

Overview: 2016 State of the RAC Program



Analyzing government and third-party reports and data, the Council for Medicare Integrity, a nonprofit organization advocating for proper Medicare billing, created a report to detail the current state of the Recovery Audit Contractor (RAC) Program as of January 2016.

Improper Payments and RAC Recoveries

According to the Office of Management and Budget, Medicare Fee-For-Service (FFS) has the highest amount of improper payments across the entire government for each of the past six years.

In 2014, the Government Accountability Office (GAO) found that Medicare FFS overpaid providers by \$46 billion – or 12.7% of payments. Of these improper payments, over 84% of overpayments collected (more than \$2 billion) came from inpatient hospital claims. For 2015, CMS reported similar results with the Medicare FFS program incorrectly paying \$43.3 billion – or 12.1% of payments – improperly to Medicare providers.

Overpayments - According to a 2015 CMS report to Congress, RACs recovered more than \$2.39 billion in overpayments in FY2014. Since the program began, it has returned more than \$10 billion to the Medicare Trust Fund.

Underpayments - According to a 2015 CMS report, RACs ensured that providers were paid more than \$173 million due to initially being underpaid for their services.

Issues RACs Can Review

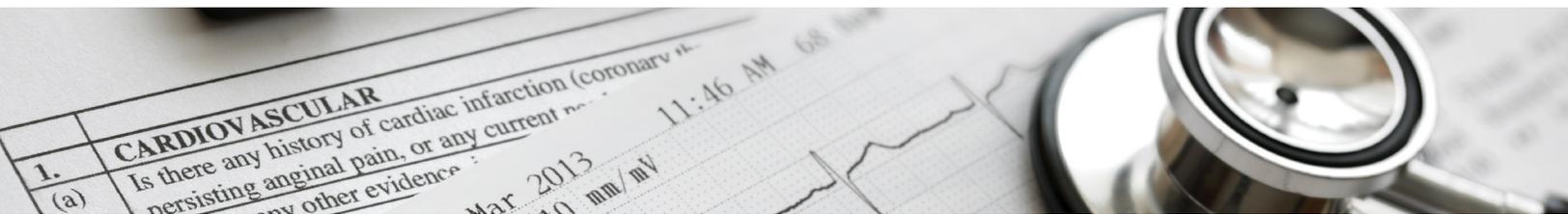
Improper Medicare payment recoveries grew strongly in the first few years of the RAC Program, however due to intense pressure from provider groups, RAC audit capabilities have been severely limited over the past few years. As a result, annual Medicare improper payment recoveries have dropped significantly, from \$3.75 billion recovered in 2013; to just \$2.39 billion recovered in 2014 – a 35% decrease.

Currently:

- RACs review little more than 350 Medicare billing issues, down from the more than 800 when the program was working at full capacity.
- In fall of 2013, RACs were prohibited from reviewing short-stay inpatient claims, an area historically causing the highest rates of improper billing within Medicare. During this time, it's estimated that the Medicare program lost more than \$8 billion in improper payments due to the moratorium placed on the review of short stay claims during this time.
- The review of short inpatient hospital stay claims has been switched over to Quality Improvement Organizations (QIOs). They are now tasked with conducting reviews of short-stay inpatient claims, with the intention to refer claims from providers with high rates of improper payments over to the RACs for further review.

| Issue | Then | Now |
|--|------|---------|
| Automated Overpayments | Yes | Yes |
| Complex Reviews of Diagnosis Related Group (DRG) validation | Yes | Yes |
| Complex Reviews of Pharmacy | Yes | Limited |
| Complex Reviews of Therapy | Yes | Limited |
| Automated underpayments | Yes | No |
| Complex Reviews of Inpatient Rehab Facilities | Yes | No |
| Complex Reviews of Skilled Nursing Facilities | Yes | Limited |
| Complex Reviews of Durable Medical Equipment, Home Health, and Hospice | Yes | No |
| Complex Reviews of inpatient claims from a clinical coding perspective | Yes | No |
| Limited Review of Prepayments | Yes | No |

This chart highlights a few of the differences in the types of claim reviews conducted between the time period when RACs were operating at full scope and how many issues they currently audit.



Improper Billing Drains Medicare

The Council for Medicare Integrity has identified the top five CMS-approved billing issues that contribute most to wasted Medicare dollars. These issues include:

- Durable Medical Equipment (DME)
- Home Health Claims
- Medicare Part A and B Pharmacy Claims
- Diagnosis Related Group (DRG) Validation
- Therapy Cap Reviews

In addition, RACs have identified several examples of egregious errors taking place within Medicare billing, including:

- Home health episodes that started after beneficiaries' deaths
- Oncology radiation calculations billed one week before the patient was seen in the office
- Drugs paid for ten times the amount administered
- Hospital claims coded with illnesses the patient didn't possess
- Excessive units of medication, where the billed dose would be harmful or lethal (to the beneficiary)
- Duplicate provider billing for a medication
- Separate billing for services that should have been bundled and paid for as a single service
- Billing for services in one area of the body where procedures are reimbursed at a higher level, when medical records reveal that patient actually received injections in an area where procedures are reimbursed at a lower level

New Additional Documentation Request (ADR) Limits

ADR limits refer to the specific number of claims any RAC can review from a Medicare provider in a 45-day period. Historically, this limit was just 2%, meaning that 98% of a provider's Medicare claims were not reviewed for accurate billing after the provider received payment.

In November 2015, CMS reduced the ADR limit on the review of inpatient claims to just 0.5% percent, a 75% percent reduction from previous limits. This now means that 99.5% of Medicare inpatient hospital claims will not be reviewed for accurate billing – despite documented high rates of improper billing in this sector.

As a part of this new ADR limit policy, CMS has also stated it will implement a “good” actor/”bad” actor program in which providers who consistently bill properly will have reduced documentation request limits and providers who consistently bill improperly will be subject to higher ADR limits.

The Latest on the Medicare Appeals Process

The Office of Medicare Hearings and Appeals (OMHA) has put in place several efforts to address the Medicare appeals backlog, reducing it by nearly 200,000 cases since late Winter 2016. Because of the following changes, the backlog is projected to be eliminated by the end of FY2019 – 2 years earlier than the original projection. OMHA now reports that appeals cases in the pipeline for review will surpass 1 million cases by the end of FY2016.

While testifying before Congress, Chief Administrative Law Judge (ALJ) Nancy Griswold stated that “51% of the incoming appeals have been filed by five appellants,” lending credence to findings by the HHS Office of the Inspector General (OIG) that a few “frequent filers” are flooding the appeals system, appealing every claim in an attempt to game the system and obtain a different outcome on their claim denial.

Previously, in an effort to reduce the appeals backlog, OMHA offered appellants the opportunity to settle their claim for 68% payment.

Despite provider protests, RAC denials have traditionally had very low rates of appeal overturns. The overall share of RAC overpayment determinations overturned on appeal at any level was 9.3% in FY 2013, the most recent year data is available from CMS. Interestingly, despite provider protests, RAC appeals do not make up the majority of appeals in the system. In fact, only 9.5% of the appeals filed in FY2016 were RAC improper payment decisions.

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