Medicare RAC Program Seeks to Recoup Losses

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.

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, which is 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 overand underpayments.

But Mr. Gaines said that the experience in the demonstration project showed that the contractors concentrated much more on detecting overpayments made to providers.

Now that the RAC program has been rolled out nationwide, four private contractors, each assigned to different regions of the country, will use data min-

ing, outlier analysis, and referrals to root out improper payments. The RAC contractors 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.

The RACs 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 the program is 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

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it needs to act to contain costs.

During the pilot phase of the pro-

gram, 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

management services were exempt from audit, but that is not the case now that the RAC is a permanent program.

During the demonstration

project, evaluation and

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 ex-

> trapolate an error rate across a larger number of Medicare claims. For example, if an 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 only be employed 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 the 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," he said.

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



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WARNING: Suicidality and Antidepressant Drugs

WARNING: Suicidality and Antidepressant Drugs

Antidepressants increased the risk compared to placebo of suicidal thinking and behavior (suicidality) in children, adolescents, and young adults in short-term studies of Major Depressive Disorder (MDD) and other psychiatric disorders. Anyone considering the use of Pristiq or any other antidepressant in a child, adolescent, or young adult must balance this risk with the clinical need. Short-term studies did not show an increase in the risk of suicidality with antidepressants compared to placebo in adults beyond age 24; there was a reduction in risk with antidepressants compared to placebo in adults aged 65 and older. Depression and certain other psychiatric disorders are themselves associated with increases in the risk of suicide. Patients of all ages who are started on antidepressant therapy should be monitored appropriately and observed closely for clinical worsening, suicidality, or unusual changes in behavior. Families and caregivers should be advised of the need for close observation and communication with the prescriber. Pristiq is not approved for use in pediatric patients [see Warnings and Precautions (5.1), Use in Specific Populations (8.4), and Patient Counseling Information (17.1 in the full prescribing information)].

INDICATIONS AND USAGE: Pristiq, a selective serotonin and norepinephrine reuptake inhibitor (SNRI), is indicated for the treatment of major depressive disorder (MDD).

is indicated for the treatment of major depressive disorder (MDD).

CONTRAINDICATIONS: Hypersensitivity-Hypersensitivity to desvenlafaxine succinate, venlafaxine hydrochloride or to any excipients in the Pristiq formulation. Monoamine Oxidase Inhibitors-Pristiq must not be used concomitantly in patients taking monoamine oxidase inhibitors (MAOIs) or in patients who have taken MAOIs within the preceding 14 days due to the risk of serious, sometimes fatal, drug interactions with SNRI or SSRI treatment or within their seriotnoregic drugs. Based on the half-life of desvenilataxine, at least 7 days should be allowed after stopping Pristiq before starting an MAOI [see Dosage and Administration (2.5) in the full prescribing information]. WARNINGS AND PRECAUTIONS: Clinical Worsening and Suicide Risk-Patients with major depressive

taken MAOIs within the preceding 14 days due to the risk of serious, sometimes tatal, unjuniterations with NIN or SRI returnent or with other sendomeric drugs, alsed on the half live of desemblations, at least 7 days should be allowed after stopping Pristip before starting an MAOI (see Dosage and Administration (2.5) in the full prescribing information; where the starting information; and the starting of the starting of their depression and or the emergence of sucidal by our particle (suicidally) or unassociated and starting of their depression and or the emergence of sucidal by our particle (suicidally) or unassociated (suicidally) or unassociated and starting or the starting of the starting of the depression and or the emergence of sucidal properties of suicidal in the starting of the

3 consecutive on-therapy visits. In clinical studies, regarding the proportion of patients with sustained hypertension, the following rates were observed: placebo (0.5%), Pristiq 50 mg (1.3%), Pristiq 100 mg (0.7%), Pristiq 200 mg (1.1%), and Pristiq 400 mg (2.3%). Analyses of patients in Pristiq controlled studies who met criteria for sustained hypertension. Abnormal Bleeding-SSRis and SVRIs can increase the risk of bleeding events. Concomitant use of aspirin, other drugs that affect platelet function, nonsteroidal and-inflammatory drugs, warrain, and other anticoagulants can add to this risk. Bleeding events related to SSRis and SNRIs have ranged from ecrytimosis, hematoma, epistaxis, and petechiae to life-threatening hemorrhages. Patients should be cautioned about the risk of bleeding associated with the concomitant use of Pristiq and NSAIDs, aspirin, or other drugs that affect coagulation or bleeding. Narrow-angle Glaucoma-Mydriasis has been reported in association with Pristiq; therefore, patients with raised intraocular pressure or those at risk of acute narrow-angle glaucoma (angle-closure glaucoma) should be monitored. Activation of mania/hypyomania has also been reported in a small proportion of patients with Pristiq, Activation of mania/hypyomania has also been reported in a small proportion of patients with pain; affective disorder who were treated with other marketed antidepressants. As with all antidepressants, Pristiq should be used cautiously in patients with a history or family instory of mania or hypomania. Cardiovascular/Gerebrovascular or lipid metabolism disorders (see Adverse Reactions (6.1), Increases in blood pressure and heart rate were observed in clinical studies with Pristiq Pristiq has not been evaluated systematically in patients with a recent history of mycardial infarcion, unstable heart disease, uncontrolled hypertension, or cerebrovascular disease. Patients with these diagnoses, except for cerebrovascular disease were excluded from clinical studies in disponder of patients with

se bet nersult of the syndrome of inappropriate antiduretic hormone secretion (SADH). Editing batterists can be at greater risk of developing hyponatemian with SSRs and SNRs Asp, patients taking diuretics or who are otherwise volume depleted can be at greater risk (see *lese* in *Specific Populations (8.5)* and Clinical Paramazology (12.6) in full prescribing information), Discontinuation of Pristiq should be considered in a patients with symphomatic hyponatemia and appropriate medical intervention should be instituted. Coadministration of Drugs Containing Desventlaction and Ventataxine Desventlactions is the major active metabolic of ventalaxine products containing desventlactions and products containing ventalaxine should not be used concomitantly with Pristiq, interstitial Lung Disease and Cosinophiline Perunomana associated with ventalaxine the parent drug of Pristiq interstitial ungolisease and vental proported. The possibility of these adverse events should be considered in patients the pristip have been rapid reported. The possibility of these adverse events should be considered in patients the patient with progressive dyspine, cough, or chest discomitor. Such patients the patient of the patients of the

recommended dose in patients with hepatic impairment is 50 mg/day. Dose escalation above 100 mg/day is not recommended [see Clinical Pharmacology (12.6)].

OVERDOSAGE: Human Experience with Overdosage- There is limited clinical experience with desvenlafaxine succinate overdosage in humans. In premarketing clinical studies, no cases of fatal acute overdose of desvenlafaxine were reported. The adverse reactions reported within 5 days of an overdose >600 mg that were possibly related to Pristiq included headache, vomiting, agitation, dizziness, nausea, constipation, diarrhea, dry mouth, paresthesia, and tachycardia. Desvenlafaxine (Pristiq) is the major active metabolite of venlafaxine. Overdose experience reported with venlafaxine (the parent drug of Pristiq) is presented below; the identical information can be found in the Overdosage section of the venlafaxine package insert. In postmarketing experience, overdose with venlafaxine (the parent drug of Pristiq) has occurred predominantly in combination with alcohol and/or other drugs. The most commonly reported events in overdosage include tachycardia, changes in level of consciousness (ranging from somnolence to coma), mydriasis, seizures, and vomiting. Electrocardiogram changes (eg, prolongation of OT interval, bundle branch block, ORS prolongation), sinus and ventricular factory-cardia, protension, rhabotomyosis, vertigor, liver necrosis, serotonin syndrome, and death have been reported. Published retrospective studies report that venilafaxine overdosage may be associated with an increased risk of fatal outcomes compared to that observed with SSRI antidepressant products, but lower than that for tricyclic antidepressants. Epidemiological studies have shown that venilafaxine-treated patients have a higher pre-existing burden of suicide risk factors than with good patients. The extent to which the finding of an increased risk of fatal outcomes can be attributed to the toxicity of venlafaxine-in overdosage, as opposed to some characteristic(s) of venlafaxine-treate This brief summary is based on Pristig Prescribing Information W10529C009, revised September 2009

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