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Recovery Audit Contractors Are Not Going Away… Will Your Facility Survive the Assault?

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Medicare processes approximately 1.3 billion claims annually, and it is estimated that 4% of Medicare dollars are paid based on claims that are not in compliance with Medicare coverage, billing, coding, and payment regulations. The federal government estimates **$10.8 billion** in Medicare dollars are **paid improperly**. To help curb the tide of improper payments, Congress authorized the Recovery Audit Program. As an incentive to recover fraudulently paid claims, the auditors are paid a 20% contingency fee based on overpayments collected.

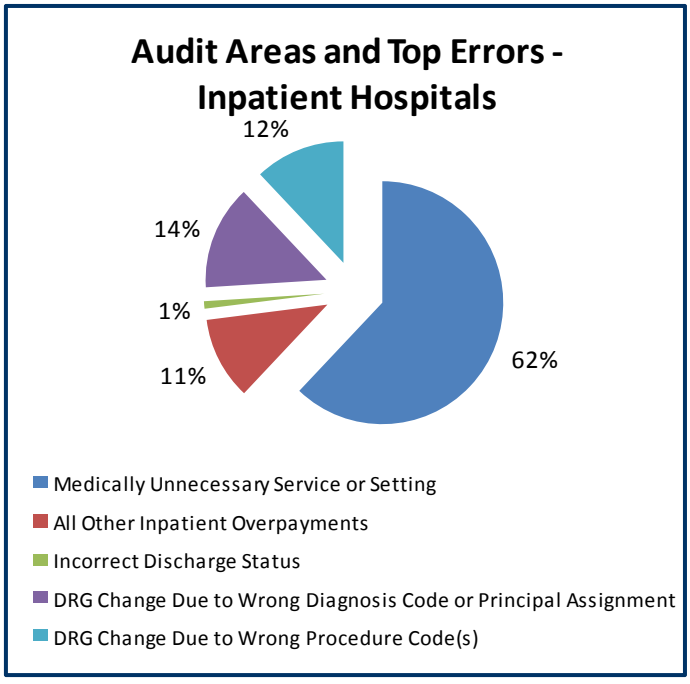
RESULTS OF RAC FRAUD AUDIT 2004-2007 (millions)	
Overpayments Collected	**$992.7**
Less: Underpayments Repaid	**$37.8**
Overturned on Appeal	**$46.0**
RAC Re-reviews	**$14.0**
Cost to Run Program	**$201.3**
Returned to Medicare Trust Fund	**$693.6**

Results from the Recovery Auditors demonstrate more monies were recovered in 2007 than in 2004-2006 combined. Fraud audits are not going away but instead aggressively gaining momentum. The results from the RAC audits have demonstrated to Congress that fraud audits are bringing home the bacon, just as Congress has major pressure to control the health care budget. **CMS has accelerated the Audit timetables and requested RACs begin reviewing claims in all 50 states by late 2008.**

Facilities need to be aware there are multiple layers of fraud audits. Health care providers enrolled in Medicare and Medicaid programs can be audited by multiple agencies: Federal, State, third party payers and contractors. There are ten separate fraud audit programs in process, with more fraud programs added each month.

Due to the multiple layers of audits, providers should expect over-lapping audits, changing standards, and procedural issues. Each of the audits has different time lines for filing an appeal. **Providers need to be vigilant so they don't miss an appeal deadline.**

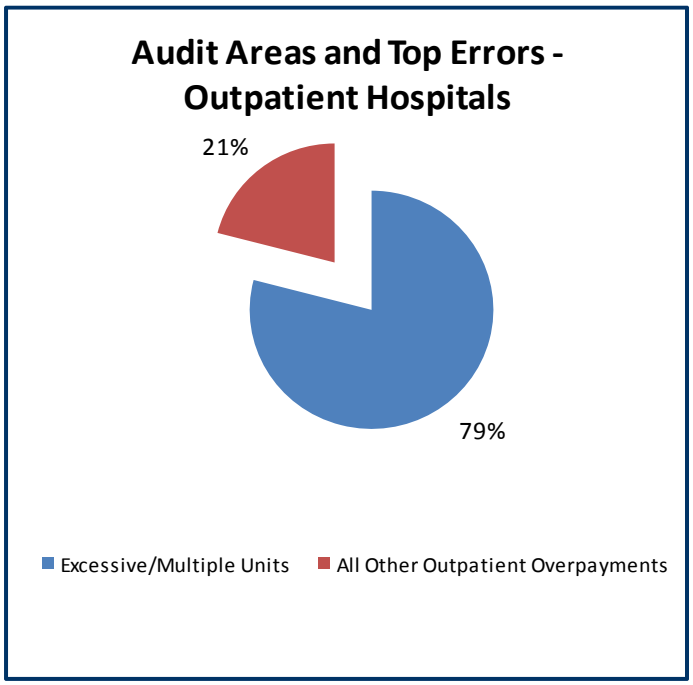
The RACs were given nearly 1.2 billion claims to review and they determined 525 thousand were overpaid. Inpatient hospitals represented 85% of overpayments. Rehabilitation represented 6%, SNF 2%, Outpatient hospitals 4%, Physicians 2% and other facilities 1%.



Inpatient Focus on Audits:

- Medical necessity
- Observation and admissions

- Transfers and discharges
- One-day stays
- Lack of documentation
- Extensive OR procedures unmatched to principal diagnosis
- Inpatient procedures eligible for outpatient surgical setting
- Unbundling procedure codes to obtain additional reimbursement
- Excisional debridement
- Joint replacement surgery
- Heart failure and shock
- Drugs and biologicals
- Chest pain/back pain
- Billing for items/services before they were delivered/performed
- Billing for non-covered services under a covered procedure code



Outpatient Focus on Audits:

- Excess units
- Multiple claims
- Speech & therapy claims
- Infusion therapy

Critical Access Facilities **are included** in the current Recovery Fraud Audits. One of the areas being focused on in CAH hospitals is observation. Are CAHs admitting patients to observation in order to stay under the 25 bed rule and the 96 hour average? Are providers using observation as overflow units?

One day stays in CAHs are closely monitored, as are the three day qualifying hospital stays prior to admission to a SNF unit. Small facilities are often cited for lack of documentation.

For small rural facilities and CAHs with fewer than 100 employees, overpayments collected on fraud audits averaged just over $1 million.

For just a fraction of the amount being recovered through RAC repayments, a facility can be proactive and avoid being targeted by establishing the necessary internal mechanisms. It has proven to be cost effective to invest in a solid compliance plan, hire an outside expert to conduct external audits, and create a training program for all employees, physicians, and board members. Spend your money to protect yourself not on contingency fees to RACs.

APPEALS

Bear in mind $46 million in claims deemed overpayments in the fraud audits were successfully appealed by the providers. The number of cases appealed and won increases as second and third quarter statistics are added. RACs rely on their data mining programs and often do not look at the medical records or other documentation. The rationale for medical necessity, appropriate setting, and correct coding often cannot be seen without the medical record. **Providers should always appeal any valid claims.**

For compliance and our tips and experience on Fraud Audits see our future articles in the winter editions of the *Washington Healthcare News*.

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