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 over- and 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 mining, 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

it needs to act to contain costs.

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.

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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 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. ■