# CMS
# RAC Status Document

## FY 2006

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

November 22, 2006

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# I. Introduction

There is growing concern that the Medicare Trust Funds may not be adequately protected against erroneous payment through current administrative procedures. Section 306 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) (see Appendix A) directs the Secretary of the U.S. Department of Health and Human Services (HHS) to demonstrate the use of Recovery Audit Contractors (RACs) in:

1) identifying Medicare underpayments and overpayments; and

2) recouping Medicare overpayments.

Under the demonstration, the Centers for Medicare & Medicaid Services (CMS) pays the RACs on a contingency basis; that is, the RACs receive a portion of what they identify and collect. The demonstration program is designed to determine whether the use of RACs will be a cost-effective means of adding resources to ensure correct payments are being made to Medicare providers and to ensure that taxpayer funds are used for their intended purpose.

The legislation requires the Secretary to conduct the demonstration for payments made under part A or B of Title XVIII of the Social Security Act (i.e., traditional fee-for-service (FFS) Medicare). Thus the RAC demonstration does not include the audits of payments for Medicare Part C (managed care) or Part D (the prescription drug benefit).

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# II. Executive Summary

The RAC program is consistent with the President's Management Agenda objective to prevent improper payments in federal programs. CMS designed the demonstration to accomplish two specific goals:

1. to demonstrate whether RACs can identify past improper payments in the Medicare FFS program; and

2. to determine whether the RACs can provide information to CMS and to the Medicare claims processing contractors, Quality Improvement Organizations (QIOs) and Program Safeguard Contractors (PSCs) that could help in preventing future improper payments thereby lowering the Medicare FFS error rate.

This document describes the operations and findings of the CMS RAC program during fiscal year (FY) 2006 (i.e., between October 1, 2005 and September 30, 2006). CMS hired:

- Three RACs that were tasked with performing claim review functions. They reviewed claims and medical records to identify improper payments. These RACs are called "Claim RACs."

- Three RACs that were tasked with performing Medicare Secondary Payer (MSP) functions; that is, identifying situations where Medicare should not have paid the claim because the beneficiary had health insurance coverage from another insurance company who is responsible for paying the claim. These RACs are called "MSP RACs."

The three-year demonstration began in March of 2005 and is now at the halfway point. Preliminary results indicate that the use of recovery auditors is a viable and useful tool for ensuring accurate payments.

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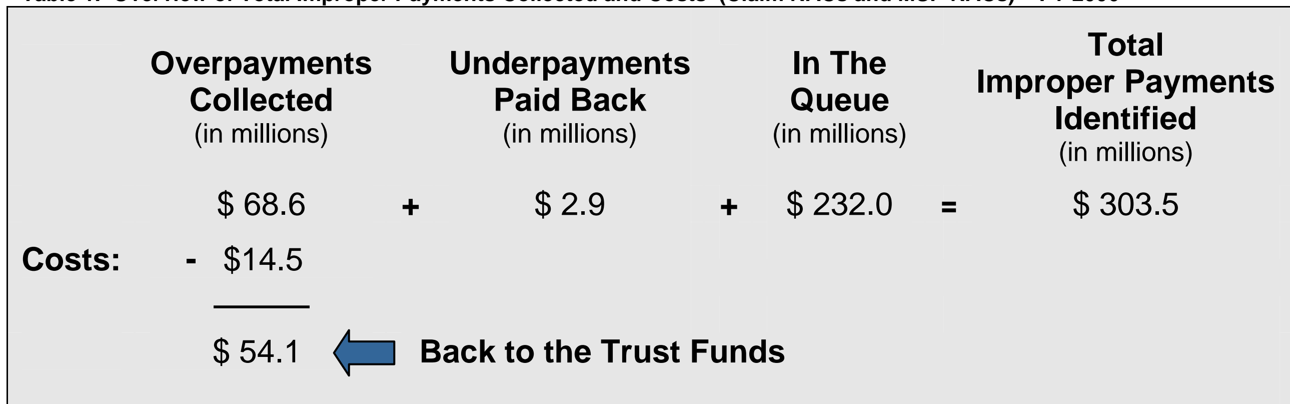
**Table 1. Overview of Total Improper Payments Collected and Costs (Claim RACs and MSP RACs) – FY 2006**



| | Overpayments Collected (in millions) | | Underpayments Paid Back (in millions) | | In The Queue (in millions) | | Total Improper Payments Identified (in millions) |
|---|---|---|---|---|---|---|---|
| | $ 68.6 | + | $ 2.9 | + | $ 232.0 | = | $ 303.5 |
| Costs: | - $14.5 | | | | | | |
| | $ 54.1 | ⇐ Back to the Trust Funds | | | | | |

Table 1 summarizes the improper payments collected and paid back by the Claim RACs and MSP RACs as well as the costs of operating both programs. In addition to the $68.6 million actually collected, and the $2.9 million in underpayments that have already been paid back, an additional $232.0 million is in the collection or repayment process but has not yet been returned by or to the provider. Thus, the total improper payment dollars identified by the Claim RACs and MSP RACs is $303.5 million. The $14.5 million in costs represents the amount paid for RAC contingency fees, expenses incurred by the Medicare claims processing contractors to support the RAC program, plus the costs of evaluating the program. See Table 14 for more details.

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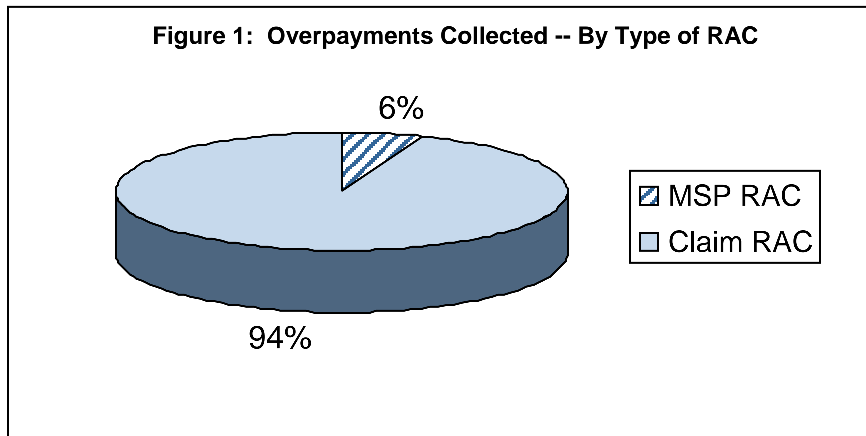


Figure 1 displays overpayments collected by Claim and MSP RACs. The figure shows that the vast majority of the RAC collections are being generated by the Claim RACs ($64.6 million) rather than the MSP RACs ($4 million). Although there were only two MSP RACs for much of FY 2006 (as opposed to three claim RACs for the full fiscal year), CMS believes that this fails to account for most of the disparity in overpayment collection amounts. Instead, CMS suspects that there are simply more overpayments made by the Medicare program due to lack of medical necessity and incorrect coding of claims than there are overpayments due to Medicare being the secondary payer.

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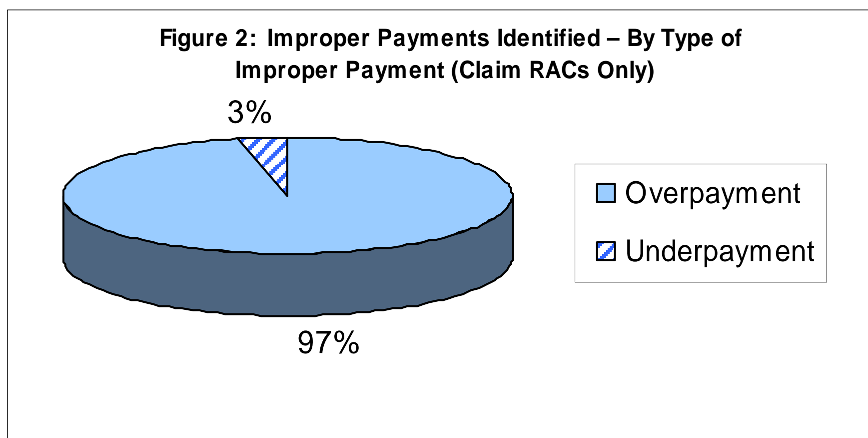


Figure 2 depicts the improper payments identified by the Claim RACs during FY 2006. The Claim RACs identified $289.1 million in overpayments but only $10.4 million in underpayments. These underpayments have been or are in the process of being paid back to the provider. Several factors explain why only 3 percent of the RAC identified improper payments were underpayments. First, during about half of the fiscal year, the RACs did not receive financial incentives to identify underpayments. It was not until Spring 2006 that CMS revised the RAC contract to provide financial incentives to the RACs for the identification of Medicare underpayments. Second, although all three Claim RACs have years of experience working in the private market identifying overpayments, none of them had experience identifying underpayments. Each of the RACs have had to build the algorithm software to seek out these underpaid claims. Finally, a lower percentage of underpayment identifications is expected

because the Improper Medicare FFS Payments Report found that a random sample of claims shows only 9 percent of improper payments are underpayments while 91 percent are overpayments.

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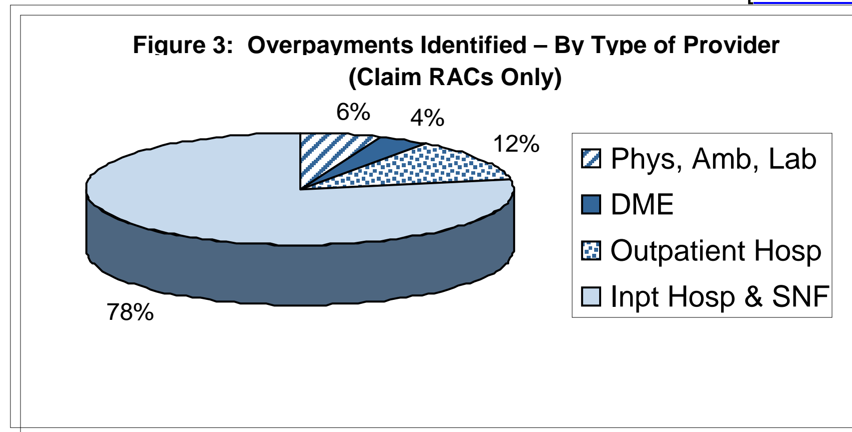


Figure 3 shows the overpayments identified by the Claim RACs categorized by type of provider. Most overpayments identified by the Claim RACs ($224 million or 78 percent) were from inpatient hospital and skilled nursing facility (SNF) providers. Table 8 provides more detail about the overpayments identified by type of provider. For example, Table 8 breaks down the data by RAC jurisdiction showing separate data for California, Florida and New York. By analyzing this data more thoroughly, CMS and its QIOs can identify appropriate corrective actions to reduce improper payments made to inpatient hospital providers.

The vast majority of the overpayments in the "inpatient hospital and SNF" category were the result of overpayments to inpatient hospitals rather than SNFs. In future reports, CMS will report data separately for inpatient hospitals and SNFs.

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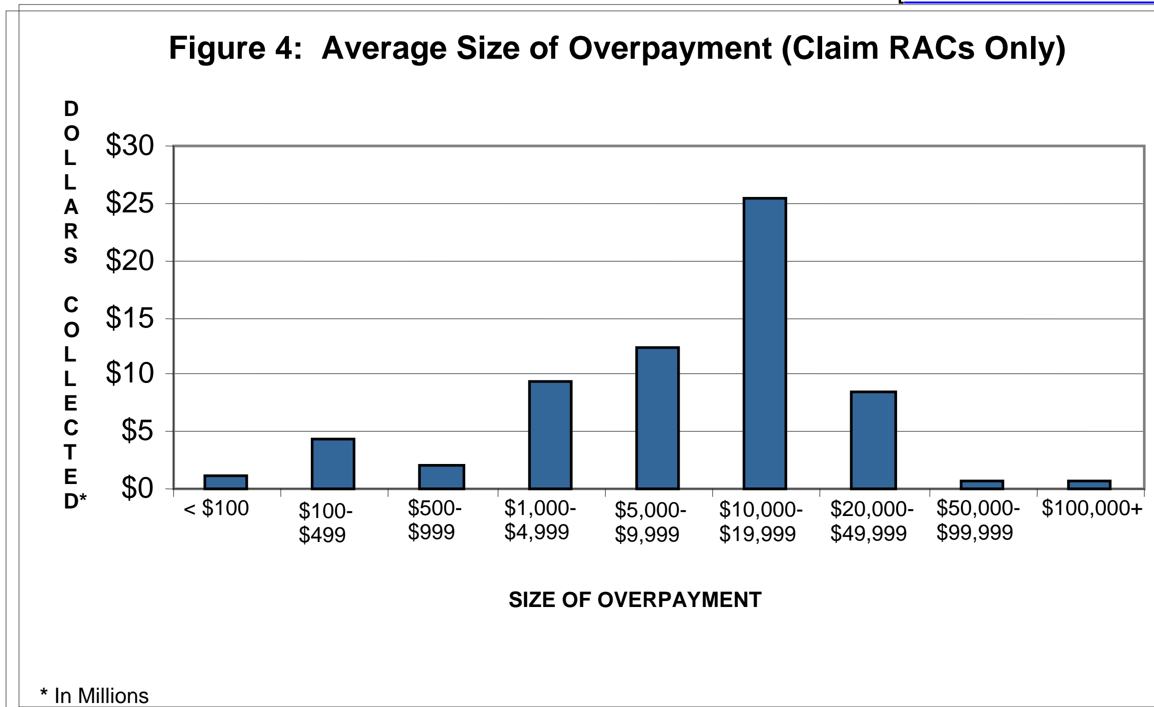


Figure 4 describes the average size of the overpayments identified by the Claim RACs. The figure shows that less than $1 million of the collections made by the Claim RACs involved small overpayments (those that were less than $100). Likewise, very few of the collections made by Claim RACs were for large overpayments (over $50,000). Instead, the majority of the overpayments collected by the Claim RACs involved overpayment amounts of $10,000 – $19,999. This finding held true for all three jurisdictions. To see the data regarding average overpayment size in further detail, see Table 10.

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**Table 2: CMS' Timeline for developing a RAC Corrective Action Plan**

| Date | Description of Activity |
|---|---|
| October - December 2006 | CMS will conduct an in-depth analysis of the RAC findings |
| January 2007 | CMS will draft a proposed RAC Corrective Action Plan |
| February 2007 | CMS will begin implementing the RAC Corrective Action Plan (releasing Medlearn Matters articles, installing new edits, etc.) |

CMS will develop a corrective action plan that contains jurisdiction-specific initiatives aimed at preventing future improper payments of the type the RAC found during FY 2006.

Each **carrier, DME PSC, and fiscal intermediary (FI)** in a RAC state – the Medicare contractors responsible for ensuring accurate coding, coverage and medical necessity on claims from **all provider types except inpatient hospitals** -- will adjust their local error rate reduction plans based on the RAC findings in their area. The primary improper payment prevention tools used by carriers, DME PSCs, and FIs in preventing improper payments are:

- data analysis,
- provider education,
- automated prepayment review (auto-deny edits), and
- complex prepayment review[1] and
- complex postpayment review[2].

In addition, each **QIO** in a RAC state – the Medicare contractors responsible for ensuring accurate coding, coverage and medical necessity for claims from **inpatient hospitals** – will take corrective actions based on the RAC findings in their area. The primary improper payment prevention tools used by QIOs are:

- data analysis and
- provider education.
- very limited amounts of complex postpayment review[3]

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# III. Background

## *A. Medicare Makes Improper Payments*

"Traditional" Medicare, also known as the fee-for-service (FFS) Medicare program, is a large and complex program and inadvertent errors can run into the billions of dollars annually as overpayments to providers. The Improper Medicare FFS Payments Report for November 2006 shows that 4.4 percent of the Medicare dollars paid did not comply with one or more Medicare coverage, coding, billing, and payment rules. This equates to $10.8 billion in Medicare overpayments and underpayments.

CMS employs a network of contractors to process claims submitted by physicians, hospitals and other health care providers and make payment to those providers in accordance with the Medicare rules and regulations. These contractors are called Carriers, Fiscal Intermediaries, and Medicare Administrative Contractors. For the purpose of this report, these contractors will be called "Medicare claims processing contractors." In addition, CMS employs Quality Improvement Organizations (QIOs) which are responsible for ensuring accurate coding, coverage and medical necessity of inpatient hospital claims and DME Program Safeguard Contractors (PSCs) which are responsible for ensuring accurate coding, coverage and medical necessity of DME, prosthetic, orthotic and supply claims.

The Department of Health and Human Services (DHHS), Office of Inspector General (OIG) and the Government Accountability Office (GAO) have for years issued reports describing the

[1] Complex review occurs when a human reviewer compares the claim submitted by the provider to the patient's medical record to determine if an overpayment or underpayment exists.
[2] See definition of "complex review" above.
[3] See definition of "complex review" above. QIO complex postpayment reviews are also known as "special project reviews."

improper payments made by the Medicare FFS program. Although the CMS and the Medicare claims processing contractors, QIOs and PSCs have undertaken aggressive actions to recoup those overpayments and prevent future improper payments, it is impractical to prevent all improper payments. Most improper payments in the Medicare FFS program occur because the provider submitted the claim improperly to Medicare.

### *B. Legislation Gave CMS A Different Type of Payment Mechanism for RACs*

CMS uses tax dollars appropriated by Congress to pay each Medicare claims processing contractor, QIO and PSC a budgeted amount to ensure that payment for claims is as accurate as possible. Congress gave CMS the authority under the RAC demonstration legislation to pay the RACs differently. CMS pays each RAC on a contingency fee basis; that is, CMS pays the RACs a percentage of what the RACs identify and collect in overpayments from providers. This demonstration is the first time the Medicare program has ever paid a contractor on a contingency fee basis for claim review and overpayment collection work.

### *C. RACs were Chosen Competitively*

CMS held a full and open competition to select the first six RACs for the demonstration. Three of the RACs were tasked with performing claim review functions such as reviewing claims and medical records to identify improper payments. The other three RACs were tasked with performing MSP functions such as identifying situations where Medicare should not have paid the claim because the beneficiary had health insurance coverage from another insurance company who is responsible for paying the claim. The following table lists the names of the Claim RAC and MSP RAC for each of the three jurisdictions.

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**Table 3. Names of RACs in CMS RAC Demonstration During FY 2006**

| Jurisdiction | Claim RACs | MSP RACs |
|---|---|---|
| **California** | PRG-Schultz | Diversified Collection Services |
| **Florida** | Health Data Insights | Public Consulting Group |
| **New York** | Connolly Consulting | Public Consulting Group |

California, Florida, and New York were 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.

To avoid a conflict of interest, the legislation made Medicare claims processing contractors ineligible to bid on the RAC contracts.

### *D. RAC Tasks*

The RACs selected for this demonstration were tasked with identifying and collecting Medicare claims overpayments and identifying underpayments that were not previously identified by the Medicare claims processing contractors, QIOs or PSCs. During FY 2006, CMS gave each RAC all the claims for their jurisdiction that had been paid by the Medicare claims processing

contractors between October 1, 2001 and September 30, 2005. CMS excluded a number of claim types from review by the RACs. These exclusions included:

- **Physician Evaluation and Management Services**. CMS excluded these services from RAC review while CMS considered a proposal by the American Medical Association that might change the way these services are reviewed.

- **Hospice and Home Health Services**. CMS excluded these from the demonstration for administrative simplification purposes.

- **Claims Previously Reviewed by Another Medicare Contractor**. CMS prohibited the RACs from reviewing these claims so as not to "hassle" the provider with multiple requests for the same medical record.

- **Claims Involved in a Potential Fraud Investigation.** CMS excluded these claims from RAC review so as not to interfere with law enforcement's cases.

The RACs analyzed the claims data using their proprietary software and identified claims that clearly contained improper payments and those that likely contained improper payments. In the case of clear improper payments, the RAC contacted the provider and requested a refund of any overpayment amounts and paid the provider any underpayment amounts. In the case of claims that contained likely improper payments, the RAC requested the medical record from the provider, reviewed the claim and medical record and then made a determination as to whether the claim contained an overpayment, an underpayment or a correct payment.

Improper payments include:

- Payments for services that are not medically necessary (e.g., a claim for a medical back treatment at an inpatient hospital when the services could have been performed as an outpatient),

- Excessive or insufficient payment for services that are incorrectly coded (e.g., the provider bills for 15 minutes of therapy but the medical record indicates that 45 minutes of therapy were actually provided),

- Duplicate payments, and

- Payments for which another insurance company is responsible.

RACs apply statutes, regulations, CMS national coverage, payment and billing policies as well as Local Coverage Determinations (LCDs) that have been approved by the Medicare claims processing contractors. RACs do not develop or apply their own coverage, payment or billing policies.

The FY 2006 Claim RAC program involved:

- CMS sending each Claim RAC all the claims for their jurisdiction that had been processed by the Medicare claims processing contractors between October 1, 2001 and September 30, 2005 (this amounted to over 1 billion claims totaling at $167 billion);

- The RACs subjecting all the claims to their proprietary automated review software algorithms to identify overpayments and underpayments that can be detected without medical record review;
- The RACs subjecting some of the claims ($928 million) to medical record review. These reviews entail requesting medical records from the health care provider that submitted the claim.
  - Where medical records were submitted by the provider, the RAC reviewed the selected claim and the associated medical records to see if the claims complied with Medicare coverage, coding and billing rules.
  - Where medical records were not submitted by the provider, CMS instructed the RACs to classify the case as an overpayment; and
- The RAC sending provider overpayment notices and making adjustments for claims that were overpaid or underpaid.

The collection policies applied in this demonstration are the same as those currently in effect for the Medicare claims processing contractors, including assessment of interest on the portion of any debt that is unpaid 30 days after issuance of the demand letter.

Providers may appeal any negative determinations.

## *E. Key Dates in the RAC Demonstration*

The RAC demonstration began on March 28, 2005. The RAC legislation prohibits continuation of the demonstration beyond 3 years. The demonstration will end on March 27, 2008. The following table describes the key dates in the demonstration:

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**Table 4. Key Dates**

| Year | Month | Description |
|---|---|---|
| 2005 | January | CMS announces RAC Demonstration<br>CMS releases Requests for Proposal for CA, FL, NY |
| | March 28 | CMS signs contracts for Claim RACs in CA, FL, NY<br>CMS signs contracts for MSP RACs in CA, FL<br>***3-year clock begins*** |
| | April | RACs start receiving claims from CMS |
| 2006 | January | RACs begin releasing significant overpayment notifications |
| | February 23 | CMS signs contract for MSP RAC in NY |
| | September 30 | CLOSE OF FY 2006 |
| | November | CMS releases *FY 2006 RAC Status Document* |
| 2007 | September 30 | CLOSE OF FY 2007 |
| | November | CMS plans to release *FY 2007 RAC Status Document* |
| 2008 | March 27 | ***3-year demonstration ends*** |
| | September | CMS plans to release *RAC Demonstration Report To Congress* |

September 30 CLOSE OF FY 2008

November CMS plans to release *FY 2008 RAC Status Document*

## F. Reporting Periods

The RAC findings in this document include all cases in which the RAC notified a provider of the overpayment or underpayment between October 1, 2005 and September 30, 2006. During this time period, CMS gave the RACs claims that were paid by the Medicare claims processing contractor in their jurisdiction between October 1, 2001 and September 30, 2005. The following table outlines the reporting period for this report as well as the planned reporting periods for upcoming reports.

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**Table 5. Reporting Periods for RAC Status Documents**

| Document | Cases where the RAC notified the carrier or MAC of the improper payment between these dates PLUS Cases where the fiscal intermediary or MAC adjusted the claim at the RACs' request between these dates | Universe of claims from which RACs could identify these cases |
|---|---|---|
| **FY 2006 Status Document** (released 11/06) | Oct 1, 2005 – Sept 30, 2006 | Claims processed by Medicare claims processing contractors between Oct 1, 2001 and Sept 30, 2005 |
| **FY 2007 Status Document** (planned for release 11/07) | Oct 1, 2006 – Sept 30, 2007 | Claims processed by Medicare claims processing contractors between Oct 1, 2002 and Sept 30, 2006 |
| **FY 2008 Status Document** (planned for release 11/08) | Oct 1, 2007 – Sept 30, 2008 | Claims processed by Medicare claims processing contractors between Oct 1, 2003 and Sept 30, 2007 |
| **REPORT TO CONGRESS** (planned for release 9/08) | A report on all the findings of the entire 3 year demonstration. | |

## IV. Improper Payments Identified by the Claim RACs

### *A. Improper Payments by Demonstration Year*

The following chart displays the improper payments collected and identified by the Claim RACs in FY 2006.

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**Table 6. Improper Payments -- by Demonstration Year (Claim RACs only) – FY 2006**

| Demo Year | **Overpayments** (in millions) | | | **Underpayments** (in millions) | | | **All Improper Payments (Overpayments + Underpayments)** (in millions) | | |
|---|---|---|---|---|---|---|---|---|---|
| | Collected | In the Queue | Total Identified | Paid Back | In the Queue | Total Identified | Collected/ Paid Back | In the Queue | Total Identified |
| **FY 2006** | $64.6 | $224.5 | $289.1 | $2.9 | $7.5 | $10.4 | $67.5 | $232.0 | $299.5 |
| **FY 2007** (planned) | -- | -- | -- | -- | -- | -- | -- | -- | -- |
| **FY 2008** (planned) | -- | -- | -- | -- | -- | -- | -- | -- | -- |

Table 6 shows that 97 percent of all improper payments identified by the Claim RACs were overpayments ($289.1 million) while 3 percent of the improper payments identified by Claim RACs were underpayments ($10.4 million)[4]. Because this is the first year of the demonstration, there are no prior time periods against which to compare the FY 2006 data. (Please Note: the difference between Table 6 data and Table 1 data is that Table 1 contains MSP RAC and Claim RAC data while Table 6 contains data about the Claim RACs only).

[4] NOTE: RACs did not receive a financial incentive to identify and recommend repayment of underpayments until Spring of 2006.

## B. *Improper Payments by Jurisdiction*

The following chart displays the RAC-identified improper payments by jurisdiction.

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**Table 7. Improper Payments -- by Jurisdiction (Claim RACs only) – FY 2006**

| Jurisdiction | **Overpayments** (in millions) | | | **Underpayments** (in millions) | | | **All Improper Payments (Overpayments + Underpayments)** (in millions) | | |
|---|---|---|---|---|---|---|---|---|---|
| | Collected | In the Queue | Total Identified | Paid Back | In the Queue | Total Identified | Collected/ Paid Back | In the Queue | Total Identified |
| **CA** | $29.2 | $75.8 | $105.0 | $2.6 | $3.4 | $6.0 | $31.8 | $79.2 | $111.0 |
| **FL** | $9.8 | $23.8 | $33.6 | $0.2 | $3.4 | $3.6 | $10.0 | $27.2 | $37.2 |
| **NY** | $25.6 | $124.9 | $150.5 | $0.1 | $0.7 | $0.8 | $25.7 | $125.6 | $151.3 |
| **TOTAL** | **$64.6** | **$224.5** | **$289.1** | **$2.9** | **$7.5** | **$10.4** | **$67.5** | **$232** | **$299.5** |

Table 7 shows that the NY and CA Claim RACs identified significantly more improper payments than the FL Claim RAC. Differences in claim review strategies may have accounted for some of these differences. For example, the NY and CA Claim RACs chose to review more inpatient hospital claims (which are higher dollar claims) whereas the FL Claim RAC chose to focus on physician claims (which are lower dollar claims).

Table 7 also shows that the CA Claim RAC found significantly more underpayments than the other two Claim RACs.

Finally, Table 7 indicates that between 71 – 83 percent of the dollars identified by the Claim RACs as an overpayment were still in the collection queue as of September 30, 2006. CMS is working to develop computer systems changes that would speed up the claim adjustment process and decrease these percentages in future years.

### *C. Improper Payments by Provider Type*

The following chart displays the RAC-identified improper payments by provider type.

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**Table 8. Improper Payments -- by Provider Type (Claim RACs only) – FY 2006**

| Type of Provider | Overpayments (in millions) | | | Underpayments (in millions) | | | All Improper Payments (Overpayments + Underpayments) (in millions) | | |
|---|---|---|---|---|---|---|---|---|---|
| | Collected | In the Queue | Total Identified | Paid Back | In the Queue | Total Identified | Collected/ Paid Back | In the Queue | Total Identified |
| **Physicians, Ambulance, Lab, Other carrier-billers** | $3.2 | $14.7 | $17.9 | - | - | - | $3.2 | $14.7 | $17.9 |
| **DME, prosthetics, orthotics, supplies** | $0.0 | $11.0 | $11.0 | - | - | - | $0.0 | $11.0 | $11.0 |
| **Outpatient Hospitals** | $12.0 | $24.3 | $36.3 | - | - | - | $12.0 | $24.3 | $36.3 |
| **Inpatient Hospitals & SNFs** | $49.5 | $174.5 | $224.0 | $2.9 | $7.5 | $10.4 | $52.4 | $182.0 | $234.4 |
| **TOTAL** | $64.6 | $224.5 | $ 289.1 | $2.9 | $7.5 | $10.4 | $67.5 | $232.0 | $ 299.5 |

Table 8 indicates that 77 percent of the Claim RACs overpayments collections, 77 percent of overpayment identifications, and 100 percent of the underpayments were from inpatient hospitals and SNFs. Although CMS did not collect separate data for inpatient hospitals and SNFs, anecdotal evidence shows that almost all of the overpayments collected, in the queue, and identified were from inpatient hospitals.

The following table shows the RAC-identified improper payments by provider type and jurisdiction.

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**Table 9. Overpayments Collected -- by Provider Type and Jurisdiction (Claim RACs only) – FY 2006**

| Type of Provider | Overpayments Collected (in millions) | | | |
|---|---|---|---|---|
| | **CA** | **FL** | **NY** | **Total** |
| **Physicians, Ambulance, Lab, Other carrier-billers** | $0.5 | $2.7 | $0.0 | $3.2 |
| **DME, prosthetics, orthotics, supplies** | $0.0 | $0.0 | $0.0 | $0.0 |
| **Outpatient Hospitals** | $0.6 | $0.0 | $11.3 | $12.0 |
| **Inpatient Hospitals & SNFs** | $28.1 | $7.0 | $14.3 | $49.5 |
| **TOTAL** | $29.2 | $9.8 | $25.6 | $64.6 |

Table 9 shows that of all the overpayments collected from SNFs and inpatient hospitals, 57% was collected from providers in California. In addition, of all the overpayments collected from physicians, ambulances, labs and other carrier-billers, 100 percent was from providers in Florida. Readers should keep in mind that because these data were not obtained from a random sample, one cannot conclude that a certain provider type in a certain jurisdiction billed incorrectly more often than their peers in another state. Instead, one must conclude that the focus areas of the RACs were different from one jurisdiction to the next. Stated another way, there were more inpatient hospital overpayments in California than in the other states because the California RAC chose to focus its identification efforts on inpatient hospitals more intensely than the Claim RACs in Florida and New York.

### *D. Overpayments by Jurisdiction and Size of Overpayment*

The following chart displays the RAC-identified overpayments by jurisdiction and size of overpayment.

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**Table 10. Overpayments Collected-- by Jurisdiction and Overpayment Size (Claim RACs and MSP RACs) – FY 2006**

| Overpayment Size | Overpayments Collected (in millions) | | | |
|---|---|---|---|---|
| | CA | FL | NY | Total |
| < $100 | <0.1 | $0.5 | $0.5 | $1.1 |
| $100-$499 | $0.1 | $1.2 | $3.0 | $4.3 |
| $500-$999 | $0.1 | $.5 | $1.4 | $2.0 |
| $1,000-$4,999 | $4.8 | $2.2 | $2.4 | $9.4 |
| $5,000-$9,999 | $7.4 | $2.3 | $2.6 | $12.3 |
| $10,000-$19,999 | $12.9 | $2.7 | $9.8 | $25.4 |
| $20,000-$49,999 | $2.7 | $0.4 | $5.4 | $8.5 |
| $50,000-$99,999 | $0.7 | - | $0.1 | $0.8 |
| $100,000+ | $0.5 | - | $0.3 | $0.8 |
| TOTAL | $29.2 | $9.8 | $25.6 | $64.6 |

Table 10 shows that most money collected by RACs came from claims submitted with an allowed amount of between $10,000 and $19,999. See Figure 4 for a graphical representation of this data.

### E. Average Overpayment Amount

In Florida much of the initial focus was on physician claims. The average overpayment per demand letter to physicians was $135 in FY 2006. The Florida RAC also performed some coding reviews of inpatient hospital claims and the average overpayment per demand letter was $5,800.

In New York the primary focus was on hospital inpatient claims and hospital outpatient claims. The average overpayment per provider for inpatient claims was $164,372. The average overpayment per provider for outpatient claims was $32,364.

In California the RAC focused initially on inpatient hospital claims and some DME and physician claims. The average overpayment per provider for inpatient claims was $75,856. The average overpayment per physician/supplier was $216.

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## F. Overpayments by Jurisdiction and Claim Year

Figure 5 displays the RAC-identified overpayments by jurisdiction and year of claim submission.

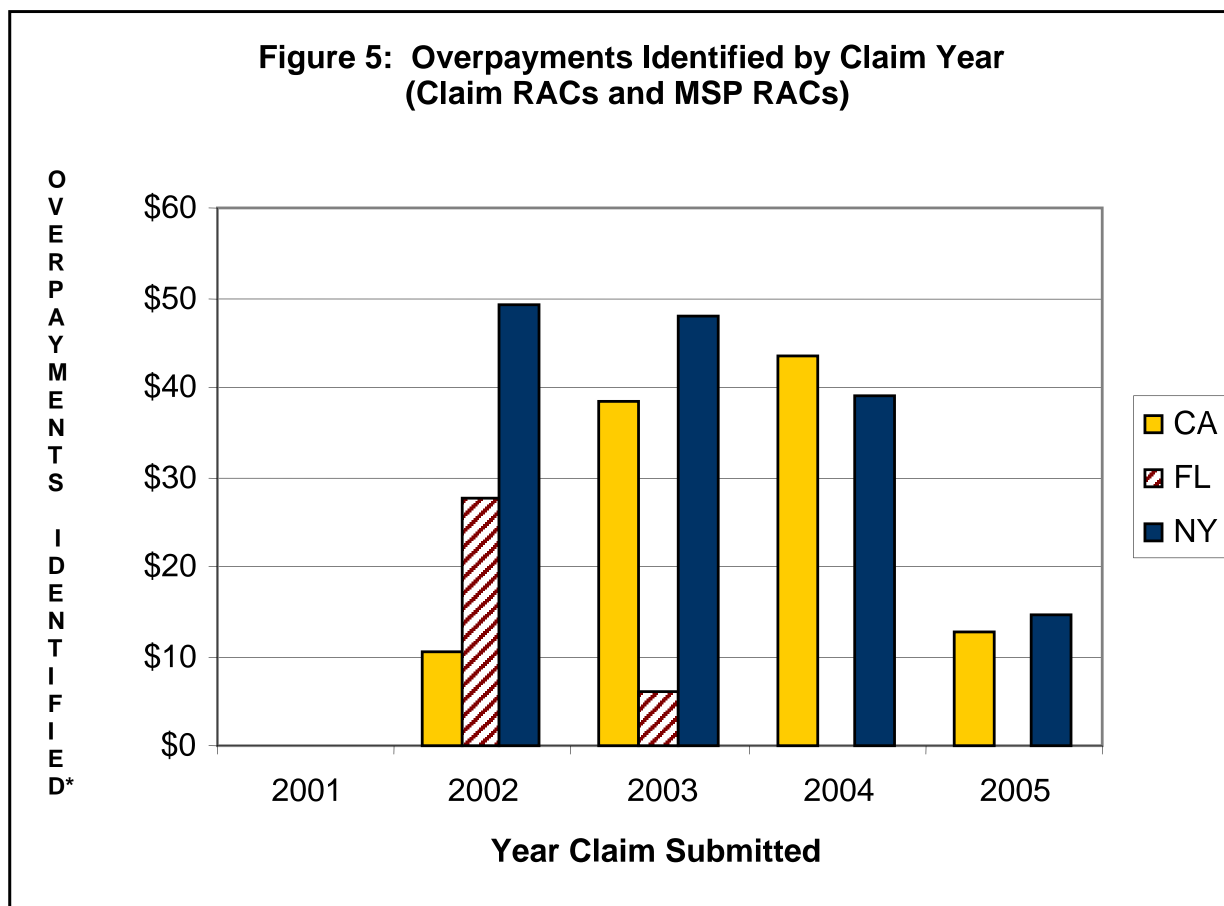


Figure 5 shows that although CMS gave RACs claims from 2001, the RACs did not identify or collect any overpayments for that year. This is likely due to the time limit CMS imposes on all its contractors – except in limited circumstances (such as potential fraud) contractors cannot make denials on claims that are more than 4 years old. Because of this time limit, all RAC collections occurred on claims submitted in 2002 and later. The figure also shows the variation in the claim review strategies of the RACs (i.e., some RACs focused on 2002 claims while others focused on 2004 claims). Table15 shows the detailed data behind Figure 5.

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## G. Overpayments by Service

The following chart displays some of the services for which Medicare overpaid.

Table 11. Examples of Services with Overpayments (Claim RACs only) – FY 2006

| Description of Service (Billing Code) | Overpayments Collected (in millions) |
|---|---|
| **INPATIENT HOSPITAL SERVICES** | |
| **Skin graft &/or debridement for skin ulcer or cellulitis (263)**<br>INCORRECT CODING: Provider billed for "excisional" debridement but medical record fails to meet definition for this code | $ 3.9 |
| **Wound debridement and skin graft, exc. hand for musculoskeletal and connective tissue disease (217)**<br>INCORRECT CODING: Provider billed for "excisional" debridement but medical record fails to meet definition for this code | $ 13.9 |
| **Medical back problems (243)**<br>NOT MEDICALLY NECESSARY: Services could have been provided as an outpatient (probably represent cases where the provider admitted the beneficiary for 3 days in order to qualify for SNF coverage) | $ 2.0 |
| **NON-INPATIENT HOSPITAL SERVICES** | |
| **Injection, pegfilgrastim 6mg (J2505) -- Neulasta**<br>INCORRECT CODING: Provider billed one service per 1mg but… definition of this code is one service per 6mg vial<br><br>EXAMPLE: A provider administered 6mgs of Neulasta to the beneficiary but billed for 6 units of J2505. According to the definition of the code, six units of J2505 would be 36mg of Neulasta. | $ 0.5 |
| **Speech/hearing therapy (92507)**<br>INCORRECT CODING: Provider billed one service for each 15 minutes but…. definition of this code is one service per session<br><br>EXAMPLE: A therapist provided a 45 minute session of therapy to the beneficiary but billed for 3 units of 92507. According to the definition of the code, three units of 92507 would be for 3 separate sessions of therapy on the same day. | $ 0.4 |
| **Blood transfusion service (36430)**<br>INCORRECT CODING: Provider billed one service per pint of blood but…. definition of this code is one service per transfusion session<br><br>EXAMPLE: An emergency room provided one transfusion session during which 2 pints of blood were administered to the beneficiary. But the hospital billed for 2 units of 36430. According to the definition of the code, two units of 36430 would be for 2 separate transfusion sessions in the same day. | $ 2.4 |

## H. Appeals

The following table displays the number of appeals of RAC-initiated denials that were filed by providers in FY 2006 by state and by type of provider. Only a few of these appeals were for cases where the provider had initially failed to supply the medical record. In the majority of these cases, the provider was challenging the underlying medical necessity or correct coding determination made by the Claim RAC.

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**Table 12. Provider Appeals of RAC-Initiated Denials – FY 2006**

| Type of Provider | CA | FL | NY | Total |
|---|---|---|---|---|
| Physicians, Ambulance, Lab, Other carrier-billers | 20 | 1463 | 0 | 1483 |
| DME, prosthetics, orthotics, supplies | 0 | 0 | 0 | 0 |
| Outpatient Hospitals | 165 | 0 | 9 | 174 |
| SNF, Inpatient Hospitals | 453 | 88 | 398 | 939 |
| **TOTAL** | **638** | **1,551** | **407** | **2,596** |

Because of the timing of an appeal, many of these appeals are still pending. Future status documents will describe the outcome of the appeal determination (i.e., the percentage of RAC determinations that are upheld vs. overturned by the appeal contractor).

## I. Technical Findings

In the course of implementing this demonstration, CMS has made some findings regarding technical issues. For example, the RACs produced an unexpectedly large volume of overpayments and underpayments. The Medicare claims processing contractors – who must process each of these overpayment or underpayment adjustments manually – were not prepared for the influx of work. Slow ramp up time caused some initial backlogs. In addition, CMS determined that law enforcement had cast too wide a net in suppressing claims that might be involved in a potential fraud investigation. Finally, CMS discovered that months of lead time are needed for CMS to get the claims to the RAC.

## J. Future Questions

Because the RACs have only been identifying improper payments for one year, CMS cannot yet see if the Medicare claims processing contractors and QIOs in RAC states are able to lower their paid claims error rates more rapidly than other states.

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# V. Improper Payments Identified by the MSP RACs

The MSP RACs identify situations where Medicare paid primary and the beneficiary had coverage with another insurance carrier who should have paid primary. Upon receiving notification of a MSP debt, an employer and/or insurer is afforded the opportunity to submit a valid documented defense proving why it should not have paid primary for that particular claim and/or time period. Since this occurs relatively frequently, CMS has chosen to only supply collection figures for the MSP RACs. Including additional items in the queue may overestimate identifications.

**Table 13. Medicare Secondary Payer Occurrences by Jurisdiction – FY 2006**

| Jurisdiction | Overpayments Collected (in millions) |
|---|---|
| CA | $ 3.9 |
| FL | $ 0.1 |
| NY | $ 0.0 |
| TOTAL | $ 4.0 |

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# VI. Costs

The demonstration costs fall into three categories. ***RAC contingency fees*** include the fees paid to RACs for identifying and recouping overpayments plus the fees paid for identifying underpayments. ***Medicare claims processing contractor costs*** are the monies paid to the carriers, and fiscal intermediaries for processing the overpayment/underpayment adjustments, handling appeals of RAC-initiated denials and other costs incurred to support the RAC program. ***RAC Evaluation fees*** are the dollars paid to the RAC Evaluation Contractor and the RAC Database Contractor. The costs of operating the CMS RAC Program for FY 2006 are listed below.

**Table 14. Cost of Operating CMS RAC Program -- FY 2006**

| Cost Categories | Costs (in millions) |
|---|---|
| RAC Contingency Fees | $12.0 M |
| Medicare Claims Processing Contractor Costs | $ 1.0 M |
| RAC Evaluation/Database Expenditures | $ 1.5 M |
| **TOTAL** | **$14.5 M** |

When total cost data from Table 14 is compared to overpayments collected data from Table 1, one can see that the RAC program:

- achieved a respectable return on investment of 373 percent[5] in FY 2006.

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[5] ROI calculated as follows: $68.6M - $14.5M = $54.1M net savings / $14.5 M = 3.73 * 100 = 373%

- experienced a $4.73:$1[6] benefit:cost ratio in FY 2006
- spent only 21 cents[7] for each dollar returned to the Trust Funds

These numbers were calculated on <u>actual</u> collections. The numbers would be much higher if they had been calculated on <u>expected</u> collections (also known as 'overpayment identifications').

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## VII. Conclusions and Corrective Actions

CMS is committed to tracking the progress of the demonstration and to using the information to improve the claim payment accuracy rate. During the first quarter of 2007, CMS will analyze the RAC findings to develop a comprehensive corrective action plan to prevent future improper payments from occurring.

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## VIII. Next Steps

The CMS RAC demonstration is already a very cost effective program and the steps CMS is now taking, including initiatives to streamline the steps by which RAC overpayments are processed by the Medicare claims processing contractors, will result in an even more cost effective program next year.

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. The program returned significant dollars to the Medicare Trust Funds without unnecessarily burdening the provider community or the Medicare claims processing contractor workflow. CMS views the RAC demonstration as a value-added adjunct to its present programs. The RAC program not only gives CMS a new mechanism for correcting improper payments made in the past, but also gives CMS a valuable new tool for preventing future overpayments.

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## IX. Contact Information

CMS RAC Project Officer: Connie Leonard (CMS RecoveryAuditDemo@cms.hhs.gov)
CMS Public Affairs Contact: Barbara Cebuhar (Barbara.Cebuhar@cms.hhs.gov)

[6] Benefit:Cost Ratio calculated as follows: $68.6 M / $14.5 M = $4.73
[7] Cents spent for every dollar saved calculated as follows: $14.5M / $68.6M = .21

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## Appendix A – MMA 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.

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## Appendix B – Terms and Acronyms

| *Term* | *Acronym* | *Description* |
|---|---|---|
| Carriers | --- | The Medicare claims processing contractors that processes claims for physician services, ambulance, lab, etc. These contractor are responsible for preventing improper payments on all claims they process. |
| Claim Recovery Audit Contractor | Claim RAC | A type of RAC that is responsible for identifying improper payments caused by a provider submitting a claim that is incorrectly coded, not medically necessary or other non-MSP reasons. |
| Durable Medical Equipment Program Safeguard Contractors | DME PSC | The Medicare contractor with primary responsibility for preventing improper payments on claims for durable medical equipment, prosthetics, orthotics and supplies. |
| Durable Medicare Equipment Medicare Administrative Contractor | DME MAC | The Medicare claims processing contractor that processes claims for durable medical equipment, prosthetics, orthotics and supplies. |
| Diagnosis Related Group | DRG | A classification of hospital case types into groups expected to have similar hospital resource use. Medicare uses this classification to pay for most inpatient hospital care. |
| Fiscal Intermediaries | FIs | The Medicare claims processing contractors that process claims from inpatient hospitals, outpatient hospitals, skilled nursing facilities, etc. These contractors have primary responsibility for preventing improper payments on all claims they process except inpatient hospital claims. |
| Government Accountability Office | GAO | A federal oversight agency that produces reports describing improper payments made by other federal agencies. |
| Healthcare Common Procedure Coding System | HCPCS | A classification system for services billed to carriers and DMERCs. Medicare uses this classification to pay for most physician, lab, and DME services. |
| Health Data Insights, Inc. | HDI | The Claim RAC in Florida |
| U.S. Dept. of Health and Human Services | HHS | The agency with authority to operate the RAC demonstration. The parent organization of the Centers for Medicare & Medicaid Services |

| | | |
|---|---|---|
| Medicare Secondary Payer Recovery Audit Contractor | MSP RAC | A type of RAC that is responsible for identifying overpayments caused by Medicare paying a claim for which it was not responsible for paying. |
| Office of the Inspector General | OIG | A federal oversight agency that produces reports describing improper payments made by other federal agencies. |
| Program Safeguard Contractors | PSCs | Some of these Medicare contractors are responsible for ensuring accurate coding, coverage, and medical necessity for durable medical equipment, prosthetics, orthotics, and supplies. |
| Public Consulting Group, Inc. | PCG | The MSP RAC in FL and NY. |
| Quality Improvement Organization | QIO | The Medicare contractor responsible for ensuring accurate coding, coverage and medical necessity for most inpatient hospital claims. |
| Recovery Audit Contractors | RAC | The entities hired by CMS under the MMA 306 authority |

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## Appendix C – Supplementary Data

**Table 15. Overpayments by Jurisdiction and Initial Claim Processing Year (Claim RACs and MSP RACs)**

| Year of Initial Claim Processing | Overpayments Collected (in millions) | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | CA | | FL | | NY | | Total | |
| | Collected | Identified | Collected | Identified | Collected | Identified | Collected | Identified |
| **2001** | $0.0 | $0.0 | $0.0 | $0.0 | $0.0 | $0.0 | $0.0 | $0.0 |
| **2002** | $8.4 | $10.5 | $9.6 | $27.6 | $10.8 | $49.1 | $28.8 | $87.2 |
| **2003** | $10.8 | $38,4 | $0.2 | $6 | $6.8 | $47.9 | $17.8 | $92.3 |
| **2004** | $9.1 | $43.4 | $0.0 | $0.0 | $7.2 | $39.0 | $16.3 | $82.4 |
| **2005** | $0.9 | $12.7 | $0.0 | $0.0 | $0.8 | $14.5 | $1.7 | $27.2 |
| **TOTAL** | **$29.2** | **$105.0** | **$9.8** | **$33.6** | **$25.6** | **$150.5** | **$ 64.6** | **$289.1** |