An Ounce of Prevention: How Ancillary Providers Can Best Prepare For Audits and Avoid Overpayments

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BACKGROUND

- In the Tax Relief Health Care Act of 2006, Congress required a permanent national RAC program to be in place by January 1, 2010.

BACKGROUND

- Medicare receives over 1.2 billion claims per year
  - 4.5 million claims per work day
  - 574,000 claims per hour
  - 9,579 claims per minute

BACKGROUND

Demonstration Program

- RACs were used to identify over and underpayments in:
  - California
  - Florida
  - New York
  - Massachusetts
  - South Carolina
  - Arizona

BACKGROUND

Demonstration Program

- Between 2005 and 2009, the RACs identified:
  - 900 Million in overpayments
  - 38 Million in underpayments
  - 96% of the claims were overpayments and only 4% were underpayments

GOAL OF THE RACs

- To identify improper payments made on claims for health care services provided to Medicare Beneficiaries.

GOAL OF THE RACs

- The RAC program is designed to:
  - Detect and correct past improper payments in the Medicare FFS program.
  - Provide information to CMS and Medicare contractors to help prevent fraud in the future and to lower the claims payment error rate.

RECOVERY AUDIT CONTRACTOR WINNERS

- Diversified Collection Services, Inc. of Livermore, California (Region A) initially working in Main, New Hampshire, Vermont, Massachusetts, Rhode Island and New York.
- CGI Technologies and Solutions, Inc. of Fairfax, Virginia (Region B) initially working in Michigan, Indiana, and Minnesota.

RECOVERY AUDIT CONTRACTOR WINNERS

- Connolly Consulting Associates, Inc. of Wilton, Connecticut (Region C) initially working in South Carolina, Florida, Colorado and New Mexico.
- HealthDataInsights, Inc. of Las Vegas, Nevada (Region D) initially working in Montana, Wyoming, North Dakota, South Dakota, Utah and Arizona.

RECOVERY AUDIT CONTRACTOR WINNERS

- Under the program, the four RACs will contract with subcontractors to supplement their efforts.
  - PRG-Schultz, Inc. will serve as a subcontractor to HDI, DCS and CGI in Regions A, B and D.
  - Viant Payment Systems, Inc. will serve as a subcontractor to Connolly Consulting in Region C.

RECOVERY AUDIT CONTRACTOR WINNERS

- Each subcontractor has negotiated different responsibilities in each region, including some claim review.

GENERAL INFORMATION ABOUT RACS

- RACS are paid on a contingency basis.
  - If the claim is overturned on appeal, the RAC must repay its fee.
  - The types of issues undergoing review will be listed on each RACs website.

GENERAL INFORMATION ABOUT RACS

- Each RAC must hire a full time medical director.
- From inception through March 27, 2008, it cost the RACs only .20 to collect a dollar.
- During the demonstration program RACs collected $187.2 million in contingency fees.

IMPROPER PAYMENTS

- Improper payments were estimated at 10.8 billion dollars in 2007.

IMPROPER PAYMENTS

- The main reasons for the improper payments were:
  - Payments were made for services that don’t meet Medicare medical necessity requirements.
  - Payments were made for services that are incorrectly coded.

IMPROPER PAYMENTS

- The main reasons for the improper payments were:
  - Providers failed to submit documentation when requested, or
  - Fail to submit enough documentation to support the claim.

IMPROPER PAYMENTS

- The main reasons for the improper payments were:
  - Other reasons such as basing claim payments on outdated fee schedules, or
  - The provider is paid twice because duplicate claims were submitted.

AUTOMATED REVIEWS

- RACs use 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 a clear improper payment, the provider is contacted and an overpayment is requested or the underpayment paid.

COMPLEX REVIEWS

- If the claim contains likely errors, the RAC can ask for medical records.
- Very expensive process.
- Clinical staff will review records.
- Hospice and home health services claims were excluded from the demonstration.
- Can request education from the RACs Medical Director.

ADDITIONAL FRAUD FIGHTING EFFORTS FOR DMEPOS SUPPLIERS AND HOME HEALTH AGENCIES

- More stringent reviews of new DMEPOS supplier's applications, including background checks to ensure that a principal, owner or manager owner has not been suspended by Medicare.

ADDITIONAL FRAUD FIGHTING EFFORTS FOR DMEPOS SUPPLIERS AND HOME HEALTH AGENCIES

- Making unannounced site visits to ensure that suppliers and home health agencies are actually in business.

ADDITIONAL FRAUD FIGHTING EFFORTS FOR DMEPOS SUPPLIERS AND HOME HEALTH AGENCIES

- Implementing extensive pre- and post-payment review of claims submitted by suppliers, home health agencies and order or referring physicians.

ADDITIONAL FRAUD FIGHTING EFFORTS FOR DMEPOS SUPPLIERS AND HOME HEALTH AGENCIES

- Validating claims submitted by physicians who order a large volume of DMEPOS or home health visits by sending a follow up letter to the physicians.

ADDITIONAL FRAUD FIGHTING EFFORTS FOR DMEPOS SUPPLIERS AND HOME HEALTH AGENCIES

- Verifying the relationship between physicians who order a large volume of DMEPOS or home health visits and the beneficiaries who the items or services are ordered for.

ADDITIONAL FRAUD FIGHTING EFFORTS FOR DMEPOS SUPPLIERS AND HOME HEALTH AGENCIES

- Identify and visiting high risk beneficiaries to ensure they are appropriately receiving the times and services for which Medicare is being billed.

STEPS PROVIDER CAN TAKE TO BE READY FOR RAC AUDITS

- Conducting an internal assessment to ensure that submitted claims meet the Medicare rules.
- Identify areas of concern by looking at the RAC websites and assess their own claims in light of the RAC findings.

STEPS PROVIDER CAN TAKE TO BE READY FOR RAC AUDITS

- The RACs often chose to review services highlighted by the OIG and GAO.
- Implement procedures to promptly respond to RAC request for medical records.
- Keep track of denied claims and correct previous errors.

STEPS PROVIDER CAN TAKE TO BE READY FOR RAC AUDITS

- When necessary develop corrective action plans to respond to denied claims.
- Developing a good working relationship with referring providers.

APPEALS

- Provider has 120 days from the claim adjustment to file an appeal.
- Appeal process is handled by regular Medicare claim process.
- As of March 27, 2009, only 14% of the RAC determinations were appealed and only 4.6 percent were overturned on appeal.

THE END

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