Physicians, Be Wary of Medicare's RAC Audits

BY MARY ELLEN SCHNEIDER

LAS VEGAS — The federal government is stepping up its audit activities in Medicare, and that could mean greater scrutiny of billing practices, including the use of observation codes.

One development that physicians should keep a close eye on is the recent nationwide rollout of Medicare's Recovery Audit Contractor program, said Edward R. Gaines III, vice president and chief compliance officer at CBIZ Medical Management Professionals Inc. The program, known as the RAC, began as a demonstration project in New York, California, and Florida.

Under the program, private contractors are given contingency fees for identifying improper Medicare payments to health care providers, including over- and underpayments. But Mr. Gaines said the experience in the demonstration project showed that the contractors concentrated much more on detecting overpayments.

Now that the RAC program has been rolled out nationwide, four private contractors, each assigned to different regions of the country, will use data mining, outlier analysis, and referrals to root out improper payments. The RACs will earn contingency fees for finding errors, with fees that vary from around 9% to 12%.

Physicians need to be aware of the RAC activities and do their own outlier analyses so they can be ready to defend against an audit, Mr. Gaines advised during a meeting on reimbursement sponsored by the American College of Emergency Physicians.

One area that could be part of the review by the RACs is observation services. The RACs focused on that area during the demonstration phase, Mr. Gaines said. One option available to RACs is to perform a concordance review, in which they compare the consistency of hospital and physician claims for the same patient. That may be one way for RACs to evaluate whether observation services were appropriate, he said.

The RACs also will look at evaluation and management services. During the demonstration project, evaluation and management services were exempt from audit, but that is not the case now that the RAC is a permanent program.

Medicare is raising the bar for audits because they are in a financial squeeze, Mr. Gaines said. Right now, Medicare receives more than 1.2 billion medical claims a year—and that's before the bulk of the baby boomer generation has entered the program. Add to that recent news reports that the Medicare and Medicaid programs are hemorrhaging tens of billions of dollars to fraud, and the federal government is in a position in which it needs to act to contain costs.

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The RAC program makes financial sense for the government, he said. During the pilot phase of the program, the RACs collected $1 for every 20 cents spent by the government. "So, if you can get five times the rate of return and you're the federal government, this is a no-brainer," Mr. Gaines said.

One area of specific concern with the RACs is that they have the power, at least in certain limited circumstances, to extrapolate an error rate across a larger number of Medicare claims.

For example, if a RAC finds a 10% error rate on 50 medical records, extrapolation would allow the contractor to apply that error rate across all of a physician's Medicare patients over multiple years—potentially dramatically increasing the penalty.

There are restrictions to that power. For example, it can't be applied during the initial audit phase, and officials at the Centers for Medicare and Medicaid Services have stated that it can be employed only in cases where there is a sustained or a high level of payment error, or a failure to correct the error. In addition, penalties cannot be applied to claims before Oct. 1, 2007.

But the ability to perform extrapolation at all is making physicians uneasy. Although there are restrictions on when extrapolation could be applied, Mr. Gaines said, it's unclear how CMS would put it into practice. And the fact that the RACs would earn contingency fees on extrapolated claims seems to increase the likelihood that the method would be used, he said. "That's where the money is," Mr. Gaines noted.

Physicians who are audited by the RAC and have errors in 1 out of 50 charts would likely be at low risk for extrapolation, Mr. Gaines said. However, the risk likely is higher for a physician or group that has been subject to audits in the past or has been subject to corrective action.

The best defense is to be prepared by knowing how the physicians in your group compare with others in the area by performing your own internal outlier analysis, he said.

If you are audited, consider doing a case summary of the clinical presentations and the code choices. Write up a narrative of what the patient presented with, how the coder viewed the case, and the medical decision making involved. Also, linking the reason for admission and the emergency physician's work-up is important, Mr. Gaines said.

Emergency medicine groups also should be aware of the standard Medicare appeals process.

Although the standard appeals process applies to the RACs, the timelines for stopping recoupment of an improper payment are shorter than some of the standard appeals deadlines. ■

EXPERT OPINION

Greening Your Practice

Physicians in private practice have a large role to play in reducing medicine's impact on the environment. The opportunities to reduce your footprint are similar whether you're running a large hospital or a small- to moderate-size private practice.

BY TED SCHETTLER, M.D.

There's no right or wrong way to approach this effort. Multiple points of intervention can make a difference, but the emphasis will vary depending on the practice's location, its size, and the urgency of the issues at hand. In areas where water is scarce, for example, practices might address issues of water consumption and waste. In other areas, the focus might be on energy. But in all regions, practices can make progress simply by looking at the flow of material coming in the front door and going out the back door.

A recycling program can go a long way toward reducing the volume of waste. So can converting from disposable to washable patient robes, to e-mail in lieu of paper-based communication, and to printing double-sided documents when a paperless route isn't an option.

Using energy-efficient light bulbs and turning the heat or air conditioner down at night are other simple steps to reduce consumption.

Consider the impact of your medical and office-supply purchasing choices. Practices that band together in group-purchasing organizations can greatly influence manufacturers. Even if you are not in such an arrangement, ask vendors for more clarity and transparency about the products you buy so you can make more informed decisions.

Big changes can occur when consumers let their wishes be known. For years, highly toxic flame-retardant chemicals were standard in all types of electronics and computers. Although such chemicals prevent electronics from bursting into flame, they can also leach into our homes and offices, and they present a significant problem when it comes time to dispose of these technologies. In response to consumer pressure, several manufacturers have phased out particularly toxic flame retardants and have replaced them with safer alternatives.

Another hazardous material that's still common in smaller health care settings is mercury. Not long ago, the health care sector was responsible for as much as 10% of the mercury levels emitted from waste incinerators. But pressure on hospitals and suppliers led to the increased use of mercury-free thermometers, sphygmomanometers, and lab chemicals.

Medical supplies are often shipped in an enormous amount of unnecessary packaging. This can be reduced by making your wishes known to manufacturers, in order to reduce waste coming in the front door.

Depending on the size of your practice, you also may be able to make considerable strides in energy efficiency. In many areas of the country, energy consumers can negotiate with competing suppliers to lock in a contracted price per kilowatt hour for the year. When energy companies compete with each other in a reverse auction to get your contract, prices drop. Consumers can also specify that a certain percentage of the energy come from renewable sources, such as solar, wind, or hydropower.

You can also encourage patients to avoid flushing unused prescription drugs down the toilet. Water-treatment facilities are unable to eliminate most of these chemicals from the water system, and trace amounts of pharmaceuticals have been found in streams and rivers across the country. It's debatable whether these trace amounts are having an impact on human health, but there's no doubt that wildlife are affected and that levels are rising. Some pharmacies and municipalities have started take-back campaigns to safely dispose of unused medications. Another way to reduce this problem is to avoid prescribing a large amount of a new medication, when a trial week might help determine if the drug is effective and well tolerated.

Don't know where to start? Try visiting the Web sites of Health Care Without Harm (www.noharm.org) and Practice Greenhealth (www.practicegreenhealth.org). The resources that are available at these sites can help providers design a road map for what they can do tomorrow and in the months and years to come. ■

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