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**Connecticut State Medical Society testimony presented to the Program Review and  
Investigations Committee  
Medicaid: Improper Payments  
June 29, 2012**

Senator Fonfara, Representative Rowe and members of the Program Review and Investigations Committee, on behalf of the more than 6,500 physicians and physicians in training of the Connecticut State Medical Society, thank you for the opportunity to provide testimony to you today regarding this study to describe and evaluate the processes the state uses to prevent, detect and recover improper payments in the Medicaid program due to fraud, abuse and errors. This study is important to us for a few reasons. First is to guarantee that the limited funding for providers participating in the Medicaid program in Connecticut is available for medically appropriate care and the associated procedures and services provided to patients. Second is to understand and further evaluate the complexities and often overwhelming and ever-changing administrative requirements that can increase the number of unintentional coding, processing and documentation mistakes or errors. As you know, Medicaid pays physicians substantially less than Medicare and private insurers in Connecticut. Therefore, any program to identify overpayments must be fair and not unduly burdensome for physicians. It must also identify underpayments, cases in which Medicaid did not fully fund the identified services or procedures provided to Medicaid recipients. Finally, and maybe most critical is the fact that many organizations and jurisdictions have struggled with the burden of defining what constitutes fraud and abuse versus simple errors or mistakes in coding, billing or claims processing.

We offer to the committee that just as important as understanding the efficiency and effectiveness of payment recovery programs, is the need to ascertain and understand the incredible expense and administrative burden these programs can have on physicians' offices and how these recovery programs often restrict and even delay the provision of medical care. Such programs can impact a physician's overall practice and therefore his/her ability to participate in the Medicaid program as a provider of care.

Audit programs exist to identify overpayments for many reasons, including fraud and abuse. However, they are also in the unique position to identify program vulnerabilities, including system vulnerabilities and billing errors associated with providers as well as the program and its administrator of claims processing and payment. Therefore, we encourage the committee to review aspects of the program that promote outreach and education to physicians when these vulnerabilities and common coding, billing and processing errors are identified.

The best way to reduce improper coding or billing errors is through robust provider education and outreach, something that CSMS has done over the years for our members and their office staff. Outreach programs must be widely available and easily accessible to all physicians. At a minimum they must include (1) the purpose of an audit, (2) policies, protocols and the process used to identify overpayments, (3) information on how audits can be avoided, (4) how to proceed when in receipt of a demand letter and (5) specific details on an appeals process and how to engage in meaningful discussions with program staff when information is received or submitted.

As mentioned, the aggressiveness of the need to identify fraud and abuse must be balanced with the need to prevent an overburdening of diligent health care providers and the associated, and at times unnecessary, cost to their practices. Therefore, in addition to outreach, it is critical that audits have a set limit in the number and frequency of medical records reviewed within a limited time. Reproducing records is time-consuming and expensive for physicians and their staff. Furthermore, on-site audits take more office time and further increase the associated costs audits have on physician practices. These add costs to providing medical care and must be addressed in any audit structure and process implemented in Connecticut.

CSMS is opposed to extrapolation-based methods of audits and reviews for two central reasons: they tend to overlook other factors such as process and system dynamics; and fairly often they overestimate the frequency of the problem encountered. However, if extrapolation is initiated, it must be appropriate and consistent with common actuarial factors of review and analysis. For example, in a practice with 10,000 records, looking at 10 records and determining that one is in error cannot and should not result in a determination of 1,000 records in error (and the associated payment) In addition; look-back periods must be limited. Three years of review is currently consistent with Medicare. Finally, due to the expense and time consumption of an audit, it is imperative that the person responsible for determining the accuracy of a paid claim has the appropriate education, experience and understanding of physician billing practices to effectively and accurately review claims. Auditors should not be paid a bounty based on the number of claims found with error (or fraud or abuse). The audit and review should be based on sound actuarial principles and not driven by financial incentives to the auditors.

Most, if not all, of these suggestions are reflected to some extent in the audit program of the Department of Social Services (DSS). The intent of this testimony, as stated, was to comment on the need for a balanced approach to auditing physicians and recognizing that mistakes happen and they should be viewed and identified as such, while at the same time, true fraud should be prosecuted to the full extent of the law. PRI staff has offered and we are currently coordinating meetings with a sample of physicians participating in the Medicaid program with personal experience with DSS audits. We appreciate this opportunity and believe it will provide solid results.

We further offer any assistance to this Committee and its staff as you work to complete this project.