

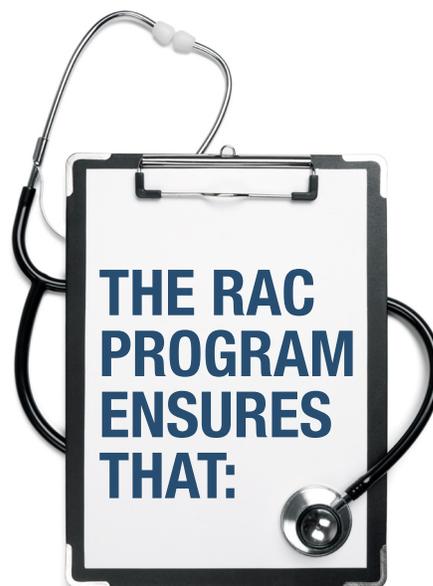


Recovery Auditing Ensures the Best Care for Medicare Beneficiaries

Recovery Audit Contractors (RACs) were mandated by Congress to work to identify and recover improperly billed Medicare funds to preserve and protect the long-term solvency of the program. Since the RAC Program began, auditors have returned more than \$10 billion in improper payments to the Medicare Trust Funds, extending the life of the program by two full years. Auditors have also identified and returned more than \$800 million in underpayments to providers, ensuring that the important care they provide is appropriately compensated.

In addition to preserving Medicare solvency, recovery auditing provides a sentry effect to benefit Medicare patients. RAC audits review medical records to confirm that patients receive the correct course of treatment, and that the patient's medical services were delivered according to Medicare guidelines. Recovery auditing provides patients with an important window into their providers' course of treatment, to ensure that the patient received the appropriate care as evidenced by their billing records, and did not receive the wrong service or treatment altogether.

In fact, Congress created the RAC Program to incentivize accuracy: Medicare providers should ensure that they provide only the medically necessary patient treatment and services as well as accurate billing for those services. Within the paradigm of [new document review limits for recovery auditing](#), providers are rewarded for ongoing accurate and appropriate care and billing practices. The higher a provider's billing accuracy, the less they are subjected to auditing. Conversely, if a provider has a history of billing practices against Medicare guidelines, they are subject to audits of a higher percentage of their submitted Medicare claims.



- **Patients receive the care they really need – not unnecessary services that may afford the provider a higher reimbursement.**
- **Providers treat patients appropriately and bill for that care accurately, according to Medicare policy.**

Provider Misbilling Impacts Care

Unfortunately, extensive improper billing continues within Medicare, to the detriment of patients and all of us as taxpayers. The program faces a 12.1 percent billing error rate, which equates to a loss of more than \$43 billion per year. In 2015, the GAO released a report alerting Congress that Medicare has the highest rate of improper payments government-wide. In fact, Medicare Trustees have warned that at current spending levels and this high rate of improper payments, [the Medicare program will be bankrupt by the year 2028](#), which will greatly reduce or eliminate the program's ability to provide healthcare services for America's seniors.

In a program as large as Medicare, one might think it natural for there to be some mistakes in billing and patient care. However, many of the errors are blatantly inappropriate in order to increase provider revenue and, of most import, often detrimental to patient health.

These are some examples of the treatment and billing concerns that auditors have detected:

- Patients administered invasive treatments for illnesses they did not actually possess (i.e. chemotherapy and radiation).
- Excessive units of medication administered.
- Home health visits billed that supposedly took place after a beneficiary's death.
- Hospital claims coded with illnesses the patient didn't actually possess.
- Physical therapy sessions administered when a patient didn't need it.
- Patients received injections in an area of the body where procedures are reimbursed at a lower level, but the provider documented and billed that the procedure was done in a part of the body that reimburses at a higher rate.
- Providers approving patients for hospice care who are not terminally ill.
- Patients pushed into extensive and unnecessary testing for simple diagnoses, like high blood pressure.

Auditing Is Not a Burden to Providers

Providers often complain that Medicare auditing is a "burden" to their ability to do business. Interestingly, Medicare providers comply every day with the auditing requirements of private health insurance companies, which are able to review up to 100 percent of their submitted claims for accuracy. In comparison, RAC auditors are only permitted to review between 0.5 and 5 percent of a provider's submitted Medicare claims – based on that provider's specific history of accurate or inaccurate billing practices. This means that 95 percent or more of Medicare payments are not audited, also explaining Medicare's all-time high rate of improper payments approximately \$46 billion in FY2014 alone.

Medicare providers are also compensated by RAC auditors for the medical records they provide, whereas commercial payers do not pay for often the same records. Reputable providers recognize that complying with claim auditing is merely a very basic cost of doing business today.

Support Medicare Integrity Programs to Ensure Proper Care for Patients & Reimbursement For Providers.

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