



Dig Into RAC Preparation: Use Data Mining

Seeing the big picture to solve the biggest problems in health care.

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RAC Purpose

- To detect and correct overpayments and underpayments
 - > Refund underpayments to the providers
 - > Collect overpayments from the providers

Medicare receives 1.2 billion claims per year:

-4.5 million claims per work day

-574,000 claims per hour

-9,579 claims per minute

Reasons for Incorrect Payment*

- Payments are made for services that do not meet Medicare's medical necessity criteria.
- Payments are made for services that are incorrectly coded.
- Providers fail to submit documentation when requested, or fail to submit enough documentation to support the claim.
- Other reasons, such as basing claim payments on outdated fee schedules, or the provider is paid twice because duplicate claims were submitted.

*The Medicare Recovery Audit Contractor Program: An Evaluation of the 3-Year Demonstration, June 2008

Average Overpayment Amounts

Type of Provider	Average Overpayment Amount					
	Connolly*		HDI*		PRG	
	Per Claim	Per Provider Per Year	Per Claim	Per Provider Per Year	Per Claim	Per Provider Per Year
IP, IRF, SNF	\$12,157	\$483,774	\$3,917	\$118,834	\$6,309	\$850,502
OP	327	10,398	567	6,465	398	24,640
Physician	140	372	103	1,441	214	602
Ambulance, Lab, Other	--	---	88	429	231	2,631
DME	174	1,361	466	1,039	126	1,943

*Announced as permanent RAC

Follow the Money!

- Review data sources
 - > Own facility data
 - > Comprehensive Error Rate Testing (CERT) Program
 - > Office of the Inspector General (OIG) Audit Reports
 - > www.hospitalbenchmarks.com
 - > MedPar data
 - > Facility Decision Support
 - > Hospital Compare
(http://www.cms.hhs.gov/HospitalQualityInits/11_HospitalCompare.asp)
 - > www.Healthgrades.com
- Convert data to information
- Research difficult to code/bill areas
- Review each issue
- Perform chart and claim audit
- Communicate results

What We Know...

- The permanent RACs are to be nationally implemented by January 1, 2010
- The demonstration RACs have focused on for inpatients:
 - > Surgical procedures in wrong setting (e.g. cardiac defibrillators)
 - > Excisional debridements
 - > Treatment for heart failure/shock in wrong setting
 - > Respiratory system diagnoses w/vent support
 - > Discharge status
 - > Principal procedure does not match principal diagnosis
 - > Respiratory system procedures
 - > Respiratory infections (e.g. pneumonia)
 - > Kidney & urinary infections

What We Know...

- The RACs have focused on for outpatients:
 - > Neulasta (medically unnecessary)
 - > Speech and Language service (medically unnecessary)
 - > Infusion services
 - > Drug codes (Oxaliplatin, Darbopoetin) incorrect
- The RACs have minimally reviewed at physician billing

Outpatient Example

- **SCENARIO:** An auditor identifies that there is a problem with tetanus vaccine charge. The tetanus vaccine (90703) is coded in chargemaster as tetanus immune globulin (J1670).
- **ISSUE:** Tetanus vaccine is packaged and tetanus immune globulin is reimbursed by CMS (\$106/dose).
- **IMPACT:** 200 cases were identified as charged incorrectly.
- **RESULT:** \$21,200 to be repaid

Inpatient Example

- **SCENARIO:** An auditor identifies that there is a coding problem with percutaneous transcatheter uterine artery embolization procedures performed in Radiology.
- **ISSUE:** Procedure is coded as 39.79 instead of 99.29 as advised by Coding Clinic, First Quarter 2001.
- **IMPACT:** MS-DRG 983 (RW 2.9737) is assigned instead of MS-DRG 761 (RW .5569).
- **RESULT:** Potential repayment could be \$11,787.82 per case.

CERT Program Results, May 2008

Contract or Type	Total \$ Paid (billions)	Overpayments (billions)		Underpayments (billions)		Overpayments + Underpayments	
		Payment	Rate	Payment	Rate	Improper Pay	Error Rates
Carrier	\$ 74.9	\$ 3.2	4.2%	\$ 0.2	0.3%	\$ 3.4	4.5%
DMERC	\$ 9.9	0.9	8.9%	0.0	0.1%	\$ 0.9	9.0%
FI	\$ 89.4	1.2	1.3%	0.1	0.2%	\$ 1.3	1.5%
QIO	\$102.0	4.0	4.0%	0.5	0.5%	\$ 4.6	4.5%
All FFS	\$276.2	\$ 9.3	3.4%	\$ 0.9	0.3%	\$10.2	3.7%

OIG Audits

- High dollar reimbursements/payments
 - > IP - \$100,000
 - > OP - \$50,000
 - > SNF - \$50,000
 - > Physician - \$10,000
- Units for oxaliplatin
- Skilled nursing facility excessive units
- Outpatient rehabilitation therapy services
- Units for blood clotting factor
- Outlier payments
- Power mobility devices

Potential Targets

- Cases with one CC/MCC
- Highly reimbursed cases
- High cost/reimbursed medications/biologicals
- Sepsis with line sepsis as secondary diagnosis
- High frequency cases (e.g. CHF with pleural effusion with respiratory failure; pneumonia with sepsis cases)
- Frequently rejected cases for medical necessity

Conclusion

- CMS is moving forward with the RAC Permanent Program
- RAC-type programs are growing among other payers
 - > Medicaid Integrity Contractors
 - > Third Party Commercial Payers DRG Validation Programs
- Medical necessity is a BIG deal
- Accurate billing is a focus
- Accurate coding is required
- Advantage is given to proactive research
 - > October 1, 2007 payment date until the present

Resources

- CMS Manual 100-04
- CMS, “The Medicare Recovery Audit Contractor (RAC) Program: An Evaluation of a 3-Year Demonstration Report”; June 2008
- <http://www.cms.hhs.gov/RAC/Downloads/RACStatusDocument>
- http://www.cms.hhs.gov/apps/er_report/preview_er_report_print.asp?from=public&which=long&reportID=9
- <http://www.hhs.gov/budget/09budget/2009Highlights.pdf>
- Wilson, Donna; “Recovery Audit Contractors (RACs)”; April 2007
- MedLearn Matters, MM4019, “MMA – Changes to Chapter 29 – General Appeals Process in Initial Determinations”; October 7, 2005
- Wall, Harriet; Revenue Cycle Strategist, “RAC Reviews: Are You Ready?”; July 2008, pg. 1 – 3.
- Orsini, John; Healthcare Financial Management, “Surviving the RAC: How to Take the Take-Backs”; May 2008; pg. 66-69.