contractor had no idea at all when the request letters were mailed that the records requested might not support claims made up to 4 years earlier. Fulfilling these requests for records of patients who may have already expired or have not been seen for years can be very time consuming and compliance has taken a great deal of effort by office staff.

Nor is this the only example of the staff time and overhead necessary to comply with RAC requests. Many offices are receiving multiple letters for patients reaching back 4 years and more. Some medical oncology offices in California have received such requests in batches of 50-100 at a time and in waves. Not only is this placing an inordinate (and non-reimbursed)

demand on staff time but some offices have received multiple different requests for the same patient but for different dates of service which requires the office staff to go back to the same record over and over. We have asked PRG Schultz Vice President William Davis (who visited the NHIC Carrier Advisory Committee in person to hear our complaints and concerns April 18, 2007) to modify some of these abusive situations but little has been done so far. The committee asked that the number of records requests made of offices be limited to lessen the onerous work necessary to comply.

We have asked that, if multiple requests are made on a given patient for different dates of service, that they be bundled together to lessen the office staff's work allowing them to reply more efficiently. We have asked them to modify their letters requesting records to make them less threatening and to provide more information about what aspect of the patient's care is being reviewed to allow the office to supply all that is necessary for their nurses to adequately assess the care given. And we have asked that they have reviews performed by a physician competent and knowledgeable in the areas of medicine that are being reviewed. Finally, we have also asked that any repayment demands be accompanied by an explanation in order to understand their criticism and sufficient information to allow the physician to appeal if appropriate. Little or none of these changes have been made to date. The continued demand for records has been painful at best but at times, has become a crushing burden even while unjustified. Little has been demonstrated so far that the areas investigated are problem prone or the offices targeted have been found out of compliance with Medicare rules.

HIPAA violation with Contractor requesting patient records from wrong practice

In at least one case, a urology office received several requests on different dates for patients they had never seen, billed for nor collected payment on. Of course, this necessitated a thorough review of their records to determine that the patients were not theirs, taking valuable time away from patient care and increasing overhead costs. I have already notified Melanie Combs of this case and sent supporting documentation. Not only did this waste time in the office that received the letters but it violated HIPAA by divulging protected medical information to individuals who had no right to that information. And the targeted office is further upset at having to make several phone calls to correct the demands for repayment that otherwise would have been withheld from future Medicare payments based on the RAC's mistaken belief that the office had incorrectly been paid.

Contractor went two years beyond Scope of Work with no immediate response or resolution of this major concern.

Another major criticism came to light this past month when PRG Schultz began mailing demands to California urologists and medical oncologists for repayment of claims settled in 2002 and early 2003 for LHRH drug injections provided to men with prostate cancer. Despite ongoing discussions at that time between the state's Medicare carrier NHIC and representatives of those medical specialties responsible for treating prostate cancer that led to an understanding on how claims were paid, the RAC contractor unilaterally went back and recalculated payments by unilaterally imposing the least costly alternative policy in a fashion different from what had been used 4-5 years ago. At the time in question, discussions were ongoing about which drugs to use in calculating the least costly and when and how to apply the policy. PRG Schultz re-priced claims based on the published LMRP at that time without consideration of those discussions and

what was generally understood by all involved. They claimed physicians were responsible for knowing the policy (as they interpreted it) even though all doctors involved at that time did, in fact, understand the policy as it stood and were satisfied that payments were correct.

More importantly, the RAC Statement of Work limits look back on claims to 4 years from the first letter of demand. And yet, PRG Schultz has gone back well before that date to review claims that should have been denied to them by statute. For the demand letters dated July 2007, the claims in question date from early 2002 through mid 2003. After investigating the published Statement of Work and contacting both CMS and our state carrier NHIC, those demands for the interval preceding the 4 year cut off have now been adjusted. But this did not occur before physicians all over the state spent a great deal of time, effort and money either repaying CMS, pulling old records for review or filing appeals. None of this should have been necessary if the contractor had openly discussed the issue first or limited themselves to that interval allowed them under the RAC regulations.

Furthermore, a careful reading of the RAC Statement of Work draws a clear distinction between “automated audits” that may be performed by computer and “complex audits” that demand a human review. Based on the definitions and examples provided in the Statement of Work, it is clear that the issue of pricing LHRH agonist drugs for prostate cancer patients would require a complex review before determining whether the doctor had complied with the written policy or not. Since none of the PRG Schultz demands were based on records review, their entire recoupment effort would appear to be illegitimate.

Length of time to file appeal too short

Our ability to appeal these demands was impaired since the contractor routinely mailed their letters (determined by postmark) 6 days after the letter was dated causing it to be received 11 days after the letter date. Since the time to pull and review the records and file an appeal was determined by the letter’s date, physicians were routinely shorted on their appeal rights (I have notified Ms. Combs of this issue as well and forwarded copies of the materials in question). In fact, in some cases, the only notification received by physicians that the contractor had re-priced claims from 4-5 years earlier was an Explanation of Benefits with no other letter of explanation. Obviously, this made filing an appeal challenging.

Our California experience with the Recovery Audit Contractor program and with our state’s contractor PRG Schultz has been very negative. The non-reimbursed burden necessary to comply with multiple repeated records requests is siphoning time and resources away from patient care. The heavy handed demands for repayment of hundreds of thousands of dollars that were properly reimbursed in the first place have had physicians in turmoil. The contractor has repeatedly failed to respond to phone calls from physicians, to suggestions that they modify their request letters to be more informative and useful or to utilize reviewers who are competent in the areas of medicine under review. And, in the end, the money legitimately recouped through this RAC program from physicians has amounted to a very small percentage of total repayments. In their previous presentation to CMS, the RAC bundled returns from labs, ambulances and physicians together totaling no more than 6% of the total. I would submit that this small amount does not warrant the aggravation, anger and burden borne by physicians targeted by these

contractors. Certainly, mistakes have been made in billing and paying for Medicare claims. And there is no denying that some involved in the program have been guilty of fraud and abuse. However, this blanket investigation of physicians who have provided care to Medicare patients in good faith only to be investigated in some Kafka-esque fashion 4 or 5 years later is unsupportable. Unfortunately, as you know, Congress has now provided for the program to go national beginning next year. I would ask the PPAC to consider the RAC experience so far and condemn future operations or at least recommend that physicians be removed from the purview of the RAC program. Any help you can provide to ameliorate the burden this project places on physicians is deeply appreciated. Otherwise, going forward, the RAC is likely to engender a great deal of mistrust and ill-feeling between physicians and the Medicare program.

Thank you for the opportunity to place these comments before the PPAC. Please do not hesitate to contact my office now or in the future if I can offer any other input.

Sincerely Yours,

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