Medicare's Recovery Audit Contractor Program Under Scrutiny by Physicians

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WASHINGTON — The Recovery Audit Contractor program, charged with investigating and remedying improper Medicare payments to providers, must undergo some serious structural changes before it is ready for prime time, said several physicians in testimony before the House Committee on Small Business.

The Recovery Audit Contractor (RAC) program employs private contractors to investigate improper payments by Medicare to health care providers. The program was mandated in the Medicare Modernization Act and tested in New York, California, and Florida beginning in 2005. With the pilot now completed, nationwide adoption is scheduled to begin in 2010.

Dr. Karen Smith, a member of the American Academy of Family Physician's Commission on Practice Enhancement, testified about her own experience dealing with RAC audits. She said that in 2005, two representatives from one contractor, AdvanceMed, showed up at her office unannounced, flashing badges, and requested 72 charts for records from the previous year and a half.

"The care of my patients was disrupted in our open access, rural family practice as patients, pharmaceutical vendors, and other visitors of the practice observed the unannounced review," according to her submitted testimony.

Five months after the audit, Dr. Smith received notice that 72 claims with 154 services were reviewed by the RAC, of which 91 services were disallowed for payment. The RAC then used an extrapolation formula to determine how much Dr. Smith owed, except it relied on an incorrect "sampling frame size" of 2,935 Medicare patients, nearly 2,000 more than Dr. Smith had in her practice.

"The discrepancy was not acknowledged or corrected in the final calculations," Dr. Smith said. The alleged Medicare overpayment, using this flawed calculation, totalled $48,245, she said.

After a lengthy, costly, and ultimately not totally successful series of appeals, Dr. Smith was forced to use proceeds from a home equity loan to pay CMS an adjusted sum of $18,158. "The 'guilty until proven innocent' audit we endured used sampling and extrapolation calculations [that] are not properly verified for validity," said Dr. Smith.

Dr. William A. Dolan, a member of the American Medical Association board of trustees, also testified before the committee, which is chaired by Rep. Charles Gonzalez (D-Texas).

"The best way to reduce common billing and coding mistakes is through targeted education and outreach, rather than onerous audits performed by outside contractors provided with incentives to deny claims," he wrote in his testimony.

One of the greatest problems is RAC's ability to designate improper payments based on contractors' judgment of "medical necessity....We do not think that these reviews are appropriate for the RAC program and believe that they exceed the authority imparted to the RAC by Congress. These reviews should be conducted by clinicians with relevant experience and expertise," testified Dr. Michael Schweitz, a practicing rheumatologist from West Palm Beach, Fla.

Mr. Timothy B. Hill, chief financial officer and director of CMS' office of financial management, testified that once the RAC program is made permanent in 2010, each contractor will be required to have a medical director who oversees medical necessity questions. This was not the case in the demonstration project.

Another request, voiced by Dr. Dolan, was that program contractors be prohibited from reviewing claims from the past 12 months, which may be "still under review by carriers and other fiscal intermediaries." He also called for a limit on the number of medical records requested from individual physicians. "I know of a urologist in California who was hit with 50 RAC requests," he said.

"CMS should also raise the minimum claim level from $10 to at least $25," he added. In a question-and-answer period after the testimony, Dr. Dolan amended his recommendation to $100.

Mr. Hill said that contractors are paid a commission on all of the improper payments they recover. "The incentive to identify underpayments is exactly the same as the incentive to identify overpayments," he said. However, in 10 years of sampling "the vast majority of the improper payments" are overpayments. ■

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