December 8, 2014

Marilyn B. Tavenner
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Hubert H. Humphrey Building, Room 445–G
200 Independence Avenue, SW
Washington, DC 20201

Dear Administrator Tavenner:

On behalf of the American College of Emergency Physician's 33,000 members and the Emergency Department Practice Management Association (EDPMA), a trade association representing emergency physician groups and their partners who treat or support about half of the 136 million patient visits to the emergency department each year, we strongly urge you to address the two plus-year backlog of Medicare and Medicaid appeals at the Office of Medicare Hearings and Appeals (OMHA). The abrupt slowdown in assignment of appeals to Administrative Law Judges (ALJs) that was announced at the beginning of 2014 affected appeals received after April 2013. OMHA adjudicates appeals from all Medicare Part B claims and audit findings from a variety of CMS contractors and OMHA reports that its average processing time (presumably for the four levels of appeals that it oversees) exceeded 514 days in September 2014 (Source: Medicare Appellant Forum, Oct. 29, 2014). However, it has become increasingly clear that the work of Recovery Audit Contractor (RAC) program is the primary driver of the appeals backlog. In 2013, more than 60 percent of RAC determinations appealed by physicians were overturned.[1] Based on CMS' data and the experience of physicians, RAC auditors are often wrong and the bounty hunter system design of the RACS has caused physician practices undue hardship and expense. As CMS considers awarding new RAC contracts, we strongly urge the following changes to the program:

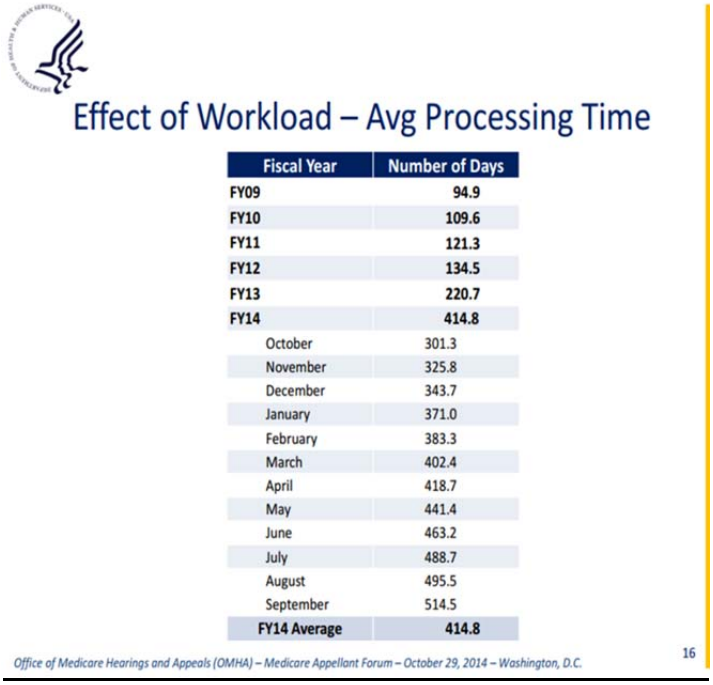
- **RACs should be subject to financial penalties for inaccurate audit findings and physicians should receive interest when they win on appeal of a RAC audit. (This has been discussed recently by MedPAC Commissioners as well.)**
- **Physicians should be permitted to rebill for recouped claims for a year following recoupment.**
- **CMS should provide an optional appeals settlement program and offers to physicians similar to that provided to hospitals.**
- **CMS should retain the current medical record request limits and allow medical record reimbursement for physician expenses of providing copies of medical records.**

[1]Centers for Medicare & Medicaid Services. Recovery Auditing in Medicare for Fiscal Year 2013. Available at http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Recovery-Audit-Program/Downloads/FY-2013-Report-To-Congress.pdf Note that this percentage included both Part B and DME claims.

- **RAC audits of physicians should be performed by a physician of the same specialty or same sub-specialty in the physician's jurisdiction.**

Effect of RAC Behavior on Appeals Backlog

Despite efforts by the OMHA to mitigate this backlog, current delays exceed statutory deadlines and are failing to provide due process for physicians.



Effect of Workload – Avg Processing Time

Fiscal Year	Number of Days
FY09	94.9
FY10	109.6
FY11	121.3
FY12	134.5
FY13	220.7
FY14	414.8
October	301.3
November	325.8
December	343.7
January	371.0
February	383.3
March	402.4
April	418.7
May	441.4
June	463.2
July	488.7
August	495.5
September	514.5
FY14 Average	414.8

Office of Medicare Hearings and Appeals (OMHA) – Medicare Appellant Forum – October 29, 2014 – Washington, D.C.

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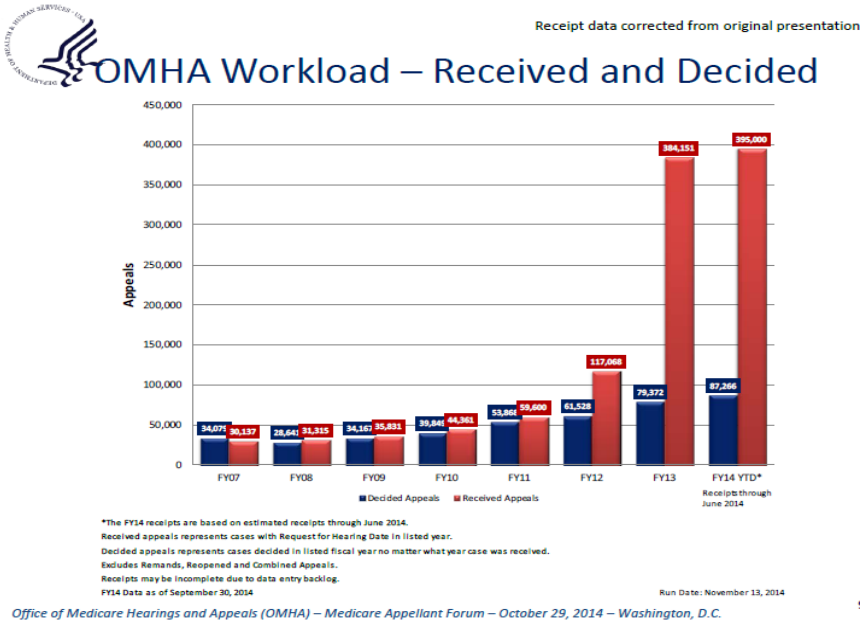
As shown in the chart below, appeals from the RACs began in 2011 and entered the ALJ level in 2012. Not surprisingly, the backlog of appeals also began in 2012, when OMHA experienced a 42 percent increase in the number of claims appealed compared to 2011. By FY 2013, the overall number of claims appealed to OMHA more than doubled from fiscal year 2012, with a 123% increase. The biggest increase in appealed claims in 2013 came from the RAC program with a 506% increase in appealed RAC program claims compared to fiscal year 2012 appealed claims from the RAC program, compared to 77% increase in appealed claims not related to the RAC program during that same period of time. Overall, these data demonstrate that the RAC program must be reformed in order to resolve the appeal backlog.



RAC Determinations Are Often Inaccurate

The RAC contingency fee structure encourages RACs to find overpayments with little regard for the accuracy of their findings. Indeed, RACs are paid a sizeable commission of approximately 9.0-12.5 % for denied claims. Only if a claim is subsequently overturned on appeal does the RAC pay back their contingency fee, providing little incentive for RACs to ensure that they limit their audits. This poorly conceptualized payment structure and the lack of financial repercussions emboldens RACs to conduct burdensome fishing expeditions that are inaccurate and often overturned on appeal. The most recent data from the program confirms that RAC decisions are frequently appealed and wrong in a majority of cases, resulting in over 60 percent of overturned decisions for Part B claims, as shown in the graph below.

Appendix K5: FY 2013 Total Appeal Decisions by Claim Type – All Levels

Claim Type	Total Appeal Decisions	% Total Overturn Decisions	% of Overpayment Determinations Overturned on Appeal
Part A	720,416	11.3%	10.0%
Part B/DME	116,433	60.2%	8.5%
Total	836,849	18.1%	9.3%

Source: Centers for Medicare & Medicaid Services. Recovery Auditing in Medicare for Fiscal Year 2013.

Without clear safeguards, such as enlisting physician medical reviewers, repealing the contingency fee basis and enacting financial penalties for incorrect RAC determinations, these inaccuracies and the growing appeal delays will continue to persist.

Significant Cost of RAC Appeals

Appeals require significant resources, time, and expense. For many physician claims appealed, the cost of the appeal is greater than the cost of the claim. Beyond this direct cost of RAC appeals, physicians also spend significant financial resources on compliance efforts to ensure they meet payment rules and regulations. Cost estimate of these efforts, which include probe audits, internal and external chart reviews, legal and educational expenses, have been estimated at approximately $1,622 per physician per year, although this amount varies depending on practice size.

Needed Changes to the RAC Program

Without action by Congress and CMS to relieve the burden on physicians, RACs will continue to operate under their current financial incentives and resist changes that would improve audit accuracy, reduce the number of appeals, and mitigate the burden on physicians. We agree with the American Medical Association and urge the following program changes:

- **RACs should be subject to financial penalties for inaccurate audit findings, and physicians should receive interest when they win on appeal of a RAC audit.**
  The program's contingency fee structure encourages RACs to perform as many audits as possible with little regard to accuracy or the burden imposed on physician practices. CMS has reported that the RAC "error rate" is not significant, but this is directly contradicted by the percentage of RAC claims overturned on appeal. Moreover, CMS fails to consider that many physicians choose not to appeal erroneous RAC determinations due to the significant expense and time in seeking an appeal, not to mention the current backlog in cases. Financial penalties on RACs would ensure they target audits, make accurate decisions, and comply with program requirements, including appropriately informing and notifying physicians. In turn, physicians who are successful in appeals should be compensated, at a minimum, for the time spent going through the time consuming appeals process.

- **Physicians should be permitted to rebill for recouped claims for a year following recoupment.**
  The timely filing rule requires that certain services be filed within one year from the date of service. However, RACs currently operate under a three year look-back period. Denied claims are likely to be ineligible for rebilling given the broader RAC review period and the time it takes for an audit to be completed. We urge CMS to allow physicians to rebill claims for the year following recoupment.

- **CMS should provide an optional appeals settlement to physicians similar to that provided to hospitals for appeals related to short-term care.**
  CMS has taken steps to mitigate the appeals backlog by offering a settlement agreement on certain hospital claims. We urge CMS to consider a similar settlement offer for physician claims that are pending appeal. Such a program could mitigate the appeals backlog by quickly resolving cases, providing CMS proposes appropriate reimbursement for the claims at issue.

- **CMS should retain the current medical record request limits and allow medical record reimbursement for physicians.**

We understand that CMS is considering revising existing RAC medical record request limits. Given the existing administrative burden and cost of RAC audits, the high denial rate, and the two-year appeals backlog, which has been largely attributed to the RAC program, these limits should not be increased. In addition, hospitals are partially reimbursed for their medical record costs. We believe that physicians, as a matter of equity, should also be reimbursed for this significant expense.

- **RAC audits of physicians should be performed by a physician of the same specialty or subspecialty licensed in the same jurisdiction.**
  Most RAC audits are evaluated by a certified coder or nurse rather than a physician. Given that treatment decisions often require a high level of expertise and familiarity with specialty areas, we believe physicians of the same specialty or subspecialty and in the same jurisdiction would be best equipped to accurately perform these reviews. Including physicians would also improve RAC accuracy and promote communication with the physician community.

ACEP and EDPMA are committed to working closely with CMS to ensure appropriate coding and billing of physician services. Should you have any questions regarding our comments, please contact Barbara Tomar, ACEP's Director of Federal Affairs, at btomar@acep.org or Elizabeth Mundinger, Executive Director, EDPMA at emundinger@edpma.org

Sincerely,

Michael J. Gerardi, MD, FACEP
President, ACEP

Sincerely,

James A. Kolka, D.O., FACEP
Chair, EDPMA Board of Directors