Medicare Learning Network
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CMS
Information for Medicare Fee-For-Service Health Care Professionals

News Flash – As a result of the Affordable Care Act, claims with dates of service on or after January 1, 2010, received later than one calendar year beyond the date of service will be denied by Medicare. For full details, see MLN Matters® articles, MM6960, at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM6960.pdf, and MM7080 at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM7080.pdf on the Centers for Medicare & Medicaid Services website.

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# Recovery Audit Contractor (RAC) Demonstration High-Risk Vulnerabilities for Physicians

Note: This article was updated on August 27, 2012, to reflect current Web addresses. All other information remains the same.

This is the fourth in a series of articles that will disseminate information on Recovery Audit Contractor (RAC) demonstration high dollar improper payment vulnerabilities. The purpose of this article is to provide education to physicians on two vulnerabilities in an effort to prevent these same problems from occurring in the future. With the expansion of the RAC Program nationally, it is essential that physicians understand the lessons learned from the demonstration and implement appropriate corrective actions.

## Physician Types Affected

This article is for all physicians that submit Fee-For-Service claims to Medicare Carriers or Part A/B Medicare Administrative Contractors (MACs).

## Physician Action Needed

Review the article and take steps, if necessary, to meet Medicare's billing requirements to avoid unnecessary denial of your claims.

## Background

The primary goal of the RAC demonstration was to determine if recovery auditing could be effective in Medicare. The Centers for Medicare & Medicaid Services (CMS) directed the RAC staff to organize their efforts primarily to attain that goal. Supplemental goals, such as correcting identified vulnerabilities, were identified after the fact and were not required tasks. CMS did collect improper payment information from the RACs. However, it was on a voluntary basis, and was done at the claim level and focused on the collection. Two high risk vulnerabilities for physician claims are listed in Table 1. These claims were denied because the demonstration RACs determined that either a duplicate claim was billed and paid or the physician reported an incorrect number of units for Current Procedural Terminology (CPT) code billed based on the CPT code descriptor, reporting instructions in the CPT book, and/or other CMS local or national policy.

Table 1

| Item | Provider Type | Improper Payment Amount (pre-appeal) | RAC Demonstration Findings |
|---|---|---|---|
| 1 | Physician | $6,635,558 | Other Services with Excessive Units - Units billed exceeded the number of units per day based on the CPT code descriptor, reporting instructions in the CPT book, and/or other CMS local or national policy. |
| 2 | Physician | $1,094,751 | Duplicate Claims - Physician billed and was paid for two claims for the same beneficiary, for the same date of service, same CPT code, and same physician. |

Note: The two findings identified in Table 1 impacted multiple codes and no specific coding trends were self-reported by the RACs for these categories.

## Summary of RAC Demonstration Findings

The two high risk vulnerabilities for physician claims listed in Table 1 were identified because the demonstration RACs determined that either a duplicate claim was billed and paid or the units billed exceeded the number of units per day according to the CPT code descriptor, instructions in the CPT book, and/or other CMS local or national policy.

## Physician Billing and Documentation Reminders

An overpayment exists when a physician bills and is paid for services that have been previously processed and paid. See the Medicare Financial Management Manual Chapter 3, Section 10.2 at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/fin106c03.pdf on the CMS website. For more specific information on what criteria constitutes a duplicate claim see the Medicare Claim Processing Manual, Chapter 1, Section 120 found at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c01.pdf on the CMS website. CMS reminds physicians that routinely submitting duplicate claims to Part B Carriers and MACs for a single service encounter is inappropriate. CMS asks physicians to discontinue this practice. For more information on avoiding duplicate billing, please review Medicare Learning Network (MLN) Matters article SE0415 found at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE0415.pdf on the CMS website.

CMS guidance requires physicians to bill using the appropriate CPT code and to accurately report the units of service. Physicians should ensure that the units billed do not exceed the number of units per day based on the CPT code descriptor, reporting instructions in the CP book, and/or other CMS local or national policy.

## Additional Information

Physicians are also encouraged to visit the CMS RAC website at http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/recovery-audit-program/index.htmlfor updates on the National RAC Program. On the website you can register to receive email updates and view current RAC activities nationwide.