



127 Washington Avenue, East Building, 3rd Floor, North Haven, CT 06473
Phone (203) 865-0587 Fax (203) 865-4997 www.csms.org

**Testimony of the Connecticut State Medical Society
House Bill 5500 An Act Concerning Provider Audits Under the Medicaid Program
Human Services Committee
March 13, 2014**

Senator Slossberg, Representative Abercrombie and members of the Human Services Committee, on behalf of the physicians and physicians-in-training of the Connecticut State Medical Society (CSMS), we thank you for the opportunity to submit testimony on **House Bill 5500, An Act Concerning Provider Audits Under the Medicaid Program**. CSMS believes there is a significant need to reform the current audit process under the Medicaid Program and supports the Committee's efforts through HB 5500 to do so.

Connecticut physicians and their office staff face a significant challenge in preparing for and responding to audits and financial reviews conducted by various private payers, as well as Medicare and Medicaid audits. CSMS understands that increased pressure to control healthcare costs and to identify fraud and abuse have led to increasingly frequent audits. CSMS believes that there are audit methodologies which can achieve these aims and support the state's need to identify deficiencies and overpayments, while also enduring fair and just treatment for physicians during the audit process. That said, certain methodologies can be implemented to ensure fair and just treatment of physicians when conducting audits while balancing the understandable needs of the state to identify deficiencies or overpayments. For that reason, we support the intent of HB 5500 and offer that further statutory or regulatory changes are necessary with regard to the audit process identified in HB 5500 to ensure that fairness and transparency are maintained throughout the process.

At the outset, CSMS would like to thank this Committee for the language contained in section (e) of HB 5500 prohibiting payment to contractors on the basis of the amount of overpayment. CSMS strongly believes that auditors should have no financial incentive throughout the course of an audit based on recoupment levels. Such financial incentives impede the audit process and raise questions about integrity of the process as a whole. To that end we would recommend that the language contained in section (e) of HB 5500 be expanded to specifically state that auditors shall be compensated on a "flat fee" basis or other formula that does not include a percentage of any financial recovery, so as not to incentivize these excessive findings without statistical merit.

The majority of the language HB 5500 specifically addresses the use of extrapolation in provider audits. We appreciate that the Committee understands the need for regulation of its use in audit procedures. However, we feel that a greater level of detail is needed because there can be misuse and abuse of extrapolation procedures that misrepresent the care provided and payments received.

Extrapolation methodologies employ a complex statistical formula. In order for results to be accurate, such formulas must be developed by a statistician with detailed knowledge of Medicaid claims analysis. Furthermore, the extrapolation formula must be provided in the audit report when the formula is used to calculate an alleged under or overpayment amount. The extrapolation itself must be done by an experienced statistician, and the name and credentials of the statistician performing the analysis must be supplied as part of the audit findings. This information is needed in order to validate the employment of a statistically reliable method applied by a trained and reliable statistician. Such validation is critical, given extrapolation has been known to be used to adversely impact physician payment for medically necessary services.

Extrapolation must be based on a statistically valid random sample using stratification when appropriate. A statistically valid random sample for a medical audit is a sample where every single claim has an equal opportunity to be included within that sample. A biased sample can result in a vast over-calculation of overpayment amounts when extrapolated to a larger universe. In other words, if a sample represents a higher average paid amount than the universe of claims, it may translate into a higher average overpayment amount than would be calculated from a true random sample. For example, without a statistically valid random sample, in a universe of 10,000 claims, a difference of \$10.00 could result in an overestimate in excess of \$100,000 in the overpayment demand. This is a key reason why a statistician with experience in statistically valid random sampling is essential to the audit process when extrapolation is used.

Additionally, all zero paid claims and claims with outliers must be removed from the sample prior to extrapolating any payment due. If the auditor believes any claims with outliers have been overpaid, those claims must be dealt with individually because they could lead to overestimation of any overpayment or underpayment. Unless the data are normally distributed, approximately normally distributed and/or symmetrical, the median (rather than the average) amount must be used to determine the central data point per unit audited as the basis for calculating the alleged overpayment. The lower bound of the two-sided 90% confidence interval should be used to calculate the alleged overpayment. Care must be taken to determine if those sampled truly represent a normalized sampling. CSMS feels strongly that such statistical analysis and statistical guidelines must be contained in statutory or regulatory language if the extrapolation methodology is going to be used. Without these statistical protections, the extrapolation process has significant potential to be fraught with errors and inaccuracies and there would be no way for such findings to be appealed.

Further, when looking at the development of a random sample or stratified random sample, care should be taken to make sure that when multiple services or procedures are provided within the context of a care visit, only claims of the same construction should be gathered. For example, if a preventive medicine visit and a sick office visit with the associated and appropriate modifier are reported using CPT® (Current Procedural Terminology) codes, guidelines, and conventions, the sampling should reflect only claims for these same services, associated codes, and modifiers. Any claims with additional services or procedures reported, or claims with only one of these two services documented, would suggest different care was provided during the patient encounter and therefore should not be used as part of the sample. Further, any claim that has previously been downcoded or bundled by the payer or state

agency should not be included in an extrapolated sampling, as the physicians coding for the service(s) tied to the particular encounter have been changed or manipulated.

In addition to the necessary constraints on the extrapolation process, additional statutory and/or regulatory protections are necessary for physicians undergoing Medicaid audits. Despite recent increases in primary care rates through the Accountable Care Act (ACA), many Connecticut physicians are electing to no longer participate in the Medicaid program, citing the uncertainty and unfairness of the Medicaid audit program as a significant reason. The costs associated with audits, both financially and in staff resources outweigh the benefits of participation. Ensuring a fair and just audit process will help to retain quality physicians in the Medicaid program, which serves an increasing number of Connecticut residents.

Statutory or regulatory guidance is also needed regarding to audit notices provided to physicians. Audit notice should be provided to physician practices with advance written notice sent by certified mail at least 30 business days prior to an audit. Additional information regarding the records required, the manner in which they are to be submitted, and any codes and modifiers in question must be provided.

With regard to auditor qualifications, statutory and/or regulatory guidance must state that all individuals performing medical audits have appropriate knowledge and experience in coding, including applicable ICD (International Classification of Diseases), CPT® (Current Procedural Terminology), and HCPCS (Healthcare Common Procedure Coding System) codes. Additionally, auditors must be familiar with the format and contents of medical records and claims forms used today in both private community practice as well as hospital based settings. Individuals auditing medical records for issues of coding and documentation should be certified in coding, with at least one year's auditing and/or coding experience. Further, individuals auditing medical records related to decisions of medical necessity must be licensed in the clinical discipline which provides appropriate knowledge and expertise to determine the medical necessity of clinical tests and procedures without the benefit of examining the patient.

Statutes and/or regulations should specify the information to be contained within the audit finding reports. The audit report should clearly identify any errors discovered in the audit, specifying all medical and reimbursement policies and procedures used in determining the outcome of the audit, and providing a copy of these policies and procedures to the physician as part of the audit report. If the auditor is unable to provide the specific medical reimbursement policies and procedures being relied upon, then the overpayment request specific to those policies and procedures should not be allowed. It is only fair that physicians be given copies of the medical policies and procedures documentation being relied upon by the auditor. If those policies and procedures are not available for any reason, the findings should be disallowed.

Additionally, the audit report should identify underpayments to the physician practice. The audit report should be provided within 30 days of the completion of the audit. Where repayment is sought, the audit report should clearly describe how the overpayment amount was calculated. The audit report should clearly detail the appeals process, and physicians should be afforded at least 30 days to challenge or appeal any audit report. CSMS strongly believes that a detailed appeals process and certain protections for physicians should be contained in statutory or regulatory language. Audit appeals should have at least two levels: an initial request for reconsideration and a second level appeal to an external qualified third party.

Furthermore, any decision to deny reconsideration should be made by a qualified physician. With regard to the second level of appeal, an external qualified third party should be utilized and such third party should be independent from the DSS staff. Finally, it should be specified that that physicians are not subject to alleged overpayment re-payments or recoupments while any appeal is pending.

CSMS also believes that the "look back" period for audits should be codified. State law currently limits the period to 18 months for commercial payers. For fairness and consistency, the proposed regulations should apply the same timeframe to the Medicaid program. Connecticut has seen multiple changes to the Medicaid contractors with vastly different physician payment rules and guidelines in a relatively short period of time. Limiting the "look back" period ensures fairness and consistency for physicians given the ever-changing Medicaid contractors used by the state.

CSMS appreciates the opportunity to provide these comments on HB 5500. We also appreciate the opportunity to provide suggestions for additional statutory and/or regulatory provisions that are necessary to ensure a fair and transparent audit process that will help retain physician participation in the Medicaid program and provide quality medical care to the patients of Connecticut.