

•Focus on Finance•

Answers to your Accounting and Tax Questions CMS RAC Program... Coming Soon!

RAC Background provided by the Centers for Medicare & Medicaid Services (CMS):

In section 306 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), Congress directed the Department of Health and Human Services (DHHS) to conduct a 3-year demonstration program using Recovery Audit Contractors (RACs) to detect and correct improper payments in the Medicare FFS program. The Recovery Audit Contractor (RAC) demonstration program was 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 providers and suppliers and, therefore, protect the Medicare Trust Fund. The demonstration operated in New York, Massachusetts, Florida, South Carolina and California and ended on March 27, 2008.

Q. Congress mandated the RAC program to detect and correct improper payments in the Medicare program, both overpayments and underpayments. CMS plans to roll out a permanent, nationwide RAC program no later than January 1, 2010. What does this mean to my New Jersey-based hospital?

A. It means you have time to prepare. In the permanent program, the RACs will ask to review Medicare claims made during the past three years, but will not be able to look for any improper payments on claims paid before October 1, 2007. The RAC expansion schedule suggests that New Jersey hospitals will be affected in January 2009 or later.

In preparation of this review, and for the benefit of your facility in general, it would be wise to conduct your own internal audit of documentation practices to ensure accuracy and minimize risk of RAC recoveries. A hospital may want to organize a RAC committee that would be responsible for reviewing samples of data on claims, admissions, documentation and coding, in order to identify repeated errors. All findings should be shared with your compliance officers, legal counsel and external auditor/accountant in order to address these issues and assess and mitigate risk.

Once the RAC program is underway at your facility, there is software available to assist you with the tracking of the audit. Such workflow management tools can expeditiously pull the information required, help identify errors and track the documentation.

As of March 27, 2008, RACs succeeded in correcting more than \$1.03 billion in Medicare improper payments. Approximately 96 percent (\$992.7 million) of the improper payments were overpayments collected from providers, while the remaining 4 percent (\$37.8 million) were underpayments repaid to providers.



Leo P. D'Orazio

Q. Which types of claims were most affected by the RAC process?

A. Of the 96% of improper overpayments corrected, 85% of that made through inpatient hospitals, equating to \$828.3 million to be recouped. The claim issues identified included incorrect payment amounts; services that should not have been covered by Medicare; services that were coded incorrectly; and duplicate services (billed more than once for the same service). According to CMS, the following five areas are examples of inpatient acute services that were subject to significant review:

1. **Short-stay Claims** – large numbers of one-day stays were denied based on RAC determinations that these patients could have been provided outpatient services in lieu of inpatient services. Also, many three-day stays were denied, claiming that patients who did not require a three-day inpatient stay were admitted in order to qualify for up to 100 days of skilled nursing services.
2. **Debridement** – RACs determined many debridement claims were inaccurately coded.
3. **Back Pain** – RAC found many of these claims to be medically unnecessary.
4. **Outpatient vs. Inpatient Surgeries** – RAC denied many procedures as they were not listed on Medicare's "inpatient-only" list, and not deemed medically necessary.
5. **Transfer Patients** – Patients discharged to another hospital were also under scrutiny, as the hospital received a full DRG payment rather than the per-diem payment associated with hospital-to-hospital transfers.

Q. Are all Medicare claims eligible to be reviewed?

A. No. There are claim-types that are excluded from the RAC review. These include:

- Services provided under a program other than Medicare fee-for-service.
- Claims denied under the cost report settlement process.
- Claims more than three years past the date the claim was originally paid.
- Claims paid earlier than October 1, 2007.

- Claims where the beneficiary is liable for the overpayment because the provider is without fault.
- Claims that are randomly selected; claims involved in a Medicare demonstration or that have other special processing rules.
- Prepayment review.

About the Authors

Leo P. D'Orazio, MBA, FACHE, is Managing Director of Health Care Services, based in the New Brunswick office of WithumSmith+Brown, CPA's. If you have further questions about the RAC program, please contact him at 732-828-1614 or ldorazio@withum.com.