TESTIMONY OF MICHAEL C. SCHWEITZ, M.D.

ON BEHALF OF

THE ALLIANCE OF SPECIALTY MEDICINE

ON

"THE IMPACT OF CMS REGULATIONS AND PROGRAMS ON SMALL HEALTH CARE PROVIDERS"

BEFORE THE HOUSE SMALL BUSINESS COMMITTEE

SUBCOMMITTEE ON REGULATIONS, HEALTH CARE AND TRADE

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Michael C. Schweitz, M.D.
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Good afternoon Mr. Chairman, Mr. Westmoreland, and members of the Subcommittee. I am Dr. Michael Schweitz, a practicing rheumatologist from West Palm Beach, Florida. I am Vice President of the Coalition of State Rheumatology Organizations (CSRO), which represents 28 of the approximately 37 state and regional rheumatology societies in the country. CSRO's principal purpose is to promote access to the highest quality care for patients with autoimmune inflammatory and musculoskeletal diseases. I am here testifying on behalf of the Alliance of Specialty Medicine, a coalition of 13 national medical specialty societies representing more than 200,000 physicians. This non-partisan group is dedicated to the development of sound federal health care policy that fosters patient access to the highest quality specialty care.

I would like to discuss physicians' experience with one aspect of the impact of CMS regulations on small health care providers, namely the CMS demonstration project referred to as the Recovery Audit Contractors program, or RAC. The RAC demonstration was mandated by Congress in the Medicare Modernization Act of 2003. In implementing the demonstration, CMS initially awarded three contracts in 2005: one

in my home state of Florida, and two others in California and New York. These three states were the largest states in terms of Medicare utilization, accounting for 25% of total Medicare payments made each year. In 2007, the demonstration was expanded to include three additional states: Massachusetts, South Carolina, and Arizona. As a result of a provision included in the Tax Relief and Health Care Act of 2006, Congress required CMS to make the RAC program permanent and nationwide by no later than January 1, 2010.

Physicians concur with the original intent of the Congress in establishing the authority of the RAC program. Medicare should be paying only for those claims that are proper and appropriate and should be correcting improper payments to any provider who was underpaid or overpaid. But something went very badly wrong in CMS' implementation of the demonstration, which created unfair and very expensive burdens for physician practices. I hope the Subcommittee understands that physician practices are small businesses, which have little capacity for dealing with arbitrary, ill-informed and often confusing policies of contractors who seem to have little interest in communicating clearly with physicians about what to expect and why. I am here to elaborate on these problems and their implications for physicians' practices and to suggest what needs to be changed before the RAC becomes nationwide and permanent.

Before I begin to describe physicians' experience with the RAC, I would like to point out to the Subcommittee that the RAC is but one example of the regulatory burden that comes with a decision by physicians to participate in Medicare. While we understand

that a large and complex program like Medicare requires refinement on a continual basis, more thought needs to be given by CMS and its contractors to the impact regulations, guidelines and manual instructions have on our small businesses. This is especially the case at a time when the fees paid to us by Medicare are declining in terms of inflation-adjusted dollars—about a 16% decline since 2002. Physicians simply can not afford the capricious application of new law and policy if we are to continue to serve Medicare beneficiaries.

The Recovery Audit Contractor (RAC) Program

The first problem encountered by physicians in Florida occurred shortly after CMS hired its contractor, HealthDataInsight (HDI), to begin operations in 2005. HDI sent letters to multiple physicians demanding repayment for claims from dates of service extending back four years. Many of these claims had already been adjudicated upon record review by the Florida Medicare carrier, First Coast Service Options, and should not have been eligible for RAC recovery.

Upon receiving numerous requests for copies of medical records from the RAC, practices across the state began retrieving charts from storage and copying records, once again. It seemed like "double jeopardy" to many providers; we were being asked by another organization hired by CMS to review these claims again. Upon review of these documents physician staff members discovered that the majority of these requests had

been previously reviewed, appealed and paid at different levels of the Medicare appeal process. These claims clearly should not have been subject to RAC audit. Sadly, many physicians paid upon receipt of the requests rather than divert office staff and administrative attention to the matter. They did not have the funds to pay for staff to review the numerous records, pull charts, retrieve charts from storage, and pay the fees for chart retrieval from the medical records storage companies. Many did complain to HDI and subsequently to CMS, and many appealed. Eventually HDI was directed by CMS to cease requests for previously reviewed claims because it was a violation of Medicare policy.

Another problem occurred in December 2007, when HDI sent demand letters to hundreds of Florida physicians asking for refunds or records pertaining to procedure codes 64470 – 64476, facet joint injections. These injection procedures are done on the small joints of the spine to relieve spinal pain. The premise for the refund request was that these joint injections must be done utilizing fluoroscopic guidance and billed with a concurrent code for the fluoroscopic guidance. The claims in question had not been submitted with the code for fluoroscopic guidance. HDI demanded refunds or records for this procedure done as far back July 2003 and cited "commentary" from the Federal Register as their authority. In fact no policy had been developed or distributed until September 30, 2007, when a Local Coverage Determination was formally adopted and published.

One group of rheumatologists had to copy and mail out over 300 patient records to comply. You can imagine how many staff hours were diverted from patient care and office management to fulfill these requests. Some practices were asked for refund payments. A few had major offsets from current Medicare checks before the 30-day CMS refund deadline had expired. Some practices had to borrow from lines of credit to accommodate the cash flow problems these offsets created. One practice had $166,000 withheld from current Medicare claims, *before* they had received the Refund Demand for payment from HDI. They had little or no time to prepare for this interruption in cash flow to their small business.

Over 75 physicians were forced to hire outside consultants and legal counsel to help deal with this disaster. The sequence of events required of the RAC as part of the identification and recoupment of overpayments was not followed. Eventually, with the assistance of the Florida Society of Rheumatology and the Florida Medical Association, as well as staff of CMS, particularly Dr. William Rogers of the PRIT (Physicians Regulatory Issues Team) and Ms Connie Leonard, both of whom I would like to publicly thank, these egregious demands were stopped. It was apparent that HDI was again not following existing Medicare rules, regulations, and written policy.

To compound the impact to the practices, Medicare notified all of the secondary payers, including but not limited to AARP, United American, Aetna, Cigna, Washington National, BCBS of AL, Michigan and Florida, of the overpayments. These are the

insurers which provide supplemental coverage to beneficiaries and pay 20% of the original Medicare allowed payment for the injection procedures. Now they too were requesting that these amounts be repaid. This created an additional burden of work for practices because their payments are based on what Medicare is required to pay first as the primary payer. In essence, once the basic problem was corrected with the RAC, these same small business practices were expected to engage additional staff time to correct the problem with the secondary payers. This would be the fourth time physician staff members were working on collecting monies and reconciling accounts for claims that were adjudicated properly by CMS in 2005. To this day, May 14, 2008, practices are still dealing with requests for refunds and overpayments on these same RAC claims.

Prior to the debacle pertaining to facet joint injections, a similar scenario, involving the oncology community, played out in Florida. Again, hundreds of practices were accosted for records or refunds, involving hundreds of thousands of dollars. Only after aggressive intervention by the Florida oncology community, the Florida Medical Association, and a national oncology society, the American Society of Clinical Oncology (ASCO), was the process stopped when it became clear that rules governing interpretation of HCPCS code G0345, for IV hydration, was misstated by the RAC in its attempt to recoup monies previously paid to the physicians.

In California urologists were asked to refund payments related to LCA (least costly alternative) policy for LHRH (luteinizing hormone-refractory hormone) drugs used to

treat prostate cancer. The urologists argued, and were successful, at reversing the demands. This reversal was successful because of the RAC's misapplication of written policy in exceeding time limits for reviewing claims.

In other instances it is also unclear what clinical guidelines RACs are utilizing in making their determinations. For example, those governing inpatient vs. outpatient implantation of cardiac devices, such as ICDs (Internal Cardioverter Defibrillator) and CRT–Ds (Cardiac Resynchronization Therapy Devices) do not specify a clear policy directive regarding site of service. Yet, RACs have been ruling that inpatient implantation procedures should have been performed as outpatient procedures and are recouping ostensible overpayment.

In New York obstetrician gynecologists face similar concerns with inpatient vs. outpatient surgery for hysterectomy. RACs have been ruling that such procedures should be performed in an outpatient setting, even though as many as 90% of hysterectomies are currently inpatient procedures. The RAC rulings ignore physicians' concerns regarding the safety of performing this procedure in an outpatient setting, and seem to be trying to establish a dangerous change in the standard of care.

These are but a few examples of the problems that physician practices have encountered. Clearly, the RAC program has not evolved into an efficient, fair and transparent program. Instead, we have come to view the program as an uncontrolled bounty hunter. When

confronted by a RAC demand letter many of our practices are forced to succumb, or turn to outside resources at considerable expense in an attempt to right the unacceptably common errors of the RAC.

It is unclear to many of our physicians of the ultimate necessity of the RAC. Clearly the CERT (Comprehensive Error Rate Testing) Program has been very effective at reducing the error rate to 4%. Would it not also be reasonable to expect our Medicare carriers to do a better job on the front end – appropriate edits, unambiguous rules and better distribution of policy changes? Might the rules be written more understandably? Many physicians must hire consultants to interpret the rules and their applications. Front-end savings should go directly to the Medicare program, not the private RAC businesses. Improved front-end functions would render the RAC redundant.

Recommendations

We support H.R.4105, the Medicare Recovery Audit Contractor Act of 2007, which proposes a moratorium on RAC activities and expansion of the current demonstration until its serious flaws are adequately evaluated and addressed.

Other recommendations include changing the Bounty Hunter payment mechanism that seems to embolden RAC behavior. Their aggressive approach lengthens the time to

resolve challenges and is instrumental in creating the excessive burdens on medical practices, especially small ones.

Also, the current Statement of Work shortens the time frame for review from four to three years, but, it no longer precludes the RAC from reviewing work from the current year. This opens the door for overlapping or concurrent reviews of claims by other contractors, such as fiscal intermediaries, carriers, MACs and quality improvement organizations (QIOs). This could potentially create a double burden in practices that have to respond to concurrent claim reviews.

In addition, the look-back period should be shortened from the current period to a twelve month period, months 12 – 24. This still gives the RAC a substantial full twelve months of claims review.

Most importantly, CMS should remove medical necessity determinations from the RAC Statement of Work. We do not think that these reviews are appropriate for the RAC program and believe they exceed the authority imparted to the RAC by Congress, which requires contracts with RACs "for the purpose of identifying underpayments and overpayments and recouping overpayments under Medicare." Medical necessity determinations are fundamentally distinct from other RAC reviews. These are significantly subjective cases and require considerable attention and expertise. They are not simple "mistakes" or "errors" more suitable for RAC identification. Medical

necessity reviews can not be completed using the automated software-based searches that identify billing errors. These reviews are individualized clinical assessments of compliance with Medicare policy. Each review should be conducted by a clinician with relevant experience and expertise to make these determinations. RACs do not appear to have used appropriately qualified staff for medical necessity reviews. Furthermore, medical necessity reviews are being done by other CMS contractors and, therefore, are redundant for the RAC.

Additionally, notification of overpayments that are sent to secondary payers should be delayed until completion of all appeals. Conversely, if recouped overpayments are reversed after notification to secondary payers, CMS should demand that secondary payers take corrective action regarding coinsurance monies to minimize the onerous burden on practices in trying to reconcile these accounts. Also, for RAC claims that are reversed, the RAC should be responsible for physician practice costs incurred with the work required in the compliance and appeals process.

SUMMARY

The RAC Demonstration Project may have been successful from the standpoint of monies restored to Medicare. However, clear evidence, based on recent events in California and Florida, shows that the program suffers from ineffective oversight. Numerous and serious errors in interpretation and application of Medicare policy and

regulations reflect the capricious and pervasive activities of the RACs. If CMS expects a reasonable error rate in its transactions, why shouldn't physicians expect the same?

The program is clearly not reasonably ready for expansion. Recent changes in the Statement of Work may be helpful in correcting some of these errors but there is still no current evidence that this is the case. Medical practices, as small businesses, are already under sobering stresses. Like all other small businesses, our cost of doing business continues to rise. Yet we face the potential of a decrease in Medicare payments of over 10% as of July 1, 2008. On a daily basis any given practice may receive multiple requests for medical records prior to or after payment is made. This is not limited to the Medicare program; other third party payers have followed Medicare's lead and conduct concurrent and retrospective audits of clams submitted for payment. We recognize the need for oversight; most small business' income is not generated from tax dollars as is the case with physicians paid by Medicare. We would, however, ask the Congress to recognize that the RAC program requires considerable fine tuning to fulfill its Congressional mandate without unfairly and unjustly burdening the physicians who provide the care and treatment of our nation's seniors.

I would like to thank you, Chairman Gonzalez, ranking member Westmoreland, and members of the Subcommittee, for the opportunity to speak to you this afternoon.