



Recovery Audit Contractors (RACs) Current Status and The Future

During the past 3 years a demonstration project that was put in place as part of the Medicare Modernization Act of 2003 section 306 directed the Department of Health and Human Services to begin the process of using Recovery Audit Contractors in an effort to thwart over and under payments to health care providers. According to the document published February of 2008 by the Department of Health and Human Services CMS processes approximately 1 billion claims per year resulting in approximately \$10.8 billion in Medicare over or under payments. A report released in November of 2007 (Improper Medicare FFS Payments Report) estimates that 3.9 percent of the Medicare dollars paid did not comply with one or more Medicare coverage, coding, billing, or payment rules.

Here is something I find very interesting regarding how RACs are compensated. According to the HHS document, 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. Information on the contingency fee is considered proprietary and not disclosable. There are plans to change the way RACs are compensated due to the costs associated with these groups performing their services.

The demonstration project ended in March 2008 and the plan is for RACs to be nation wide by 2010. There were a lot of individuals affected by the work of the RACs, mostly hospitals. Providers were affected as well and as a result there was a lot of feedback provided to CMS and based on this, CMS has made some improvements.

Below are just a few of the improvements to the RAC program:

- The look back period has been changed from 4 years to 3 years in the permanent program.
- In the demonstration, CMS did not give a maximum look back date. In the permanent program the RACs will not be able to look for any improper payments on claims paid before October 1, 2007.
- In the demonstration RACs were not allowed to review claims during the current fiscal year, but they will be allowed to review

claims during the current fiscal year in the permanent program.

- Certified coders were not mandatory in the demonstration. In the permanent program each RAC must have certified coders.
- There was an optional medical record limit set by the individual RAC in the demonstration. The permanent program will have mandatory limits set by CMS.
- During the demonstration, discussion with the Medical Director regarding claim denials if requested by providers was optional. In the permanent program it is mandatory.
- The demonstration called for limited reporting by the RACs on the problem areas they had identified. Frequent problem area reporting is mandatory in the permanent program.
- During the demonstration, the RACs only had to pay back the contingency fee if they lost at the first level of appeal. This has been changed to all levels of appeal for the permanent program.
- The RACs did not offer a web-based application that allows providers to customize addresses and contact information or see the status of cases during the demonstration. In the permanent program each RAC must have this web-based application by January 1, 2010.
- During the demonstration an external validation process was optional and it varied by state. The external validation process is mandatory for the permanent program and it is a uniform process.

In a GAO (Report Number GAO-08-377R) report issued January of 2008 Medicare is one of the top three federal programs with improper payments. As I stated above Medicare paid out approximately \$10.8 billion in FY 2007 that were considered improper payments.

During the demonstration period there were three companies awarded the contracts, they are:

1. Connolly Consulting (New York) New York (March 2005) Massachusetts (July 2007)
2. Health Data Insights (Florida) Florida (March 2005) South Carolina (July 2007)
3. PRG-Schultz (California) California (March 2005) Arizona (July 2007)

As part of the review process, CMS provided approximately \$239.6 billion dollars in claims to be reviewed by the RACs. There were some restrictions placed on the RACs with regard to what was not allowed as part of the review.

A few of the exclusions were:

1. Incorrect Level of Physician Evaluation and Management Codes.
2. Hospice and Home Health Services.
3. Claims previously reviewed by another Medicare contractor.
4. Claims involved in a potential fraud investigation.
5. Payments made to provider under a CMS conducted demonstration.

It appears from the reviews of what the RACs investigated, they chose services that were highlighted by the Office of Inspector General (Hot Issues). The review process used by the RACs is similar to other Medicare Claims Processing Contractors.


According to the HHS document used as the main source of this article, RACs identified and corrected \$371 million dollars of Medicare improper payments. Here is the staggering part. 96% of the improper payments were overpayments to providers and only 4% underpayment. As you can guess the program benefits CMS more than the providers, which should not come as any big surprise.

There were appeals made on the RAC findings as there should have been but in all honesty, there were not enough appeals. Based on the HHS document there was \$357 million in overpayment collections, \$14.3 million in underpayments and \$17.8 million overturned upon appeal. The actual operating costs for the RAC demonstration process was \$77.7 million, which means the program netted \$247.4 million back to the Medicare Trust Fund. Not bad in my opinion for a 3 year demonstration program.

Now in all fairness the majority of the refunds made were on the inpatient hospital side, but that does not mean many physician offices didn't get hit. As a matter of fact almost one half of all improper payments were the result of incorrect coding and another one third were based on lack of medical necessity. DecisionHealth Professional Services, the group I am the Vice President of has and is currently assisting practices with appealing the findings of RAC reviews performed. One client we are working with was hit for more than \$250K. The majority of the groups we are working with had overpayments in the range of \$25K-\$40K, which is still nothing to sneeze at.

There are so many more aspects to how RACs function and what specifically they are reviewing. As always, Part B News and DecisionHealth Professional Services will continue to stay on top of the issue for you and provide you with invaluable tips to ensure you are protecting yourself and your company.

Seven Things To Keep In Mind:

1. Make sure your providers are documenting to substantiate the services they are providing. If documentation is not clear it should be easily inferred as to why a service was ordered and/or performed.
2. Understand all practices are open to investigation by CMS or one of its contractors.
3. Know what services are being targeted by keeping up with the OIG Work Plan, which identifies the "Hot Issues"
4. Realize the carriers as well as the review companies make mistakes.
5. Know your appeal rights and use them.
6. If you are not sure of what you are doing, seek assistance from a professional.
7. All 50 states will have a RAC in place by 2010. 

Sean M. Weiss, CPC, CPC-P, CCP-P, ACS-EM, PCS is the Vice President of DecisionHealth Professional Services (DHPS). DHPS is a full-scale medical consultancy specializing in the areas of compliance reviews, Medicare and private insurance appeals, practice management and many other services hospitals, physician practices and ASC require assistance with. For more information on DHPS or to schedule a time to speak with one of our health care professionals please visit them online at www.dhprofessionalservices.com or sewiss@decisionhealth.com You can also reach them at 888-262-8354.