National Committee on Vital and Health Statistics
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TESTIMONY BY THE AMERICAN MEDICAL ASSOCIATION

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Standardized Forms for Audits

The American Medical Association (AMA) would like to thank the National Committee on Vital and Health Statistics (NCVHS) for the opportunity to testify on standardized forms for audits. The AMA has worked on the issue of standardized audit forms in the context of both the public health programs and private health plans, and is pleased to share our recommendations with you.

Public Health Programs

The AMA has extensive experience with the myriad audits of the federal health care programs. We believe that a discussion of the Medicare & Medicaid Recovery Audit Contractors' (RAC) and Medicare Advantage (MA) plans' use of standardized forms would productively inform the NVCHS' work.

Medicare & Medicaid RAC Standardized Forms

During the Medicare RAC demonstration program, physicians reported audit forms that were confusing and unnecessarily blunt. The lack of information relayed by the forms frustrated physicians and did not further the goal of the program: the education of physicians regarding common billing mistakes.[1] Physicians were particularly confused when the RACs sent communications without the CMS logo, causing doubt as to their origin or authenticity.

These reports prompted the AMA to ask CMS to require standardized forms for RAC audits. Specifically, the AMA requested that CMS require the RACS to provide an explanation in the audit notification letter of their identity and authority, and to reference CMS-issued educational materials explaining the RAC program. The AMA also urged CMS to require the RACs to use the CMS logo on all written communications to physicians.

Following the Medicare RAC demonstration program, CMS set requirements for Medicare RAC medical record requests and demand letters in the permanent RAC program. Medical records request must now "adequately describe the good cause for reopening the claim" and must notify the provider about the existence of the RAC "address customization system".[2]

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[1] Statement of the American Medical Association to the Practicing Physicians Advisory Council regarding Physician Quality Initiatives. Presented by John H. Armstrong, MD. March 6, 2006. See http://www.ama-assn.org/resources/doc/washington/rac-testimony-06march2006.pdf

[2] Recovery Audit Contractor Statement of Work. September 1, 2011. See https://www.cms.gov/Recovery-Audit-Program/Downloads/090111RACFinSOW.pdf

The requirements for demand letters under the RAC program are more comprehensive: letters must comply with requirements specified in the Medicare Financial Management Manual ("the Manual"), Chapter 4, Section 90 (unless specifically excluded in the RAC Statement of Work). CMS is required to approve sample demand letters before they are sent.[3] The Manual provides a sample demand letter.[4] Medicare RACs must also include the appropriate Recovery Auditor name and contact information in all demand letters associated with Recovery Auditor identified improper payments.[5]

Most recently, the AMA advocated for standardized audit forms in the context of the Medicaid RAC program. With the myriad of auditing contractors and agencies operating at the state level, the AMA asserted that some degree of uniformity was required to allow physicians to identify Medicaid RAC audits as such. The AMA requested that CMS require Medicaid RAC demand letters to include, at a minimum, patient identifier information, the date of the service in question, and the amount of alleged overpayment. Further, the AMA requested that all demand letters carry the state/Medicaid logo to ensure physicians understand that the letters come from a trusted source.

CMS did not adopt a standardized medical record request or demand letter in the Medicaid RAC program final rule, and has left this determination to the States.[6] While many States are still in the process of developing their Medicaid RAC programs, some States have already contractually required that Medicaid RACs send standardized correspondence approved by the State.

Medicare Advantage Plans Standardized Forms

We have asked CMS to require Medicare Advantage (MA) organizations to standardize audit forms including standard notices to ensure that physicians can identify the entity that is requesting information, the reason for the request, the actual records required, and the rationale for the deadline.

The AMA has expressed its concern to CMS that current MA practices are confusing and misleading including communications regarding MA organization audits of patients' charts conducted by or on behalf of MA organizations for purposes of enhanced risk adjustment. Throughout the course of MA plan audits, physicians are often asked—without compensation—to pull disproportionately large numbers of patient charts, copy records covering long periods of time, and send these materials to plans with unrealistic deadlines. Often, due to CMS' requirement for the one best record to document a patient's risk level, the same practices are audited repeatedly, essentially being punished for their accurate documentation practices. Further, the correspondence that MA organizations send to physician offices often implies that the chart reviews are mandated by CMS. Given the very small percentage of MA beneficiaries that have actually been included in CMS-required audits of MA organizations, it appears that the great majority of the chart reviews that are the subject of these complaints have been self initiated by the organizations, not required by CMS. In addition, it appears that the purpose of the audits

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[3] Id.
[4] Medicare Financial Management Manual. Chapter 4 – Debt Collection. See http://www.cms.gov/manuals/downloads/fin106c04.pdf
[5] Transmittal 192 – RAC Issued Demand Letters. See http://www.cms.gov/Transmittals/downloads/R192FM.pdf. See also Recovery Audit Contractor Statement of Work. September 1, 2011, and https://www.cms.gov/Recovery-Audit-Program/Downloads/090111RACFinSOW.pdf
[6] Medicaid RAC Final Rule. See http://www.gpo.gov/fdsys/pkg/FR-2011-09-16/html/2011-23695.htm

have been less to ensure 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 organization. The AMA continues to urge that a standard audit for risk adjustment should exclude auditing records that precede a beneficiary's enrollment in the particular plan that is conducting the audit. Whatever health services were provided to patients before they joined the plan were covered by the patient's previous plan. Adjustments to plans' risk scores should reflect patients getting sicker than they were when they came in, not documenting things that occurred before they ever joined the plan. Finally, many MA organizations utilize third parties to obtain the information from medical practices and the physician office has no idea what organization is doing the audit.

The AMA has asked CMS to 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 CMS regulatory oversight when that is not in fact the case. We have urged CMS to require that auditing entities clearly distinguish between records requests by a Medicare FFS RAC, those that are prompted by a Medicare Part C RAC demand, and those that are initiated by the MA plan itself as part of its general compliance-related activities or to secure additional payment by increasing its risk scores.

Standardized Forms in the Commercial Market

Similar Problems Exist in the Commercial Audit Market

The need for audit standardization is just as great, if not greater, in the commercial market as it is in the context of public health programs such as Medicare. The problematic issues that have been previously identified in this correspondence and that the AMA has endeavored to rectify also exist in the commercial audit market. These problems are, in fact, compounded because the commercial audit market has a dizzying array of players, which include fully-insured health plans, self-insured health plans, and a myriad of third-party contractors that perform audits for such plans and other payers. Aside from the fact that commercial audit forms typically suffer from many of the confusions that have plagued RAC audits, many of these players employ unique audit forms. Additionally, in a manner analogous to the RAC context, third-party commercial auditors frequently fail to identify sufficiently the health plan or other payer on whose behalf the third party is acting. These types of confusions, as well as overly expansive record requests and short record production deadlines, unfairly shift the burden to already overwhelmed physician practices to determine if the request is legitimate and whether the requested disclosure can be made consistent with HIPAA obligations, as well as whether any overpayment recovery request is indeed justified.

The Special Need for Standardization of Forms Concerning Extrapolated Audits

One acute problem in dire need of standardization is commercial auditor's use of extrapolation. Extrapolation is a statistical technique used to estimate overpayment amounts for a set of claims based on a sample of the claims in that set. Extrapolated overpayments may result in demands so significant that refunding the alleged overpayment may threaten a practice's financial viability or even drive the practice into bankruptcy. Because auditors are subject to few, if any, transparency obligations with respect to extrapolation methodologies, it is virtually impossible for a practice, particularly a small practice, to determine the accuracy of extrapolation-based overpayments. Some auditors just expect physician practices to readily pay at least a portion of an overpayment demand, even an overpayment that may be derived from a statistically questionable extrapolation,

simply because the practice will not have access to information necessary to mount a successful challenge.

Employee Retirement Income Security Act Preemption Requires a National Approach

The need for standardization may not be adequately addressed by State law, due to the application of Employee Retirement Income Security Act (ERISA) preemption. Put in its most general terms, ERISA preemption precludes state oversight of some activities performed by self-insured group health plans or third-parties that administer those health plans. At least half of the commercial insurance market operates in this self-insured sector. The scope of ERISA preemption is, in many cases, unclear, and whether or not ERISA preemption precludes the application of standardized audit form requirements in the self-funded sector in any given case would likely be disputed. Because resolving such disputes would be cost-prohibitive for most physicians, having state standards would likely have little practice effect. State standards would, therefore, not produce the same types of efficiencies that national standards could achieve. However, the adoption of a HIPAA standard audit and overpayment request transactions would apply to all payers, thus eliminating any ERISA preemption issue.

Recommendations with Respect to the Commercial Market

The AMA recommends that the NCVHS urge the adoption of standardized audit and overpayment recovery requirements across the entire commercial health plan market. Audit forms should, at a minimum, be required to specify:

(1) the purpose of the audit;
(2) the full legal name and tax identification number (TIN) or the HIPAA National Health Plan Identifier, when available, of the health plan on whose behalf the audit or overpayment request is being made;
(3) the full legal name and TIN of any third party that is performing the audit on behalf of a health plan,
(4) the name of the specific benefit plan to which the audit/overpayment recovery request applies;
(5) the full name, date of birth, and health plan assigned identifier applicable to each patient on whose behalf services which are the subject of the audit or overpayment refund request were performed;
(6) the specific dates of service that are involved in the audit or overpayment refund request;
(7) the CPT codes with respect to which the overpayment was made, or, if no CPT codes are available, a precise description of the services involved in the overpayment;
(8) the date the overpayment was made, how the overpayment was issued to the physician, e.g., by mail or electronically, and the number of the check or electronic funds transfer containing the overpayment;
(9) the health plan assigned identification numbers of the claims that are the subject of the audit or overpayment refund request;
(10) the health plan assigned identification numbers of any remittance advice/explanation of benefits corresponding to any health care items or services and claims that are subject to the audit or overpayment refund request;
(11) the nationally recognized standard(s) or criteria against which claims were audited, which:

(a) with respect to audits concerning Evaluation and Management services, whether the auditor employed the Centers for Medicare and Medicaid Services 1995 or 1997 Documentation Guidelines for Evaluation and Management Services;

(b) with respect to audits concerning the medically necessity of items or services, any national-recognized evidence-based medical standard or consensus-based guidelines and all criteria used to evaluate the quality of items or services.

(12) if the audit form requests records:

(a) the number of records request;
(b) the specific dates of records sought;
(c) how the records were/are to be selected;
(d) the reason why those records are being requested; and
(e) the deadline within which the auditor must receive those records; and

(13) if the audit form requests an overpayment refund:

(a) the amount of the overpayment;
(b) how the auditor calculated the overpayment, including the specific services which are alleged to have been overpaid and the mathematical calculation used to determine the amount of the overpayment demand.
(c) the basis for the allegation that there was an overpayment; and
(d) any other information necessary to enable the physician to independently verify the amount of overpayment; and

(14) if the overpayment exists because another health plan has acknowledged financial responsibility, the full legal name and tax identification number (TIN) or the HIPAA National Health Plan Identifier, when available, of that health plan;
(15) all applicable deadlines and physician appeal rights; including a telephone number or mailing address whereby the physician may submit an appeal; and
(16) the complete text of any and all statutes and regulations applicable to the audit or refund request.

All criteria used per (11)(b) above must be based on nationally-recognized evidence-based medical standards or consensus-based guidelines. Where available, these measures must be endorsed by the National Quality Forum (NQF) or other entities whose work in the area of physician quality performance is generally accepted within the health care industry. If NQF-endorsed measures are not available, these measures must be endorsed by the Ambulatory Care Quality Alliance (AQA) and its accreditors. Professional certification or accreditation may be used in determining physician quality of care, but must not be solely relied upon, as a determinant in evaluating physician quality.

Additionally, if an overpayment demand is based on extrapolation, the audit form must provide information sufficient to enable the physician to determine exactly how the auditor derived the overpayment amount and independently verify the extrapolation's statistical validity. Such information must include:

(1) an identification of each claim comprising the sample upon which the extrapolation is based;
(2) a detailed description concerning how the auditor determined that the sample was, in fact, a random sample;
(3) the average paid amount per claim included in the extrapolation universe, and the average paid amount per claim included within the sample;
(4) complete information concerning both the rank order of procedure codes in the extrapolation universe and the rank order of procedure codes in the sample;

(5) the specific statistical methodology used to perform the extrapolation, including but not limited to, the distribution and point estimate used;
(6) information sufficient to enable the physician to reproduce the data distribution using MS Excel or similar software program;

(7) an identification of both the median and the mean of the data distribution, and information sufficient to enable the physician to independently determine the median and mean;
(8) the confidence interval used;
(9) the extent to which, if at all, claims that have a zero paid amount were included in the extrapolation universe; and
(10) how the extrapolation defined outliers and how outliers were treated under the extrapolation methodology.

The National Managed Care Contract and Database

The National Managed Care Contract (NMCC) and Database is an AMA product that is designed, in part, to help physicians efficiently manage their business relationship with health plans and health plan third-party contractors. The NMCC contains provisions that focus on key topics in that relationship that reflect the most physician-favorable managed care laws and regulations from all 50 states and the District of Columbia, supported by hundreds of legal citations. Article XIV specifically addresses overpayments and underpayments and is attached for the Committee's information as it demonstrates the numerous areas state legislators and regulators have felt compelled to address in this area. The NMCC Database contains all state statutes and regulations governing overpayment refund requests. The Database also contains Issue Brief IX that discusses managed care overpayment issues in detail. The AMA would be pleased to grant the NCVHS access to the NMCC Database or provide any of its content to the NCVHS if the Committee would find it helpful.

<u>Standardization of Audit Forms Would Greatly Benefit Physicians, Payers, and the Delivery System as a Whole</u>

Standardization of audit forms and processes greatly benefits all stakeholders. In order for payers to realize the full benefits of audits, physicians must be able to determine and accept the accuracy of an audit request. This understanding can lead to the desired long term improvement in the practice operations. Helping physicians understand and rectify billing errors is perhaps the most important goal of legitimate audit activity. Physicians will recognize, accept, and correct erroneous billing practices if they are able to see for themselves where mistakes were made. Utilization of standardized audit forms and processes will empower physicians to perform the self-evaluation necessary to accept audit results and make corrections going forward. These corrections will greatly increase practice efficiency and thereby reduce overall delivery system costs.

Audit form standardization also promises to significantly reduce auditors' costs. Processing audit appeals is very costly. Any reduction in appeal frequency is therefore likely to greatly improve administrative efficiency and result in significant savings. A standardized audit form and process will reduce appeal filing frequency in at least two ways. First, physicians who are given sufficient information to evaluate audit validity and understand where they may have erred are much less likely to file appeals. Second, requiring auditors to provide specifics will help them think more clearly about the legitimacy of audit results. More careful thinking about audit result

validity will reduce the likelihood that auditors will present physicians with the kinds of results that physicians view as suspect and that trigger appeals.