

Recovery Audit Contractor (RAC) Program Expansion Underway

RAC Audits

As the three-year RAC demonstration project comes to a close, hospitals across the country are gearing up for a rollout of a permanent review program. Under the Medicare Integrity Program, the RACs are charged with identifying underpayments and overpayments and recouping overpayments under the Medicare program associated with services for which payment is made under part A or B of title XVIII of the Social Security Act.

The RAC status report reveals over **\$1.03 billion** in improper payments for the project demonstration, with **\$992.7 million** recouped in overpayments. The initial 3-year demonstration project began in the states of FL, NY and CA, with Arizona, South Carolina and Massachusetts added during the Summer of 2007. Each RAC indicated that during the demonstration phase of the project staffing levels were limited and that if they were to become a permanent RAC, they would likely hire more staff to conduct more reviews, and correct more improper payments. Hospital inpatient claims comprised 85% of the overpayment with 4% hospital outpatient, and 11% from other providers such as physicians, SNF, inpatient rehabilitation, ambulance services, DME and labs.

According to CMS “the RAC demonstration program has proven to be successful in returning dollars to the Medicare Trust Funds and identifying monies that need to be returned to providers. It has provided CMS with a **new mechanism for detecting improper payments** made in the past, and has also given CMS a valuable new tool for preventing future payments.”

Section 302 of the Tax Relief and Health Care Act of 2006 makes the RAC Program permanent and requires the Secretary to expand the program to all 50 states by no later than 2010. CMS has announced its plans for expansion of the RAC program to begin this summer in 20 states. Oklahoma and Texas, along with Nevada and Hawaii, are scheduled to begin in fall of 2008, while Arkansas, Missouri and 24 other states will be waiting until January, 2009 or later. (See <http://www.cms.hhs.gov/RAC/> then look for the “RAC Expansion Schedule”.)

With client hospitals in all three of the demonstration states – California, Florida and New York – Administrative Consultant Service has been involved in the RAC process from the beginning. We look forward to providing educational sessions and tools to assist our clients to develop strategies to effectively manage expansion of the RAC program to their facilities.

Almost half of the improper payments were the result of incorrect coding. Approximately one-third of the errors were because the claim did not meet criteria for medical necessity. Examples of overpayments cited in 2006 -2007 RAC reports include:

- Reporting of excisional debridement (86.22) without adequate medical record documentation to meet the definition of “excisional.”
- Lack of medical necessity to support admission of patients who stayed 3 days in order to qualify for SNF coverage.
- Incorrect coding of blood transfusion 36430 (billed 1 service per pint rather than 1 service per transfusion session).
- Incorrect coding of speech/hearing therapy 92507 (billed 1 service per 15 minutes rather than 1 service per session).
- Incorrect coding of Neulasta J2505 (billed 1 service per 1 mg when the definition of the code is 1 service per 6 mg vial)
- Incorrect reporting of discharge status codes, resulting in improper payment due to the transfer definition
- Lack of documentation to support medical necessity for admission to inpatient status

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RAC's Continued ...

The new RAC scope of work includes identification of improper payments that are a result of:

- Incorrect payment amounts
- Non-covered services (including services that are not reasonable and necessary under section 1862(a)(1) (A) of the Social Security Act),
- Incorrectly coded services (including DRG miscoding)
- Duplicate services

The RAC may NOT attempt to identify improper payments arising from any of the following:

1. Services provided under a program other than Medicare Fee-For-Service (for example, Medicare Managed Care is excluded)
2. Cost report settlement process (IME or GME payments)
3. Claims more than 3 years past the date of the initial determination (claim paid date)
4. Claim paid dates earlier than October 1, 2007
5. Claims where the beneficiary is liable for the overpayment because the provider is without fault with respect to the overpayment (however RAC may not attempt to recoup from a beneficiary)
6. Random selection of claims...”the RAC shall utilize data analysis techniques in order to identify those claims most likely to contain overpayments. This process is called “targeted review”. The RAC may not target a claim solely because it is a high dollar claim but may target a claim because it is high dollar AND contains other information that leads the RAC to believe it is likely to contain an overpayment.”
7. Claims Identified with a Special Processing Number (claims in demonstration programs or with special processing rules)
8. Prepayment Review

RACs will continue to be paid on a contingency fee basis, keeping a percentage of overpayments as well as being paid a percentage of underpayments identified. They are now required to use certified coders for coding reviews (*this was not a requirement in the 3-year demonstration project*), determinations of medical necessity may be made by RNs or therapists. Providers will have appeal rights in accordance with CMS guidelines. See <http://www.fbo.gov/spg/HHS/HCFA/AGG/RFP-CMS-2007-0022/Attachments.html> for more details in the latest Statement of Work.

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