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RAC Status Document

FY 2007

Status Report on the Use of Recovery Audit Contractors (RACs)
In the Medicare Program

V2

February 2008

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Introduction

“Original” Medicare, also known as the Medicare Fee-For-Service (FFS) program, is a large and multifaceted program with a number of payment systems. Over one billion Medicare claims are processed each year. Inadvertent errors can account for billions of dollars in improper payments each year. Improper payments include both underpayments and overpayments. The Improper Medicare FFS Payments Report[1] for November 2007 estimates that 3.9 percent of the Medicare dollars paid did not comply with one or more Medicare coverage, coding, billing, or payment rules. This equates to $10.8 billion in Medicare FFS overpayments and underpayments.

With increasing expenditures, expanding Federal benefits, and a growing beneficiary population, the importance and the challenges of safeguarding the Medicare program is greater than ever. The Centers for Medicare & Medicaid Services (CMS), the federal agency that operates the Medicare program, has a relatively long history of calculating improper payment estimates and developing strategies to protect the Medicare programs’ fiscal integrity. In 2003, CMS implemented the Comprehensive Error Rate Testing Program and began producing error rates and estimates of improper payments to evaluate contractor and program performance. Since the inception of this program CMS has consistently reduced its’ improper payment error rate from 9.8% in 2003 to 3.9% in 2007.

Calculating improper payment rates is only one step in the process. Remediation is the key part of CMS’ efforts to reduce improper payments. CMS, through its Medicare claims processing contractors, uses the error rates to identify where problems exist and target improvement efforts. The cornerstone of these efforts is CMS’ Error Rate Reduction Plan (ERRP), which includes agency level strategies to clarify CMS policies and implement new initiatives to reduce improper payments. In the past, ERRPs have included plans to conduct special pilot studies and specific education-related initiatives. CMS also directs the Medicare claims processing contractors to develop local efforts to lower the error rate by targeting provider education and claim review efforts to those services with the highest improper payments. The type and nature of the errors in the program all lend themselves to different types of corrective actions to mediate them. Some improper payments are best prevented when the Medicare claims processing contractors request and review the medical records associated with the claims prior to payment to ensure that payment is made only for Medicare-covered and medically necessary items and services furnished in the appropriate setting. Other improper payments can best be prevented by CMS or the Medicare claims processing contractors developing new or revised national or local coverage determinations, medical necessity criteria, or billing instructions to assist providers in understanding how to correctly submit claims for medical items and services and under what circumstances the services will be considered medically necessary. Still other improper payments are prevented when CMS and/or Medicare claims processing contractors educate the provider community about existing policies and remind them of the billing mistakes most commonly seen in the claims data.

CMS actions to safeguard Federal funds are not merely limited to the claims processing actions and error rate programs. In 2006, Program Safeguard Contractors were established nationwide across all provider and supplier types. These specialized fraud fighters perform data analysis to

[1] See www.cms.hhs.gov/CERT

identify potential problem areas, investigate potential fraud, develop fraud cases for referral to law enforcement and coordinate Medicare fraud, waste and abuse efforts with CMS' internal and external partners.

Still, there has been a growing concern that even with all these efforts, the Medicare Trust Funds may not be adequately protected against improper payments. Accordingly, Congress took action by passing legislation to enhance and support Medicare's current efforts in identifying and correcting improper payments. 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.

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

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.

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.

The RAC demonstration program is designed to determine whether the use of RACs would be a cost-effective method to ensure that improper payments to Medicare providers are detected and corrected and to help protect the Medicare Trust Funds.

The RAC demonstration program began in March 2005 and will end in March 2008. The RAC program will be a permanent program and expanded nationwide by no later than January 1, 2010.

One goal of CMS during the demonstration has been to address all concerns raised by a RAC or any other interested party while identifying successes and opportunities for improvement before the program is expanded nationally. Based on this goal, CMS has made the following 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.

CMS will transition to the permanent program gradually. The timeline is as follows:

- December 1, 2007 was the last day a demonstration RAC could issue medical record request letters.

- February 1, 2008 was the last day a demonstration RAC could issue Part B demand letters.

- February 15, 2008 was the last day a demonstration RAC could issue Part A informational letters.

- In the spring of 2008, CMS will announce the names of the companies chosen to be the permanent RACs for the 4 regions.

- In the spring/summer of 2008, CMS and the new RACs will conduct extensive provider outreach. CMS will work with provider associations to help facilitate outreach.

Improper payments can occur in the Medicare FFS program when:

- Payments are made for services that were not medically necessary or did not meet the Medicare **medical necessity** criteria for the setting where the service was rendered (e.g., a claim from a hospital for three colonoscopies for the same beneficiary on the same date of service. Only one colonoscopy per day is medically necessary);

- Payments are made for services that are **incorrectly coded** (e.g., the provider submits a claim for a certain procedure but the medical record indicates that a different procedure was actually performed);

- Providers fail to submit documentation when requested, or fail to submit enough documentation to support the claim (***no documentation or insufficient documentation***);

- Other errors are made such as the claim is paid using an outdated fee schedule, or the provider is paid twice because duplicate claims were submitted.

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.

This status report focuses on the operations and findings of the Demonstration Claim RAC Program during fiscal year (FY) 2007 (from October 1, 2006 – September 30, 2007). This report excludes data on the Medicare Secondary Payer (MSP) RAC Program. For a discussion on the differences between the Claim RAC Program and the MSP RAC Program, please see the FY 2006 RAC Status Document (www.cms.hhs.gov/RAC).

This report focuses on the findings related to the Claim RAC Program.

Background

Medicare is a large and multifaceted program. The Medicare FFS program consists of a number of payment systems, with a network of contractors that process over 1.2 billion claims each year submitted by over one million health care providers such as hospitals, skilled nursing facilities (SNFs), physicians, and durable medical equipment (DME) suppliers. These contractors, called Medicare claims processing contractors and Quality Improvement Organizations (QIOs) process claims, make payments to the health care providers in accordance with the Medicare regulations, are responsible for educating providers about how to submit accurately coded claims that meet Medicare medical necessity guidelines, and ensure the quality of services provided to beneficiaries.

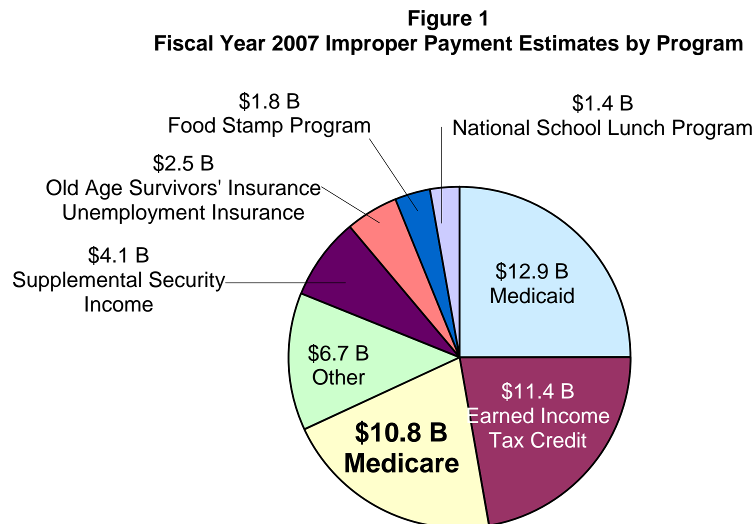
Medicare receives over 1.2 billion claims per year which is about:

- 4.5 million claims per work day
- 574,000 claims per hour
- 9,579 claims per minute

The DHHS' Office of Inspector General (OIG) and the Government Accountability Office (GAO) have issued reports describing the improper payments made by the Medicare FFS program. Although CMS, the Medicare claims processing contractors have undertaken actions to recoup those overpayments and prevent future improper payments, it is difficult to prevent all improper payments considering that over one billion claims are processed each year. Most improper payments in the Medicare FFS program occur because a health care provider submitted a claim to Medicare for a service that was not medically necessary or was incorrectly coded. To identify these types of improper payments requires more in-depth analysis of the claims and often involves a review of the medical record.

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).

Figure 1
Fiscal Year 2007 Improper Payment Estimates by Program



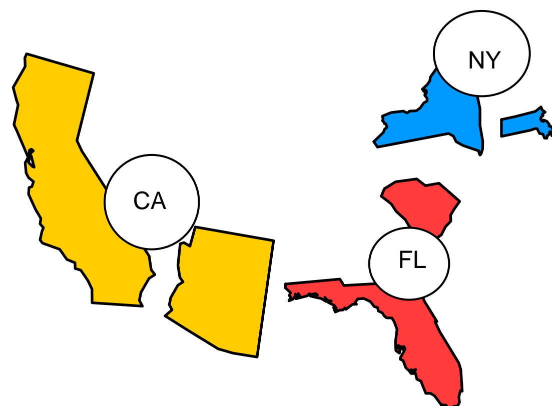
SOURCE: Federal Executive Branch Agencies' Fiscal Year 2007 Improper Payment Estimate Reporting, Government Accountability Office, January 23, 2008, Report Number GAO-08-377R (available at: http://www.gao.gov/new.items/d08377r.pdf)

Congress Authorized CMS to Use a Different Mechanism to Pay RACs. Congress gave CMS the authority to pay RACs using a different method than the Medicare claims processing contractors. The Medicare claims processing contractors are paid through funds appropriated by Congress. In contrast, CMS pays each RAC a contingency fee that is negotiated between CMS and the RAC. This demonstration is the first time the Medicare program has paid a contractor on a contingency fee basis. However, this type of payment methodology has been the accepted, standard practice among private healthcare payors for more than 20 years.

RACs were Chosen Using a Competitive Process. CMS conducted a thorough and open competitive process[2] to select the RACs for the demonstration program, and in March 2005 awarded three contracts. California, Florida, and New York were first selected for the demonstration because they are the largest states in terms of Medicare utilization. Approximately 25 percent 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. Please see Table 1-1.

Table 1-1
Names of Claim RACs and Jurisdictions

Name of RAC	Jurisdiction (start date)
Connolly Consulting (New York)	New York (March 2005) Massachusetts (July 2007)
Health Data Insights (Florida)	Florida (March 2005) South Carolina (July 2007)
PRG-Schultz (California)	California (March 2005) Arizona[3] (July 2007)



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.

[2] To avoid a conflict of interest, the legislation made Medicare claims processing contractors ineligible to bid on the RAC contracts.
[3] While contractually Arizona was added to PRG's jurisdiction in FY 2007, no Arizona claims were reviewed in FY 2007 and no Arizona claims are scheduled for review before the end of the RAC demonstration.

- **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.**

The RACs Often Chose To Review Services Highlighted by the OIG and GAO. CMS did not specify which claims the RACs had to review or even how the RACs were to identify claims for review. Instead, CMS left the claims selection methodology completely up to each RAC. Although each RAC used the knowledge they had gained from prior experience auditing health care provider payments in the private sector, the RACs also used the findings of OIG and GAO reports to help target their review efforts. The OIG and GAO issue many reports each year, some of which highlight specific Medicare services that are vulnerable to improper payments. The RACs utilized recent and past OIG and GAO reports in their efforts to identify claims most likely to contain improper payments.

The RAC Claims Review Process is Similar to that of the Medicare Claims Processing Contractors. The RACs analyzed claims data using their proprietary techniques to identify claims that clearly contained errors resulting in improper payments and those that likely contained errors resulting in improper payments. In the case of clear improper payments, the RAC contacted the provider to either collect any overpayment amounts or to pay any underpayment amounts. This process is called an automated review. In the case of claims that likely contained errors, the RAC requested medical records from the provider to further review the claim. The RAC would then make a determination as to whether payment of the claim was correct, an overpayment, or an underpayment. This process is called a complex review. These two review processes are similar to those employed by the Medicare claims processing contractors to identity improper payments.

RACs use the **same types of review staff** as the Medicare claims processing contractors.

RACs are guided by Medicare policies, regulations, national and local coverage determinations and manual instructions when conducting claim reviews. In certain instances where there is no Medicare policy, RACs review claims based on accepted clinical standards of medical practice at the time of the claim submission. RACs must follow Medicare coverage, coding or billing policies; they do not develop or apply their own coverage, coding, or billing policies. And similar to the Medicare claims processing contractors, RACs use medical personnel such as nurses, therapists and certified coders to review claims. In addition, each RAC has a physician Medical Director to oversee the medical record review process, assist nurses, therapists, and certified coders upon request during complex review, manage the quality assurance procedures, and inform provider associations about the RAC program.

For FY 2007, CMS provided the RACs with claims data from October 1, 2002 through September 30, 2006 for their jurisdictions.[4] 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[5].
  - 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;
  - 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.

The RACs Worked Closely with the Provider Community. CMS prohibited RACs from educating providers about how to submit correctly coded claims for medically necessary services since preventing improper payments through provider education is the responsibility of the Medicare claims processing contractors and QIOs. However, CMS encouraged and assisted each RAC in communicating frequently with the provider community about the RAC review process and ways it could be improved. RACs were required to operate toll-free provider inquiry phone lines. RACs held monthly conference calls with state and national physician and hospital associations. Senior RAC staff spoke to state or regional provider meetings. By forging these important communication channels with provider groups, RACs helped providers understand the RAC review process and providers offered suggestions to the RACs about how to make RAC letters clearer and ways to reduce the administrative hassle for providers.

The RAC Demonstration will end in March 2008. The RAC demonstration began on March 28, 2005 and is scheduled to end on March 27, 2008. Section 302 of the Tax Relief and Health Care Act of 2006 directs the Secretary of HHS to make the RAC program permanent and nationwide by no later than January 1, 2010.

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.

For FY 2007, RACs reviewed claims that were originally **paid between 2002 and 2006.**

[4] From the inception of the RAC demonstration through September 30, 2007, CMS gave the RACs claims data from October 1, 2001 through September 30, 2007 (with a total estimated payment amount of $239.6 billion). Demonstration RACs were not allowed to review claims that were paid in the current fiscal year.

[5] Some RACs developed a self-imposed limit on the number of medical records requests per 30 or 45 days from a given provider.

RAC-Identified Improper Payments

RACs Identified and Corrected $371 Million Dollars of Medicare Improper Payments during FY 2007. Over 96 percent 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.

Table 2-1
Summary of Total Improper Payments Corrected By The RAC Program – FY 2007

	Overpayments Collected[6]		Underpayments Repaid[7]		Total Improper Payments Corrected
New York	$ 112.5 m	+	$ 1.8 m	=	$ 114.3 m
Florida	$ 124.6 m	+	$ 4.1 m	=	$ 128.7 m
California	$ 120.1 m	+	$ 8.4 m	=	$ 128.5 m
Total	**$ 357.2 m**	+	**$ 14 .3 m**	=	**$ 371.5 m**

SOURCE: RAC Data Warehouse. m = million

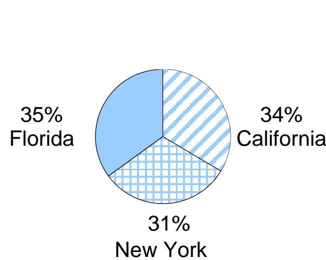


Figure 3
Underpayments by RAC

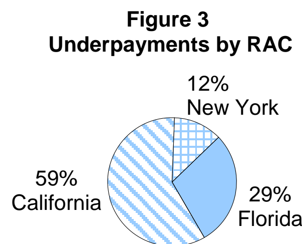


Figure 4
Overpayments vs. Underpayments

96%
Overpayments
4%
Underpayments

SOURCE: RAC Data Warehouse.

The Vast Majority of Medicare Claims Were Unaffected by the Claim RACs. From the inception of the demonstration through September 30, 2007, the New York RAC received over 400 million claims, the Florida RAC received over 280 million claims, and the California RAC received over 250 million claims for review.

Although the Improper Medicare Fee-For-Service Payments Report estimated Medicare's improper payment rate at 3.9%, RACs identified and corrected improper payments on less than 0.2% of all payments they were given to review over the life of the demonstration. The low

[6] *Collected* is defined as overpayments that have been recovered from providers and deposited.
[7] *Repaid* is defined as underpayments that have been paid back to the provider.

percentage of improper payments that were corrected is due to several factors. First, because this was only a demonstration, RACs may not have hired as many permanent full-time staff as they would have under a permanent program. Each RAC indicated that if it were to become a permanent Medicare RAC, then it would likely hire more staff, to conduct more reviews, and correct more improper payments. Second, CMS prohibited RACs from reviewing certain types of claims for administrative simplification purposes (e.g., physician visit claims, home health and hospice claims, etc). Third, RACs were sensitive to the financial impact they were having on individual providers.

RACs Returned Over $247 Million to the Medicare Trust Funds. During FY 2007, the RACs returned a significant amount of improper payments to the Medicare Trust Funds. Table 2-2 shows that after taking into account the amount repaid to providers for underpayments, the monies overturned on appeal, and the costs of operating the RAC program, the RACs returned about $247.4 million to the Medicare Trust Funds. (Further details regarding costs can be found on page 21.)

Table 2-2
Summary of Net Savings in the RAC Program – FY 2007

	Overpayments Collected		Underpayments Repaid		Amount Overturned on Appeal (Cumulative through 9/30/07)[8]		Costs to Operate RAC Demo		Back To The Trust Fund (Net Savings)
Total	**$**357.2 m	-	$ 14.3 m	-	$ 17.8 m	-	$ 77.7 m	=	**$247.4 m**

SOURCE: RAC Data Warehouse Appeal data is cumulative. m = million

Most Overpayments Were Collected From Inpatient Hospitals. Table 2-3 and Figure 5 show the overpayments identified by the RACs categorized by the type of provider. Most of the overpayment amounts collected by the RACs (about 85 percent) were from inpatient hospital providers. The Improper Medicare FFS Payments Report from November 2007 (based on a review of a random sample of claims) found that 45.4 percent of the improper payments in Medicare were made to inpatient hospitals. Several factors may explain the RAC's relatively high rate of improper payments in the inpatient hospital settings. First, CMS prohibited RACs from reviewing certain claim types (such as physician visit claims) as part of the RAC demonstration. Second, because RACs are paid on a contingency fee basis, they establish their claim review strategies to focus on high dollar improper payments, like inpatient hospital claims which give them the highest return with regard to the expense of reviewing the claim and/or medical record.

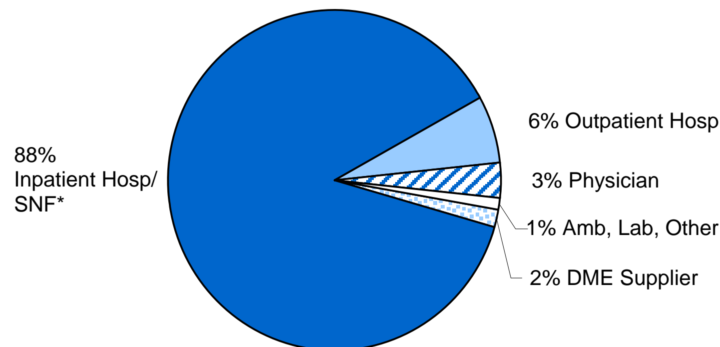
Table 2-3
OVERpayments Collected By Provider Type and Jurisdiction – FY 2007

	Inpatient Hospital and SNF	Outpatient Hospital	Physician	Ambulance Lab, Other	Durable Medical Equipment	Total Overpayments Collected
New York	$ 99.2 m	$ 8.4 m	$ 1.6 m	$ 0.0 m	$ 3.3 m	$112.5 m
Florida	$115.1 m	$ 3.4 m	$ 5.1 m	$ 1.0 m	$ 0.0 m	$124.6 m
California	$ 98.5 m	$ 10.8 m	$ 5.5 m	$ 3.1 m	$ 2.2 m	$120.1 m
Total	**$312.8 m**	**$ 22.6 m**	**$ 12.2 m**	**$ 4.1 m**	**$ 5.5 m**	**$357.2 m**

SOURCE: RAC Data Warehouse (Physician to Ambulance/Lab/Other ratio is derived from self-reported RAC data). m = million

[8] Amount Overturned on Appeal (Cumulative through 9/30/07) is used as FY 2007-only appeals data was unavailable.

Figure 5
Overpayments by Provider Type



* Self-reported RAC data indicate that SNFs account for less than 3% of the collections

SOURCE: RAC Data Warehouse (Physician to Ambulance/Lab/Other ratio is derived from self-reported RAC data)

Most Underpayments Were Repaid To Inpatient Hospitals. Table 2-4 shows that in addition to the $357 million in overpayments collected by the RACs, $14 million in underpayment amounts were repaid to providers in FY 2007, and most of these were repaid to inpatient hospitals.

Table 2-4
UNDERpayments Paid Back By Claim Type and Jurisdiction – FY 2007

	Inpatient Hospital and SNF	Outpatient Hospital	Physician	Ambulance Lab, Other	Durable Medical Equipment	Total Underpayments Repaid
New York	$ 1.2 m	$ 0.4 m	$ 0.2 m	$ 0.0 m	$ 0.0 m	$ 1.8 m
Florida	$ 4.1 m	< $ 0.1 m	$ 0.0 m	$ 0.0 m	$ 0.0 m	$ 4.1 m
California	$ 8.3 m	< $ 0.1 m	$ 0.0 m	$ 0.0 m	$ 0.0 m	$ 8.4 m
Total	**$ 13.6 m**	**$ 0.5 m**	**$ 0.2 m**	**$ 0.0 m**	**$ 0.0 m**	**$ 14.3 m**

SOURCE: RAC Data Warehouse (Physician to Ambulance/Lab/Other ratio is derived from self-reported RAC data). m = million

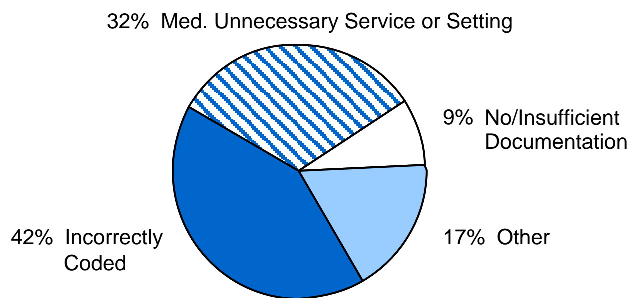
Almost Half of the Improper Payments were the Result of Incorrect Coding. Most improper payments occur when providers submit claims that do not comply with Medicare's coding or medical necessity policies and rules. Table 2-5 and Figure 6 show the overpayments collected by the RACs, net of appeals, by error type. Approximately one-third of the improper payments were on the basis that the claim did not meet Medicare's medical necessity criteria for a particular service or a particular setting. The No Documentation and Insufficient Documentation category refers to claims where a RAC requested a medical record from the provider, and the provider either failed to respond within the appropriate time limits or failed to send the complete medical records. Other types of errors include incorrectly following fee-schedules, submitting duplicate claims, or billing separately for services already included in other payments.

Table 2-5
Overpayments Collected By Error Type (NET OF APPEALS) – FY 2007

	Inpatient Hospital and SNF	Outpatient Hospital	Physician	Ambulance Lab, Other	Durable Medical Equipment	Total Overpayments Collected
Incorrectly Coded	$ 123.8 m	$ 7.6 m	$ 4.8 m	$ 2.2 m	$ 4.7 m	$ 143.2 m
Med. Unnecessary	$ 106.5 m	$ 4.8 m	$ 0.2 m	< $ 0.1 m	$ 0.0 m	$ 111.5 m
No/Insufficient Doc	$ 29.6 m	$ 0.4 m	$ 0.2 m	< $ 0.1 m	< $ 0.1 m	$ 30.3 m
Other	$ 44.8 m	$ 5.4 m	$ 7.1 m	$ 1.2 m	$ 0.5 m	$ 59.0 m
Total	**$ 304.7 m**	**$ 18.2 m**	**$ 12.3 m**	**$ 3.5 m**	**$ 5.3 m**	**$ 344.0 m**[9]

SOURCE: Self-Reported by RACs. m = million

Figure 6
Overpayments by Error Type



SOURCE: Self-Reported by RACs

[9] These numbers are net of FY 2007 appeals of which the RACs were aware on 9/30/07 and thus vary slightly from the data displayed in earlier sections of the report.

RACs Performed "Automated Review" To Detect Clear Improper Payments. Automated review is when the RAC is able to make an overpayment or underpayment determination without evaluating the medical record associated with the claim. For example, automated review can consist of a RAC using information systems to search for claims for two or more identical surgical procedures for the same beneficiary on the same day at the same hospital. The same surgical procedure is clearly not medically necessary, should not have been billed twice by the hospital, and therefore should not have been paid twice by the Medicare claims processing contractor. This type of automated review is often called an "Excessive Units Audit".

Example of an "Excessive Units" Automated Review Audit

Date of Service	*Procedure*	*Units*	*Amount Paid*
3/1/04	*47562 (Cholecystectomy)*	*3*	*$2,461.23*

CLAIM FACTS

- *Procedure code 47562 is billed and paid with 3 units of service*
- *Same date of service, same beneficiary for all 3*
- *Units should never exceed 1 for a single date of service*
- *Overpayment amount: $1,221*
- *Error Type: Medical Necessity*

CORRECTIVE ACTIONS

- *Hospitals can be more careful when submitting claims for multiple units of service*
- *Medicare can add edits to the claims processing systems to disallow these "medically unbelievable" situations*

Source: the Florida RAC

Medicare claims processing contractors can use automated system edits to help prevent these kinds of improper payments in the future.

Another example of the automated review process is the case of an incorrect discharge status code. The discharge status code indicates where the beneficiary went following discharge from a facility such as home, skilled nursing facility, etc. No medical record is needed to find inaccuracies in this field on a claim. In this case, the RAC reviews the full claims series for a given time period for a particular beneficiary. From this review, they identify that although the first claim contained a discharge status indicating that the beneficiary went home after she left the hospital, there was a second claim indicating that the beneficiary was in fact transferred from the first hospital to another inpatient acute care hospital. In a transfer situation like this, the two hospitals should split a single DRG payment instead of both receiving a full DRG payment.

Example of "Incorrect Discharge Status" Automated Review Audit

	Dates of Svc	*Discharge Status Code*	*Amount Paid*
Claim #1:	*8/21 – 23/04*	*01 (home)*	*$2,606.00*
Claim #2:	*8/23 – 27/04*	*02 (hospital)*	*$2,526.10*

CLAIM FACTS

- *Two different claims; two different providers*
- *Beneficiary was transferred from one hospital to another*
- *Claim #1 should have been billed with a discharge status of 02 (hospital). If it had been, it would have been paid at a per diem rate, rather than the DRG rate.*
- *Overpayment amount: $1,504.00*
- *Error Type: Incorrect Coding*

CORRECTIVE ACTIONS

- *Hospitals can be more careful when submitting claims with respect to the Discharge Status code*
- *Medicare claims processing contractors can remind hospitals about the importance of listing an accurate discharge status.*

Source: the Florida RAC

These types of improper payments are difficult for the Medicare claims processing system to detect since the claims are submitted at different times.

Example of a "Wrong Setting" Complex Review Audit

CLAIM FACTS

- *The beneficiary presents to the emergency room with shortness of breath. EKG is normal. Chest x-ray rules out pneumonia.*
- *The hospital admits the beneficiary for a one-day hospital stay.*
- *Medical record reviews indicates no reason why the services could not have been performed on an outpatient basis.*
- *The entire inpatient claim is denied.*
- *Error Type: Medically Unnecessary*

CORRECTIVE ACTIONS

- *Hospitals can be more careful when submitting claims for one-day stays to ensure that the services rendered were medically necessary in that setting.*
- *Medicare claims processing contractors can remind hospitals to be careful when admitting patients for one-day stays to make sure that the setting is medically necessary.*

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.

Future Improper Payments Can Be Avoided. The information in Table 2-6 describes the vulnerabilities the RACs identified during FY 2007. These data were self-reported by the RACs and were not gathered from the RAC data warehouse. All data in this section are net of appeals as of September 30, 2007. For example, if there were $10 million in overpayments collected for a particular service but $1 million of these overpayments were overturned on appeal, then the data would show $9 million.

CMS can use this detailed information from the RAC program and the Improper Medicare FFS Payments report to prevent these types of improper payments in the future by conducting more provider education and outreach or establishing new system edits. In addition, Medicare claims processing contractors in RAC states can use this information to develop their local error rate reduction plans. These contractors may choose to do more data analysis, automated prepayment reviews, and/or complex prepayment reviews in the areas identified. Even contractors in other states can use these findings to help reduce their local error rates by analyzing whether any of these improper payments are occurring in their states. Finally, providers can use these findings to help ensure that they are submitting correctly coded claims for services that meet Medicare's medical necessity criteria. By establishing strong internal controls, hospitals can use these RAC findings to train coders, physicians, medical record staff and others to help minimize future improper payments. See appendix C for details.

Table 2-6
Top Services with RAC-Initiated Overpayment Collections (NET OF APPEALS) – FY 2007

Type of Provider	Description of Item or Service	Amount Collected Less Cases Overturned on Appeal	Claims Found in Error Less Cases Overturned on Appeal	Location of Problem
Inpatient Hospital	Excisional Debridement	$ 30.5 m $ 3.2 m $ 2.5 m	2,603 423 346	NY CA FL
	IRF services following joint replacement surgery	$ 20.8 m	1,833	CA
	Heart Failure and Shock	$ 7.8 m $ 2.0 m $ 9.5 m	835 306 2190	NY CA FL
	Surgical Procedures in Wrong Setting	$17.1 m	1,610	NY
	Respiratory System Diagnoses with Ventilator Support	$ 9.5 m $ 4.1 m $ 1.7 m	577 266 123	NY CA FL
	Extensive OR procedures Unrelated to Principal Diagnosis	$ 3.9 m $ 3.1 m $ 1.5 m	299 264 123	NY CA FL
Outpatient Hospital	Colonoscopy	$ 2.0 m	5,134	NY
	Speech Language Pathology Services	$1.4 m	3,295	CA
	Infusion Services	$ 1.3 m	9,956	CA
Skilled Nursing Facility	Physical Therapy and Occupational Therapy	$ 1.9 m	1,591	CA
	Speech Language Pathology Services	$ 1.5 m	2,690	CA
Physician	Pharmaceutical Injectables	$ 2.0 m	9,534	CA
	Duplicate Claims	$ 1.8 m	15,925	CA
	Vestibular Function Tests	$ 1.4 m	13,608	FL
Lab/ Amb/ Oth	Ambulance services during a hospital inpatient stay	$ 2.0 m	5,888	CA
DME	Items during a hospital inpatient stay or SNF stay	$ 1.5 m $ 1.5 m	13,849 10,366	NY CA

SOURCE: Self-Reported by RACs

Effect on Medicare Claims Payment Error Rate Remains Undetermined. Because the RACs have only been identifying improper payments for two years, CMS cannot yet determine if the Medicare claims processing contractors in RAC states are able to lower their paid claims error rates more rapidly than Medicare claims processing contractors in other states.

RAC Validation Contractor. In order to be sure that the RACs were making accurate claim determinations, CMS contracted with an independent third party review entity, AdvanceMed, to be the RAC Validation Contractor (RVC) in August 2007. The RVC had two tasks: (1) to review a small number of claims that represented new issues for which the RAC wished to begin full-scale review; and (2) to review a random sample of overpayment claims from each RAC. The RVC has been a valuable addition to the RAC program to ensure the accuracy of the overpayment decisions made by each RAC.

Appeals of RAC Determinations

Only 5 Percent of RAC Determinations Were Overturned On Appeal. The following table displays the number of appeals of RAC determinations that were filed by providers from the inception of the RAC program through October 31, 2007. In the majority of these appeals, the provider challenged the underlying medical necessity or coding determination made by the RAC. Providers chose to appeal only 11.3 percent of the RAC determinations. Overall, data indicate that of the total RAC overpayment determinations, only 5 percent were overturned on appeal.

Only 5 percent of RAC determinations were fully or partially **overturned on appeal.**

Table 3-1
Provider Appeals of RAC-Initiated Overpayments – Cumulative through FY 2007

		Number of Claims with Overpay-ment Collections (A)	Number of Claims Where Provider Appealed To…				% Claims Where Pro-vider Appealed (any level) (E/A)	Number of Claims with an Appeal Decision in Provider's Favor (F)	% of Appealed Claims with a Decision in Provider's Favor (F/E)	% of Overpay-ment Collections Overturned on Appeal (F/A)
			1st Level (B)	2nd Level (C)	3rd Level (D)	any Level (E)				
Part A	NY	66,547	1,736	186	2	1,924	2.9%	898	46.7%	1.3%
Part A	FL	46,176	4,682	206	0	4,888	10.6%	1,914	39.2%	4.1%
Part A	CA	46,053	6,054	440	87	6,581	14.2%	271	4.1%	0.6%
Part A	Total	159,230	12,472	832	89	13,393	8.4%	3,083	23.0%	1.9%
Part B	NY	27,298	1,020	0	0	1,020	3.7%	695	68.1%	2.5%
Part B	FL	105,273	16,352	16	0	16,368	15.5%	11,567	70.7%	11.0%
Part B	CA	66,964	9,334	466	2	9,802	14.6%	2,606	26.6%	3.9%
Part B	Total	199,535	26,706	482	2	27,190	13.6%	14,868	54.7%	7.5%
Parts A & B	NY	93,845	2,756	186	2	2,944	3.1%	1,593	54.1%	1.7%
Parts A & B	FL	151,449	21,034	222	0	21,256	14.0%	13,481	63.4%	8.9%
Parts A & B	CA	113,471	15,388	906	89	16,383	14.4%	2,877	17.6%	2.5%
Grand Total		358,765	39,178	1314	91	40,583	11.3%	17,951	44.2%[10]	5.0%

SOURCE: RAC Data Warehouse and data reported by Medicare claims processing contractors. Appeals include both completed and those currently in the appeals process. There is a delay between the time when an appeal is filed and when it is reported to CMS. This table includes all appeals that had been filed on or before 9/30/07 and communicated to the RAC prior to 10/31/07. The table excludes a small number of appeals that had been filed on or before 9/30/07 but were not brought to the RAC's attention until 11/1/07or later. In addition, this table does not reflect claim determinations made or appeals filed after 9/30/07. The first column in this table is a count of all overpayment determinations that had been recouped on or before 9/30/07. There may have been a significant number of claims that were appealed after the provider received the overpayment notification letter but prior to the overpayment being recouped.

[10] NOTE: Two significant factors contributed to the higher than expected appeal filing rates and appeal overturn rates. First, the Florida RAC experienced a high volume of appeals (898 claims valued at $3.7 million) when a number of hospitals initially failed to submit the requested medical records. Second, the Florida RAC saw a large number of appeal filings (4,835 claims valued at $0.4 million) for claims that were more than 3 years past the date of service. Medicare regulations stipulate that providers are not required to refund overpayments amounts more than 3 years past to the date of services.

Cost of Operating the RAC Program

The RAC Program Cost Only 22 Cents for Each Dollar Returned to the Trust Funds[11]. The demonstration costs fall into three categories.

- **RAC contingency fees** include the fees paid to RACs for detecting and collecting overpayments plus the fees paid for detecting and refunding underpayments.
- **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.
- **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 total costs of operating the RAC Program for FY 2007 are listed below.

Table 4-1
Cost of Operating the Medicare RAC Program –FY 2007

Cost Categories	Costs
RAC Contingency Fees	$ 71.2 m
Medicare Claims Processing Contractor Costs	$ 3.9 m
RAC Evaluation, Validation, and Oversight Expenditures	$ 2.5 m
Total	**$ 77.7 m**

Source: RAC vouchers and Contractor Accounting Financial Management System (CAFM).

When total cost data from Table 4-1 is compared to overpayments collected data from Table 2-2, one can see that in FY 2007, **the RAC program:**

- achieved a respectable return on investment of 318 percent
- experienced a $4.60:$1 benefit: cost ratio
- **spent only 22 cents for each dollar collected**

(NOTE: These numbers were calculated based on actual collections)

In addition to the direct costs associated with the operation of the RAC program, CMS recognizes that there are indirect costs of the RAC program such as the costs incurred by the Qualified Independent Contractors (QICs) and Administrative Law Judges (ALJs) who process second and third level appeals as well as the cost to some providers for submitting medical records and filing appeals. CMS does not have an estimate of these costs at this time.

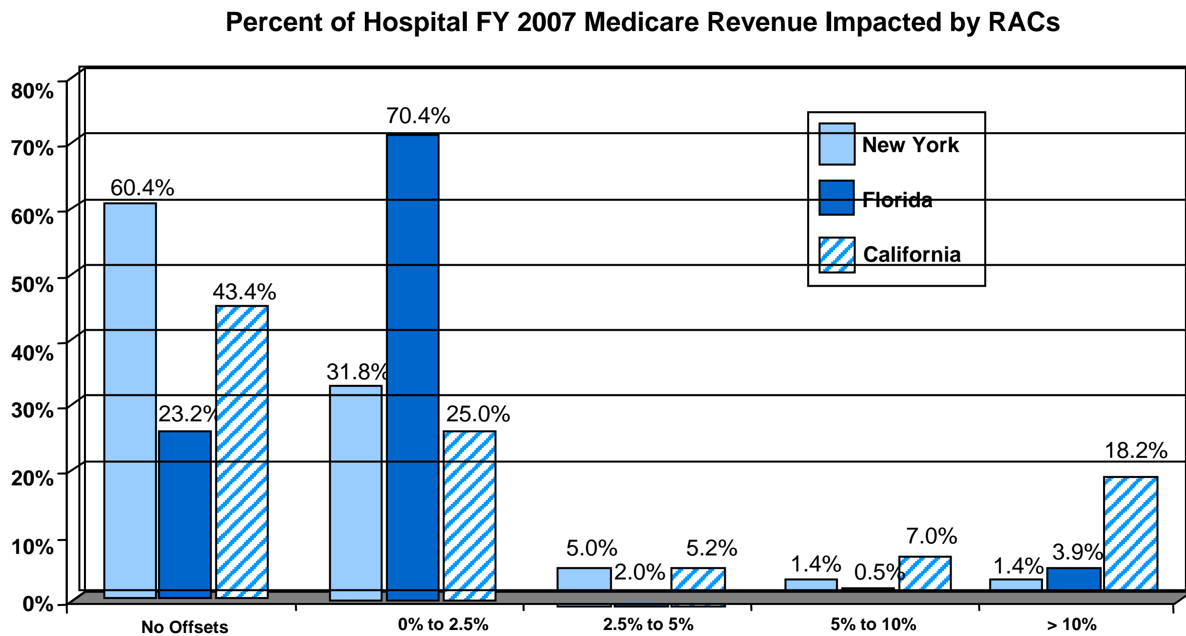
[11] ROI is calculated as follows: $357.2 m (total collections) - $14.3 m (underpayments repaid) - $ 17.8 m (overturned on appeal) - $77.7 m (cost) = $247.4 m (net savings) / $77.7 m (cost) = 3.18 * 100 = 318 percent. Benefit-Cost Ratio is calculated as follows: $357.2 m (total collections) / $77.7 m (cost) = $4.60. Cents spent for every dollar saved calculated as follows: $77.7 m (cost) / $357.2 m (total collections) = .22.

Financial Impact to Providers

RAC Program Has Limited Financial Impact to Providers. Figure 7 shows improper payments identified by the RACs as a percentage of the total FY 2007 Medicare Part A revenue for hospitals. Over 90 percent of the hospitals that were part of the RAC demonstration in New York and Florida had their 2007 Medicare revenue impacted by less than 2.5 percent. In California, 68 percent of hospitals had their 2007 Medicare revenue impacted by less than 2.5 percent.

Figure 7

Percent of Hospital FY 2007 Medicare Revenue Impacted by RACs



- 92 percent of NY hospitals had their FY 2007 Medicare revenue impacted by less than 2.5 percent.
- 94 percent of FL hospitals had their FY 2007 Medicare revenue impacted by less than 2.5 percent.
- 68 percent of CA hospitals had their FY 2007 Medicare revenue impacted by less than 2.5 percent.

Using RAC Findings to Prevent Future Improper Payments

CMS and the Medicare claims processing contractors analyze the RAC findings and identify corrective actions that can be implemented to prevent future improper payments. Service-specific vulnerabilities can be found in Table 2-6 and Appendix C of this report.

Each Medicare claims processing contractor in a RAC state can adjust its local error rate reduction plan based on the RAC findings in their area. The improper payment prevention tools used by Medicare claims processing contractors in preventing improper payments include:

- data analysis
- provider education
- automated prepayment review (auto-deny edits)
- complex pre-payment review (medical record review before a claim is paid)
- complex post-payment review (medical record review after a claim is paid)

Although some of the RAC-identified improper payments were due to claims processing errors, the majority of the improper payments were due to providers billing for services that were incorrectly coded or did not meet Medicare's medical necessity policies. Provider education about RAC-identified problem areas is a critical component of CMS' strategy to prevent future improper payments.

The RAC Program allows CMS and the Medicare claims processing contractors to **target actions aimed at preventing future improper payments.**

Next Steps and Conclusions

CMS Will Gradually Expand the RAC Program Nationwide. Due to the importance of protecting the Medicare Trust Funds, Congress included Section 302 in the Tax Relief and Health Care Act of 2006, which requires the Secretary to make the RAC program permanent and to expand the use of RACs throughout the country (see Appendix B). CMS is currently undertaking a number of initiatives to expand the RAC program.

CMS has begun the expansion process by initiating a full and open competition for four permanent RACs to begin after the end of the RAC demonstration in March 2008. (See Appendix D for map of jurisdictions).

CMS has also developed a strategy so that the RAC program will not interfere with the transition from the old Medicare claims processing contractors to the new Medicare claims processing contractors called Medicare Administrative Contractors (MACs). This strategy will allow the new MACs to focus on claims processing activities before working with the RACs.

Generally, the RAC blackout period will be:

- 3 months before a MAC begins processing claims for a given state
- 3 months after a MAC begins processing claims for a given state

The Medicare RAC Demonstration Helped CMS Plan the Permanent RAC Program. As CMS continues to evaluate the extent to which the RAC program protects the Trust Funds from future improper payments, the results described in this report clearly demonstrate that the RAC program is a viable and useful resource for detecting and correcting past improper payments.

The CMS RAC demonstration is a cost effective program and the actions CMS is now taking, including initiatives to streamline the steps by which RAC improper payments are processed by the Medicare claims processing contractors, will result in an even more cost effective program in the future.

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.

CMS views the RAC program as an adjunct to its present programs and **a valuable new tool** for helping prevent future overpayments.

Contact Information

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Appendix A – Medicare Modernization Act (Section 306)

SEC. 306. DEMONSTRATION PROJECT FOR USE OF RECOVERY AUDIT CONTRACTORS.
(a) IN GENERAL- The Secretary shall conduct a demonstration project under this section (in this section referred to as the 'project') to demonstrate the use of recovery audit contractors under the Medicare Integrity Program in identifying underpayments and overpayments and recouping overpayments under the Medicare program for services for which payment is made under part A or B of title XVIII of the Social Security Act. Under the project-

(1) Payment may be made to such a contractor on a contingent basis;

(2) Such percentage as the Secretary may specify of the amount recovered shall be retained by the Secretary and shall be available to the program management account of the Centers for Medicare & Medicaid Services; and

(3) The Secretary shall examine the efficacy of such use with respect to duplicative payments, accuracy of coding, and other payment policies in which inaccurate payments arise.

(**b) SCOPE AND DURATION** -
(1) SCOPE- The project shall cover at least 2 States that are among the States with-

(A) The highest per capita utilization rates of Medicare services, and

(B) At least 3 contractors.

(2) DURATION - The project shall last for not longer than 3 years.

(**c) WAIVER** - The Secretary shall waive such provisions of title XVIII of the Social Security Act as may be necessary to provide for payment for services under the project in accordance with subsection (a).

(d) QUALIFICATIONS OF CONTRACTORS-
(1) IN GENERAL- The Secretary shall enter into a recovery audit contract under this section with an entity only if the entity has staff that has the appropriate clinical knowledge of and experience with the payment rules and regulations under the Medicare program or the entity has or will contract with another entity that has such knowledgeable and experienced staff.

(2) INELIGIBILITY OF CERTAIN CONTRACTORS- The Secretary may not enter into a recovery audit contract under this section with an entity to the extent that the entity is a fiscal intermediary under section 1816 of the Social Security Act (42 U.S.C. 1395h), a carrier under section 1842 of such Act (42 U.S.C. 1395u), or a Medicare Administrative Contractor under section 1874A of such Act.

(3) PREFERENCE FOR ENTITIES WITH DEMONSTRATED PROFICIENCY- In awarding contracts to recovery audit contractors under this section, the Secretary shall give preference to those risk entities that the Secretary determines have demonstrated more than 3 years direct management experience and a proficiency for cost control or recovery audits with private insurers, health care providers, health plans, or under the Medicaid program under Title XIX of the Social Security Act.

(e) CONSTRUCTION RELATING TO CONDUCT OF INVESTIGATION OF FRAUD- A recovery of an overpayment to a provider by a recovery audit contractor shall not be construed to prohibit the Secretary or the Attorney General from investigating and prosecuting, if appropriate, allegations of fraud or abuse arising from such overpayment.

(f) REPORT- The Secretary shall submit to Congress a report on the project not later than 6 months after the date of its completion. Such reports shall include information on the impact of the project on savings to the Medicare program and recommendations on the cost-effectiveness of extending or expanding the project information means information about a conviction for a relevant crime or a finding of patient or resident abuse.

Appendix B – Tax Relief and Health Care Act of 2006 (Section 302)

(h) USE OF RECOVERY AUDIT CONTRACTORS.—

(1) IN GENERAL.—Under the Program, the Secretary shall enter into contracts with recovery audit contractors in accordance with this subsection for the purpose of identifying underpayments and overpayments and recouping overpayments under this title with respect to all services for which payment is made under part A or B. Under the contracts—

(A) payment shall be made to such a contractor only from amounts recovered;

(B) from such amounts recovered, payment—

(i) shall be made on a contingent basis for collecting overpayments; and

(ii) may be made in such amounts as the Secretary may specify for identifying underpayments; and

(C) the Secretary shall retain a portion of the amounts recovered which shall be available to the program management account of the Centers for Medicare & Medicaid Services for purposes of activities conducted under the recovery audit program under this subsection.

(2) DISPOSITION OF REMAINING RECOVERIES.—The amounts recovered under such contracts that are not paid to the contractor under paragraph (1) or retained by the Secretary under paragraph (1)(C) shall be applied to reduce expenditures under parts A and B.

(3) NATIONWIDE COVERAGE.—The Secretary shall enter into contracts under paragraph (1) in a manner so as to provide for activities in all States under such a contract by not later than January 1, 2010.

(4) AUDIT AND RECOVERY PERIODS.—Each such contract shall provide that audit and recovery activities may be conducted during a fiscal year with respect to payments made under part A or B—

(A) during such fiscal year; and

(B) retrospectively (for a period of not more than 4 fiscal years prior to such fiscal year).

(5) WAIVER.—The Secretary shall waive such provisions of this title as may be necessary to provide for payment of recovery audit contractors under this subsection in accordance with paragraph (1).

(6) QUALIFICATIONS OF CONTRACTORS.—

(A) IN GENERAL.—The Secretary may not enter into a contract under paragraph (1) with a recovery audit contractor unless the contractor has staff that has the appropriate clinical knowledge of, and experience with, the payment rules and regulations under this title or the contractor has, or will contract with, another entity that has such knowledgeable and experienced staff.

(B) INELIGIBILITY OF CERTAIN CONTRACTORS.—The Secretary may not enter into a contract under paragraph (1) with a recovery audit contractor to the extent the contractor is a fiscal intermediary under section 1816, a carrier under section 1842, or a Medicare administrative contractor under section 1874A.

(C) PREFERENCE FOR ENTITIES WITH DEMONSTRATED PROFICIENCY.—In awarding contracts to recovery audit contractors under paragraph (1), the Secretary shall give preference to those risk entities that the Secretary determines have demonstrated more than 3 years direct management experience and a proficiency for cost control or recovery audits with private insurers, health care providers, health plans, under the Medicaid program under title XIX, or under this title.

(7) CONSTRUCTION RELATING TO CONDUCT OF INVESTIGATION OF FRAUD.—A recovery of an overpayment to a individual or entity by a recovery audit contractor under this subsection shall not be construed to prohibit the Secretary or the Attorney General from investigating and prosecuting, if appropriate, allegations of fraud or abuse arising from such overpayment.

(8) ANNUAL REPORT.—The Secretary shall annually submit to Congress a report on the use of recovery audit contractors under this subsection. Each such report shall include information on the performance of such contractors in identifying underpayments and overpayments and recouping overpayments, including an evaluation of the comparative performance of such contractors and savings to the program under this title.

Appendix C – Service-Specific Improper Payment Examples

Table C-1
Excisional Debridements (Complex Review, Incorrect Coding)

Claim Facts

- The hospital coder assigned a procedure code of 86.22.
- In the medical record, the physician writes "debridement was performed."
- Coding Clinic 1991Q3 states "Unless the attending physician documents in the medical record that an excisional debridement was performed (definite cutting away of tissue, not the minor scissors removal of loose fragments), debridement of the skin should be coded to 86.26, non excisional debridement of skin… Any debridement of the skin that does not meet the criteria noted above or is described in the medical record as debridement and no other information is available should be coded as 82.26."
- The RAC determines that claim was INCORRECTLY CODED and issues repayment request letter for the difference between the payment amount for the incorrectly correctly coded procedure and the payment amount for the correctly coded procedure.

Corrective Actions

- Hospitals can be more careful when submitting claims for excisional debridement.
- Medicare claims processing contractors can remind hospitals about the importance of following the coding clinic guidelines when submitting claims for excisional debridement.

Table C-2
Inpatient Rehabilitation (Complex Review, Medically Unnecessary Setting)

Claim Facts

- An Inpatient Rehabilitation Facility (IRF) submitted a claim for inpatient therapy following a single knee replacement
- Medical record indicated that although the beneficiary required therapy, the beneficiary's condition did not meet Medicare's medical necessity criteria for IRF care (HCFA Ruling 85-2 and Medicare Benefit Policy Manual Section 110)
- The entire claim was denied
- The RAC determines that the service was MEDICALLY UNNECESSARY for the inpatient setting and issues repayment request letters for the entire claim.

Corrective Actions

- Inpatient Rehabilitation Facilities can be more careful when admitting Medicare beneficiaries for inpatient therapy to make sure that the Medicare medical necessity criteria are met.
- Medicare claims processing contractors can remind hospitals about the medical necessity criteria in HCFA Ruling 85-2 and the Medicare Benefit Policy Manual section 110.

Table C-3
Wrong Principal Diagnosis (Complex Review, Incorrect Coding)

Claim Facts

- Principal diagnosis on claim did not match the principal diagnosis in the medical record.
- Example: respiratory failure (code 518.81) was listed as the principal diagnosis but the medical record indicates that sepsis (code 038-038.9) was the principal diagnosis.
- The RAC issued overpayment request letters for the difference between the amount for the INCORRECTLY CODED services and the amount for the correctly coded services.
- Most common DRGs with this problem:
  - DRG 475 (respiratory system diagoses)
  - DRG 468 (extensive OR procedure unrelated to principal diagnosis)

Corrective Actions

- Hospitals can be more careful when submitting claims for DRG 475 and 468 to ensure that they choose the correct diagnosis to list as principal.
- Medicare claims processing contractors can remind hospitals about the importance of listing the correct principal diagnosis on the claim, especially when billing for DRG 468 and 475.
- Providers and Medicare claims processing contractors can refer to the Federal Register: February 11, 1998 (Volume 63, Number 28) for guidance on the proper coding of nondiagnostic preadmission services.
- Also refer also to the American Hospital Association's definitions of Principal diagnosis and Principal Procedure, found in the ICD-9-CM Official Guidelines for Coding and Reporting.

Table C-4
Wrong Diagnosis Code (Complex Review, Incorrect Coding)

Claim Facts

- Hospital reported a principal diagnosis of 03.89 (septicemia)
- Medical record shows diagnosis of urosepsis, not septicemia or sepsis; Blood cultures were negative
- Did not meet the coding guidelines for "septicemia." If it to urinary tract infection (UTI) caused the claim to group to a lower DRG
- The RAC issued a repayment request letter for the difference between the payment amount for the incorrectly coded procedure and the correctly coded procedure.

Corrective Actions

- Hospitals can be more careful when submitting claims for septicemia
- Medicare claims processing contractors can remind hospitals about the importance of listing an accurate principal diagnosis for beneficiaries with a UTI.
- Providers and Medicare claims processing contractors can refer to the Federal Register: February 11, 1998 (Volume 63, Number 28) for guidance on the proper coding of nondiagnostic preadmission services.
- Also refer also to the American Hospital Association's definitions of Principal diagnosis and Principal Procedure, found in the ICD-9-CM Official Guidelines for Coding and Reporting.

Table C-5
Neulasta (Automated Review, Medically Unnecessary Services)

Claim Facts

- In the past, the billing code for the drug Neulasta (Pegfilgrastim) indicated that providers should bill 1 unit for each milligram of drug delivered
- Several years ago, CMS changed the definition of the billing code to indicate that providers should bill 1 unit for each vial of drug delivered.
- The hospital billed for 6 units of Neulasta
- The RAC determines that 5 units of service were MEDICALLY UNNECESSARY and issues repayment request letter for the difference between the payment amount for 5 unnecessary vials.

Corrective Actions

- Transmittal 949 clarifies billing for Neulasta. The transmittal can be found at: http://www.cms.hhs.gov/transmittals/downloads/R949CP.pdf.
- Hospitals can be more careful when submitting claims for Neulasta. Hospitals can program their billing computers carefully when CMS changes the definition of a code.
- Medicare claims processing contractors can remind hospitals about the importance of listing the accurate number of "units of service" on a claim, especially when changes to the code definition occur.

Table C-6
Colonoscopy (Automated Review, Medically Unnecessary Services)

Claim Facts

- The hospital billed for multiple colonoscopies (45355, 45378, 45380, 45383, 45384, 45385) for the same beneficiary the same day.
- Beneficiaries never need more than one colonoscopy per day. The excessive services are NOT MEDICALLY NECESSARY.
- The RAC issued overpayment request letters for the difference between the billed number of services and 1.

Corrective Actions

- Hospitals can be more careful when submitting claims for colonoscopies (45355, 45378, 45380, 45383, 45384, 45385) to ensure they do not bill for more than one per day per beneficiary.
- Medicare claims processing contractors can remind hospitals about the importance of listing the accurate number of "units of service" on a claim.

Table C-7
Outpatient Hospital Speech Therapy (Automated Review, Medically Unnecessary Services)

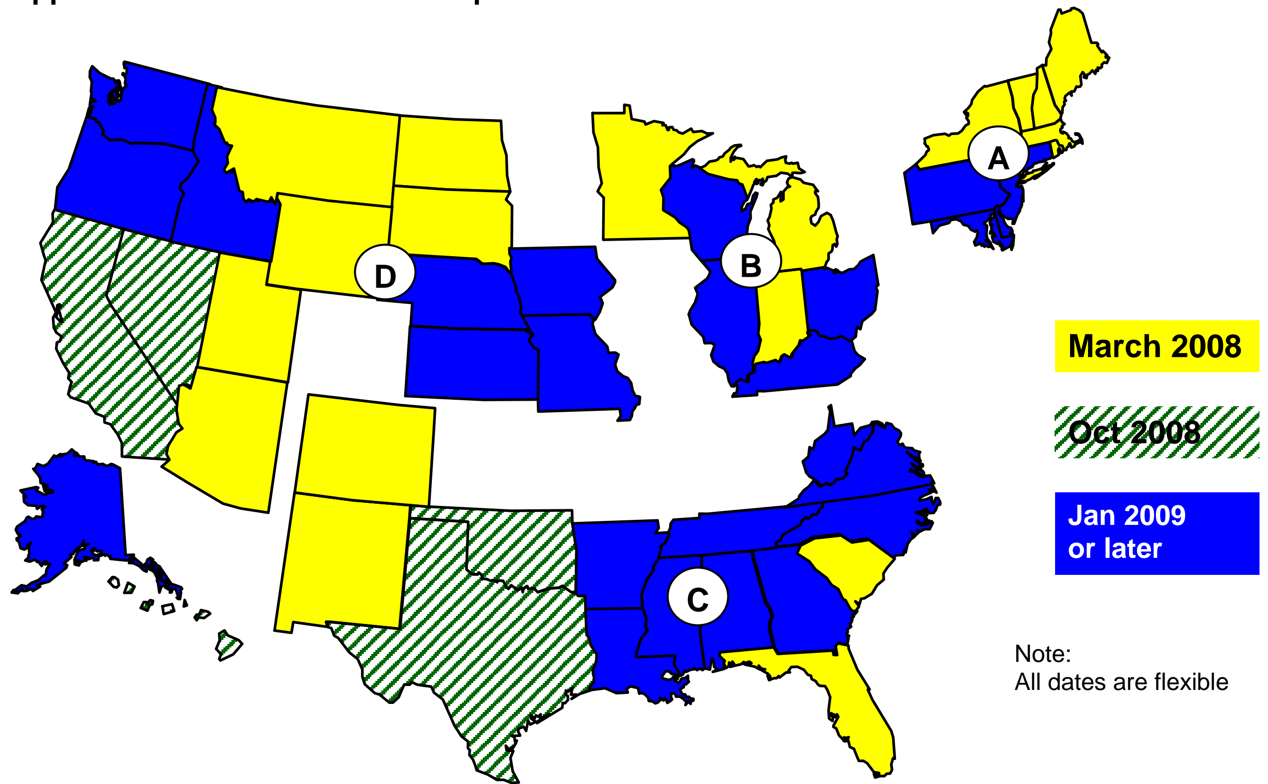
Claim Facts

- The outpatient hospital billed for each 15 minutes of therapy.
- The code definition specifies that the code is per session, not per 15 minutes.
- The units billed exceeded the approved number of sessions per day. The excessive services billed are MEDICALLY UNNECESSARY.
- The RAC issued overpayment request letters for the difference between the amount of the medically necessary number of services and the billed amount.

Corrective Actions

- CMS Claims Processing Manual 100-4, Chapter 5, Section 20.2 clarifies billing for untimed codes. The section be found at: http://www.cms.hhs.gov/manuals/downloads/clm104c05.pdf
- Hospitals can be more careful when submitting claims for therapy services.
- Medicare claims processing contractors can remind hospitals about the importance of listing the accurate number of "units of service" on a claim.

Appendix D – Permanent RAC Expansion Schedule



Although California was a RAC demonstration state, California claims will not be available for RAC review from March 2008- October 2008 due to a MAC transition. A similar RAC blackout period is planned for all states undergoing a MAC transition.