

Recovery Audit Contractors

The Beginning to Now – and Overview

RACs Challenged by Providers?

A Recent OIG Report May Be Indicating Just That

1 CEU

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Let's start at the beginning:

Congress mandated the RAC program to detect and correct improper payments in the Medicare program.

In section 306 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), Congress directed the Department of Health and Human Services (DHHS) to **conduct a 3-year demonstration program** using Recovery Audit Contractors (RACs) to detect and correct improper payments in the Medicare FFS program. In addition, in section 302 of the Tax Relief and Health Care Act of 2006 (TRHCA), Congress required DHHS to make the RAC program permanent and nationwide by no later than January 1, 2010. The RAC program does ***not*** detect or correct payments for Medicare Advantage or the Medicare prescription drug benefit.

Under the demonstration, the RACs are paid a contingency fee; that is, the RACs receive payment based on the amount of the improper payments they correct for both overpayments and underpayments.

Each RAC's contingency fee is established during contract negotiations with CMS and, as such, the contingency fee varies for each RAC.

For the 3-year demonstration required by the MMA, the Centers for Medicare & Medicaid Services (CMS) contracted with RACs to:

- 1) **Detect** Medicare improper payments (including both underpayments and overpayments); and
- 2) **Correct** Medicare improper payments (i.e., repay money to a provider who was underpaid or collect money from a provider who was overpaid).

The RACs are *guided by the same Medicare policies* and rules to identify improper payments as the Medicare claims processing contractors. **The RACs are required to use clinical staff such as nurses when conducting medical reviews. Each RAC also has a Medical Director.**

CMS designed the RAC program to:

- 1) **Detect and correct** past improper payments in the Medicare FFS program; and
- 2) **Provide information** to CMS and the Medicare claims processing contractors that can help protect the Medicare Trust Funds by preventing future improper payments thereby lowering the Medicare FFS payment error rate.

Medicare is Among the Top Three Federal Programs with Improper Payments.

According to a January 2008 report by the GAO, Medicare is one of the top three federal programs with improper payments (with an estimated \$10.8 Billion in improper payments in FY 2007).

3 Year Demonstration: RACs were Chosen Using a Competitive Process.

CMS conducted a thorough and open competitive process to select the RACs for the demonstration program, and in March 2005 awarded three contracts:

- California,
- Florida, and
- New York.

California, Florida, and New York were first selected for the demonstration ***because they are the largest states in terms of Medicare utilization. Approximately 25% of Medicare payments made each year are to providers in these states.***

Initially, each RAC had jurisdiction for a single state. However, the jurisdictions were expanded in the summer of 2007 to include an ***additional three states:***

- Massachusetts,
- South Carolina, and
- Arizona.

For FY 2007, CMS provided the RACs with claims data from October 1, 2002 through September 30, 2006 for their jurisdictions. The RAC demonstration program involved the RACs taking the following action:

- Using their proprietary automated review software algorithms to review all the claims in order to identify overpayments and underpayments that can be detected without medical record review;
- Conducting medical record reviews of claims that were likely to contain improper payments. These reviews entail requesting medical records from the health care provider that submitted the claim.

- o For the claims where medical records were submitted by the provider, the RAC reviewed these claims for compliance with Medicare coverage, coding and billing rules;
 - o For claims where medical records were not submitted by the provider, the RACs (as instructed by CMS) classified these claims as an overpayment;
- Sending provider notices and making adjustments for claims that were either overpayments or underpayments.

Some Claims Were Excluded From RAC Review. As of the end of FY 2007, CMS had given the RACs claims with a total dollar value of \$239.6 billion. These are claims that had been paid by the Medicare claims processing contractors between October 1, 2001 and September 30, 2006. The RACs could review any of the claims they were given with the following exclusions:

- **Incorrect Level of Physician Evaluation and Management Code.** CMS excluded these claims from RAC review while CMS considered a proposal by the American Medical Association that may have changed the way these services are reviewed. However, RACs were given the authority to review Evaluation & Management Services to look for other errors (e.g., duplicate payments, violations of Medicare's global surgery rules, definition of new patient, etc.). Despite being given the authority to review these services for other errors, very few of these types of claims were selected by the RACs for review during this time period.
- **Hospice and Home Health Services.** CMS excluded these claims from the demonstration for administrative simplification purposes.
- **Claims Previously Reviewed by Another Medicare Contractor.** CMS prohibited the RACs from reviewing claims that had already been reviewed by another Medicare contractor so as not to unduly burden the provider with multiple requests for the same medical record. CMS created a RAC Data Warehouse to track information about claims reviewed by the RACs. Other Medicare contractors used this Data Warehouse to designate which claims had been previously reviewed and were therefore excluded from review by the RACs.
- **Claims Involved in a Potential Fraud Investigation.** Without divulging sensitive information CMS excluded these claims from RAC review so as not to interfere with law enforcement's cases. Program Safeguard Contractors also used the RAC Data Warehouse to indicate which cases were excluded from review by the RACs.

- **Payments made to Providers under a CMS Conducted Demonstration.**

Reporting Periods. This RAC status report for FY 2007 includes claims that were originally paid by a Medicare claims processing contractor between October 1, 2002 and September 30, 2006 for which the RAC corrected the overpayment or underpayment between October 1, 2006 and September 30, 2007.

RACs Identified and Corrected \$371 Million Dollars of Medicare Improper Payments during FY 2007.

Over 96% of these improper payments were overpayments collected from providers and the remaining 4 percent were underpayments repaid to providers. Two factors explain why only 4 percent of the improper payments identified were underpayments.

First, although all three RACs have years of experience working in the private industry identifying overpayments, none of them had experience identifying underpayments before the RAC program. Each RAC had to build the algorithm software to seek out these underpaid claims. Second, a lower percentage of underpayment identifications is expected, according to the Improper Medicare FFS Payments Report, which estimated that only 9 percent of Medicare improper payments were underpayments.

Of all the overpayments collected in FY 2007, each RAC represented about one-third of the total payments recovered.

RACs Performed “Complex Review” to Detect Likely Improper Payments.

Complex review is when the RAC makes an overpayment or underpayment determination after evaluating the medical record associated with the claim in question. For example, complex review involves a RAC requesting and reviewing the medical record to check if the diagnosis code listed on the claim matches the diagnosis described in the medical record. **If the diagnosis does not match, the RAC then determines what the payment amount would have been if the claim was coded correctly.** The overpayment amount is the **difference between the original payment and the correct payment.**

Complex review also occurs when a RAC reviews a medical record to see if the beneficiary’s condition meets the Medicare medical necessity criteria for the setting where the service was rendered. For example, if a beneficiary presents to the emergency room with shortness of breath that can be safely and effectively treated in an outpatient setting, but the hospital admits the patient as an inpatient, the claim could be denied as medically unnecessary for that setting.

“Complex Review” Performed By Other Medicare Contractors.

Medicare claims processing contractors and QIOs perform complex review on a very small percentage of Medicare claims.

Errors detected through complex reviews - those that require a review of the medical record – are the most difficult for Medicare contractors to identify. This is because these improper payments are not evident from the claim alone and thus the Medicare contractor must request the medical record from the health care provider who submitted the claim.

The clinical staff at the Medicare claims processing contractor or QIO then reviews the medical record against Medicare’s national and local coverage determinations (and against standards of practice in cases where no national or local coverage determinations exist) to determine if the services are medically necessary and correctly coded. ***This type of review is very labor intensive and thus quite expensive.*** Congress appropriates a limited budget to CMS each year to fund these reviews. Therefore, only a tiny percentage of the claims submitted by providers and paid by Medicare can be reviewed.

Targeted complex review BEFORE claim payment is often called “prepayment review” while targeted complex review AFTER claim payment is often called “postpayment review.”

Medicare claims processing contractors do not randomly choose claims for review but, rather, target these prepayment and postpayment review to providers with a history of submitting claims that are not correctly coded or do not comply with Medicare’s medical necessity guidelines.

Once providers have re-established the practice of billing correctly, they are removed from targeted review. Medicare claims processing contractors then use the results of their prepayment and postpayment reviews to give provider feedback and education regarding the review findings. Providers can use this feedback and education to ensure proper billing practices in the future

The RAC Program Cost Only 22 Cents for Each Dollar Returned to the Trust Funds.

The demonstration costs fall into three categories.

- 1. RAC contingency fees** include the fees paid to RACs for detecting and collecting overpayments plus the fees paid for detecting and refunding underpayments.
- 2. Medicare claims processing contractor costs** are the funds paid to the carriers, fiscal intermediaries, and MACs for processing the overpayment/underpayment adjustments, handling appeals of RAC-initiated denials and other costs incurred to support the RAC program.

- 3. RAC evaluation, validation and oversight fees** are the funds paid to the RAC Evaluation Contractor, the RAC Data Warehouse Contractor, the RAC Validation Contractor and the federal employees who oversee the RAC program.

The RAC demonstration program has proven to be successful in returning overpayments to the Medicare Trust Funds and identifying underpayments for providers.

The program returned a significant amount of improper payments to the Medicare Trust Funds while limiting, to the extent possible, the burden on the provider community and the Medicare claims processing contractors. Furthermore, because RACs are required to repay any fees received for collecting overpayments that are later overturned on appeals, there is an incentive for RACs to identify improper payments accurately. In conclusion, CMS believes that the contingency-fee based payment system correctly aligns incentives among CMS, its providers, and the RACs.

RAC Today: 2009

January 26, 2009 Memorandum Report

In a January 26, 2009 Memorandum Report, Inspector General Daniel R. Levinson detailed the performance of the Office of Medicare Hearings and Appeals (OMHA) from its first to its third year of operations July 2005 through 2008. The OMHA is responsible for overseeing activities of Administrative Law Judge (ALJ) appeals.

Memorandum Report: "Medicare Administrative Law Judge Hearings: Update, 2007-2008," OEI-02-06-001 11.

Along with the establishment of the OMHA came a requirement for ALJ decisions, barring complications, to be rendered in 90 days or less. In short, IG Levinson stated

“From the first to third year of operation, OMR's caseload increased 37% and the proportion of cases subject to the 90-day decision requirement also increased. At the same time, there was little change in the hearing formats used and the types of primary appellants. In addition, OMHA improved the timeliness of its decisions from its first to third year of operation. For the cases that had a 90-day decision requirement, OMRA decided 94% on time in its third year, compared to 85% in its first year of operation. For the cases without the 90-day decision requirement, OMRA decided a slightly greater percentage of these cases within 6 months; however, there was also a slight increase in the average number of days to decide these cases. Lastly, OMRA improved the quality of the data in the appeals system from its first to its third year of operation.”



However, one new category emerged of which we should take special note: in his statement of the results of the three (3) year study, Inspector General Levinson states “***Approximately one quarter of the increase in OMHA’s caseload was attributable to appeals associated with the Recovery Audit Contractor program, a new Medicare program designed to detect and collect overpayments.***”

Look at the last sentence - Mr. Levinson states that of the 37% increase in caseload over the period studied, around 25% of the increase was due to **appeals over Recovery Audit Contractor (RAC)** determinations!

Now remember - at the ALJ level the provider has already attempted an appeal with the Medicare contractor and an independent review party. **This 25% shows us providers are willing to push their cases up to the ALJ level because they believe they have sufficient evidence to disprove the RAC’s findings.** Providers universally know you do not go to ALJ lightly, without substantial evidence to validate your counter-charge against findings.

The report does not tell us how many of these cases were overturned in favor of the provider: but it is not necessary here. What is relevant is that providers are not letting RAC decisions stand, and are challenging them at some of the highest levels of appeal available. RACs do not receive compensation unless they discover overpayments, and are bound by numerous regulations to keep their activities fair.

Let’s look at some elements which may be playing a part in these challenges.

First, RACs are not paid unless they find overpayments the federal health care programs can recoup.



This is serious motivation to find problems, and can sway or prejudice an auditor and her or his results. If the provider can prove prejudice then the audit cannot stand. CMS Program Integrity Manual 100-08 also very clearly delineates the criteria for acceptable audits, and proving flaws in any aspect can garner the provider very significant gains at ALJ. ***For example, the charts audited must be random.*** The ***number of charts*** must also be random, while concurrently being enough to **provide statistical significance**. If a provider can reasonably argue the sample was neither random nor statistically significant then the results cannot stand. **Another requirement is the charts audited be representative of the universe (total number of possible charts, patients and payer, to name a few) the RAC could audit.** Although not hugely successful, some providers have **argued this at ALJ successfully.**

More generally, and possibly more importantly, all documentation and methodology must be made available to the audited provider upon request.

Summary of Medical Record Limits (for FY 2009)

Inpatient Hospital, IRF, SNF, Hospice

10% of average monthly Medicare claims (max of 200) per 45 days

Maximum of 200 medical records per 45 days

- Example 1: Local Community Hospital
1,200 Medicare paid claims in 2007 Divided by 12 = average 100 Medicare paid claims per month x 10% = 10
Limit = 10 medical records per 45 days
- Example 2: Major Medical Center
12,000 Medicare paid claims in 2007 Divided by 12 = average 1,000 Medicare paid claims per month x 10% = 100
Limit = 100 medical records per 45 days

Other Part A Billers (Outpatient Hospital, HH)

1% of average monthly Medicare services (max of 200) per 45 days

Maximum of 200 medical records per 45 days

- Example 1: 1,500 Medicare paid services in 2007 Divided by 12 = average 125 Medicare paid services per month x 1% = 1.25
Limit = 2 records/45 days
- Example 2: 360,000 Medicare paid services in 2007 Divided by 12 = average 30,000 Medicare paid services per month x 1% = 300
Limit = 200 records/45 days (capped at the maximum)

Physicians

- **Solo** Practitioner: **10** medical records per 45 days
- **Partnership** of 2-5 individuals: **20** medical records per 45 days
- **Group** of 6-15 individuals: **30** medical records per 45 days
- **Large Group** (16+ individuals): **50** medical records per 45 days

Other Part B Billers (DME, Lab)

1% of average monthly Medicare services per 45 days

Maximum of 200 medical records per 45 days

- Example 1: 1,500 Medicare paid services in 2007 Divided by 12 = average 125 Medicare paid services per month x 1% = 1.25
Limit = 2 records/45 days
- Example 2: 360,000 Medicare paid services in 2007 Divided by 12 = average 30,000 Medicare paid services per month x 1% = 300
Limit = 200 records/45 days (capped at the maximum)

Summary

It has been shown in cases that auditors incompletely follow (or do not follow at all) PIM (**Program Integrity Manual**) 100-08.

Presently there are also additional requirements the RACs must follow in other CMS Manuals. **If every detail of the audit is not surrendered the provider can often win her or his case based on the fact he or she could not reproduce the audit or its results.** The provider can also inquire to the status of the computer data used. If a section or information is missing the audit again cannot be reproduced. Just looking through the 100-08 rules for statistical sampling and validation one can find many more specifics which can be argued at ALJ when challenging the RACs.

There is every reason to believe providers are increasingly challenging the RACs and they are willing to take their case at least to the ALJ level.

This is noteworthy and may represent shortfalls in the system perhaps not apparent upon initiation of the RAC program. It will be very interesting indeed to watch these cases and their verdicts.

The RACs will likely learn from any defeats they suffer throughout the appeals process. At the same time it is clear providers are also learning and are keenly aware of their rights.

Should news of ALJ verdicts become available there will be follow up articles to this to inform you. - Carl