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From Legislative Authorization To National Implementation: The Key RAC Milestones, Results and Lessons to Date

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Agenda

Recovery Audit Contractors (RACs) – Background

Lessons Learned from the RAC Demonstration

How to Prepare for the Permanent Program

What is the RAC program?

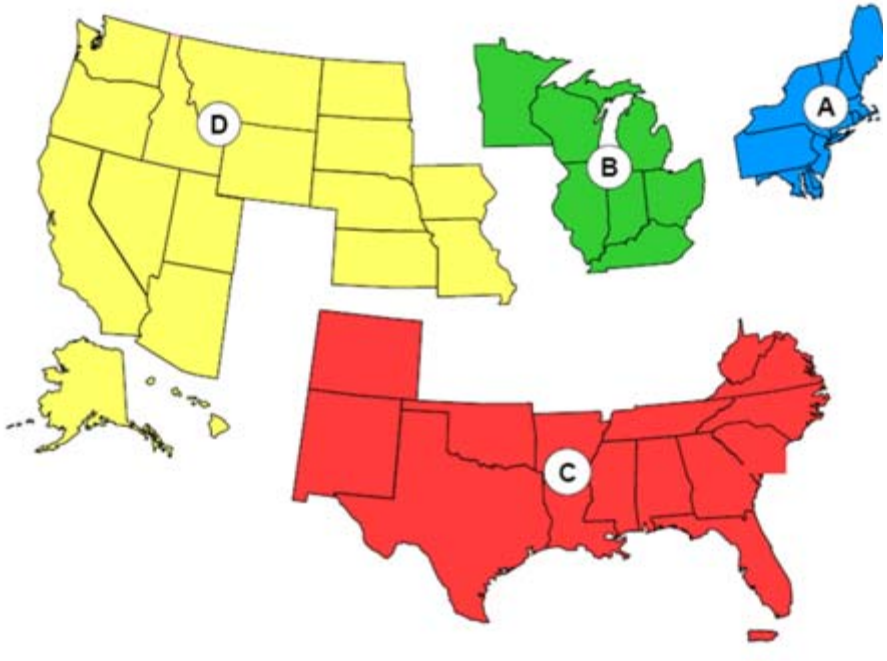
- The Medicare Modernization Act of 2003 (MMA), Section 306, directed DHHS to conduct a 3-year demonstration program using RACs to detect and correct improper payments in the Medicare FFS program.
- The Tax Relief and Health Care Act of 2006 (TRHCA), Section 302, requires DHHS to make the RAC program 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.
- Legislation passed to enhance Medicare's current efforts to correct improper payments.

- Achieved a return on investment of almost 500%
- Spent only $0.20 for each dollar collected

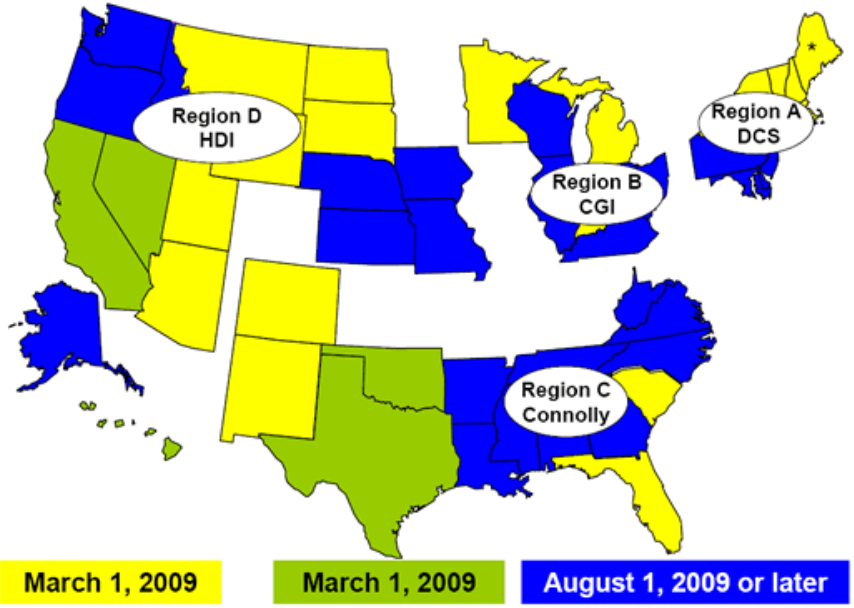
RAC Implementation Timeline

After a year of the demonstration, Congress required CMS to expand the RAC program to all states by January 1, 2010. Contractors were announced in October 2008, and an ensuing bid protest, which temporarily put the national rollout on hold, was resolved in February of this year. RAC contractors have begun conducting outreach sessions and the first issues eligible for RAC review have been posted.

Proposed RAC Jurisdictions



RAC Phase-In Schedule



*VT, NH, ME, MA, RI, CT (J14) Part A claims (including Part B of A) will not be available for RAC review until August 2009 due to the MAC transition. Part B claims in RI will not be available for RAC review until August 2009 due to the MAC transition. All other Part B claims are available for RAC review beginning March 1, 2009.

RAC Claim Review Process

- The RAC Claims Review Process is similar to that of the Medicare Claims Processing Contractors.
- Proprietary techniques are used to identify claims that contain errors resulting in improper payments and those that likely contain errors resulting in improper payments.

Automated Review:

- Clear improper payments are identified.
- The provider is contacted to either collect overpayments or to pay underpayments.

Complex Review:

- Claims that likely contain errors.
- Medical records are requested from the provider for further review.
- The medical record is reviewed and then a determination is made as to whether payment of the claim was correct, an overpayment, or an underpayment.
- RACs use the same types of review staff as the Medicare claims processing contractors.

RAC Permanent Program – Timeline

- Automated Reviews (Black & White Issues)
  - June 2009 – August 2009
- DRG Validation (Complex Reviews)
  - August 2009 – November 2009
- Complex Review for coding errors
  - August 2009 – November 2009
- DME Medical Necessity Reviews (Complex Reviews)
  - Fiscal year 2010
- Medical Necessity Reviews (Complex Reviews)
  - Calendar year 2010

Source: CMS RAC Review Phase-in Strategy as of 6/24/09

Demonstration Results

RAC	Overpayments Collected	Underpayments Repaid	Total Improper Payments Corrected (Million Dollars)
Connolly	$ 266.1	$ 4.3	**$ 270.4**
HDI	$ 396.1	$ 20.8	**$ 416.9**
PRG	$ 317.8	$ 12.7	**$ 330.5**
Claim RAC Subtotal	***$ 980.0***	***$ 37.8***	***$ 1,017.8***
HMS	$ 1.3	$ 0.0	**$ 1.3**
DCS	$ 11.4	$ 0.0	**$ 11.4**
MSP RAC Subtotal	***$ 12.7***	***$ 0.0***	***$ 12.7***
Grand Total	**$ 992.7**	**$ 37.8**	**$ 1,030.5**

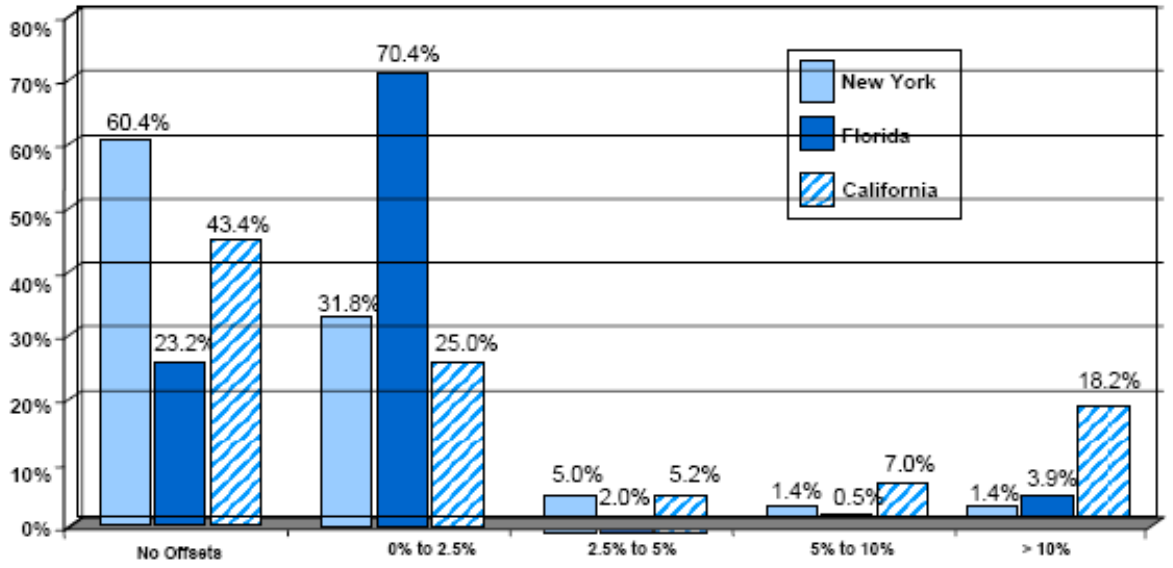
Source: The Medicare Recovery Audit Contractor (RAC) Program: Update to the Evaluation of the 3-Year Demonstration, January 2009, Table JU4: Improper Payments Corrected by the RAC Demonstration: Cumulative through 3/27/08, Both Claim RACs and MSP RACs

RAC Program Financial Impact

Sixty-eight to ninety-four percent of the hospitals in the three demonstration states had a revenue impact less than 2.5%.

Figure 7

Percent of Hospital FY 2007 Medicare Revenue Impacted by RACs



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

RAC Determinations Appealed

Includes the number of appeals of RAC determinations that were filed by providers from the inception of the RAC program through August 31, 2008. In the majority of these appeals, the provider challenged the underlying medical necessity or coding determination made by the RAC. Providers chose to appeal 22.5. percent of the RAC determinations.

Table JUL3: Provider Appeals of RAC-Initiated Overpayments: Cumulative through 8/31/08, Claim RACs only, Parts A and B claims combined

Claim RAC	Claims with Overpayment Determinations	# appealed to FI	# appealed to QIC	# appealed to ALJ	# appealed to DAB	# appealed (all levels)	% appealed (all levels)	# favorable to provider	% favorable to provider	% of all claims overturned on appeal
Connolly	110,635	8,852	1,123	113	18	10,106	9.1%	5,462	54.1%	4.9%
HDI	239,205	55,431	10,385	2,997	8	68,821	28.8%	28,236	41.0%	11.8%
PRG	175,293	24,438	4,371	1,526	172	30,507	17.4%	5,120	16.8%	2.9%
RAC not known*	n/a	0	7,896	721	0	8,617	n/a	1,297	15.1%	n/a
All RACs	525,133	88,721	23,775	5,357	198	118,051	22.5%	40,115	34.0%	7.6%

Source: RAC invoice files, RAC Data Warehouse, and data reported by the AdQIC and Medicare claims processing contractors. Includes all completed appeals and some pending appeals. This is because some Medicare claims processing contractors cannot distinguish between pending appeals of RAC determinations and pending appeals of other contractor determinations. These statistics are based on appeals that were known to the AdQIC and Medicare claims processing contractors on or before 8/31/08. Any QIC or ALJ appeals processed by the appeal entities or reported to the Medicare claims processing contractors after that date are not included in these statistics. *This table includes 1,219 Part A appeals and 7,398 Part B appeals that cannot be attributed to a specific RAC.

Demonstration vs. Permanent Program

- During the demonstration, CMS required 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.

Demonstration Program	Permanent Program
1) No maximum look back period.	1) The look back period has been changed from 4 years to 3 years in the permanent program. (No claims prior to Oct 2007).
2) Provider concerns with accuracy and transparency of RAC reviews.	2) Issue review board implemented w/ annual accuracy rates for RACs as well as website w/ new issues and claim status.
3) Physicians and certified coders were not mandatory.	3) Must have a physician medical director and certified coders.
4) Optional medical record limit set by the individual RAC.	4) Mandatory limits for medical records are set by CMS.

Common RAC Issues Identified

Top Services with RAC Initiated Overpayment Collections (Net of Appeals); Cumulative Through 3/27/08, Claim RACs Only

Source: The Medicare RAC Program: Evaluation of the 3-Year Demonstration, June 2008, Appendix G

Inpatient Hospital

1. Surgical Procedures in wrong setting (Medically unnecessary) - $88 million recovered (5,421 claims)
2. Excisional debridement (incorrectly coded) - $66.8 million recovered (6,092 claims)
3. Cardiac defibrillator implant in wrong setting (Medically unnecessary) - $64.7 million recovered (2,216 claims)
4. Treatment for heart failure and shock in wrong setting (Medically unnecessary) - $33.1 million (6,144 claims)
5. Respiratory system diagnoses with ventilator support (Incorrectly coded) - $31.6 million (2,102 claims)

Common RAC Issues Identified (cont.)

Outpatient Hospital

1. Neulasta (Medically unnecessary) - $6.5 million recovered (3,253 claims)
2. Speech language pathology services (Medically unnecessary) - $3.2 million recovered (24,991 claims)
3. Infusion services (Medically unnecessary) - $2.3 million recovered (19,271 claims)

Skilled Nursing Facility

1. Physical and occupational therapy, speech language pathology services (Medically unnecessary) - $8.4 million (80,923 claims)

Physician

1. Pharmaceutical injectables (Incorrect coding) - $5.8 million (18,930 claims)

Preparing for the RACs

Compliance and audit committees, health information management (HIM) and senior management should all be made aware of the focus and timing of these audits.

In light of the high-dollar amount of overpayments identified thus far by the RAC audits, providers also should review their current policies and procedures for dealing with overpayments to government programs. Additional actions for providers to consider when planning for the RAC audits include the following:

Identify Resources	• Appoint an internal RAC liaison, a backup, and a RAC multidisciplinary workgroup. In addition, providers should identify other needed internal and external resources.
Risk Assessment	• Conduct a risk assessment of the type of claims that were identified for improper payment in the demonstration project as well as additional codes that have been identified as "high risk" codes.

Preparing for the RACs (continued)

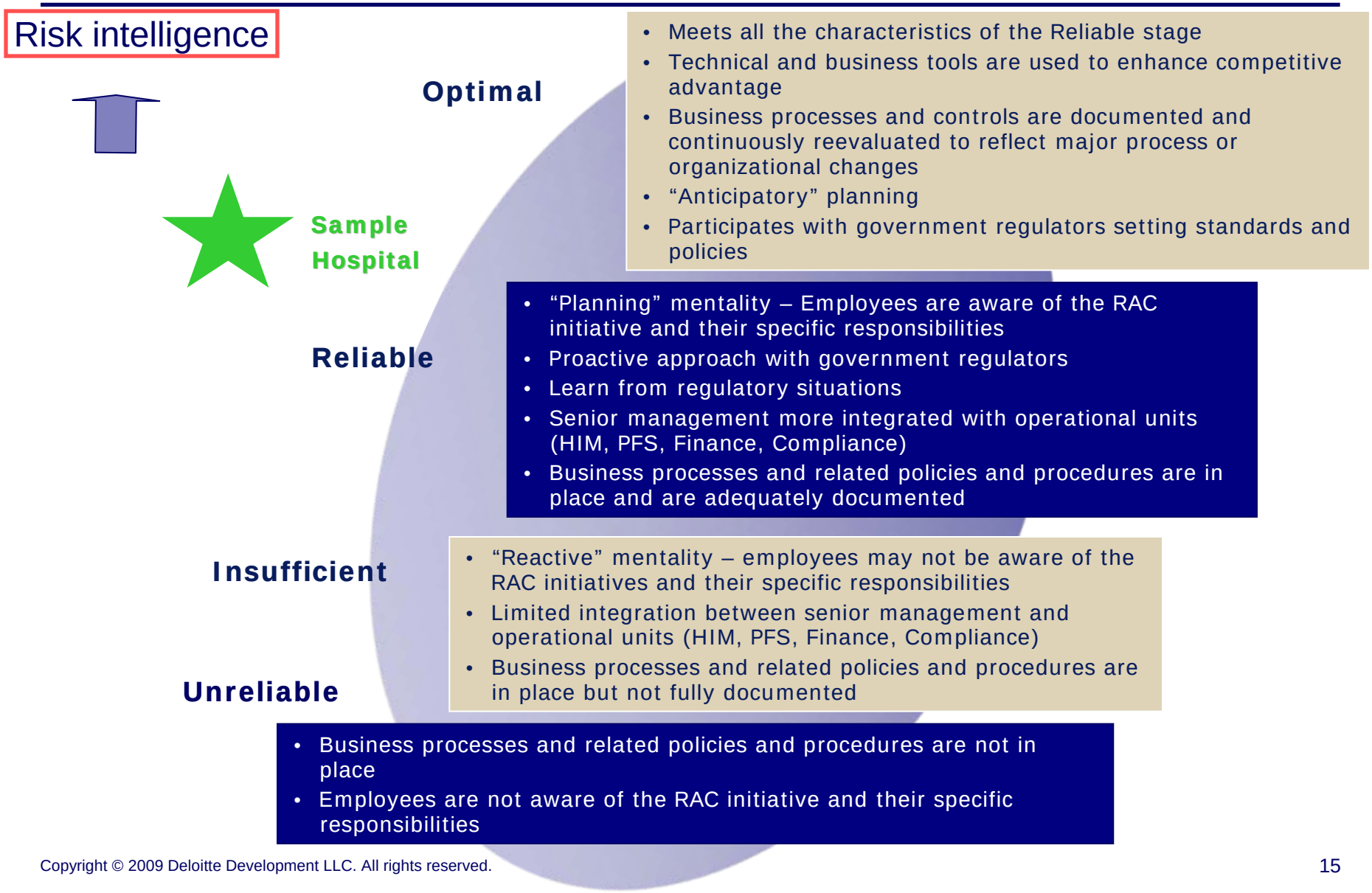
Coding & Billing Claims Audits	• Based on the results of the risk assessment, providers may want to initiate coding and billing claim audits for the types of services that the demonstration project has found to be most problematic.
Claim Review	• Proactively review a sample of claims specifically focusing on the type of claims the RACs have addressed in their audits to determine if a root-cause analysis should be performed.
RAC Audit Process	• Establish a process to address all aspects of the RAC audits, such as making sure that RAC-requested medical records are complete and well-organized. Determine how appeals will be handled as part of the process.
Monitor for the Future	• Monitor local Medicare contractor activities to project what future areas of focus could be and what new system edits should be implemented.

Preparing for the RACs (continued)

Review & Prepare	• Review all correspondence from RACs and other Medicare contractors to be prepared for the RAC implementation date for the provider's state.
Establish an Approach	• Establish a plan and a dedicated team approach to research issues (e.g., incorrect coding, lack of medical necessity) related to a RAC request and to defend claim denials.
Appeal Process	• Become familiar with the process of filing a timely appeal. Consult legal counsel as appropriate.

In summary, a provider's key compliance, quality, and coding professionals should become familiar with the CMS Evaluation of the RAC Demonstration from June 2008 and understand the RAC audit results to date. The emphasis on increased claims data scrutiny requires action now. It is imperative that providers develop a thorough plan to respond to RAC audits.

Stages of Preparation



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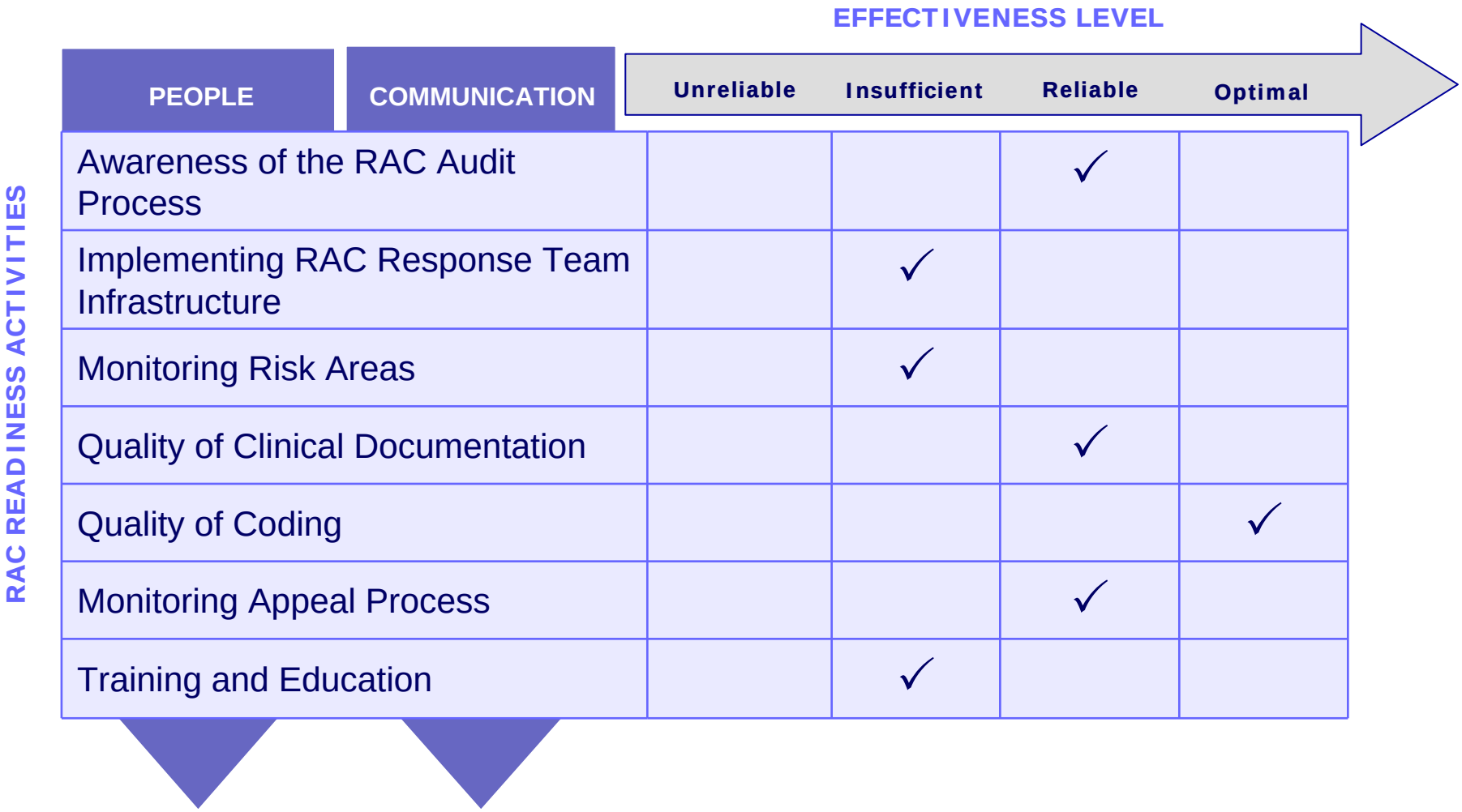
Stages of Preparation – Where are you?

Snapshot of Sample Hospital Preparation Effectiveness



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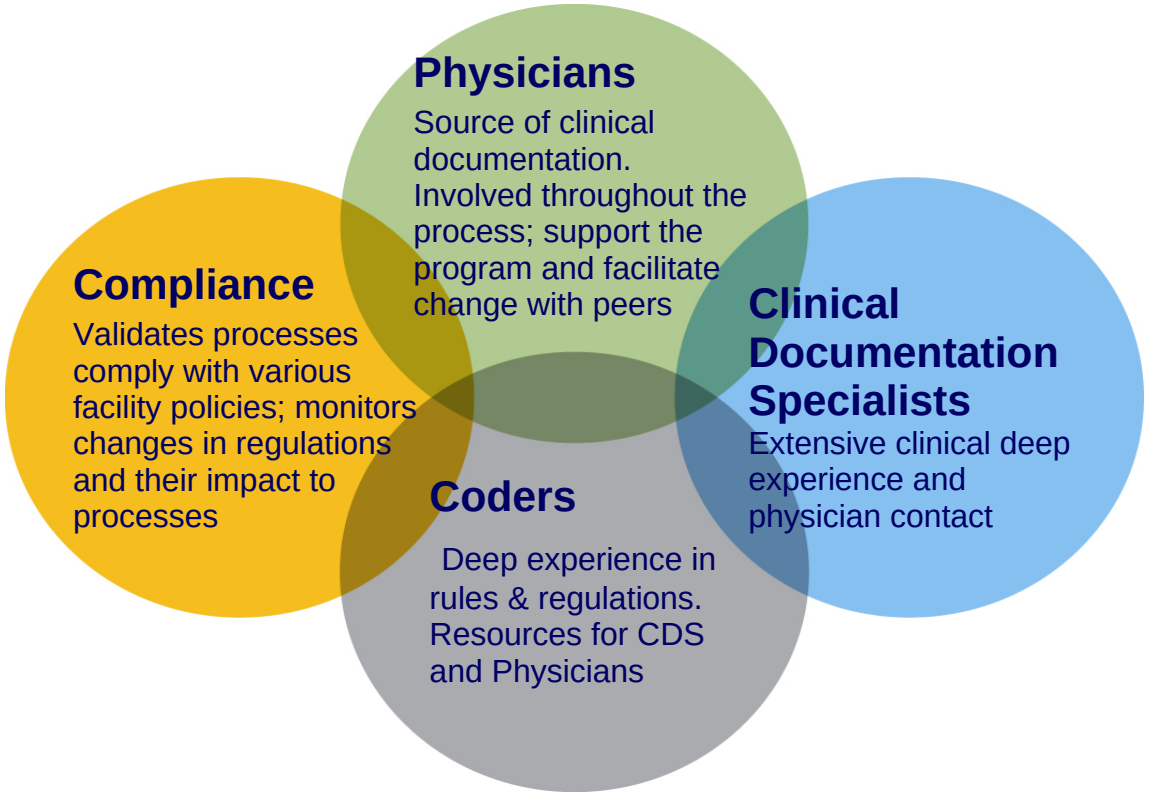
Clinical Documentation Excellence (CDE)

Complex RAC audits have specifically targeted undocumented medical conditions for medical necessity denials. Better clinical documentation can help to mitigate the risk of denials and increase compliance with billing and coding.

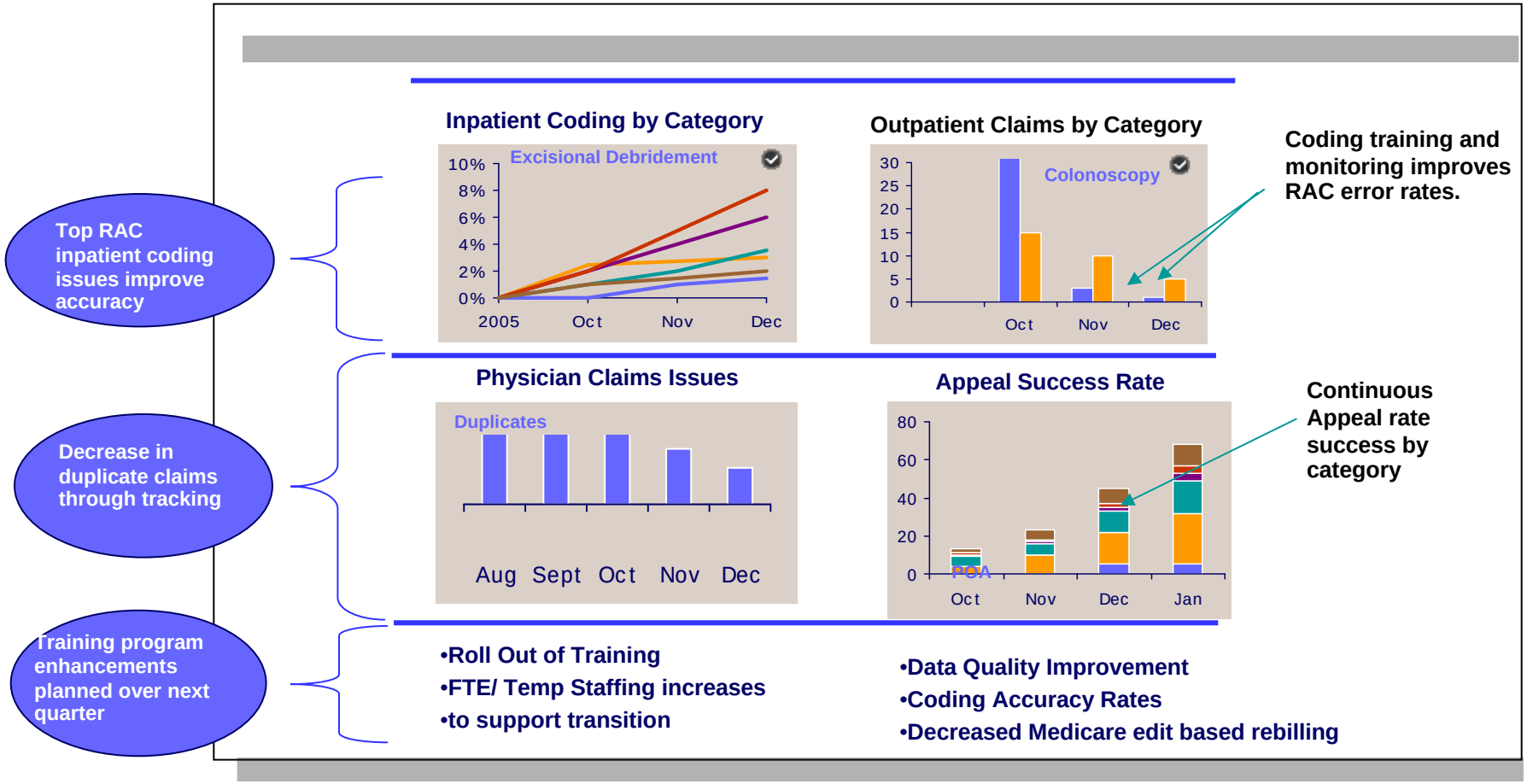


CDE establishes a concurrent review process using an interdisciplinary team to assess whether all conditions and treatments are appropriately described in the medical record for appropriate MS-DRG assignment and quality reporting based on CMS regulations.

Strong CDE programs incorporate a multidisciplinary approach to build effective processes and relationships.

RAC Dashboard Reports

Example RAC Report Card



Exact report card format will be determined by facilities based on program specific compliance and RAC Preparation Program goals and objectives.

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