



**Connecticut State Medical Society
Testimony in front of the Human Services Committee on House Bill 5069
An Act Reducing Health Care Fraud Waste and Abuse
February 19, 2013**

Senator Slosberg, Representative Abercrombie and members of the Human Services Committee, on behalf of the almost 8,500 physicians and physician-in-training members of Connecticut State Medical Society (CSMS) and the Connecticut Chapters of the American College of Physicians (ACP) and the American College of Surgeons (ACS), thank you for the opportunity to present this testimony to you today on House Bill 5069 An Act Reducing Health Care Fraud Waste and Abuse. We fully believe that committee members and CSMS share the same goal of ensuring that every dollar approved for health care services is used to provide the medically necessary services intended.

First and foremost, we fully agree with the need for the state to provide to the Department of Social Services (DSS) the resources necessary to develop an advanced system that (1) regularly updates those providers actively enrolled and providing services, (2) captures claim data real time to ensure proper payment, and (3) ensures that savings generated by such a program exceed costs. In supporting the language of the proposed legislation, CSMS stands fully ready to continue our work with DSS and policy makers to accomplish this goal.

However, we do need to raise some strong words of caution tied to various aspects of this proposed legislation. Due to fiscal constraints, several proposals at the state and federal level have been pared back to simply implement a situation in which privately contracted entities have been retained to identify savings and these entities have focused on the "bounties" and not on the processes and the actual and critical review of patient medical records and care modalities. This has placed a burden and barrier on health care professionals providing the medically necessary services. While we understand this is not the intent of the committee, in addition to offering our assistance, we felt it necessary to provide to you comments and information recently submitted to the Program Review and Investigations Committee to flag concerns we have with potential audit procedures as outlined in this legislation.

Specifically, we are concerned with extrapolation based audit methods focused on a limited number of chart reviews, unlimited look back periods in which providers must produce files

from over a significant period, and the requirement for in office review based solely on the review of printed and reproduced charts. The financial impact on a physician office from all three of these concerns can place an insurmountable burden on practice. We also suggest the best way to reduce improper coding or billing errors is through robust provider education and outreach, something that hawse have 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.

We feel that the physicians who participate in the program can offer a tremendous amount of knowledge and input into the development of an advanced system meeting the three goals stated in the proposed legislation. We welcome the opportunity to work with the committee on this legislation and the administration on any steps needed to implement

Thank you for the opportunity to provide these comments to you today.