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RAC Memorandum 08-07

TO: Chief Executive Officers and Chief Financial Officers

SUBJECT: Medicare Recovery Audit Contractor:  
CMS Final Report on the Three-Year Demonstration Project

COPY TO: Medicare Recovery Audit Contractor Liaisons

Last week the Centers for Medicare & Medicaid Services (CMS) released its long-awaited report on the three-year Medicare Recovery Audit Contractor (RAC) demonstration program, which ended in March 2008. The demonstration was conducted primarily in California, Florida, and New York, with three additional states (Arizona, Massachusetts, and South Carolina) added during the latter phase of the project. The [attached report](#) offers a comprehensive review of the RAC demonstration program and describes improvements that will be implemented for the permanent RAC program, which will be phased-in across the country beginning later this summer. This memorandum outlines highlights from the report and reviews further program improvements that are needed.

### **Major Findings from the Demonstration**

- RACs identified \$1.03 billion in improper payments during the three-year demonstration program, consisting of \$992.7 million in overpayments and \$37.8 million in underpayments. These figures include \$12.7 million in recoveries for improper payments due to situations where the Medicare claims should have been paid by a different health insurer.
- Hospital claims accounted for 95% of overpayments collected by RACs, with 85% of overpayments related to inpatient services; 4% related to hospital outpatient services, and 6% related to inpatient rehabilitation services.
- After expenses, appeals and underpayments repaid to providers, the program returned \$693.6 million to the Medicare Trust Fund. The costs of operating the demonstration RAC program, including contingency fees paid to the RACs, totaled \$201.3 million. There were \$37.8 million in underpayments, \$14.0 million was spent to “re-review” inpatient rehabilitation claims in California, and \$46.0 million in overpayments were reversed on appeal.
- Of the overpayments collected, nearly 40% were based on RAC determinations that the care provided was either not medically necessary or was provided in the wrong setting. Incorrect

coding accounted for 35% of overpayments, insufficient of lack of documentation accounted for another 8%, while other types of errors, such as duplicate claims for the same date of service or duplicate claims paid under another Medicare service payment system, accounted for the remaining 17%.

- The greatest recoveries, net of appeals, for inpatient hospital services included claims for excisional debridement, inpatient rehabilitation services following joint replacement surgery, surgical procedures in the wrong setting, cardiac defibrillator implant in the wrong setting, treatment for heart failure and shock and respiratory system diagnoses with ventilator support. Neulasta generated the greatest recoveries for outpatient hospital services.
- As of March 2008, only 14% of all RAC reviews had been appealed, and approximately one-third of these were overturned in favor of the provider. Since many denials are still in the appeals process and final figures on the outcome of those appeals will not be available for some time, CMS plans to issue periodic updates through summer 2008 as decisions are made. CMS noted that many providers did not appeal certain claims if the administrative cost of appeal outweighed the potential recovery.

### **Improvements for the Permanent RAC Program**

The CMS report outlines lessons learned from the RAC demonstration, and concludes that the RAC program can effectively prevent future improper Medicare payments. Listed below are some of the significant improvements that CMS will implement in the permanent RAC program:

- The RAC look-back period (from claim payment date to the date of the medical record request) is reduced from four years to three years; and no audits may be conducted on claims paid prior to October 1, 2007.
- RACs must provide frequent public reporting of the vulnerabilities, or problem areas, that are subject to audits. CMS will approve in advance any new areas targeted by RACs, and RAC denials will be independently audited for accuracy. Requests for records and overpayment letters (including those for claims over one year old) will be standardized and must include the reason for the review/overpayment.
- RACs must have a physician medical director and this person must be available, upon request, to discuss denials with providers. RACs must also use certified coders, and the clinical credentials of RAC reviewers must be available upon request.
- RACs are required to return any contingency fees if audit decisions are overturned at any level of appeal. CMS will be required to publically disclose the RAC contingency fees.
- CMS will place limits on the number of medical records RACs can request for a specific time period (yet to be defined by CMS). RACs will be required to accept electronically scanned records.
- The permanent RAC will not include Medicare Secondary Payer reviews.

### **Additional Improvements are Required**

In a recent *Special Bulletin*, the American Hospital Association noted that while CMS has made significant improvements to the permanent RAC program, additional refinements are needed before the program expands nationwide. IHA and MCHC will continue to support AHA's advocacy efforts for these and other important RAC program changes:

- Investment in provider education and Medicare systems edits so that errors are minimized and claims are paid correctly the first time.
- Expanded role of physicians with respect to medical necessity reviews.
- Implementation of uniform processes for re-billing denied claims at the appropriate level of care and through waiver of timely filing limits, where applicable.
- Adoption of a standard tracking system for all RACs to share the status of their audits and appeals.
- Use of a shorter look-back period and a more balanced focus on underpayments.
- Extension of reimbursement of medical record copying and shipping costs from inpatient and long-term care services to all hospital services, and expanded use of electronic vehicles to request and accept provider documentation.

### **RAC Activity in Illinois**

Later this summer CMS will announce the names of the permanent RACs for the four regions of the country. Extensive provider outreach by CMS and the new RACs is planned, and IHA and MCHC will help facilitate this effort. RAC reviews of claims for Illinois providers are scheduled to begin in 2009, although the anticipated announcement later this summer of a new Medicare Administrative Contractor in the state and the subsequent transition to the MAC may impact this plan.

Please feel free to contact either of us directly if you have any questions about the CMS report or if you need additional information about the RAC program.

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Att: *The Medicare Recovery Audit Contractor (RAC) Program: An Evaluation of the 3-Year Demonstration (June 2008)*