CARDIOLOGY ADVOCACY ALLIANCE

National leadership on issues that affect cardiovascular patients and their physicians 202.505.2221 ▪ cardiologycaa.com

December 15, 2011

Centers for Medicare & Medicaid Services
Office of Strategic Operations and Regulatory Affairs
Division of Regulations Development
Attention: Document Identifier CMS-10417
Room C4-26-05
7500 Security Boulevard
Baltimore, Maryland 21244-1850

Dear Sir or Madam:

Thank you for the opportunity to comment on the emergency review of the collection of information related to the pre- and post-payment review of Medicare claims by Medicare contractors. On behalf of the 5,000 cardiologists in private practice and within integrated organizations across the country that we represent, the Cardiology Advocacy Alliance (CAA) submits the following observations about the proposed CMS-10417 information collection. The proposal is related to an 11 state expansion[1] of current Medicare contractor medical utilization review of medical claims. In their review of alleged aberrant or unusual claims, the contractors request and review clinical documentation of the medical services provided to ensure that the documentation reflects what was billed following Medicare national and local coverage guidelines and other industry coding and documentation standards. The review asks commenters to consider (1) the necessity and utility of the proposed information collection for the proper performance of the agency's functions; (2) the accuracy of the estimated burden; (3) ways to enhance the quality, utility and clarity of the information to be collected; and (4) the use of automated collection techniques or other forms of information technology to minimize the information collection burden.

CAA's mission is to support the sustainability of the cardiovascular professional regardless of practice setting. CAA represents the common interests of the cardiovascular patient and professional on such issues and encourages its members to advocate for their patients and their practices. CAA member practices devote themselves to continuous quality improvement and use benchmarking data and other tools to ensure that they are offering the highest quality care to their patients. As such, the super majority of CAA members have electronic medical records and already have attained the meaningful use threshold for Phase I.

In response to this proposed expanded information request by the Centers for Medicare & Medicaid Services (CMS), CAA is disappointed by the clear increase in cost and waste to private practice medicine to respond to contractor documentation requests. This unfunded mandate is further exacerbated by the simple fact that the seven days afforded by this emergency public information collection review is simply not adequate for appropriate and legally required public comment. In light of these concerns and others expressed below, the **CAA recommends that CMS delay the implementation of this proposed information request until the following occurs: (1) a renewed public information collection review request of no fewer than 30 business days for appropriate public comment; (2) the final Attachments Rule is published by CMS; (3) a public opportunity to review the contractor request process and materials with no fewer than 30**

[1] The 11 states are: California, Florida, Illinois, Louisiana, Michigan, Missouri, New York, North Carolina, Ohio, Pennsylvania and Texas.

business days for comment; and (4) a system is developed, tested and deployed to coordinate the request activities of various Medicare contractors in California, Florida, Illinois, Louisiana, Michigan, Missouri, New York, North Carolina, Ohio, Pennsylvania and Texas.

Necessity and utility of the proposed information collection for agency

CAA supports and agrees that CMS should take reasonable efforts to ensure that fraudulent providers are not a burden on the Medicare program. Yet, pre- and post-payment review is an unsophisticated tool by its breadth and labor intensive process. For instance, there isn't an easy way to transmit the clinical data requested in pre- or post-payment reviews today. Instead, this type of granular information is dropped to paper and copies of medical records are sent through the mail for contractor review. Without a comprehensive final Attachments Rule that addresses how medical record chart abstracts, that may even originate in an electronic medical record, can be transmitted securely through a standardized electronic transaction, efficient and complete clinical data sharing cannot be achieved. To adopt this program without the final Attachments Rule undermines the Agency's commitment to electronic interchange and adoption of electronic medical records. Simply, these interactions between contractors and Medicare providers *must be electronic* to have any utility. **CAA recommends that this program be delayed until the publication of the final Attachments Rule.**

CMS announced this program in a press release on Nov. 15, 2011. Even with the supplemental information with the CMS-10417 Notice, the public has not had an opportunity to review the details of how this program will function and the nature of what information will be collected. Thus, *CAA cannot evaluate the necessity and utility of the information proposed for collection.* **Therefore, CAA recommends that the program be delayed until a public opportunity to review the contractor request process and materials is achieved with no fewer than 30 business days for comment.**

The proposed expansion of this program, as stated in the Supporting Statement for the CMS-10417 Notice, is more than doubling of current claims reviews, moving from 1.2 million to 2.7 million claims. Further, additional contractors, including the Medicare Administrative Contractors, Affiliated Contractors, Zone Program Integrity Contractors and Program Safeguard Contractors are joining this campaign. With the significant increase in volume and actors involved in review, the emergency information request and immediacy of implementation is misguided. To our knowledge, a uniform platform for the identification of a claim under review has not been established. This is a fundamental requirement to ensure that a provider is not asked for unnecessary documentation on the same claim by different contractors and to preserve the findings of the final contractor review. **CAA recommends that the program be delayed until a system is developed, tested and deployed to coordinate the request activities of various Medicare contractors in the 11 states.**

Accuracy of the estimated burden

Today, CAA members spend a great deal of time and expense on evaluating how claims were processed and why coverage is being questioned through a prior authorization or post claim review. This time could be better spent on direct patient care. CAA appreciates CMS' comments on the increased burden to respond to these requests from 20 minutes to 30 minutes, acknowledging that this is an average and some of these requests will only require 15 minutes of physicians and administrative staff time to attest that a record and associated charges were performed by them. This estimate of time includes administrative staff time to locate, photocopy and transmit medical information.

According to our members who have undergone a Recovery Audit Contractor (RAC) audit, which CAA believes is substantially similar to the proposed information request, 30 minutes is a fair estimate for the administrative staff time for one average claims request. However, the estimate does not include additional management, physician or legal counsel time or expense spent to validate and review the materials responding to the pre- or post-payment review request. Also, it does not include the average time or expense required to appeal the audit findings.

Our members also observed that the time spent to respond to a RAC audit request varies dramatically based on the complexity of care provided to the beneficiary and whether the request is for surgical procedure claims. Especially in cases where the hospital records are necessary for the physician audit response, these requests can range from 60 to 200 minutes.

Also, note that procedural specialists likely will bear the significant percentage of the complex cases under pre- or post-payment review. Thus, these practices, who are likely CAA members, bear an undue burden under this information request. Every effort must be made to decrease the burden of responding to these requests and minimize the discriminatory nature of specialty services under review to minimize the impact of this unfunded mandate on Medicare providers.

Based upon a quick, informal assessment of our members, **CAA recommends that the time associated with each request be increased to 60 minutes and include the time and costs associated with management, clinical and legal review, in addition to the administrative staff time already attributed at 30 minutes**. CAA welcomes the opportunity to work with CMS to clarify the time spent cardiology practices spend to respond to pre- and post-payment requests, the time allotment to the various roles of personnel in the responding medical practice as well as the average salaries of these personnel.

Ways to enhance the quality, utility, and clarity of the information to be collected

One best practice that has been adopted by the majority of private insurance companies that perform similar reviews to the proposed information request is that they have the review performed by a board-certified physician (or other clinician) in the same specialty as the rendering physician on the claim. The Supporting Statement notes that "[c]omplex medical review generally involves the application of clinical judgment by a licensed medical professional in order to evaluate medical records […]". Further, requiring reviews to be performed by medical professional licensed in the same state is very important as the scope of practice and hospital privilege requirements may dictate what services may be performed by a specialty and how they are rendered. Lastly, a requirement that the reviewing professional have practiced medicine within the last three years is a reasonable requirement that ensures that the reviewing physician or other medical clinician is able to exercise judgment based on current medical practices.

The program outlined in the CMS-10417 Notice requires providers to respond to a contractor request for additional clinical documentation within 30 days (CMS Program Integrity Manual (100-08), Chapter 3, Section 2.3.2). According to CAA members, this timeframe for response is too short. Getting this request to the right person for response is ever more difficult and time consuming with the reorganization of medical practices into integrated systems and coordinated care organizations. Consistent with the policies of private insurance companies, **CAA recommends that the timeframe for provider response be extended from 30 days to 45 calendar days.**

Use of automated collection techniques or other forms of information technology to minimize the information collection burden

CAA strongly believes that automation is necessary for the implementation of the CMS-10417 Notice program in 11 states. This can only be facilitated once the final Attachments Rule is published and national standards for electronic clinical data exchange are developed. To date, the electronic dialog to facilitate pre- or post-payment records request(s) is not a standardized transaction or data set. Both the information submitted by ordering physicians for the review and by the responding contractor must be standardized to enable clarity on the rationale for review of coverage for medical appropriateness. The response must be granular enough to clearly identify what guideline was used and why the ordered medical services did not meet the criteria for coverage. Additionally, this solution cannot be a Medicare-only solution. It must be a standard that is used by the industry and could be endorsed by a national standards body such as the Committee on Operating Rules for Information Exchange. Therefore, **CAA recommends that CMS promote and facilitate the establishment of a national electronic standard for the exchange of clinical data for the purposes of pre- and post-payment review and prior authorization.**

On a related note, the nomenclature used for all of these transactions must also be standardized. Today, quality metrics, prior authorization programs and pre- and post-payment review use incongruent medical terminology. **CAA strongly recommends that CMS adopt the SNOMED medical nomenclature standard for all pre- and post-payment document requests and transactions** so that all health plans, contractors, venders and providers may pull and compare data consistently.

Lastly, for the prior authorization pilot mentioned in passing in the CMS-10417 Supporting Statement, **CAA strongly recommends that the prior authorization process be enhanced by facilitating beneficiary eligibility and medical service coverage verification for the services being evaluated through prior authorization at the time that the prior authorization review is initiated.**

In conclusion, the quality, utility and clarity of the information request(s) outlined in this proposal can be greatly enhanced through standardization. However, to adequately respond to this request, more time must be afforded to the public to evaluate this request with additional detail on what the request entails.

Thank you very much for the opportunity to share our thoughts on this proposal. CAA realizes that CMS is called upon to accomplish an extremely difficult and complex task to ensure that Medicare dollars are appropriately spent. Our members and staff are available as resources to you as you examine and address the concerns outlined above. Please feel free to contact Jen Searfoss, Executive Director, at 202-505-2221 or jen@cardiologycaa.com for any assistance.

Sincerely,

/s/
Dan Caldwell
President

/s/
Mark Victor, M.D.
Vice President, Medical Affairs