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June 28, 2013

Ms. Marilyn Tavenner, Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-6045-P
PO Box 8013
Baltimore, MD 21244-8013

Re: Medicare Program; Requirements for the Medicare Incentive Reward Program and Provider Enrollment

Dear Ms. Tavenner:

The American Urological Association (AUA), representing more than 90 percent of the practicing urologists in the United States, welcomes the opportunity to comment on CMS' proposed rule, which would revise the Incentive Reward Program provisions and certain provider enrollment requirements.

The AUA spends a good deal of its resources on educating our membership to make sure they comply with Medicare rules, regulations, and appropriate coding and billing practices. The AUA reviews all documents through rulemaking process and analyzes the rules to alert our members of changes and provides these comments to CMS. In addition, the AUA publishes a bi-monthly on-line newsletter, the Health Policy Brief, which alerts our members to any changes to Medicare policies and coding changes to ensure correct coding. The AUA also has a Coding and Reimbursement Committee that reviews issues on coding and reimbursement to ensure correct use of Current Procedural Terminology (CPT) codes. Our Practice Management Department also offers regional coding seminars to our members in order to comply with appropriate coding of urologic procedures and services. The AUA works diligently to help our members appropriately code and our leadership is eager to support and cooperate on curtailing Medicare fraud and abuse.

While we support efforts to curtail actual fraud and abuse in the Medicare program, we have concerns with CMS proposal, which we outline in our comments below.

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Incentive Reward Program

The AUA is concerned with CMS' proposal that would significantly increase the potential reward structure under the Incentive Reward Program. Specifically, CMS proposes to significantly increase the reward amount to help incentivize beneficiaries and others to report suspicious and potentially fraudulent and abuse activity.

In the proposed rule, CMS explains that "[t]he purpose of these provisions is to help protect the Medicare Trust Funds by providing incentives to Medicare beneficiaries and other parties to report suspected conduct…not to provide rewards for 'simple mistakes' or unintentional billing errors."

While we appreciate the intent of CMS' proposal, we disagree that providing significant financial incentives are the most effective way to curtail fraud and abuse in Medicare. We maintain that providing significant financial rewards for reporting potential fraud and abuse creates a perverse incentive for beneficiaries to make frivolous reports stemming from beneficiary misunderstandings about Medicare's rules and regulations for billing, payment, or coverage.

We note that CMS' recent release of quarterly Medicare Summary Notice's (MSNs) to beneficiaries have complicated the matter further. The new MSNs will now reflect services rendered by multiple providers over the course of three months. Depending on the volume of services provided, the beneficiary or caregiver reviewing the MSN may have forgotten about the service(s) that were provided, particularly if they did not retain a copy of their receipt or "super bill."

In addition, the beneficiary or caregiver may be confused when attempting to reconcile the MSN and the "super bill," particularly if the terminology used to describe the various services is inconsistent. Most beneficiaries and caregivers are not well versed in medical and clinical coding terminology used in the MSN or the provider super bill.

Furthermore, the MSN may list a billing provider or group practice name that is unfamiliar or different from the actual practitioner who saw the beneficiary or provided services, which is likely in cases where the provider who rendered the service(s) is an employee of, or billing under, another provider or group practice name.

Finally, the new MSN emphasizes reporting fraud and abuse to the Medicare program, but does not offer any advice or suggestions to prompt the beneficiary or their caregiver to contact the billing provider to clarify whether or not services were, in fact, provided.

We maintain that CMS' investigation of such frivolous reports will lead to an increase in Medicare audits, which are already a significant burden on physician practices. The AUA has previously shared concerns with increasingly confusing program integrity efforts by CMS. For example, multiple program integrity contractors make it confusing for physicians to know who's who, what each contractor is responsible for, what each contractor is allowed to ask for, and the timeframes in which a response is required.

We have also stated that physicians need more information and education on common billing and coding mistakes, which could be easily corrected, and better guidance on how to avoid audits, which would minimize hassles for both physicians and CMS. While we appreciate CMS' efforts to prepare and provide new comparative billing reports (CBRs) through its contractor, SafeGuard Services LLC, we would also recommend and request that additional information and guidance be made available. Specifically, we recommend that CMS collect and make publicly available data on common billing and coding errors, as well as aggregate statistics on the common coding and billing errors at a local (MAC level) and national level, as well as by specialty. We also recommend that CMS educate providers on these errors through existing education channels, including National Provider and Open Door Forum calls, MedLearn Matters articles, and the monthly and quarterly bulletins published by MACs, among CMS' other education channels and outlets. Furthermore, we recommend the development of a dedicated web presence for publishing the aforementioned information, as well as an associated CMS email list-serve to disseminate new information as it becomes public. Finally, we encourage CMS to provide technical assistance for physician practices, primarily those with a high volume of coding and billing errors, on how to avoid these errors. This could be accomplished through an expanded scope of work for Medicare's quality improvement organizations (QIOs).

We believe CMS should focus its energies on providing better educational materials on proper billing and coding to help practices avoid common coding and billing errors, which are sometimes confused with fraud and abuse. More guidance also is needed on the myriad of Medicare rules and regulations, which are oftentimes burdensome and confusing. CMS' efforts to address these issues

should negate the need to significantly increase financial rewards for reporting fraud and abuse.

Provider Enrollment
CMS also proposes several changes that would ensure certain providers would be unable to maintain Medicare billing privileges. For example, one proposal would revoke the billing privileges of physicians with a pattern of billing Medicare for services that do not meet "Medicare requirements." CMS proposed a number of "screens" to determine whether a provider falls into this category, such as the percentage and total number of submitted claims that were denied. While CMS specifically discusses its concerns with "medical necessity", CMS could revoke billing privileges for a provider that frequently makes erroneous coding and billing mistakes.

We appreciate CMS' clarification that its proposal "is not meant to be used to revoke providers and suppliers for isolated and sporadic claim denials or for innocent errors in billing." However, the agency's focus "on situations where a provider or supplier regularly fails to submit accurate claims in such a way as to…pose a risk to the Medicare Trust Fund" is very broad and encompasses much more than providers' misunderstanding or misapplication of Medicare's medical necessity guidelines as noted elsewhere in the proposed rule.

We maintain that physician practices have contended with unclear guidance on a variety of issues, such as the E/M guidelines for coding office visits or inconsistent guidance between Medicare's contractors and CMS. Until there is a greater understanding of these challenges, physicians should not be at risk of having their Medicare privileges revoked due to the appearance of fraud or abuse.

We emphasize that the need for clear and concise guidelines from CMS to help physician practices avoid billing and coding errors, which should reduce administrative costs for both CMS and the MACs, and assist the agency with its mandate to reduce its payment error rate, as well as assist physicians with improving coding and billing practices, which will reduce the likelihood of an unwanted Medicare audit, improve their ability to receive timely payment, and avoid the hassles of re-filing corrected claims and filing appeals.

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We appreciate the opportunity to provide comments on this important issue to urology practices. We look forward to working with you closely as the agency considers the best way in which to implement these recommendations. If we can be of assistance to you or provide additional details, please contact Stephanie N. Stinchcomb, Senior Manager, Reimbursement and Regulations at 410 689 3786 or sstinchcomb@auanet.org.

Sincerely,

David F. Penson, MD, MPH
Health Policy Chair