Governmental Affairs & Public Policy

Statement to the PPAC on the Office of Financial Management Program Integrity Customer Service Plan

June 5, 2000

The American College of Physicians-American Society of Internal Medicine (ACP-ASIM), representing over 115,000 members, is pleased to provide the following testimony to the Practicing Physicians Advisory Council (PPAC) regarding the Office of Financial Management (OFM) Program Integrity Customer Service Plan.

Physicians typically base their perception of the Medicare program solely on the quality of interaction with their Medicare carrier. To many, the carrier is Medicare. ACP-ASIM is concerned that the Health Care Financing Administration (HCFA) has not done enough to monitor and improve physician-carrier relations. HCFA should make addressing physician distrust of carriers—and therefore distrust of the Medicare program—a top priority. Allaying physician concerns regarding carrier performance and intent will allow physician to further focus on caring for their patients.

In addition to our comments on the HCFA Program Integrity Group customer service plan, our statement addresses three specific areas in which HCFA can improve physician satisfaction with the Medicare program: (1) toll free phone lines; (2) medical review; and (3) physician input into carrier performance.

Customer Service Plan

ACP-ASIM is pleased that HCFA plans to assess physician satisfaction with program integrity customer service. We believe that the results of the planned survey will enable HCFA to improve customer service. We are encouraged that the agency also plans to assess the quality of physician interaction with customer service personnel beyond program integrity. Assessing physician satisfaction with carrier personnel regarding billing and coding questions and claim status inquiries is equally important. We believe that the planned survey should also solicit feedback regarding these carrier activities. The survey results will also help HCFA identify deficiencies in its program integrity and physician education processes.

Our members often cite failure to get a clear and/or consistent answer from carrier personnel as the most frustrating part of their interaction with the Medicare program. This discourages physicians from seeking answers from the entity that ultimately holds them accountable for their billing and coding decisions.

Considering the importance of the HCFA effort to understand physician perceptions and attitudes across the broad range of carrier interactions, we are concerned that the customer service initiative is being spearheaded by the OFM Program Integrity Group. Receiving feedback from physicians regarding the quality of carrier educational services, i.e. billing and coding assistance and understanding Medicare
policies, should be a dual priority. The entity within HCFA that oversees carrier contracts with the agency should co-direct this initiative along with the OFM Program Integrity Group.

ACP-ASIM looks forward to working with HCFA on this important initiative. We believe that HCFA should take immediate action on the following issues to improve carrier-physician relations and improve physician confidence in the program. These issues are: (1) toll free phone lines; (2) medical review; and (3) physician input into carrier performance.

1. Toll-Free Provider Telephone Lines

We commend HCFA for its plan to mandate that its carriers provide physicians with access to toll free phone lines. We understand that HCFA will soon instruct carriers to have toll free provider lines operational. HCFA should update PPAC regarding the timing of the restoration of this valuable service. Toll free lines provide incentive for physicians to contact their carrier, enabling them to get information and establish a trusting relationship. Plus, the mere existence of a toll free line will help restore physician confidence in the program.

2. Medicare Medical Review

Medicare medical review is a major concern of physicians. The audit experience of an internist in Florida illustrates the need to improve training of carrier medical review audit personnel and the medical review process. The following includes: (a) an example of an inappropriate physician audit; (b) discussion and recommendations regarding carrier medical review audit personnel; and (c) discussion and recommendations regarding the medical review process.

a. Example of Inappropriate Carrier Audit

The internist contacted us with an audit problem that he was unable to resolve with his Florida Medicare carrier. He was asked to repay Medicare for services in which he was paid even though they were provided by another physician. He failed to understand why the carrier issued the overpayment request because the claims he submitted indicated that the services billed where furnished by a covering physician under a locum tenens arrangement. Medicare allows a physician to bill and be reimbursed for services provided by a covering physician in the regular physician's absence when certain criteria are met. The claims submitted for the covering physician's services meet the locum tenens criteria and included the appropriate modifier to indicate it was a locum tenens situation.

After requesting the documentation to support the claims in question, carrier personnel contacted the physician to find out if the services were furnished by a member of his group. He responded that the physician was not a member of his group and subsequently received a overpayment request letter. When the physician called to contest the overpayment request, carrier representatives repeatedly told the him that he was required to repay the amount in question because he did not provide the services. The carrier representative told him she was unfamiliar with a locum tenens arrangement when he explained the situation. He was then told he had to request an administrative law judge (ALJ) hearing to appeal further. In the meantime, he was expected to repay the overpayment amount in full.
We contacted the carrier in an attempt to prevent the physician from having to take his case to the next level of appeal. We explained that his claims he submitted appropriately identified the locum tenens situation—that it was appropriate for him to bill for services provided by a covering physician. Carrier representatives initially informed us that they could not review the claims as they had been archived and that it was impossible to reopen the case—an ALJ hearing was the only option. The physician filed a letter requesting an ALJ hearing.

Carrier representatives finally reviewed the archived claims, at our request, and confirmed that the claims, in fact, indicated a locum tenens arrangement. Carrier representatives promptly instructed the physician to send a letter withdrawing his ALJ request and informed him that he did not have to repay the overpayment amount to Medicare.

We appreciate the responsiveness of the carrier personnel in addressing the physicians concerns. However, the scenario highlights the need to improve both customer service provided by carrier audit personnel and the medical review process. First, carrier representatives failed to clearly explain the reason for the overpayment request to the audited physician. Second, carrier representatives failed to give the physician guidance even when it appeared that there may have been a simple explanation for the billing discrepancy. Third, the rigid audit protocol adhered to by carrier personnel made it extremely difficult for them to detect and correct their mistakes.

HCFA should improve funding for training of carrier personnel and implement changes that allow carriers to be more responsive to physician concerns. ACP-ASIM believes it is important to improve physician-carrier relations. We are currently working to foster a more collaborative relationship between our members and the carriers that serve them and their patients. HCFA should also reform the process by which carriers conduct audits. Further discussion is contained below regarding: improving training of medical review personnel and improving the medical review process. Each section contains recommendations.

b. Improving Training of Medical Review (Audit) Personnel

The United States Government Accounting Office (GAO) released two reports in July 1999 documenting serious flaws in the performance and integrity of several Medicare contractors. The GAO noted that contractors improperly screened, processed, and paid claims to inflate the Contractor Performance Evaluation scores they presented to HCFA. The GAO's findings were further supported by OIG Deputy Inspector General George Grob, who in July 1999 presented the following congressional testimony detailing fraudulent conduct of some Medicare contractors:

"Of all the problems we have observed, perhaps the most troubling has to do with contractors' own integrity—misusing government funds and actively trying to conceal their actions, altering documents and falsifying statements that specific work was performed. In some cases, contractors prepared bogus documents to falsely demonstrate superior performance for which Medicare rewarded them with bonuses and additional contracts. In other examples, contractors adjusted their claims processing so that system edits designed to prevent inappropriate payments were turned off, resulting in misspent Medicare Trust Fund dollars. The examples I describe are not isolated cases. At any given time, several contractors may be under investigation by our office. To date, our investigations have resulted in 9 civil
settlements and 2 criminal convictions, and we currently have 21 former or current contractors actively under investigation."

HCFA should provide additional funding for training carrier personnel that conduct audits and interact with physicians. HCFA must ensure that carrier personnel are knowledgeable about Medicare policy. The agency must ensure that they conduct Medicare audits and related activities with integrity and in a professional manner.

Further, carrier personnel review of physician claims for evaluation and management (E/M) services is a specific concern. Carrier audits of physicians' E/M service claims often fail to account for the fact that physicians and auditors can legitimately disagree regarding the appropriate level of service. A study conducted by the OIG in 1995 suggests that coding for E/M services is largely subjective. The OIG asked eight Medicare carriers to use the E/M codes to code five different hypothetical patient office visits. The report states that "none of the five vignettes were coded in the same way by all sampled carriers, which illustrates carrier difficulty in understanding the visit codes." **HCFA should instruct its carriers to be sensitive to the complexities of E/M service coding.** Also, HCFA must ensure that carriers are fully trained to identify one-level undercoding—and underpayment—as they are in identifying one-level upcoding. This is especially relevant as HCFA is drafting a memorandum to carriers instructing them to adjust for undercoding when reviewing medical record documentation. **PPAC should ask HCFA for information regarding this pending carrier directive.**

c. Improving the Medical Review Process

HCFA should reform the medical review process to promote fairness and dispel physician mistrust of the program. The current medical review process denies physicians their due process. The design also coerces physicians into entering into a settlement with their carrier. Physicians often have a disincentive to prove their billing is appropriate as the legal costs involved in appealing an audit determination can rival the amount in question as the overpayment amount is often determined by extrapolating the results of a small sample.

We recommend the following improvements to the Medicare medical review process:

**Carriers should use detailed statistical analyses of severity-adjusted provider billing patterns to identify true outliers.** Outliers who fail to exhibit egregious behavior should receive educational coding assistance before being subjected to comprehensive audits. While improved technology makes this possible, it is essential that carriers share the results of statistical analyses with providers and use them in a constructive manner.

**HCFA should standardize the process for how carriers conduct medical review and provide oversight when necessary.** The process then needs to be clearly communicated to physicians. Currently, carriers have wide latitude when conducting physician audits. We are aware of a physician in Connecticut who had to endure three separate audits of the same time period because the successive carrier audits were each determined to be statistically invalid.

Program integrity entails paying claims appropriately in addition to detecting and preventing fraud and
abuse. Carrier-initiated medical review should be furnished by a physician licensed in the same specialty as the physician whose claim(s) is under review. Also, appeal of overpayment requests over a certain monetary threshold should be conducted by an independent organization, such as the state Peer Review Organization. These steps would inject fairness and give physicians more confidence in the Medicare medical review process. HCFA should use the stable source of funding provided by Congress for the Medicare Integrity Program to assure fairness in medical review activities.

Physicians should be able to retain their appeal rights without opening themselves up to a more comprehensive audit. Currently, physicians must open themselves up to a review of the patient records pertaining to all claims for the identified service(s) over an open-ended period of time simply to maintain their appeal rights. In addition to opening oneself up to such a practice-disrupting audit, physician can accumulate substantial legal costs.

Physicians should not have to repay carrier-determined overpayment amounts until they exhaust all appeal rights and an accurate overpayment amount has been established. Currently, physicians must repay overpayments within 30 days even if the case is under appeal.

ACP-ASIM is encouraged that HCFA has contracted with the consulting firm of PricewaterhouseCoopers (PwC) to make recommendations to improve the effectiveness and the efficiency of medical review. PPAC should ask HCFA for an update regarding the status of the PwC report.

3. Physician Input Into Medicare Carrier Performance

We believe it is important for carriers to be responsible for the service they provide to physicians. Assessing physician satisfaction with that service is an important first step to improving customer service. However, HCFA needs to go further. Physicians must have input into carrier performance.

HCFA should establish a mechanism to assess valid regulatory hassles imposed by a specific policy or by carrier misinterpretation of HCFA policy identified by state and/or national medical societies. Carrier misinterpretation of national Medicare policy is problematic. Carriers are unlikely to recognize that their interpretation of a national policy is incorrect, leaving physicians no outlet to address their concerns. There are numerous instances in which a carrier(s) implemented a policy that inappropriately denied or reduced payment for services that were billed correctly. The audited physician who was mistakenly asked to repay funds provides an example. It is extremely difficult for physicians to get beyond the initial decision-making person or entity, even if that decision is incorrect.

Frustrated, rank-in-file physicians need a mechanism to address valid concerns. It is imperative that a process be established to listen and respond to these concerns so that physicians do not feel that the government is unresponsive to their legitimate concerns.

We envision that medical societies would only bring well-documented problems and/or carrier misinterpretations of national policy to the attention of the HCFA central office. We do not envision that frivolous or trivial policy matters would be brought to the attention of the HCFA central office. The HCFA central office would only become involved if a problem could not be resolved at the carrier or
regional office level.

As noted above, it is our understanding that the HCFA regional offices are vital to addressing physician concerns regarding carrier policy. Individual physicians and their medical society representatives can have difficulty in locating appropriate regional office staff. **The HCFA central office should designate a Medicare liaison in each regional office to serve as a contact for medical societies and individuals. HCFA should make contact information available through its Internet site.** Providing medical societies access to central and regional office officials encourages dialogue and collaborative efforts to solve legitimate problems.

**HCFA should use such a mechanism to collect and assess concerns about carrier actions so the agency is able to stay better informed regarding the performance of its carriers.** The GAO recently issued reports detailing HCFA's general lack of oversight of its Medicare carriers and other contractors. HCFA cannot fully evaluate its carriers if it lacks a mechanism to collect documented inappropriate carrier actions. Also, the lack of such a mechanism unnecessarily antagonizes physicians by making it difficult for them to get relief for their valid concerns.

Further, HCFA communicates policy instructions to its Medicare carriers through Program Memoranda and other transmittals, which are then implemented by the carriers. HCFA should ensure that these instructions are clear to avoid misinterpretations. **The instructions HCFA sends to its Medicare carriers should be reviewed by practicing physicians to promote clarity and to assure that the regulatory burden is minimized.**

ACP-ASIM thanks PPAC for the opportunity to comment on the Program Integrity Customer Service Plan. Please do not hesitate to contact our Washington, DC office if you have any questions or comments.