THE MEDICARE RECOVERY AUDIT CONTRACTOR (RAC) PROGRAM:

An Evaluation of the 3-Year Demonstration

June 2008

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Background

Medicare is a multifaceted program. The Medicare Fee-for-Service (FFS) program consists of a number of payment systems, with a network of contractors that process over 1.2 billion claims each year, submitted by more than 1 million health care providers such as hospitals, physicians, skilled nursing facilities, labs, ambulance companies, and durable medical equipment (DME) suppliers. These contractors, called "Medicare claims processing contractors," process claims, make payments to health care providers in accordance with Medicare regulations, and are responsible for educating providers about how to submit accurately coded claims that meet Medicare's medical necessity guidelines. Despite actions to prevent or recoup improper payments, it is impractical to prevent all improper payments. A January 2008 report by the Office of Management and Budget (OMB) indicated that Medicare is among the top three Federal programs with improper payments, totaling an estimated $10.8 billion in 2007.

Improper payments on claims can occur for the following reasons:

- 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- Other reasons, such as basing claim payments on outdated fee schedules, or the provider is paid twice because duplicate claims were submitted.

Medicare Secondary Payer (MSP) improper payments can occur when Medicare pays a claim that should have been paid by a different health insurance company.

The RAC Demonstration

The purpose of this report is to evaluate the RAC demonstration and to share with all interested parties information about the demonstration. Congress authorized the RAC demonstration for the purpose of identifying underpayments and overpayments and recouping overpayments under part A or B of the Medicare program. Under this authority, Congress provided for payments to the RACs on a contingent basis for detecting and correcting overpayments and underpayments. Correcting includes both collecting overpayments from providers and refunding underpayments to providers.

A full and open competition was held to competitively select three Claim RACs and two Medicare Secondary Payer (MSP) RACs for the demonstration. Initially each Claim RAC was given a single State jurisdiction. California, Florida, and New York were selected for the demonstration because they are the largest States in terms of Medicare utilization. Each jurisdiction was expanded by one State in the summer of 2007 to include Massachusetts, South Carolina, and Arizona.

Claim RACs use a review process similar to that of Medicare claims processing contractors. Automated reviews occur when the RACs have identified improper payments because the provider clearly billed in violation of Medicare policy. For complex reviews, the RACs have identified a likely improper payment and request the medical records from the provider to conduct a more in-depth review.

The Centers for Medicare & Medicaid Services (CMS) initially provided the Claim RACs with four years of claims data for their jurisdictions. Subsequently, the Claim RACs received an additional three months of claims on a quarterly basis.

The RAC data warehouse has facilitated CMS oversight of the RAC demonstration. CMS developed

the RAC data warehouse to automate means of administering and overseeing the Claim RAC component of the demonstration.

Results of the RAC Demonstration

As of March 27, 2008, RACs succeeded in correcting more than $1.03 billion in Medicare improper payments. Approximately 96 percent ($992.7 million) of the improper payments were overpayments collected from providers, while the remaining 4 percent ($37.8 million) were underpayments repaid to providers. The MSP RACs collected fewer overpayments ($12.7 million) than the Claim RACs ($980.0 million).

During a similar time period, the Medicare claims processing contractors in New York, Florida, and California corrected far fewer improper payments ($13 million in overpayments and less than $0.1 million in underpayments) but *prevented* a significant amount of improper payments by denying $1.8 billion in claims prior to payment.

Claim RAC efforts to correct improper payments grew over time. Of the total $1.03 billion in improper payments corrected by the Claim RACs from the inception of the demonstration through March 27, 2008, approximately 4 percent occurred in FY 2006, 34 percent in FY 2007, and 62 percent in the first half of FY 2008.

The majority of Medicare claims were unaffected by the Claim RACs. Of a total $317 billion in Medicare claim payments available for review by the Claim RACs through March 27, 2008, the Claim RACs identified and corrected improper payments on only 0.3 percent ($1.03 billion) of the claims received.

As of March 27, 2008, providers had chosen to appeal 14.0 percent of the RAC determinations. Of all the RAC overpayment determinations, only 4.6 percent were overturned on appeal.

Even after subtracting the dollars in refunded underpayments, overpayments overturned on appeal, and RAC demonstration operating costs, the RACs still returned millions to the Medicare Trust Funds. Through March 27, 2008, the RACs had returned $693.6 million to the Medicare Trust Funds. This number includes appeals overturned through March 27, 2008. However, it is important to note that because CMS currently is unable to track all pending first-level appeals of RAC determinations, the dollar amounts returned to the Trust Funds are subject to change. Providers have 120 days to appeal from the date of the claim adjustment, and CMS anticipates that most first-level appeals of RAC determinations will have been filed by July 1, 2008. The Medicare appeal process is described in more detail in Chapter 4.

Most overpayments (85 percent) were collected from inpatient hospital providers, 6 percent from inpatient rehabilitation facilities (IRFs), and 4 percent from outpatient hospital providers. Most overpayments occur when providers submit claims that do not comply with Medicare's coding or medical necessity policies.

Future improper payments can be avoided by analyzing the Claim RACs' service-specific findings. CMS can use this information to implement more provider education and outreach activities or establishing new system edits, with the goal of preventing future improper payments. Hospitals and other health care providers can use the information to help ensure that they are submitting correctly coded claims for services that meet Medicare's coding and medical necessity policies.

In order to determine providers' satisfaction with the RAC demonstration, CMS tasked the Gallup Organization to conduct telephone interviews with a selected sample of 589 providers between May 2007 and July 2007. The sample was selected randomly from more than 4,200 providers who had received a medical record request or an overpayment recoupment from a RAC at least once in the 12 months before the survey date. The survey asked providers questions such as whether they felt CMS's efforts to recoup overpayments are fair and reasonable, and whether they think the RACs will help ensure more accurate billing practices in the future. The survey results showed that 74 percent of the respondents found CMS's efforts to recoup overpayments to be fair and reasonable. Seventy-one percent thought that RAC reviews correctly applied Medicare policies.

The RAC demonstration had limited financial impact on most providers. Most did not receive any overpayment request letters from a RAC, and of those providers who were asked to repay an overpayment, those repayments were small in comparison with the providers' overall income from Medicare.

From its inception through March 27, 2008, the RAC demonstration cost only 20 cents for each dollar collected. RAC contingency fees were $187.2 million over the life of the demonstration. Medicare claims processing contractors' costs were $8.7 million, and other expenses were $5.4 million.

Independent Verification of Demonstration Results

Several independent organizations beyond the RACs have supported CMS in the evaluation of the RAC demonstration. To ensure the validity of data underlying the demonstration, CMS tasked Econometrica, Inc., with assessing the completeness of certain data entered in the RAC data warehouse. Econometrica also supported CMS by verifying certain summary data included in this report and documenting the results of that effort. As noted earlier, the Gallup Organization conducted an independent survey of providers to determine their level of satisfaction with the RAC demonstration. In addition, the Claim RAC Validation Contractor, AdvanceMed, provided external validation and helped ensure the accuracy of the RAC claim determinations by conducting independent, third-party reviews of improper payments.

Lessons Learned

As a result of the RAC demonstration, many of the key questions about the feasibility and merits of applying recovery audit principles and methods to the Medicare program have been answered. Namely, the demonstration has shown the following:

- Claim RACs are able to find a large volume of improper payments.
- Providers do not appeal every overpayment determination.
- Overpayments collected were significantly greater than program costs.
- Claim RACs are willing to spend time on provider outreach activities, developing strong relationships with provider organizations.
- It is administratively possible to have a RAC work closely with a Medicare claims processing contractor.
- RAC efforts did not disrupt Medicare or law enforcement anti-fraud activities.
- It is possible to find companies willing to work on a contingency fee basis.

One of CMS's goals during the RAC demonstration was to address all concerns raised by a RAC, a provider, or any other interested party, while identifying successes and opportunities for improvement before the program is expanded nationally. A number of changes were made to improve the RAC permanent program, most notably:

- Having all new issues a RAC wishes to pursue for overpayments validated by CMS or an independent RAC Validation Contractor and to share the upcoming new issues with provider organizations
- Requiring each new RAC to hire a physician medical director as well as certified coders
- Requiring the RACs to pay back contingency fees when an improper payment determination is overturned at any level of appeal
- Changing from a 4-year look-back period to a 3-year look-back period
- Adding a maximum look-back date of October 1, 2007
- Adding a Web-based application that will allow providers to look up the status of medical record reviews.

CMS is confident that these changes will help contribute to an even more successful RAC permanent program.

Implementation of the RAC Permanent Program

CMS plans to implement the RAC permanent program gradually, beginning with a limited number of States in the summer of 2008. The statute requires

that the RAC program be nationwide by January 10, 2010.

CMS and the permanent RACs will undertake aggressive outreach to providers in every State before overpayment notices and medical record requests are issued.

Conclusion

The RAC demonstration was an important tool in helping CMS prepare for and shape the RAC permanent program. This preparation led to the incorporation of several important components of the RAC permanent program, including building cooperative relationships with Medicare claims processing contractors, fraud fighters, the Department of Justice, and appeals entities; contracting with a RAC validation contractor to conduct independent third-party reviews of RAC claim determinations; limiting the claim review look-back period to three years; requiring each RAC to hire a medical director; and conducting significant outreach to providers. CMS will expand the RAC program gradually.

A Note on This Report

This evaluation report will be updated by CMS to reflect updated appeals and other statistics on a monthly basis through the summer of 2008.

Section 306 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) required CMS to complete a demonstration project to determine whether recovery audit contractors (RACs) could be utilized efficiently and effectively in Medicare when tasked with identifying Medicare overpayments and underpayments and recouping overpayments. It also mandated a Report to Congress 6 months after the end of the demonstration on the impact of the project on savings to the Medicare program and recommendations on the cost-effectiveness of extending or expanding the project.

In December 2006, in the Tax Relief and Health Care Act of 2006 (TRHCA), Congress authorized the expansion of RACs nationwide by January 2010. Because the question of expansion was addressed even before the end of the demonstration, the need for the Report to Congress to include recommendations to expand the program was negated. Congress realized this in TRHCA and modified the language regarding the Report to Congress to require an annual report that includes information on the performance of the contractors and an evaluation of the comparative performance of such contractors. Thus, this evaluation bridges a gap between a fully independent evaluation of the demonstration (had TRHCA provisions not been enacted) and a standard report on program performance.

At the beginning of the RAC demonstration, CMS tasked several additional contractors with helping to verify and validate the RAC results. The work of these independent entities has been included in this report.

Acronyms Used in This Report

ALJ: Administrative Law Judge

CAFM: Contractor Accounting Financial Management System

CMD: Contractor Medical Director

CMS: Centers for Medicare & Medicaid Services

Connolly: Connolly Consulting (the New York and Massachusetts Claim RAC)

CPT: Current Procedural Terminology

DCS: Diversified Collections Services (the California MSP RAC)

DHHS: Department of Health and Human Services

DME: Durable Medical Equipment

DOJ: U.S. Department of Justice

DRG: Diagnosis Related Group

ERRP: Error Rate Reduction Plan

FFS: Fee-for-Service

HCFA: Health Care Financing Administration

HCPCS: Healthcare Common Procedure Coding System

HDI: HealthDataInsights (the Florida and South Carolina Claim RAC)

IRF: Inpatient Rehabilitation Facility

LCD: Local Coverage Determination

MAC: Medicare Administrative Contractor

MMA: Medicare Prescription Drug, Improvement, and Modernization Act of 2003

MSP: Medicare Secondary Payer

NCD: National Coverage Determination

NDNH: National Database of New Hires

OIG: Office of Inspector General

OMB: Office of Management and Budget

PRG: PRG-Schultz (the California and Arizona Claim RAC)

PSC: Program Safeguard Contractor

QIC: Qualified Independent Contractor

QIO: Quality Improvement Organization

RAC: Recovery Audit Contractor

RFP: Request for Proposals

RVC: RAC Validation Contractor

SNF: Skilled Nursing Facility

TRHCA: Tax Relief and Health Care Act of 2006

VDSA: Voluntary Data Sharing Agreements

1. Introduction

This report presents an evaluation of the Medicare RAC demonstration from its inception in 2005 through March 27, 2008. More detailed data are available in the FY 2006 RAC Status Document and the FY 2007 RAC Status Document, available on www.cms.hhs.gov/RAC. CMS will release updates to this RAC Evaluation Report on a regular basis at least through the summer of 2008. The update reports will contain updated appeals and other statistics.

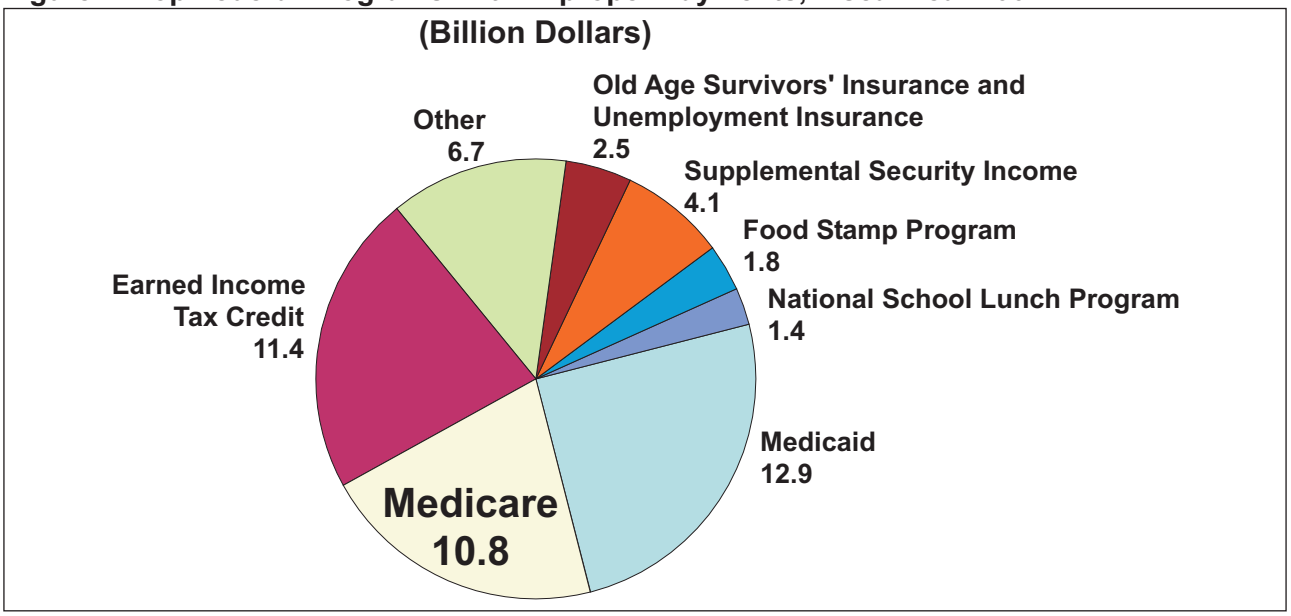
Overview of Concerns With Improper Payments in Medicare

According to a January 2008 report by the OMB, Medicare—with an estimated $10.8 billion in improper payments in 2007—is one of the top three Federal programs with improper payments (see Figure 1).

With increasing expenditures, expanding Federal benefits, and a growing beneficiary population, the importance and the challenges of safeguarding the Medicare program are greater than ever. CMS, the Federal agency that operates the Medicare program, has a relatively long history of calculating improper payment estimates and developing strategies to protect the Medicare program's fiscal integrity. In 2003, CMS implemented the Comprehensive Error Rate Testing Program and began producing error rates and estimates of improper payments to evaluate contractor and program performance. Since the inception of this program CMS has consistently reduced its improper payment error rate, from 9.8 percent in 2003 to 3.9 percent in 2007.

Calculating improper payment rates is only one step in the process to reduce improper payments. Remediation is another key part of CMS's efforts. CMS, through its Medicare claims processing contractors, uses the error rates to identify where problems exist and target improvement efforts. The cornerstone of these efforts is CMS's Error Rate Reduction Plan (ERRP), which includes agency-level strategies to clarify CMS policies and implement new initiatives to reduce improper payments. In the past, ERRPs have included plans to conduct special pilot studies and specific education-related initiatives. CMS also directs the Medicare claims processing contractors

Figure 1. Top Federal Programs With Improper Payments, Fiscal Year 2007



Source: Office of Management and Budget, *Improving the Accuracy and Integrity of Federal Payments* (January 31, 2008), available at: http://www.whitehouse.gov/omb/financial/fia/2007_ipia_final.pdf.

to develop local efforts to lower the payment error rate by targeting provider education and claim review efforts to those services with the highest improper payments. The type and nature of the errors in the program lend themselves to different types of corrective actions to fix them.

Some improper payments are best prevented when the Medicare claims processing contractors request and review the medical records associated with the claims prior to payment to ensure that payment is made only for Medicare-covered and medically necessary items and services furnished in the appropriate setting. Other improper payments can best be prevented by CMS or the Medicare claims processing contractors developing new or revised national or local coverage determinations, medical necessity criteria, or billing instructions to assist providers in understanding how to correctly submit claims for medical items and services and under what circumstances the services will be considered medically necessary. Still other improper payments are prevented when CMS and/or Medicare claims processing contractors educate the provider community about existing policies and remind them of the billing mistakes most commonly seen in the claims data.

CMS actions to safeguard Federal funds are not merely limited to claims processing actions and error rate programs. In 2006, Program Safeguard Contractors were established nationwide across all provider and supplier types. These specialized fraud fighters perform data analysis to identify potential problem areas, investigate potential fraud, develop fraud cases for referral to law enforcement, and coordinate Medicare fraud, waste, and abuse efforts with CMS's internal and external partners.

OIG and GAO Findings

Over the years, the Department of Health and Human Services (DHHS) Office of Inspector General (OIG) and the Government Accountability Office (GAO) have issued reports describing the improper payments made by the Medicare FFS program. Although CMS, the Medicare claims processing contractors, and Quality Improvement Organizations (QIOs) have undertaken actions to recoup those overpayments and prevent future improper payments, it is difficult to prevent all improper payments, considering that more than 1 billion claims are processed each year. CMS has determined that most improper payments in the Medicare FFS program occur because a provider has submitted a claim to Medicare for a service that was not medically necessary or was incorrectly coded.

Legislation

Section 306 of the MMA authorized CMS to complete a demonstration project to determine whether RACs could be utilized efficiently and effectively in Medicare when tasked with identifying Medicare overpayments and underpayments and recouping overpayments. The MMA also mandated that a report to Congress be developed 6 months after the end of the demonstration to include information on the impact of the project on savings to the Medicare program and to provide recommendations on the cost-effectiveness of extending or expanding the project. In December 2006, in the TRHCA, Congress authorized the expansion of RACs nationwide by January 2010.

A full and open competition was used in selecting the RACs for the demonstration. CMS evaluated the original RAC proposals based on the bidders' technical ability to perform the Statement of Work tasks, their personnel and past performance, and the percent contingency fee that they required. Technical ability was the most important element, with the contingency percentage being secondary. Technical ability included knowledge of Medicare claims, knowledge of Medicare coverage policies, knowledge of the appeal system, understanding of the impact on providers, and ability to work with Medicare contractors, provider associations, and providers.

To fulfill the MMA requirements for a report to Congress to address the impact of the demonstration, CMS contracted with Econometrica, Inc., in June 2005 to support CMS in this work. The initial scope of work involved collecting and analyzing data focused on determining the effectiveness of the program in Medicare.

As the demonstration proceeded, CMS began to get inquiries from congressional offices regarding collections and the impact on providers. To provide

some level of transparency, CMS released a Fiscal Year 2006 Status Report, which included quantitative data such as the amount of collections, appeals, costs, and vulnerabilities.

For the next 15 months, CMS operated on parallel tracks. The RAC demonstration was continuing and coming to an end on one track. On the other track CMS was devising its expansion strategy. It was important for the RAC demonstration to continue and come to an end, because the demonstration developed the base for the expansion. The expansion strategy was driven by the lessons learned from the demonstration. These lessons related to issues that were raised by providers and associations, in addition to details that CMS investigated. Each issue helped improve the expansion strategy.

Purpose of This Report

The purpose of this report is to evaluate the RAC demonstration and share with all interested parties information about the demonstration. In addition to the reporting by the RACs and Medicare claims processing contractors, a number of other independent organizations, including Econometrica, Inc., the Gallup Organization, and AdvanceMed, provided data and assistance that were instrumental to the RAC demonstration and to the production of this report.

2. Background

Overview

The Medicare FFS program consists of a number of payment systems, with a network of contractors that process more than 1.2 billion claims each year, submitted by over 1 million providers such as hospitals, skilled nursing facilities (SNFs), physicians, labs, ambulance companies, and durable medical equipment (DME) suppliers. These contractors—called Medicare claims processing contractors—process claims, make payments to health care providers in accordance with the Medicare regulations, and educate providers about how to submit accurately coded claims that meet Medicare medical necessity guidelines. In addition, QIOs ensure the quality of services provided to beneficiaries.

Because of the large volume of claims submitted by providers, Medicare claims processing contractors pay most claims without requesting or scrutinizing the medical records associated with the services listed in the claim.

Circumstances Where Improper Payments Occur

Improper payments on claims can occur in the Medicare FFS program when:

- Payments are made for services that were **medically unnecessary** or did not meet the Medicare medical necessity criteria for the setting where the service was rendered (e.g., a claim from a hospital for three colonoscopies for the same beneficiary on the same date of service, whereas only one colonoscopy per day is medically necessary; or physical therapy provided in the inpatient setting when the therapy could have been safely and effectively provided in the outpatient setting).
- Payments are made for services that are **incorrectly coded** (e.g., the provider submits a claim for a certain procedure, but the medical record indicates that a different procedure was actually performed).

Medicare receives over 1.2 billion claims per year. This equates to:

- 4.5 million claims per work day
- 574,000 claims per hour
- 9,579 claims per minute.

- Providers fail to submit documentation to support the services provided when requested or fail to submit enough documentation to support the claim.
- **Other errors** are made, such as when the Medicare claims processing contractor pays the claim according to an outdated fee schedule, or the provider is paid twice because duplicate claims were submitted.

Medicare Secondary Payer (MSP) improper payments can occur in the Medicare FFS program when Medicare pays a claim that should have been paid by a different health insurance company. For example, when a Medicare beneficiary is employed and gets health benefits through his or her job, it is that health insurance company—not Medicare—that may be the primary payer of the beneficiary's health care services.

CMS Programs To Prevent Improper Payments

CMS actions to safeguard Federal funds are not merely limited to the claims processing actions and error rate programs. In 2006, Program Safeguard Contractors (PSCs) were established nationwide across all provider and supplier types. These specialized fraud fighters perform data analysis to identify potential problem areas, investigate potential fraud, develop fraud cases for referral to law enforcement, and coordinate Medicare fraud, waste, and abuse efforts with CMS internal and external partners.

There has been a growing concern that, even with all these efforts, the Medicare Trust Funds may not

be adequately protected against improper payments. Accordingly, Congress took action by passing legislation to enhance and support Medicare's current efforts in identifying and correcting improper payments. In Section 306 of the MMA, Congress directed the DHHS to conduct a 3-year demonstration using RACs to detect and correct improper payments in the Medicare FFS program (see Appendix A). Later, in Section 302 of the TRHCA, Congress required the DHHS to make the RAC program permanent and nationwide by no later than January 1, 2010 (see Appendix B). The

Congress mandated the RAC demonstration and RAC permanent program to find and correct improper payments in the Medicare program.

RAC demonstration *did not* detect or correct payments for Medicare Advantage or the Medicare prescription drug benefit program. As currently designed, the RAC permanent program also does not include the detection and correction of improper payments in either of these programs.

3. The RAC Demonstration

Purpose of the Demonstration

The RAC demonstration was designed to:

1. Detect and correct *past* improper payments in the Medicare FFS program; and
2. Provide information to CMS and the Medicare claims processing contractors that could help protect the Medicare Trust Funds by preventing *future* improper payments thereby lowering the Medicare FFS claims payment error rate.

Congress authorized CMS to use a different mechanism to pay the RACs. The Medicare claims processing contractors and QIOs are paid through funds appropriated by Congress. In contrast, CMS paid each RAC a contingency fee that was negotiated between CMS and the individual RAC. This demonstration was the first time the Medicare program has paid a contractor on a contingency fee basis; however, this type of payment methodology has been the accepted standard practice among private healthcare payers for more than 20 years.

The RACs were chosen through a competitive process. CMS held a full and open competition to select the three Claim RACs and two MSP RACs for the demonstration. In March 2005, CMS awarded the contracts and held a kickoff conference to prepare the RACs for the demonstration. California, Florida, and New York were selected for the demonstration because they are the largest States in terms of Medicare utilization, with approximately 25 percent of Medicare payments each year made to providers in these States. Initially, each Claim RAC had jurisdiction for a single State. The Claim RAC jurisdictions were expanded in the summer of 2007 to include the following three additional States: Massachusetts, South Carolina, and Arizona (see Table 1 for the names and jurisdictions of the Claim RACs and Table 2 for the names and jurisdictions of the MSP RACs).

The RAC Review Process

The RACs were bound by Medicare policies, regulations, national coverage determinations, local coverage determinations, and manual instructions when conducting claim reviews under the demonstration. In instances where there is no Medicare policy, the RACs reviewed claims based on accepted standards of medical practice at the time of claim submission. The RACs did not develop or apply their own coverage, coding, or billing policies. Similar to the Medicare claims processing contractors, the RACs used medical personnel, such as nurses and therapists, to review claims for medical necessity. In addition, each Claim RAC had a

Table 1. Names of Claim RACs and Their Jurisdictions

Name of RAC	Jurisdiction (Start Date)	Number of Claims Sent by CMS from Inception Through December 2007[a] (Millions)	Dollar Value of Claims Sent by CMS from Inception Through December 2007[a] (Billion Dollars)
Connolly Consulting (Connolly)	New York (March 2005)	414.5	$109.2
	Massachusetts (July 2007)	23.6	$ 18.6
HealthDataInsights (HDI)	Florida (March 2005)	466.8	$ 90.9
	South Carolina (July 2007)	8.7	$ 9.1
PRG-Schultz (PRG)	California (March 2005)	254.3	$ 89.2
	Arizona[b] (July 2007)	—	—
Total		**1,167.9**	**$317.0**

[a]No claims were sent in January, February, or March 2008.
[b]While contractually, Arizona was added to PRG's jurisdiction in July 2007, no Arizona claims were reviewed before the end of the RAC demonstration.
Source: Self-reported by the RACs.

Table 2. Names of MSP RACs and Their Jurisdictions

Name of RAC	Jurisdiction (Start Date)
Health Management Systems:	New York (February 2006)
Health Management Systems:	Florida (March 2005)
Diversified Collection Services:	California (March 2005)

physician Medical Director to oversee the medical record review process, assist nurses, therapists, and certified coders upon request during complex review, manage the quality assurance procedures, and inform provider associations about the RAC demonstration.

The RACs analyzed claims data using their proprietary techniques to identify claims that clearly contained errors resulting in improper payments and those that likely contained errors resulting in improper payments. In the case of *clear* improper payments, the RAC contacted the provider to either collect any overpayment amounts or pay any underpayment amounts. This process is called an automated review. For example, a RAC could use information systems to search for claims for two or more identical surgical procedures for the same beneficiary on the same day at the same hospital. The duplicate surgical procedures are clearly not medically necessary, should not have been billed twice by the hospital, and should not have been paid twice by the Medicare claims processing contractor. The RAC could perform automated review only when the improper payment was obvious (e.g., a duplicate claim) or a written Medicare policy, Medicare article, or Medicare-sanctioned coding guideline (e.g., CPT statement, CPT Assistant statement, Coding Clinic statement, etc.) existed and precisely described the coverage conditions.

In the case of claims that *likely* contained errors, the RAC requested medical records from the provider to further review the claim. The RAC could then make a determination as to whether payment of the claim was correct or whether there was an overpayment or an underpayment. This process is called a complex review. For example, a RAC could choose to review claims for beneficiaries admitted to an inpatient hospital due to chest pain. Because the RAC cannot determine from the claim alone whether the beneficiary meets the CMS medical necessity criteria for this setting, the RAC must examine the patient's medical record to determine whether the claim contained an improper payment.

RACs use the **same types of review staff** as the Medicare claims processing contractors.

These two review processes—automated review and complex review—are similar to those employed by the Medicare claims processing contractors to identify improper payments.

Claims Available for Review

From the inception of the demonstration through March 27, 2008, CMS provided each RAC with claims data from 2001 through 2007 for its jurisdiction (which accounted for an estimated total value of $317 billion). Some RACs focused their reviews on inpatient claims. Others targeted physician claims. CMS did not specify which claim types a RAC must review. It was up to each RAC to identify the claims most likely to contain an improper payment. For the demonstration, the RACs:

- Reviewed all claims in order to identify overpayments and underpayments that can be detected without medical record review, using their proprietary automated review software algorithms.
- Conducted medical record reviews of claims that the RAC thought—based on OIG/GAO/CERT reports, their knowledge of the health care industry, etc.—were likely to contain improper payments. These reviews entailed requesting medical records from the health care provider that submitted the claim. Though not required by CMS, some RACs developed self-imposed limits on the number of medical records they would request from a given provider over a 30- or 45-day period. Each RAC attempted to target these reviews to the greatest extent possible in order to minimize the burden on the provider and maximize the RAC's return on investment.
- Notified providers and directed the Medicare claims processing contractors to make adjustments for claims that were either overpayments or underpayments.

Claims Excluded from Review

The RACs could review any of the claims they were given, with the following exclusions:

- **Incorrect level of physician evaluation and management code.** CMS excluded these claims from RAC review while CMS considered a proposal by the American Medical Association that could have changed the way these services are reviewed. However, RACs were given the authority to review Evaluation & Management Services to look for other errors (e.g., duplicate payments, violations of Medicare's global surgery rules, definition of new patient, etc.). Despite being given the authority to review these services for other errors, very few of these types of claims were selected by the RACs for review during this time period.
- **Hospice and home health services.** CMS excluded these claims from the demonstration for administrative simplification purposes.
- **Payments made to providers under a CMS-conducted demonstration.**
- **Claims previously reviewed by another Medicare contractor.** CMS prohibited the RACs from reviewing claims that had already been reviewed by another Medicare contractor, so as not to unduly burden the provider with multiple requests for the same medical record. CMS created a RAC data warehouse to track information about claims reviewed by the RACs. Other Medicare contractors used this data warehouse to designate which claims had been previously reviewed and were therefore excluded from review by the RACs.
- **Claims involved in a potential fraud investigation.** Without divulging sensitive information, CMS excluded these claims from RAC review so as not to interfere with law enforcement's cases. Program Safeguard contractors also used the RAC data warehouse to indicate which cases were excluded from review by the RACs.

CMS oversight of the RAC demonstration has been facilitated by the RAC data warehouse. The RAC data warehouse was developed to provide CMS with an automated means of administering and overseeing the Claim RAC component of the demonstration. The RAC data warehouse serves as the repository for data about all claims with improper payments identified by the Claim RACs, and it is used by CMS to ensure that RACs do not review claims previously subjected to medical record review by another review entity (such as a QIO or Medicare claims processing contractor) or currently under a fraud investigation. This important tool minimizes the unnecessary burden to providers and prevents overlap with other Medicare program safeguard activities. The RAC data warehouse is also the principal data source for reporting improper payment findings to CMS and the public.

CMS developed the RAC data warehouse as a Web-based system intended to facilitate the activities of the multiple entities participating in the RAC demonstration project. These entities include: CMS, Claim RACs, Medicare claims processing contractors, QIOs, PSCs, and law enforcement agencies. The RAC data warehouse was designed to automate numerous administrative functions such as coordinating, tracking, and reporting on Claim RAC activity.

CMS tasked Econometrica, Inc., with assessing the completeness of certain data routinely entered into the RAC data warehouse. This process involved reconciling the number of claims and their associated dollar error amounts with "invoice data" (received from the Claim RACs) and "transaction data" (received from the Medicare claims processing contractors). The purpose of the reconciliation is to ensure that the number of improper claims and amounts found to be in error, as archived in the data warehouse, match the data that CMS receives from other sources. Econometrica's ongoing reconciliation work supports CMS in its oversight of the Claim RACs and in developing an archive of reliable program data.

Demonstration Costs

The cost to run the RAC demonstration was significantly less than the amount it returned to the Medicare Trust Funds. The demonstration costs fall into three categories: (1) *RAC contingency fees* include the fees paid to RACs for detecting and collecting overpayments plus the fees paid for detecting and refunding underpayments; (2) *Medicare claims processing contractor costs* are the funds paid to the carriers, fiscal intermediaries, and MACs for processing the overpayment/underpayment adjustments, handling appeals of RAC-initiated denials and other costs incurred to support

the RAC demonstration; and (3) *RAC evaluation, validation and oversight fees* are the funds paid to the RAC Evaluation Contractor, the RAC Data Warehouse Contractor, the RAC Validation Contractor, and the Federal employees who oversee the RAC demonstration. The costs of operating the RAC demonstration from inception through March 27, 2008, are shown in Table 3.

From its inception through March 27, 2008, the RAC demonstration spent only 20 cents for each dollar collected, calculated as follows: $201.3 million (cost) / $992.7 million (total collections) = $0.20. These numbers were calculated based on actual collections and reimbursements.

In addition to the direct costs associated with the operation of the RAC demonstration, CMS acknowledges that costs were incurred by entities not directly involved in the demonstration, such as the Qualified Independent Contractors (QICs) and Administrative Law Judges (ALJs) who processed the second- and third-level appeals. CMS also acknowledges that there were costs to those providers who were selected for medical record review and those providers who chose to appeal the RAC determinations. CMS is unable to quantify these costs for purposes of this report.

Table 3. Cost of Operating the Medicare RAC Demonstration: Cumulative Through 3/27/08, All RACS

Cost Categories	Costs (Million Dollars)
RAC contingency fees	$ 187.2
Medicare claims processing contractor costs	$ 8.7
RAC evaluation, validation, and oversight expenditures	$ 5.4
Total	**$ 201.3**

Source: RAC vouchers and Contractor Accounting Financial Management System (CAFM).

These cost data indicate that the RAC demonstration was a cost-effective program, successful in returning improper payments to the Medicare Trust Funds. CMS anticipates that changes planned for the RAC permanent program will result in an even more cost-effective program in the future.

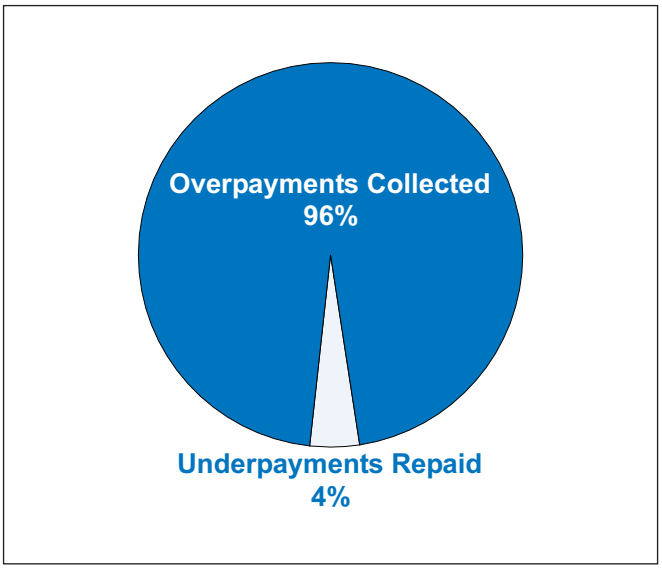
4. Results of the RAC Demonstration

The RACs succeeded in correcting over $1.03 billion of Medicare improper payments. Over 96 percent of these improper payments were overpayments that were collected from providers. The remaining 4 percent were underpayments that were repaid to providers (see Table 4 and Figure 2). During a similar time period, the Medicare claims processing contractors in New York, Florida, and California corrected over $13 million in improper payments and prevented an additional $1.8 billion in improper payments by denying claims before they were paid. Unlike RACs, which perform revisions only *after* a claim has been paid, Medicare claims processing contractors may automatically review claims or choose claims for medical review *before* they are paid. The $1.8 billion figure includes both automated and complex prepay review. The disparity between overpayments and underpayments is even greater in the reviews performed by the Medicare claims processing contractors (99.9 percent of overpayments collected vs. <0.1 percent of underpayments repaid).

Medicare Secondary Payer RACs

Prior to the MSP RAC demonstration, several companies would assert to CMS that they had insurance

Figure 2. Overpayments Vs. Underpayments



Source: For Claim RACs, RAC invoice files and RAC Data Warehouse. For MSP RACs, Treasury deposit slips.

Table 4. Improper Payments Corrected by the RAC Demonstration: Cumulative Through 3/27/08, Both Claim RACs and MSP RACs
(Million Dollars)

RAC	Overpayments Collected[a]	Underpayments Repaid[b]	Total Improper Payments Corrected
Connolly	$ 266.1	$ 4.3	**$ 270.4**
HDI	$ 396.1	$ 20.8	**$ 416.9**
PRG	$ 317.8	$ 12.7	**$ 330.5**
Claim RAC Subtotal	***$ 980.0***	***$ 37.8***	***$ 1,017.8***
HMS	$ 1.3	$ 0.0	**$ 1.3**
DCS	$ 11.4	$ 0.0	**$ 11.4**
MSP RAC Subtotal	***$ 12.7***	***$ 0.0***	***$ 12.7***
Grand Total	**$ 992.7**	**$ 37.8**	**$ 1,030.5**

[a]Collected is defined as overpayments that have been recovered from providers and deposited.
[b]Repaid is defined as underpayments that have been paid back to the provider. MSP RACs were not tasked with identifying underpayments.
Note: For this Evaluation Report, CMS lists all dollars actually collected and repaid between March 2005 and March 2008. In contrast, reporting for the FY 2006 RAC Status Document was based on overpayment and underpayment *notification letters* that were sent to providers and to the Medicare claims processing contractor during the fiscal year.
Source: For Claim RACs, RAC invoice files and RAC Data Warehouse. For MSP RACs, Treasury deposit slips.

data available to them that would identify a significant number of MSP occurrences. Many companies perform this type of work with Medicaid State agencies, and some felt that their Medicaid methodologies, which have proven to be very successful, would easily translate into the Medicare environment. The payment methodology for the Medicaid contracts was normally contingency based. Since Section 306 was not prescriptive regarding just the review of claims, CMS felt it was the opportune time to determine whether a MSP RAC could be effective in the Medicare environment. However, the MSP RACs collected considerably fewer overpayments ($12.7 million) than the Claim RACs ($980.0 million).

Initially two MSP RAC contracts were awarded. Approximately one year into the demonstration CMS awarded a third. The MSP RACs initially identified a large number of potential improper payments; however, the majority of those selected overpayments were not MSP occurrences. More specifically, the MSP RACs had identified a number of beneficiaries with reported income, which appeared to be wages. This would indicate that the beneficiaries were employed and should be receiving health coverage from their employers, not Medicare. Upon further investigation, the MSP RAC learned that the income was in the form of retirement benefits rather than wages. Thus, Medicare was the rightful payer.

The MSP RACs were responsible for obtaining and reviewing insurance information to determine whether Medicare should have been the primary payer of a claim or the beneficiary had other insurance that may have been responsible for the primary payment. However, one of the greatest challenges for the MSP RACs was determining whether a beneficiary was in a retired status. The insurance information available to the MSP RACs did not indicate whether payments were made as wages or as retirement payments. This resulted in a large number of false positives, which challenged the MSP RACs throughout the entire demonstration.

The MSP RACs were very creative and attempted numerous activities to identify MSP occurrences. They attempted to obtain access to the States' wage and earnings file but were only successful in the State of Florida. (The MSP RACs might have been able to obtain access in the State of New York, but the demonstration ended.) This helped identify some MSP occurrences, but the numbers still outweighed the original potential suggested by the MSP RACs.

The MSP RACs were able to identify certain areas of MSP occurrences. For example, the MSP RAC in California was very successful identifying occurrences at universities where tenured professors normally teach well past their Medicare eligibility age. This was already a known occurrence to CMS and CMS had been working with some of the larger university systems to share data. CMS develops Voluntary Data Sharing Agreements (VDSA) with employers to determine active employees. Some universities that were reluctant to enter into a VDSA with CMS expressed more interest after the MSP RAC began identifying a large number of occurrences.

However, it is important to note that CMS had already been saving a significant amount of Medicare dollars each year by identifying situations where Medicare should not have been the primary payer. This work was completed by a Coordination of Benefits contractor, which consolidated much of the prepay work (questionnaires to beneficiaries and identifying occurrences prior to the payment of the claim), and through the Medicare claims processing contractors, who identified potential leads and collected amounts that were paid in error. During the course of the RAC demonstration, CMS consolidated the collection efforts of the collection of the MSP debt into one national contractor. The MSP RACs were seen as an addendum to the current CMS process. CMS did not significantly alter any of the processes for the MSP RAC demonstration.

While the MSP RACs collected considerably fewer overpayments ($12.7 million) than the Claim RACs ($980.0 million) CMS does not consider the MSP RAC demonstration to be a failure. Although the MSP RACs tested a number of possible methodologies to identify the MSP occurrences without much success and the limited success they did have was not new to CMS, the MSP RAC demonstration proved that CMS's current efforts to identify MSP

occurrences are working and are appropriate. It also highlighted the need for mandatory insurance reporting and access to the National Database of New Hires (NDNH) which is currently used by the Administration of Children and Families for child support enforcement and by the Department of Education for the collection of defaulted student loans.

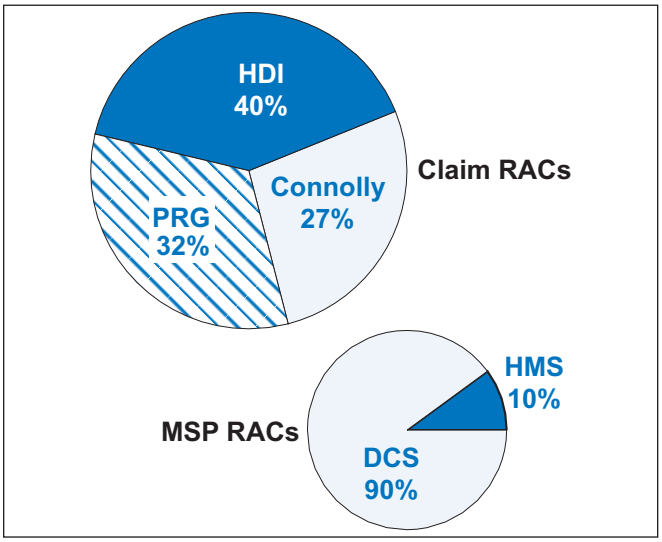
Claim RACs

The Claim RACs corrected $980.0 million in overpayments and $37.8 million in underpayments. HealthDataInsights (HDI), the Claim RAC for Florida and South Carolina, collected approximately 40 percent of the overpayments; PRG-Schultz (PRG), the Claim RAC for California, collected approximately 32 percent; and Connolly Consulting (Connolly), the Claim RAC for New York and Massachusetts, collected approximately 27 percent (see Figure 3).

Providers can use the findings in Appendix P to help improve the accuracy of their claim submissions and thereby avoid future improper payments.

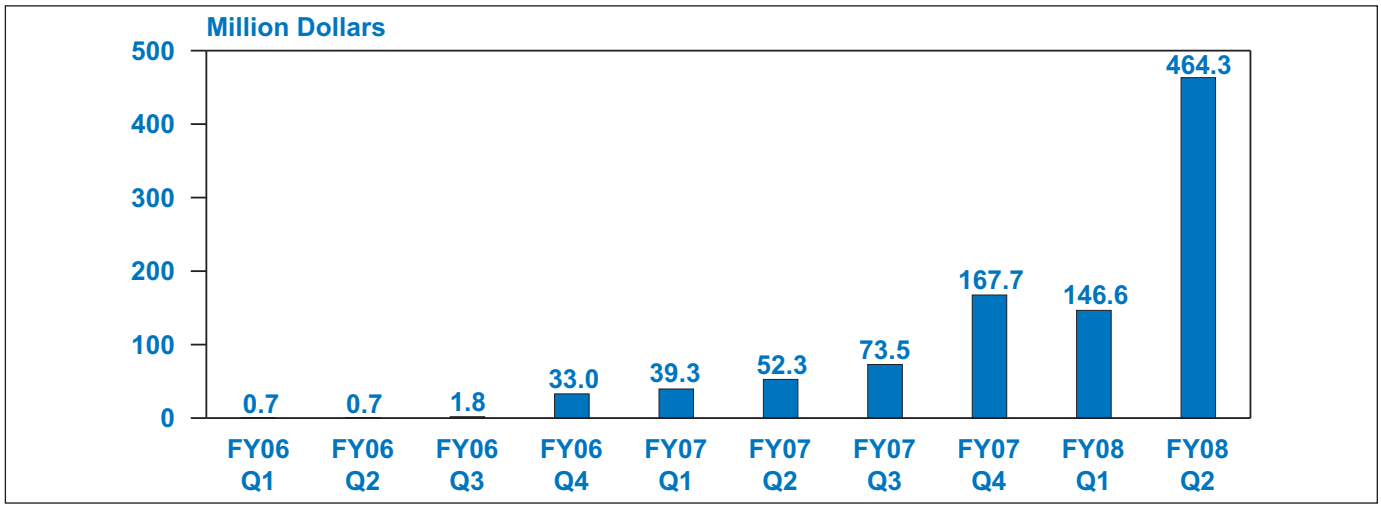
Claim RACs' improper payment correction efforts improved over time (Figure 4). This was due in part to the nature of the contingency fee arrangement. Because each Claim RAC started with a Medicare-provided budget of $0, each had to invest its own capital to hire the staff to start reviewing Medicare claims for potential improper payments. When those few initial reviews enabled the Claim RACs to correct actual improper payments, CMS paid them contingency fees, which in turn allowed the Claim RACs to hire more reviewers. Further, improvements occurred over time because of the increased experience with the Medicare recovery process, staffs becoming more familiar with Medicare policies, better collaboration with Medicare claim processing contractors, and improved provider outreach (see Appendix C for yearly corrections and quarterly collections by the Claim RACs). CMS expects that the same "ramp up" period will be seen in

Figure 3. Overpayments Collected



Note: Percentages shown for Claim RACS do not sum to 100 due to independent rounding.
Source: For Claim RACs, RAC invoice files and RAC Data Warehouse. For MSP RACs, Treasury deposit slips.

Figure 4. Overpayments Collected by Quarter: Claim RACs Only



Source: RAC invoice files and RAC Data Warehouse.

the permanent RAC program. Less "ramp up" time will be needed by an incumbent Claim RAC, should one of them win a contract.

Most Medicare claims were unaffected by the RACs. Over the life of the RAC demonstration (through March 27, 2008), CMS gave the Claim RACs 1.2 billion claims, with a value of $317.0 billion. Although $1.03 billion in improper payments corrected by RACs over 3 years seems very large, it is less than 1 percent of the dollar value of all claims the Claim RACs were given. According to the *Improper Medicare FFS Payments Report, FY2007* (also known as "the CERT report"), the Medicare estimated improper payment rate is 3.9 percent (see Appendix D). For comparison purposes, Claim RACs identified and corrected improper payments on 0.3 percent of all the payments that were available for review over the life of the demonstration (see Table 5).

Even after subtracting the amounts repaid to providers for underpayments, the amount overturned on appeal, and the costs of operating the RAC demonstration, the RACs returned $693.6 million to the Medicare Trust Funds (see Table 6). This number includes appeals overturned through March 27, 2008. Providers have 120 days to appeal from the date of the claim adjustment, and CMS anticipates that most first-level appeals of Claim RAC determinations will have been filed by July 1, 2008. Further details regarding costs can be found on page 13.

Table 5. Improper Payments Corrected by Claim RACs as a Percentage of All Medicare Claims Received: Cumulative Through 3/27/08, Claim RACs Only

Dollar Value of All Claims Given to Claim RACs by CMS (Billion Dollars)	Improper Payments Corrected by Claim RACs (Billion Dollars)	Percent Corrected
$317.0	$1.0	0.3%

Source: The $317.0 billion figure was self-reported by the Claim RACs. Payments corrected were verified by the RAC invoice files and RAC Data Warehouse.

Approximately 85 percent of the overpayments collected by the Claim RACs were from inpatient hospitals (Figure 5). The *Improper Medicare FFS Payments* report from November 2007 (based on a review of a random sample of claims) found that 45.4 percent of the improper payments in Medicare were made to inpatient hospitals. Several factors may explain the Claim RACs' relatively high rate of improper payment identifications in the inpatient hospital settings. Because the Claim RACs were paid on a contingency fee basis, they establish their claim review strategies to focus on high-dollar improper payments, like inpatient hospital claims, which gave them the highest return with regard to the expense of reviewing the claim and/or medical record. CMS anticipates that the permanent RACs will adopt a similar strategy at first.

Figure 6 shows the overpayments collected under the RAC demonstration, net of appeals and by error type. Payments for claims that did not meet Medicare's medical necessity criteria for that service or setting and payments for claims that were incorrectly coded each account for more than 35 percent of overpayments corrected by the Claim RACs. Of the $828.3 million improperly paid to inpatient hospitals, about 36 percent was due to incorrect coding and 41 percent was due to the service being rendered in a medically unnecessary setting—often referred to as "wrong setting" improper payments (see Appendix E). These are situations where the beneficiary needed care but did not need to be admitted to the hospital to receive that care.

Appendixes F and G provide more information on the errors and service-specific vulnerabilities that

Table 6. Summary of Net Savings in the RAC Demonstration: Cumulative Through 3/27/08, Both Claim RACs and MSP RACs

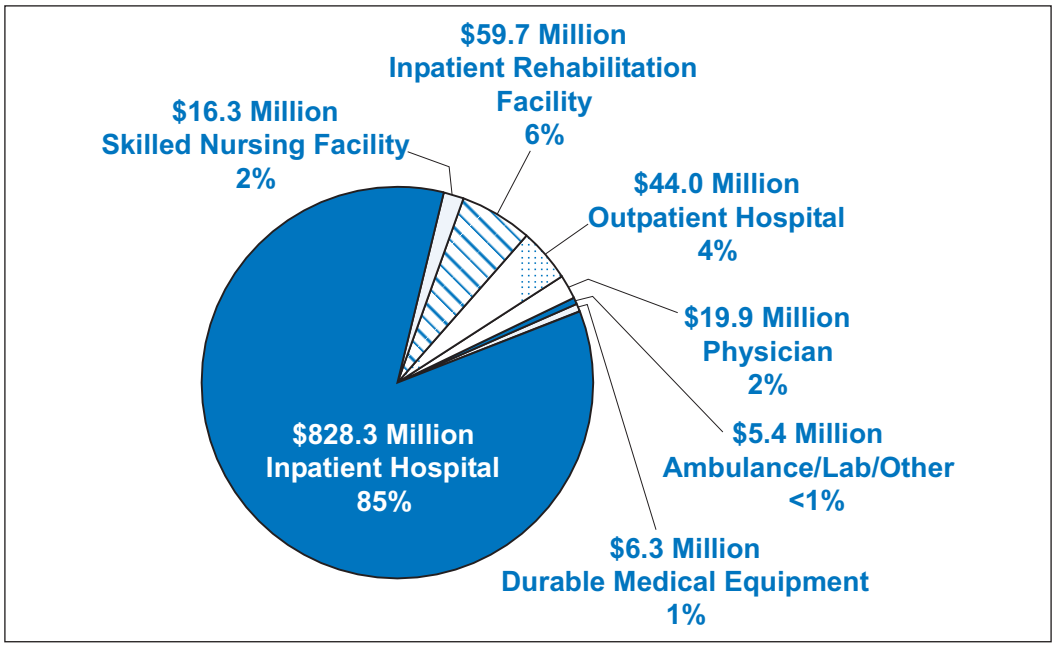
(Million Dollars)

Overpayments Collected		Underpayments Repaid		Amount Overturned on Appeal		PRG IRF Re-reviews		Costs To Operate RAC Demonstration		Net Savings Back to the Trust Funds
$992.7	-	$37.8	-	$46.0	-	$14.0	-	$201.3	=	**$693.6**

Source: FFS collections and reimbursements were verified by RAC invoice files and the RAC Data Warehouse. MSP RAC deposits were verified by the CMS Accounting Division.

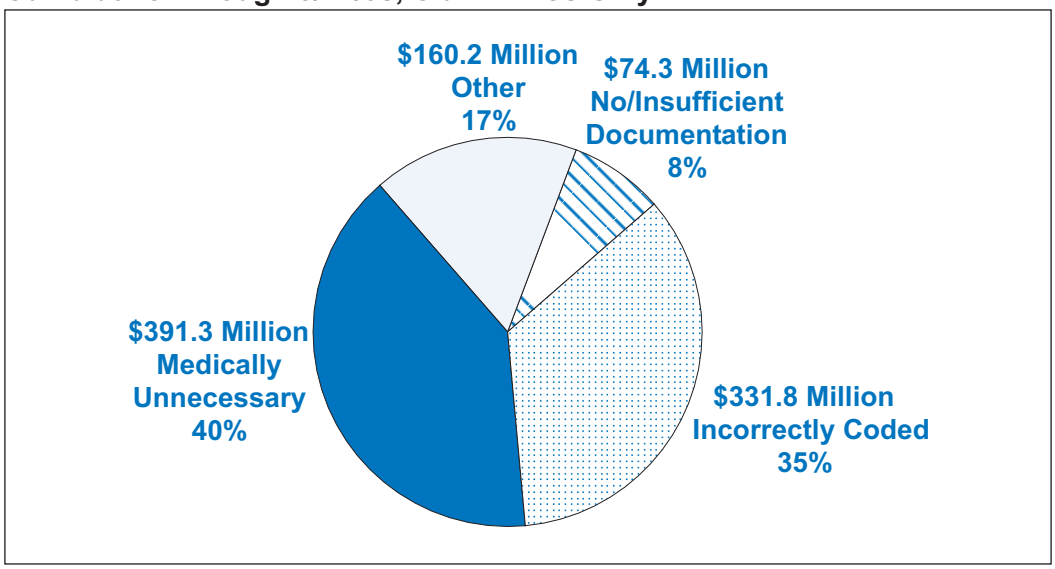
resulted in RAC-identified overpayments. Appendix H provides information on service-specific vulnerabilities that resulted in RAC-identified underpayments. These data were self-reported by the Claim RACs and were not gathered from the RAC data warehouse. All data in this section are net of appeals that were known as of March 27, 2008. For example, if there were $10 million in overpayments collected for a particular service but $1 million of these overpayments were overturned on appeal, the data would show $9 million.

Figure 5. Overpayments Collected by Provider Type: Cumulative Through 3/27/08, Claim RACs Only



Note: These data are *not* net of appeals.
Source: RAC invoice files and RAC Data Warehouse (ratios needed to calculate Physician percentages from Ambulance/Lab/Other data were self-reported by the Claim RACs).

Figure 6. Overpayments Collected by Error Type (Net of Appeals): Cumulative Through 3/27/08, Claim RACs Only



Source: Self-reported by the Claim RACs.

Provider Impact

The RAC demonstration had a limited financial impact on most providers. Figure 7 shows improper payments as a percentage of Medicare Part A revenue for hospital providers in fiscal years 2006 through 2008. On average, over 84 percent of the hospitals in PRG's and HDI's jurisdictions had their Medicare revenue impacted by less than 2.5 percent. Over 94 percent of hospitals in Connolly's jurisdiction had their Medicare revenue impacted by less than 2.5 percent. Appendixes I, J, and K include more data on provider impacts.

Appeals Statistics

From the inception of the RAC demonstration through March 27, 2008, providers chose to appeal only 14.0 percent (73,266) of the Claim RAC determinations. Overall, the data indicate that of all the Claim RAC overpayment determinations (525,133), only 4.6 percent (24,376) were overturned on appeal (see Table 7).

By comparison, from FY 2005 to FY 2007, the Medicare claims processing contractors' medical review departments in all States made improper payment determinations on 312 million claims. These include both prepayment and postpayment determinations. Providers chose to appeal 4 percent of these determinations (12.2 million claims). Of all the determinations made by Medicare claims processing contractors, only 2.3 percent (7.2 million claims) were overturned on appeal. (See Table 8 for a comparison of appeal rates for Medicare claims processing contractors and the RACs.)

Only 4.6 percent of RAC determinations were fully or partially **overturned on appeal**.

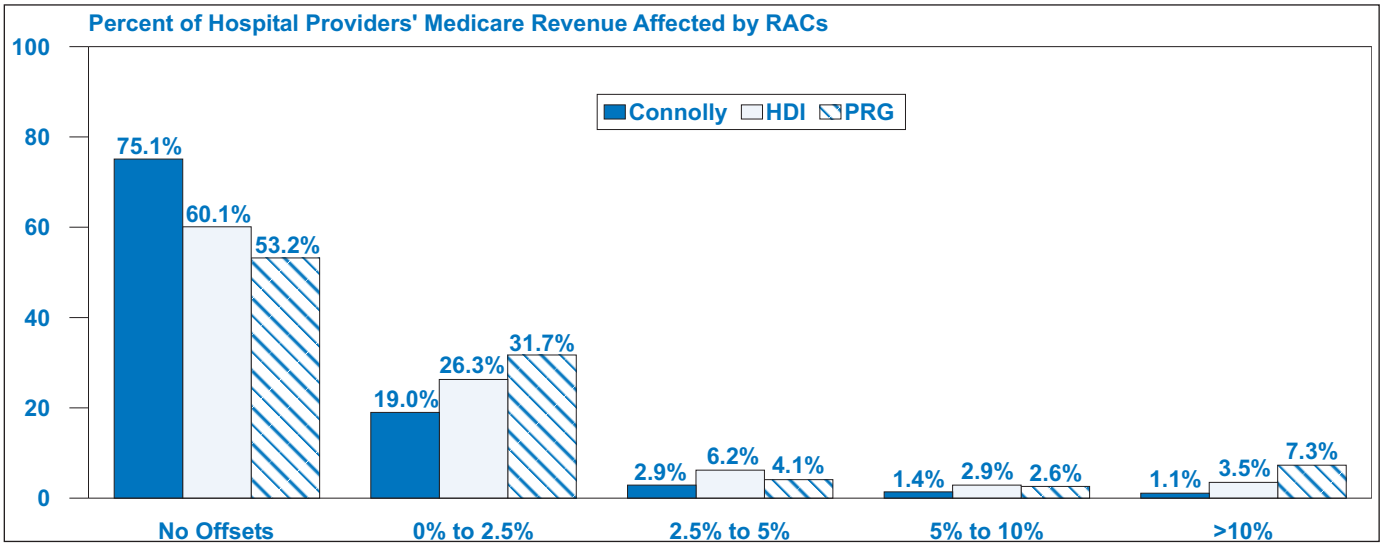
The demonstration required that if a RAC determination was overturned on the first level of appeal, the RAC was required to pay back their contingency fee. If the RAC determination was overturned at the second or higher level of appeal, the RAC was not required to pay back its contingency fee, although one RAC (PRG) volunteered to do so. A number of providers voiced concern about the perception created by the Claim RAC retaining a contingency fee on a claim when the RAC determination was overturned on second- or third-level appeal (see Chapter 6, Issue #8).

Table 7. Claims Overturned on Appeal: Cumulative Through 3/27/08, Claim RACs Only

Number of claims with overpayment determinations	525,133
Number of claims where provider appealed (any level)	73,266
Number of claims with appeal decisions in provider's favor	24,376
Percentage of appealed claims with a decision in provider's favor	33.3%
Percentage of claims overturned on appeal	4.6%

Source: RAC invoice files, RAC Data Warehouse, and data reported by Medicare claims processing contractors.

Figure 7. Financial Impacts on Hospital Providers: Fiscal Years 2006-2008, Claim RACs Only



Source: Self-reported by the Claim RACs.

In addition to the data in Table 7, as of May 1, 2008, there are an additional 3,009 claims (valued at $25.3 million) pending at the QIC and ALJ levels of appeals—the second and third levels of appeals, respectively (see Table 9). At this time, CMS is not able to determine the number of appeals pending at the first level of appeal. CMS can estimate that, as of May 1, 2008, there are claims valued at $255.1 million where the provider still has the right to file a first-level appeal. For this reason, the tables and figures in this report will be updated on a regular basis through the summer of 2008.

Table 8. Comparison of Medicare Contractors' Appeal Statistics

	Percentage of Denials Appealed by Providers	Percentage of Appealed Denials with Decision in Provider's Favor	Percentage of All Denials with Decision in Provider's Favor
Claims processing contractors[a]	4.0%	59.0%	2.3%
RACs[b]	14.0%	33.3%	4.6%

[a]For all States from FY 2005 to FY 2007.
[b]From March 27, 2005, through March 27, 2008.
Note: Appeals by Medicare claims processing contractors include those in all States.
Source: Medicare claims processing contractors.

Table 9. Pending Appeals as of 5/1/08

Level of Pending Appeal	Number of Claims	Value of Claims (Million Dollars)
Pending at QIC	2,181	$ 2.8
Pending at ALJ	828	$ 22.5
Timeframe for appeal still open	—	$ 255.1

Source: Ad-QIC and RAC Data Warehouse.

5. Independent Verification of Demonstration Results

To ensure the validity of the data underlying the demonstration, CMS tasked Econometrica, Inc., with assessing the completeness of certain data that were routinely entered into the RAC data warehouse. This process involved reconciling the number of claims and their associated dollar error amounts with invoice data (obtained from the Claim RACs) and transaction data (obtained from the Medicare claims processing contractors). The purpose of the reconciliation was to ensure that the number of improper claims and amounts found to be in error that are archived in the data warehouse match the data CMS received from other sources. Econometrica's data reconciliation is completed through fiscal years (FY) 2006 and 2007, and they are continuing to reconcile data through FY 2008. This is an additional layer of data verification beyond CMS's own efforts. Econometrica's ongoing reconciliation work supports CMS in its oversight of the Claim RACs and in developing an archive of reliable program data. Econometrica's performance was measured through the timely submission of data to its CMS project officer.

Econometrica also supported CMS by verifying certain summary data included in this report and documenting the results of that effort. This work included analyzing numerous RAC invoice files and selected data in the RAC data warehouse to verify results derived by CMS and documenting the methodology used to calculate the findings. This effort provided a separate, third-party verification of CMS's findings.

In addition, through a contract under the supervision of Econometrica, the Gallup Organization conducted an independent survey of providers' perceptions of the RAC program. Between May 2007 and July 2007, using computerized telephone interviews, the Gallup Organization contacted a sample of more than 500 providers who had received either a medical record request letter or an overpayment recoupment from a RAC at least once in the year before the survey. These independent survey results established an important baseline for provider satisfaction with the RAC demonstration. The Gallup Organization was a subcontractor to Econometrica. The Gallup Organization's performance was measured through its timely completion of the provider survey.

AdvanceMed, the Claim RAC Validation Contractor (RVC), provided external validation and helped ensure the accuracy of the RAC claim determinations by conducting independent, third-party reviews of improper payments identified by the RACs (see Appendix N for a description of the review procedures used by the RVC during the demonstration). Beginning in September 2007, initial batches of claim reviews were conducted at CMS's request. Additional claims were randomly selected by Econometrica and independently reviewed by AdvanceMed. AdvanceMed also provided validation of the accuracy of some of the new issues the Claim RAC wished to pursue for potential improper payments. AdvanceMed's performance was measured through the timely submission of review findings to CMS.

Finally, the RAC program was structured in such a way as to require that provider appeals of RAC determinations be submitted not to the RAC, but instead to the Medicare claims processing contractors. The claims processing contractors independently reviewed all RAC improper payment determinations that providers appealed. The claims processing contractors followed the standard Medicare appeals process when hearing RAC claims, including the timeframes for filing, etc.

Supported by these independent sources, CMS prepared this evaluation of the RAC demonstration in an effort to make data available to interested parties and provide a mechanism for sharing current data as the normal appeals process runs its course. Currently, CMS is planning to release monthly updates to this report through the summer of 2008.

6. Lessons Learned from the RAC Demonstration

A number of questions were identified during the preliminary planning of the RAC demonstration. Responses to those questions were one of the metrics used to evaluate the effectiveness of the RAC demonstration.

- **CMS found that it is possible to gradually expand the RAC program.**
  When the RAC demonstration began, RACs were present in only three States—New York, Florida, and California. When the Tax Relief and Health Care Act of 2006 was passed, requiring CMS to make the RAC program permanent and nationwide by January 1, 2010, CMS decided to expand the demonstration into several additional States. CMS found that it is possible to expand the jurisdiction of the RACs but also learned how important good provider communication is during such an expansion. Communication was accomplished by CMS through the use of conference calls and visits to provider organizations in each affected State. Therefore, CMS has decided not to expand to all 50 States via a "big bang" approach in December 2009. Instead, CMS plans to phase in the new RACs gradually, beginning in the summer of 2008 through December 2009. CMS believes that this gradual ramping up will allow for the formation of strong communication channels with the provider community, which are necessary for the success of the program.

- **CMS found that RACs can find improper payments in Medicare.**
  All three Claim RACs found a significant volume of improper payments.

- **CMS determined that providers would not appeal every RAC overpayment determination.**
  Providers appealed only 14.0 percent of RAC determinations from the inception of the demonstration through March 27, 2008. Of all RAC determinations, only 4.6 percent were overturned on appeal.

Both the RAC demonstration and the RAC permanent program allow CMS and the Medicare claims processing contractors to **target actions aimed at preventing future improper payments**.

- **CMS learned that the cost to run the RAC demonstration was significantly less than the amount it returned to the Medicare Trust Funds.**
  The total costs were 20 cents for each dollar collected.

- **CMS determined that contingency fee contractors were willing to spend time on provider outreach activities (meeting with providers, addressing provider concerns, etc.).**
  All RACs developed working relationships with the provider organizations in their jurisdictions.

- **CMS learned that contingency fee contractors did not disrupt Medicare's anti-fraud efforts.**
  The RAC demonstration succeeded in developing the cooperation needed to ensure that RAC activities did not compromise ongoing law enforcement investigations. The relationships built during the RAC demonstration have improved the overall coordination of these activities and will provide a framework for the nationwide expansion of the RAC permanent program.

- **CMS determined that it is administratively possible to pay contractors on a contingency fee basis.**
  CMS developed a mechanism to pay the RACs using a voucher process. All collections were processed by Medicare claims processing contractors and were reconciled with RAC vouchers before contingency fee payments were made to the RAC.

- **CMS determined that it is possible find companies willing to be paid on a contingency fee basis.**

The RAC demonstration also highlighted certain issues and processes that needed improvement. Some of the major concerns are discussed below. Improvements CMS has made to the RAC permanent program as a result of the demonstration are summarized in Table 10.

ISSUE #1: Medicare claims processing systems were overwhelmed by the high volume of improper payments uncovered by Claim RACs. The Claim RACs submitted an unprecedented volume of claims during the demonstration to the Medicare claims processing contractors for re-adjudication. This created severe backlogs within some of the Medicare claims processing contractors early in the demonstration. These backlogs not only delayed the recovery of overpayments but, with regard to older claims, the backlogs also resulted in many lost recoveries due to the 4-year limitation on overpayment review activities. This backlog also created time delays (often of several months) between the date of a Claim RAC letter to a provider indicating the amount to be collected and the date of the actual collection. This was confusing to providers.

CHANGE: To address this problem, CMS initially increased the staff at the Medicare claims processing contractors and worked with the RACs to establish procedures to consolidate claims in order to improve efficiency and reduce the backlog. Later, CMS began to implement changes in the claims processing computer systems to automate the adjustment process and eliminate the need for costly and time consuming manual intervention. Importantly, this computer change ensured that overpayment recovery or underpayment reimbursement occurred promptly, reduced provider confusion, and ultimately will minimize the burden on the Medicare claims processing contractors.

ISSUE #2: Not all Claim RAC issues were "validated" prior to widespread review. IRF providers in California were concerned that PRG was misinterpreting the CMS medical necessity criteria for IRF services and therefore making inaccurate overpayment determinations (see Appendix O). Other providers in all three demonstration States were concerned that the Claim RACs could be misinterpreting a CMS coverage or payment policy. Providers were universally concerned that CMS would not even become aware of such RAC mistakes until after a significant number of providers had spent money on copying and sending medical records and filing appeals.

CHANGE: In August 2007 CMS instituted a new issue review process and contracted with an independent third-party review entity, AdvanceMed, to be the Claim RAC Validation Contractor (RVC). For each new issue a RAC wished to pursue for potential improper payments, the RAC submitted to CMS information on the issue, including the provider type, error type, policy violated, and potential improper payment amount per claim. CMS staff reviewed each issue and determined whether the RAC could proceed with its review, or whether the issue should be reviewed by the RVC. If the issue required RVC review, the RAC sent the RVC a small sample of claims (and medical records if complex review was required). The RVC then issued a recommendation to CMS on whether the RAC should proceed with a full-scale review. CMS will continue this process for all new issues when the RAC permanent program begins and will require that the new issues be posted online. Thus, a RAC cannot perform any automated or complex reviews in excess of 10 medical records without CMS approval.

ISSUE #3: Providers felt that there was no measure of RAC accuracy. Some providers were concerned that the Claim RACs could be making inaccurate claim determinations, but CMS would not know since providers sometimes choose not to appeal a RAC-initiated overpayment with which they disagree. These providers may believe that the effort and cost involved in filing an appeal outweigh the benefits of winning an appeal.

CHANGE: CMS tasked the RVC with reviewing a random sample of overpayment claims from each Claim RAC. The RVC has been valuable in ensuring the accuracy of the overpayment decisions made by each RAC. CMS will publicly release each permanent RAC's accuracy score.

ISSUE #4: Hospitals could not resubmit claims when necessary services were provided in the wrong setting.

CHANGE: During the RAC demonstration, CMS waived the "timely claim filing" limits and allowed hospitals to resubmit claims for outpatient ancillary services in these situations. CMS is exploring whether it is possible to continue this waiver during the RAC permanent program.

ISSUE #5: A four-year look-back period is too long. Many providers felt that the four-year look-back period conflicted with the regulation stipulating that providers were liable only for repaying overpayments within three years of the original claim payment.

CHANGE: CMS has changed the look-back period under the RAC permanent program to only three years and established a maximum look-back date of October 1, 2007.

Table 10. Improvements Made to the RAC Permanent Program

Issue	Demonstration RACs	Permanent RACs
RAC medical director	Not Required	Mandatory
Coding experts	Optional	Mandatory
Credentials of reviewers provided upon request	Not Required	Mandatory
Discussion with CMD regarding claim denials if requested	Not Required	Mandatory
Minimum claim amount	$10.00 aggregate claims	$10.00 minimal claims
AC validation process	Optional	Limited
External validation process	Not Required	Mandatory
RAC must payback the contingency fee if the claim is overturned on appeal	Only required to pay back if claim is overturned on the first level of appeals	Required to pay back if claim is overturned at all levels of appeals
Vulnerability reporting	Limited	Frequent and mandatory
Standardized base notification of overpayment letters to providers	Not Required	Mandatory
Look back period (from claim pmt date - date of medical record request)	4 years	3 years
Maximum look back date	None	10/1/2007
Allowed to review claims in current fiscal year?	No	Yes
Limits on # of medical records requested	Optional. Each RAC set own limit	Mandatory. CMS will establish uniform limits
Time frame for paying hospital medical record photocopying vouchers	None	Within 45 days of receipt of medical record
MSP included	Yes	No
Quality assurance/ Internal control audit	No	Mandatory
Remote call monitoring	Yes	Yes
Reason for review listed on request for records letters and overpayment letters	Not Required	Mandatory
RAC claim status Web page	Not Required	By January 2010
Public disclosure of RAC contingency fees	No	Yes

ISSUE #6: Fulfilling medical record requests can be burdensome on providers. During the RAC demonstration, CMS suggested that each Claim RAC establish limits on the number of medical records they would request from a provider. Two RACs set a number limit over a 30- or 45-day period, and one RAC used a limit based on the financial impact on a provider. Thus, there was significant variation in the limits imposed across the demonstration. The limits were a single number and did not expand or contract based on the size of the provider. Thus, the same limit was used with a 700-bed hospital and a solo-practice physician office.

CHANGE: In the RAC permanent program, CMS will establish a uniform "sliding-scale" limit across all four RACs. Thus, the limit will be higher for large facilities and lower for small providers. CMS will make these limits available to the public before the first medical record request is issued.

ISSUE #7: The RACs paid back contingency fees only at the first level of appeal. Under the RAC demonstration, the RACs were required to return contingency fees if the claim determination was overturned on first-level appeal. Demonstration RACs were allowed to retain their contingency fees on determinations overturned on second- or third-level appeal. CMS chose this methodology during the initial planning of the RAC demonstration, to quell fears that no companies would bid to become RACs if they would be required to return contingency fees for determinations overturned years later. Also, because the demonstration was authorized for only three years and it can often take more than three years for a claim to complete the entire appeals process, CMS did not have the legal authority to take back money from companies no longer under contract. Providers were concerned that by allowing the RACs to retain contingency fees on overturned decisions, CMS was perpetuating the feeling that the RACs would make inaccurate determinations just to increase their fees.

CHANGE: In the RAC permanent program, CMS will require all RACs to refund any contingency fees they received if an overpayment determination is overturned at any level in the appeals process.

ISSUE #8: Providers felt that lack of a physician presence at the RAC equated to claims being erroneously denied.

CHANGE: CMS has required each RAC to hire a physician Medical Director to oversee the medical record review process, assist nurses, therapists, and certified coders upon request, manage quality assurance procedures, and inform provider associations about the RAC permanent program.

ISSUE #9: There was no electronic platform for tracking status. Many providers wanted to closely monitor the status of their medical record submissions to the RACs. This required providers to place frequent phone calls to RACs and to read a list of case ID numbers to see whether the RAC had received the medical records.

CHANGE: By 2010, CMS will require the new, permanent RACs to maintain a Web portal to display to each provider the status of all RAC medical record requests.

ISSUE #10: Provider confusion existed about the roles of the various Medicare contractors involved with detecting and correcting improper payments.

CHANGE: CMS will post a fact sheet to its Web site to clarify the roles of Medicare claims processing contractors, CERT contractors, QIOs, and RACs, as summarized in Table 11.

Table 11. Roles of Medicare Review Contractors

Improper Payment Function	Contractor Performing Function
Preventing future improper payments through pre-pay review and provider education	Medicare claims processing contractors
Detecting past improper payments	RACs
Measuring improper payments	CERT
Performing higher-weighted DRG reviews and expedited coverage reviews	QIOs

ISSUE #11: The RACs were inconsistent in documenting their "good cause" for reviewing a claim. Although the Departmental Appeals Board ruled that lack of good cause is not grounds to file an appeal, CMS continues to believe that RACs should consistently document their good cause for choosing a claim for review.

CHANGE: CMS issued instructions to the RACs requiring that they consistently document their "good cause" for reviewing a claim.

ISSUE #12: MSP RACs collected few improper payments.

CHANGE: CMS has decided not to contract with separate MSP RACs in the permanent RAC program.

ISSUE #13: CMS's nondisclosure of RAC contingency fees increased apprehension for some providers.

CHANGE: In the RAC permanent program, CMS will publicly disclose the RAC contingency fees.

Future Improper Payments Can Be Avoided

An important outcome of the demonstration is that the Claim RAC findings can be analyzed by CMS and the Medicare claims processing contractors to identify corrective actions that can be implemented to prevent future improper payments. Further, providers can use these findings to help ensure that they are submitting correctly coded claims for services that meet Medicare's medical necessity criteria. Although some of the RAC-identified improper payments were due to claims processing errors, the majority of the improper payments were due to providers billing for services that were incorrectly coded or did not meet Medicare's medical necessity policies. By establishing strong internal controls, hospitals can use these findings to train coders, physicians, medical record staff and others to help minimize future improper payments. Appendixes G and F provide information on the top services and errors that resulted in RAC-identified overpayments. Appendix H provides a list of the top services with RAC-identified underpayments.

Provider education about RAC-identified problem areas is a critical component of CMS's strategy to prevent future improper payments. By educating providers about the coding and medical necessity rules, providers can submit future claims correctly and thereby avoid being overpaid. Even claims processing contractors in other States can use these findings to help reduce their local error rates by analyzing whether any of these improper payments are occurring in their States.

CMS and the Medicare claims processing contractors have already taken a number of actions aimed at reducing improper payments. Several claims processing edits were installed to deny obvious errors, such as excessive units for Neulasta and colonoscopies. CMS also held regular conference calls with Medicare contractors throughout the demonstration to discuss the Claim RAC findings and will continue to do so during the permanent program. However, CMS is unable to determine at this point whether the Medicare claims processing contractors in the RAC States are able to lower their paid claims error rates more rapidly than Medicare claims processing contractors in other States.

7. Implementation of the Permanent RAC Program

CMS will gradually implement the RAC permanent program nationwide. Due to the importance of protecting the Medicare Trust Funds, Congress included Section 302 in TRHCA, which requires the Secretary to implement the RAC program throughout the country by no later than January 1, 2010 (see Appendix B). CMS is undertaking a number of initiatives to gradually implement the RAC permanent program.

CMS has begun the expansion process by initiating a full and open competition for four permanent RACs to begin after the end of the RAC demonstration in March 2008. (See Appendix Q for a map of future RAC jurisdictions.)

CMS has also developed an effective strategy to ensure that the RAC permanent program will not interfere with the transition from the old Medicare claims processing contractors to the new Medicare claims processing contractors, called Medicare Administrative Contractors (MACs). This strategy will allow the new MACs to focus on claims processing activities before working with the RACs. Generally, the RAC blackout period will be:

a. 3 months before a MAC begins processing claims for a given State

b. 3 months after a MAC begins processing claims for a given State.

In addition, CMS and the permanent RACs will undertake aggressive provider outreach. As soon as practical after the award of the contracts, CMS and the new RACs will visit each State in the "Summer 2008" group. The permanent RACs will vet all review topics through the CMS New Issue Review process, which will involve review by CMS clinical and coding experts, Medicare claims processing contractor reviewers, and/or through the RVC. The New Issue Review process concludes when the RAC posts a description of the new issue on its Web site (with appropriate links to coding guidelines, CMS manuals, local policies, etc.).

8. Conclusions

The RAC demonstration allows CMS and Medicare claims processing contractors to target actions aimed at preventing future improper payments. As a result, several claims processing edits have been installed to deny obvious errors, such as excessive units for Neulasta and colonoscopies. Further, provider education about RAC-identified problem areas is a critical component of the CMS strategy to prevent future improper payments. By educating providers about coding and medical necessity rules, providers can submit future claims correctly and thereby avoid being overpaid.

The RAC demonstration helped CMS plan the RAC permanent program. The results described in this report clearly indicate that the RAC demonstration was a useful resource for detecting and correcting past improper payments. CMS will evaluate the extent to which the RAC permanent program can protect the Medicare Trust Funds from future improper payments, thereby lowering the claims payment error rate and helping to preserve the Medicare Trust Funds for future generations.

The RAC demonstration was a cost-effective program, and the actions CMS is now taking, including initiatives to streamline the steps by which RAC improper payments are processed by the Medicare claims processing contractors, will result in an even more cost-effective program in the future.

> "It is critical that we ensure every dollar is spent wisely **so that the program is affordable for taxpayers and future generations of beneficiaries**."
>
> *– Kerry Weems, CMS Acting Administrator*

The RAC demonstration has proven to be successful in returning dollars to the Medicare Trust Funds and identifying underpayments for providers. The demonstration returned a significant amount of improper payments to the Medicare Trust Funds while limiting, to the extent possible, the burden on the provider community and the Medicare claims processing contractors. CMS views the RAC demonstration as an important financial management strategy that supports the President's goal of reducing improper payments and complements existing Medicare program safeguard activities. The RAC demonstration provided CMS with a new mechanism for detecting improper payments made in the past and has given CMS a valuable new tool for preventing overpayments in the future.

APPENDIXES

Appendix A
Medicare Modernization Act (Section 306)

SEC. 306. DEMONSTRATION PROJECT FOR USE OF RECOVERY AUDIT CONTRACTORS.
(a) IN GENERAL- The Secretary shall conduct a demonstration project under this section (in this section referred to as the 'project') to demonstrate the use of recovery audit contractors under the Medicare Integrity Program in identifying underpayments and overpayments and recouping overpayments under the Medicare program for services for which payment is made under part A or B of title XVIII of the Social Security Act. Under the project-

(1) Payment may be made to such a contractor on a contingent basis;

(2) Such percentage as the Secretary may specify of the amount recovered shall be retained by the Secretary and shall be available to the program management account of the Centers for Medicare & Medicaid Services; and

(3) The Secretary shall examine the efficacy of such use with respect to duplicative payments, accuracy of coding, and other payment policies in which inaccurate payments arise.

(**b) SCOPE AND DURATION** -
(1) SCOPE- The project shall cover at least 2 States that are among the States with-

(A) The highest per capita utilization rates of Medicare services, and

(B) At least 3 contractors.

(2) DURATION - The project shall last for not longer than 3 years.

(**c) WAIVER** - The Secretary shall waive such provisions of title XVIII of the Social Security Act as may be necessary to provide for payment for services under the project in accordance with subsection (a).

(d) QUALIFICATIONS OF CONTRACTORS-
(1) IN GENERAL- The Secretary shall enter into a recovery audit contract under this section with an entity only if the entity has staff that has the appropriate clinical knowledge of and experience with the payment rules and regulations under the Medicare program or the entity has or will contract with another entity that has such knowledgeable and experienced staff.

(2) INELIGIBILITY OF CERTAIN CONTRACTORS- The Secretary may not enter into a recovery audit contract under this section with an entity to the extent that the entity is a fiscal intermediary under section 1816 of the Social Security Act (42 U.S.C. 1395h), a carrier under section 1842 of such Act (42 U.S.C. 1395u), or a Medicare Administrative Contractor under section 1874A of such Act.

(3) PREFERENCE FOR ENTITIES WITH DEMONSTRATED PROFICIENCY- In awarding contracts to recovery audit contractors under this section, the Secretary shall give preference to those risk entities that the Secretary determines have demonstrated more than 3 years direct management experience and a proficiency for cost control or recovery audits with private insurers, health care providers, health plans, or under the Medicaid program under Title XIX of the Social Security Act.

(e) CONSTRUCTION RELATING TO CONDUCT OF INVESTIGATION OF FRAUD- A recovery of an overpayment to a provider by a recovery audit contractor shall not be construed to prohibit the Secretary or the Attorney General from investigating and prosecuting, if appropriate, allegations of fraud or abuse arising from such overpayment.

(f) REPORT- The Secretary shall submit to Congress a report on the project not later than 6 months after the date of its completion. Such reports shall include information on the impact of the project on savings to the Medicare program and recommendations on the cost-effectiveness of extending or expanding the project information means information about a conviction for a relevant crime or a finding of patient or resident abuse.

Appendix B
Tax Relief and Health Care Act of 2006 (Section 302)

(h) USE OF RECOVERY AUDIT CONTRACTORS.—
(1) IN GENERAL.—Under the Program, the Secretary shall enter into contracts with recovery audit contractors in accordance with this subsection for the purpose of identifying underpayments and overpayments and recouping overpayments under this title with respect to all services for which payment is made under part A or B. Under the contracts—

(A) payment shall be made to such a contractor only from amounts recovered;
(B) from such amounts recovered, payment—
(i) shall be made on a contingent basis for collecting overpayments; and
(ii) may be made in such amounts as the Secretary may specify for identifying underpayments; and
(C) the Secretary shall retain a portion of the amounts recovered which shall be available to the program management account of the Centers for Medicare & Medicaid Services for purposes of activities conducted under the recovery audit program under this subsection.

(2) DISPOSITION OF REMAINING RECOVERIES.—The amounts recovered under such contracts that are not paid to the contractor under paragraph (1) or retained by the Secretary under paragraph (1)(C) shall be applied to reduce expenditures under parts A and B.
(3) NATIONWIDE COVERAGE.—The Secretary shall enter into contracts under paragraph (1) in a manner so as to provide for activities in all States under such a contract by not later than January 1, 2010.
(4) AUDIT AND RECOVERY PERIODS.—Each such contract shall provide that audit and recovery activities may be conducted during a fiscal year with respect to payments made under part A or B—

(A) during such fiscal year; and
(B) retrospectively (for a period of not more than 4 fiscal years prior to such fiscal year).

(5) WAIVER.—The Secretary shall waive such provisions of this title as may be necessary to provide for payment of recovery audit contractors under this subsection in accordance with paragraph (1).
(6) QUALIFICATIONS OF CONTRACTORS.—

(A) IN GENERAL.—The Secretary may not enter into a contract under paragraph (1) with a recovery audit contractor unless the contractor has staff that has the appropriate clinical knowledge of, and experience with, the payment rules and regulations under this title or the contractor has, or will contract with, another entity that has such knowledgeable and experienced staff.

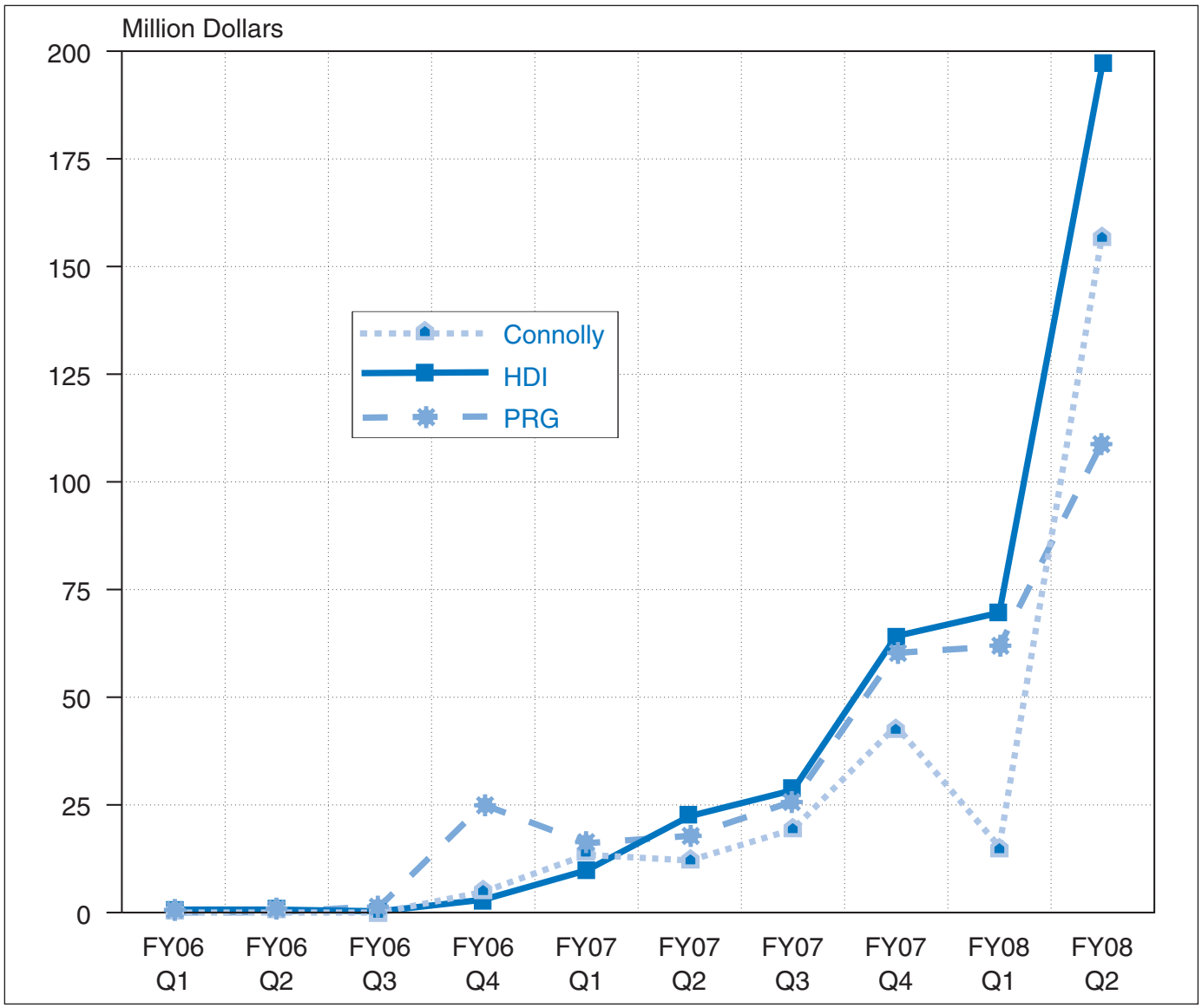
(B) INELIGIBILITY OF CERTAIN CONTRACTORS.—The Secretary may not enter into a contract under paragraph (1) with a recovery audit contractor to the extent the contractor is a fiscal intermediary under section 1816, a carrier under section 1842, or a Medicare administrative contractor under section 1874A.

(C) PREFERENCE FOR ENTITIES WITH DEMONSTRATED PROFICIENCY.—In awarding contracts to recovery audit contractors under paragraph (1), the Secretary shall give preference to those risk entities that the Secretary determines have demonstrated more than 3 years direct management experience and a proficiency for cost control or recovery audits with private insurers, health care providers, health plans, under the Medicaid program under title XIX, or under this title.

(7) CONSTRUCTION RELATING TO CONDUCT OF INVESTIGATION OF FRAUD.—A recovery of an overpayment to a individual or entity by a recovery audit contractor under this subsection shall not be construed to prohibit the Secretary or the Attorney General from investigating and prosecuting, if appropriate, allegations of fraud or abuse arising from such overpayment.
(8) ANNUAL REPORT.—The Secretary shall annually submit to Congress a report on the use of recovery audit contractors under this subsection. Each such report shall include information on the performance of such contractors in identifying underpayments and overpayments and recouping overpayments, including an evaluation of the comparative performance of such contractors and savings to the program under this title.

Appendix C
Improper Payments Corrected Over Time

Figure C1. Overpayments Collected by Fiscal Quarter Through 3/27/08, Individual Claim RACs



*The sharp decline in Connolly's FY08 Q1 collections is due to the Medicare claims processing contractor's transition to a new CMS-mandated computer system. Because all claims had to be manually adjusted during the transition, only a limited number of claims were adjusted in December before the end of the reporting period.
Source: RAC invoice files and RAC Data Warehouse.

Table C1. Improper Payments Corrected by Fiscal Year: Claim RACs Only

(Million Dollars)

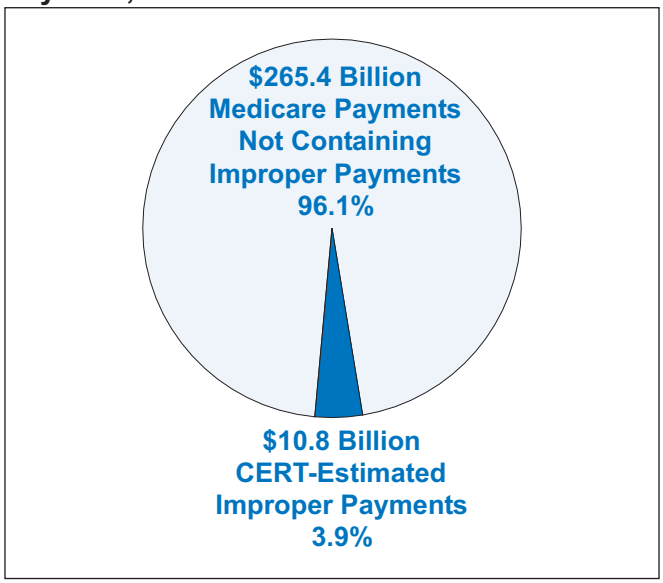
Period	Overpayments Collected	Underpayments Repaid	Total Improper Payments Corrected
FY 2006[a]	$ 36.2	$ <0.1	**$ 36.2**
FY 2007	$ 332.9	$ 14.1	**$ 347.0**
FY 2008, through 3/27/08	$ 610.9	$ 23.7	**$ 634.6**
Total	**$ 980.0**	**$ 37.8**	**$ 1,017.8**

[a]For this Evaluation Report, CMS lists all dollars actually collected and repaid that were invoiced between March 2005 and March 2008. This is in contrast to the reporting for the FY 2006 RAC Status Document, which was based on a combination of actual overpayments collected and underpayment *notification letters* that were sent to the providers and to the Medicare claims processing contractors during the fiscal year.

Source: RAC invoice files and RAC Data Warehouse.

Appendix D
CERT-Estimated Improper Payments in Medicare

Figure D1. Estimated Percentage of All Medicare Payments Containing an Improper Payment, FY 2007



Note: $276 billion in total dollars paid, less $10.8 billion in dollars improperly paid, gives the $265.4 billion total for payments that did not contain improper payments.
Source: FY 2007 Improper Medicare FFS Payments Report.

Appendix E
Overpayments Collected by Error Type and Provider Type

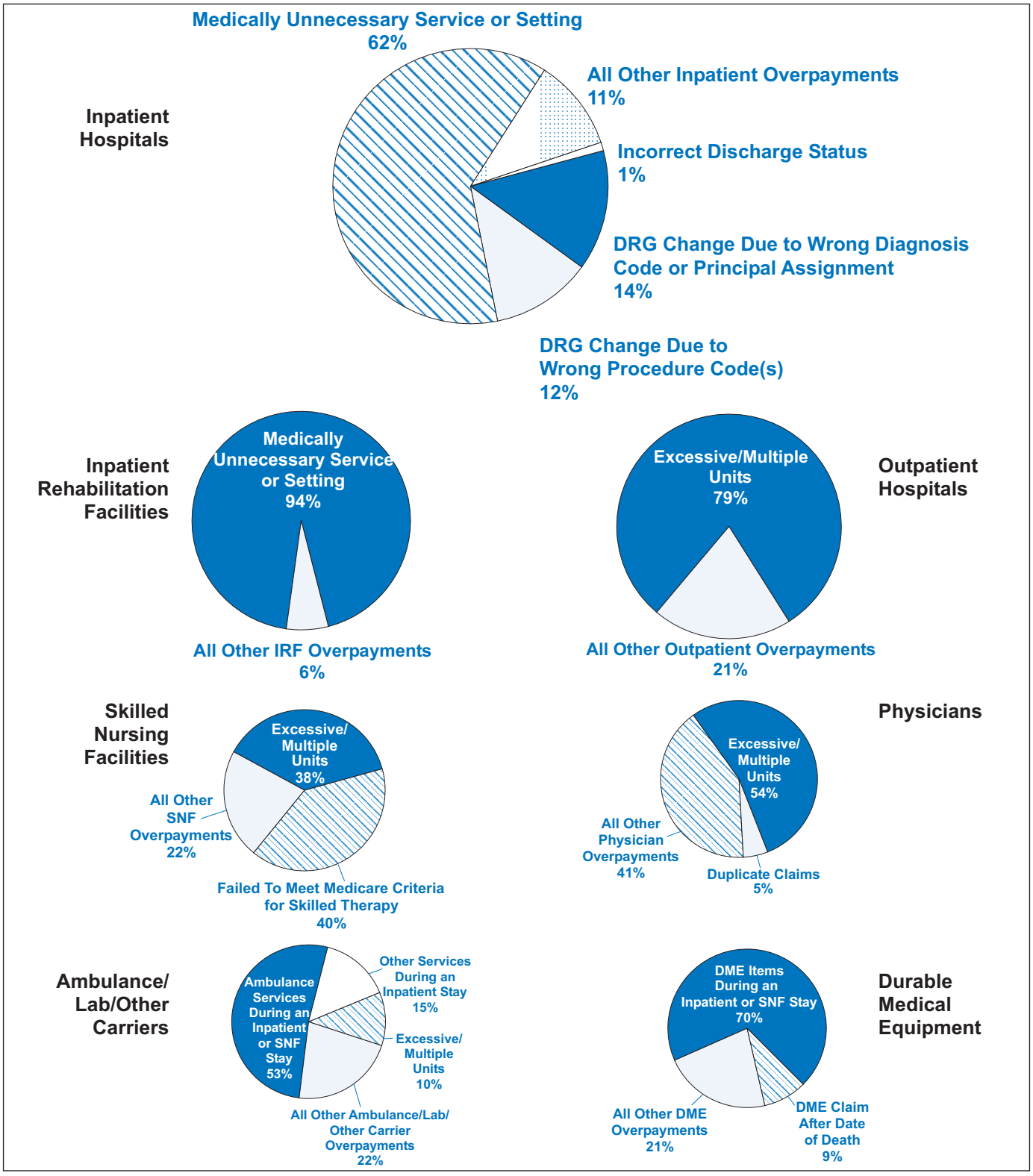
Table E1. Overpayments Collected by Error and Provider Type (Net of Appeals): Cumulative Through 3/27/08, Claim RACs Only
(Percent of Total)

Error Type	Inpatient Hospital	Inpatient Rehabilitation Facility	Skilled Nursing Facility	Outpatient Hospital	Physician	Ambulance/ Lab/Other	Durable Medical Equipment	Total Overpayments Collected
Medically Unnecessary	34.50	5.63	0.26	0.47	0.00	0.00	0.00	40.86
Incorrectly Coded	30.48	0.00	0.62	2.44	1.05	0.06	0.00	34.66
No/Insufficient Documentation	6.63	0.44	0.48	0.11	0.00	0.00	0.09	7.76
Other	12.57	0.00	0.41	1.22	1.44	0.45	0.63	16.72
Total	**84.19**	**6.07**	**1.76**	**4.25**	**2.50**	**0.51**	**0.72**	**100.00**

Note: These percentages are net of appeals and thus vary slightly from the data shown in other sections of the report.
Source: Self-reported by the Claim RACs.

Appendix F
Audit Areas and Top Errors by Provider Type

Figure F1. Audit Areas and Top Errors by Provider Type, Net of Appeals: Cumulative Through 3/27/08, Claim RACs Only (Percent of Overpayment Amount)



Source: Self-reported by the Claim RACs.

Appendix G
Top Services With Overpayments

Table G1. Top Services With RAC-Initiated Overpayment Collections (Net of Appeals): Cumulative Through 3/27/08, Claim RACs Only

Type of Provider	Description of Item or Service	Amount Collected Less Cases Overturned on Appeal (Million Dollars)	Number of Claims With Overpayments Less Cases Overturned on Appeal	Location of Problem
Inpatient Hospital	Surgical procedures in wrong setting (medically unnecessary)	88.0	5,421	NY
	Excisional debridement (incorrectly coded)	66.8	6,092	NY, FL, CA
	Cardiac defibrillator implant in wrong setting (medically unnecessary)	64.7	2,216	FL
	Treatment for heart failure and shock in wrong setting (medically unnecessary)	33.1	6,144	NY, FL, CA
	Respiratory system diagnoses with ventilator support (incorrectly coded)	31.6	2,102	NY, FL, CA
Inpatient Rehabilitation Facility	Services following joint replacement surgery (medically unnecessary)	37.0	3,253	CA
	Services for miscellaneous conditions (medically unnecessary)	17.4	1,235	CA
Outpatient Hospital	Neulasta (medically unnecessary)	6.5	558	NY, FL
	Speech-language pathology services (medically unnecessary)	3.2	24,991	NY, CA
	Infusion services (medically unnecessary)	2.3	19,271	CA
Skilled Nursing Facility	Physical therapy and occupational therapy (medically unnecessary)	6.8	77,911	CA
	Speech-language pathology services (medically unnecessary)	1.6	3,012	CA
Physician	Pharmaceutical injectables (incorrect coding)	5.8	18,930	NY, CA
	Neulasta (medically unnecessary)	3.0	56	NY
	Vestibular function testing (other error type)	1.4	13,805	FL
	Duplicate claims (other error type)	1.0	11,165	CA
Lab/Ambulance/Other	Ambulance services during a hospital inpatient stay (other error type)	2.9	13,589	FL, CA
Durable Medical Equipment	Items during a hospital inpatient stay or SNF stay (other error type)	4.8	38,257	NY, FL, CA

Source: Self-reported by the Claim RACs.

Appendix H
Top Services With Underpayments

Table H1. Top Services With Underpayments Refunded to Providers: Cumulative Through 3/27/08, Claim RACs Only

Type of Provider	Description of Item or Service	Amount Refunded	Number of Claims With Underpayments	Location of Problem
Inpatient Hospital	Discharge status (incorrectly coded)	$19.6 million	8,584	FL, CA
	Wound debridement (incorrectly coded)	$ 3.0 million	622	NY, FL, CA
	Operating room procedures unrelated to principal diagnosis (incorrectly coded)	$ 1.1 million	181	FL, CA
	Respiratory system procedures (incorrectly coded)	$ 643,255	133	NY, CA
	Surgical procedures with an incorrect DRG (incorrectly coded)	$ 491,248	62	NY
	Circulatory system diagnosis (incorrectly coded)	$ 323,087	78	FL, CA
	Bowel procedure (incorrectly coded)	$ 250,548	25	CA
	Respiratory infections and inflammation (incorrectly coded)	$ 240,656	46	CA
	Kidney and urinary tract Infections (incorrectly coded)	$ 239,633	66	CA
	Pneumonia (incorrectly coded)	$ 239,071	74	CA
Outpatient Hospital	Drug codes (incorrectly coded)	$ 1.1 million	1,084	NY
	Oxaliplatin (incorrectly coded)	$ 614,269	346	NY
	Darbopoetin (incorrectly coded)	$ 260,176	726	NY
Durable Medical Equipment	Initial item/service was paid so accompanying item/service should be paid (incorrectly coded)	$ 140,847	602	FL

Source: Self-reported by the Claim RACs.

Appendix I
Average Overpayment Amounts

Table I1. Average Overpayment Amounts: Cumulative Through 3/27/08, Claim RACS Only

Type of Provider	Average Overpayment Amount					
	Connolly		HDI		PRG	
	Per Claim[a]	Per Provider per Year	Per Claim[a]	Per Provider per Year	Per Claim[a]	Per Provider per Year
Inpatient hospital/IRF/SNF	$ 12,157	$ 483,774	$ 3,917	$ 118,834	$ 6,309	$ 850,502
Outpatient hospital	$ 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
Durable medical equipment	$ 174	$ 1,361	$ 466	$ 1,039	$ 126	$ 1,943

[a]Average overpayment amount per claim based on number of overpayments collected from 10/1/06 to 3/27/08, where the collection amount was greater than $0.
Source: Self-reported by the RACs.

Appendix J
Medical Record "Hit Rates"

Thirty-three percent of medical record reviews resulted in an overpayment finding. RACs attempted to target their medical record request letters to those claims most likely to contain improper payments, in an effort to minimize the burden on providers and maximize the return on investment for RACs. Out of all of the medical records reviewed from the inception of the demonstration through March 27, 2008, 33 percent resulted in overpayment collections. This ratio—number of medical record requests to number of claims with improper payment findings—is also known as a medical record "hit rate." Table J1 shows that all the RACs' medical record hit rates were similar, ranging from 29 percent to 37 percent, and quite similar to the hit rate (31%) experienced by Medicare claims processing contractors nationwide from FY 2005 through FY 2007.

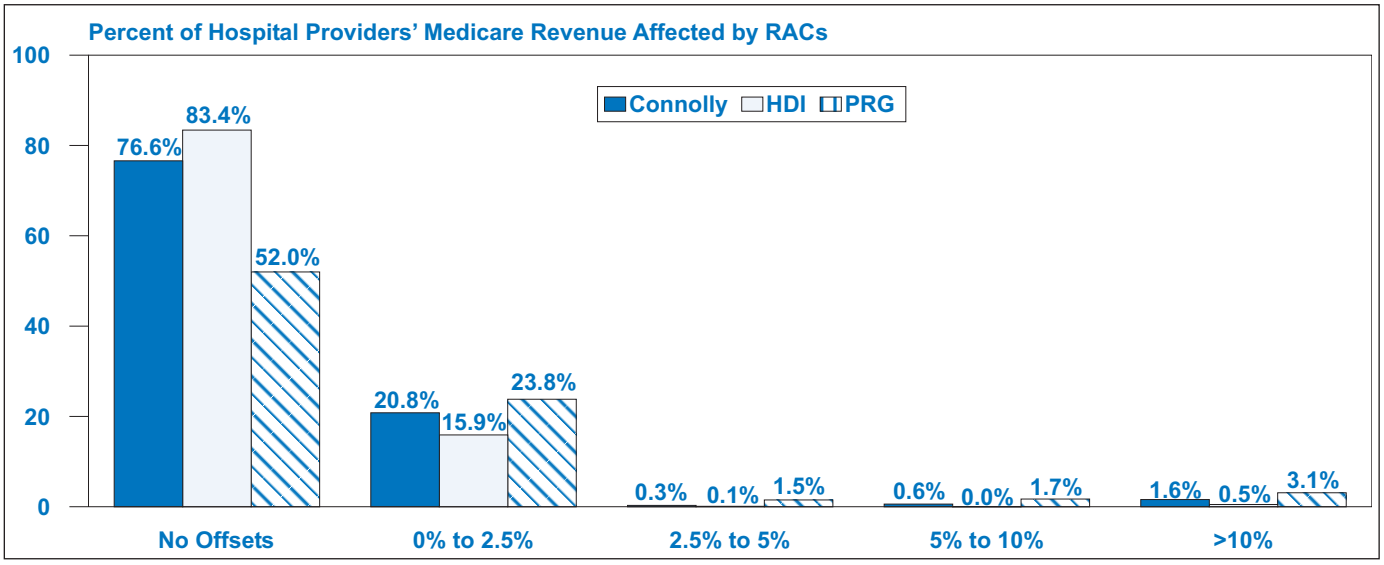
Table J1. Cumulative Claim Counts for Complex Reviews Through 3/27/08, Claim RACs Only

Type of Claim	Number of Claims			
	Connolly	HDI	PRG	All RACs
Claims where the RAC conducted a complex review	57,228	198,243	234,288	**489,759**
Claims where the RAC collected an overpayment following a complex review	20,049	72,965	67,897	**160,911**
Percentage of complex reviews that resulted in an overpayment collection	35%	37%	29%	**33%**

Source: Self-reported by the Claim RACs.

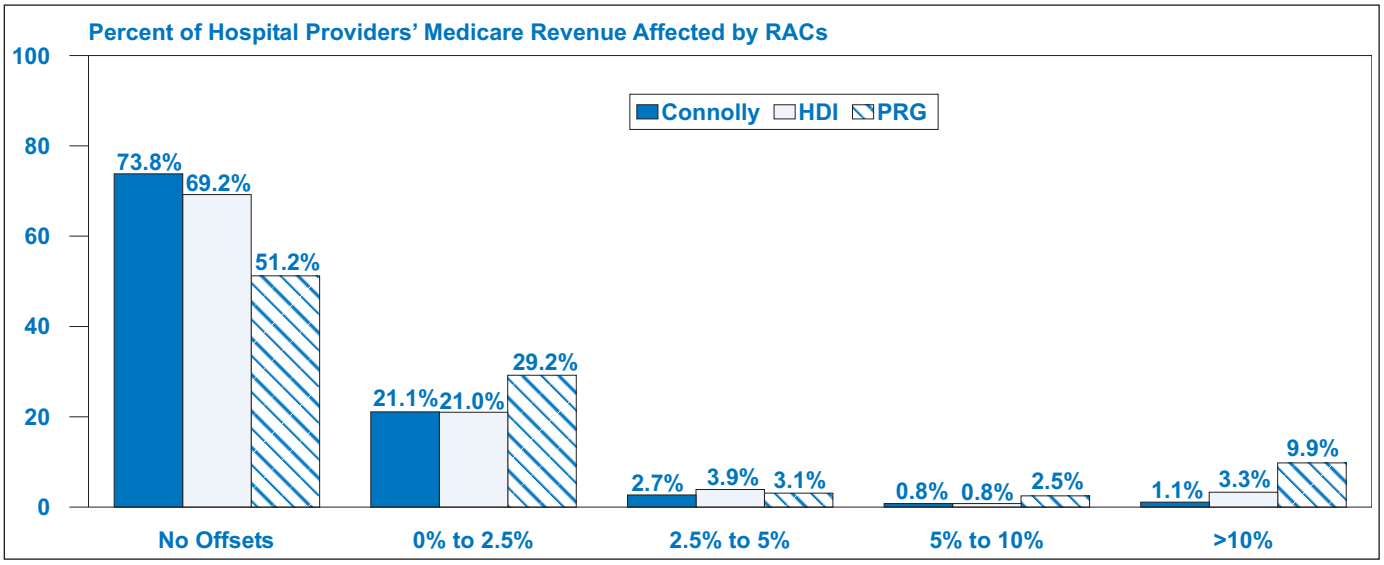
Appendix K
Financial Impact on Hospital Providers

Figure K1. Financial Impacts on Hospital Providers: Fiscal Year 2006, Claim RACs Only



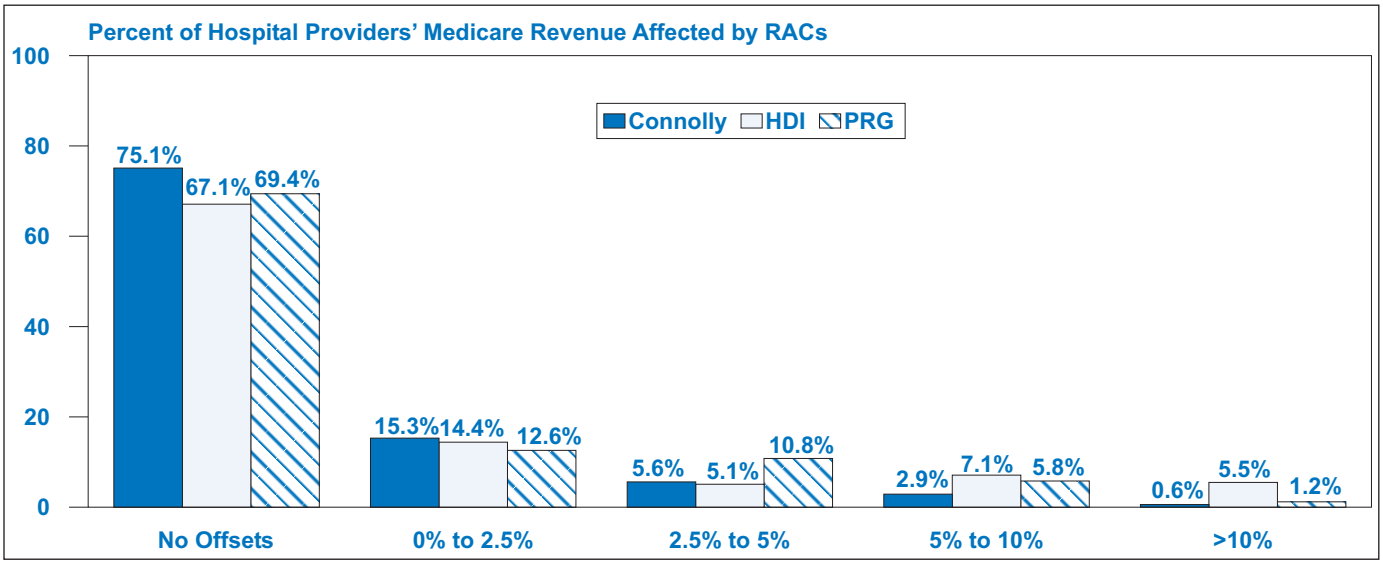
Source: Self-reported by the RACs.

Figure K2. Financial Impacts on Hospital Providers: Fiscal Year 2007, Claim RACs Only



Source: Self-reported by the RACs.

Figure K3. Financial Impacts on Hospital Providers: Fiscal Year 2008, Claim RACs Only



Source: Self-reported by the RACs.

Appendix L
Provider Appeals

Table L1. Provider Appeals of RAC-Initiated Overpayments: Cumulative Through 3/27/08, Claim RACs Only

Type	Claim RAC	Number of Claims with Overpayment Determinations	Number of Claims Where Provider Appealed				Claims Appealed by Providers at Any Level		Appealed Claims with Decisions in Provider's Favor		Percentage of Overpayment Determinations Overturned on Appeal
			FI	QIC	ALJ	DAB	Number	Percent	Number	Percent	
Part A	Connolly	78,698	3,796	457	7	0	4,260	5.4%	2,195	51.5%	2.8%
	HDI	104,394	11,545	695	0	0	12,240	11.7%	4,207	34.4%	4.0%
	PRG	91,860	10,763	1,715	301	9	12,788	13.9%	1,129	8.8%	1.2%
	Subtotal	*274,952*	*26,104*	*2,867*	*308*	*9*	*29,288*	*10.7%*	*7,531*	*25.7%*	*2.7%*
Part B	Connolly	31,937	2,006	8	0	0	2,014	6.3%	1,380	68.5%	4.3%
	HDI	134,811	29,672	16	0	0	29,688	22.0%	12,912	43.5%	9.6%
	PRG	83,433	11,099	1,022	155	0	12,276	14.7%	2,553	20.8%	3.1%
	Subtotal	*250,181*	*42,777*	*1,046*	*155*	*0*	*43,978*	*17.6%*	*16,845*	*38.3%*	*6.7%*
Parts A and B Combined	Connolly	110,635	5,802	465	7	0	6,274	5.7%	3,575	57.0%	3.2%
	HDI	239,205	41,217	711	0	0	41,928	17.5%	17,119	40.8%	7.2%
	PRG	175,293	21,862	2,737	456	9	25,064	14.3%	3,682	14.7%	2.1%
Total	**All RACs**	**525,133**	**68,881**	**3,913**	**463**	**9**	**73,266**	**14.0%**	**24,376**	**33.3%**	**4.6%**

Source: RAC invoice files, RAC Data Warehouse, and data reported by Medicare claims processing contractors. Includes all completed appeals and some appeals pending in the appeals process. This is because some Medicare claims processing contractors cannot distinguish between appeals of RAC determinations and appeals of other contractor determinations. These statistics are based on appeals that were known to the Medicare claims processing contractors on or before 3/27/08. Any QIC or ALJ appeals reported to the Medicare claims processing contractors after that date are not included in these statistics.

Table L2. Dollars Overturned on Appeal: Cumulative Through 3/27/08, Claim RACs Only
(Million Dollars)

Overpayments collected	$ 980.0
Amount overturned on appeal	$ 46.0
Percentage of overpayment collections overturned on appeal	4.7%

Source: RAC invoice files, RAC Data Warehouse, and data reported by Medicare claims processing contractors.

Appendix M
Summary of Work Performed by Econometrica, Inc. Under the RAC Demonstration Project

ECONOMETRICA, INC.

May 19, 2008

Wayne Slaughter, Ph.D.
RAC Evaluation Contractor Project Officer
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244-1850

Dear Dr. Slaughter:

Since the Recovery Audit Contractor (RAC) demonstration project has concluded, this letter summarizes the tasks that Econometrica has performed under the project and is currently performing in support of the transition to the permanent RAC program.

Recently, at the request of CMS, we have supported the agency in the production of the provisional evaluation report on the RAC demonstration project. Toward this end, we verified certain summary data included in this report and are currently in the process of documenting the results of that effort. We also supported CMS in developing a format for the report as well as in making edits to the content of the report as requested by CMS staff.

A second data verification effort we have been performing over the past several months has been in support of CMS' quality assurance of RAC data processes. This work has involved assessing the completeness of certain data that are routinely entered into the RAC data warehouse and reporting on the results. The process includes reconciling the number of claims and their associated dollar-error amounts with invoice data and transaction data (CMS receives invoice data from the Claim RACs and transaction data from the Medicare claims processing contractors). The purpose of the reconciliation is to ensure that the number of improper claims and amounts found to be in error that are archived in the data warehouse match the improper claims data CMS receives from other sources. To date, we have reported the results for data matched through December 2007, and are now finalizing the reconciliation of data submitted through March 2008. Our ongoing reconciliation work will continue to support CMS in its oversight of the Claim RACs under the permanent program and in developing an archive of reliable program data stored in the data warehouse.

As part of this activity, we have also developed a framework for reporting on RAC collection and other performance activities on a monthly or quarterly basis. This framework will be a useful

tool for monitoring key indicators on performance by the RACs under the permanent program and will support preparation of future annual reports. We have submitted a draft outline of such a report to CMS for review. Once we complete our data reconciliation work and finalize the report format, we will be able to develop annual and/or quarterly reports going forward, as data under the permanent program are collected.

Another task we have been performing is sampling for the RAC validation effort. To this end, we supported the development of an initial sampling approach for the validation work under the demonstration project, which involved drawing monthly stratified random samples of RAC-reviewed claims that had been identified with an overpayment or underpayment. To help facilitate expansion of quality assurance under the future RAC program, we have developed a sampling plan methodology for conducting the validation work under the permanent program. The sampling plan includes the sample frame, the universe of claims from which we would sample, how the sample claims would be drawn, and how the data are to be analyzed. To date, we have provided random samples of claims data for the months of September 2007 through February 2008. We expect to continue to perform this work for the validation effort under the permanent RAC program.

Another task we performed was a survey of providers' views toward the RAC project. Under the supervision of Econometrica, the Gallup Organization conducted an independent survey of providers' perceptions of the RAC program in 2007. Using computerized telephone interviews, the Gallup Organization contacted a sample of providers between May and July 2007. These providers had received either a medical record request letter or an overpayment recoupment from a RAC at least once in the year prior to the survey. We submitted the final report on the survey results in September 2007. The survey established an important baseline for assessing provider satisfaction with the RAC demonstration. CMS may wish to conduct follow-on surveys as part of the future expansion of the RAC program.

Another component of our work has been the development and deployment of the OFM Efficiency Tool software, which was rolled out to CMS in September 2007. The idea was to have CMS work with the software as part of a testing phase. We are now in the process of specifying changes to make the software more user-friendly and to develop a strategy for implementing this tool to support CMS in its ongoing administration of the RAC program.

As part of our future program-integrity work in analyzing payment error findings, we are working to develop a methodological approach that would help CMS identify trends in claims with problematic errors under the permanent RAC program. We are in the initial stage of this work, but the goal is to develop a predictive approach that would flag claims with probable improper payments. We plan to use data from the RAC data warehouse to develop this methodology.

The tasks described above reflect, to the best of our knowledge, CMS' priorities, which have been articulated through numerous discussions over the course of the demonstration. Should you have any questions or require further information, please feel free to contact me at (301) 657-8311.

Sincerely,

Econometrica, Inc.

Cyrus Bagherpour
President/CEO

cc: Gerald Walters
George Mills
Edward Berends
Melanie Combs
Craig Gillespie

Appendix N
Summary of RAC Validation Work Performed by AdvanceMed

advancemed Corporation

April 21, 2008

Melanie Combs-Dyer, Recovery Audit Contractor (RAC) Technical Advisor
7500 Security Blvd.
Baltimore, MD 21244-1850

Dear Ms. Combs-Dyer:

This letter serves to summarize the work that AdvanceMed performed for the Recovery Audit Contractor (RAC) demonstration program as the RAC Validation Contractor (RVC).

In September 2007 CMS tasked AdvanceMed with assessing the accuracy of RAC-identified overpayment determinations. At CMS' request, our first task involved reviewing a sample of Inpatient Rehabilitation Facility (IRF) claims on which a RAC had collected overpayments.

AdvanceMed then began reviewing a number of "new issues" that the RAC wished to pursue for potential overpayments. Each RAC would send a small sample of claims and/or medical records for each new issue CMS wished to have validated before allowing the RAC to proceed with a larger-scale review. We would then issue a report with claim count and dollar amount accuracy rates, as well as a brief rationale for each new issue.

AdvanceMed also reviewed a random sample of claims on which the RACs had previously identified and collected overpayments. We issued a monthly accuracy report for each RAC and are developing the cumulative accuracy report. These reports also included claim count and dollar amount accuracy rates, along with more detailed explanations.

Should you have any questions or require further information, please let me know.

Sincerely,

John Simpson
CERT Program Director

1530 East Parham Road
Richmond, VA 23228
804.264.1778 Fax 804.264.8191

Appendix O
Re-Review of IRF "Wrong Setting" Claims

The vast majority of improper payments collected from inpatient rehabilitation facilities (IRFs) were due to the "wrong setting" issue (Figure F1). Over the life of the demonstration, PRG denied 5,237 claims on the basis that the beneficiary did not require the intensive rehabilitation services provided in an IRF, and that the therapy was appropriate in a less intensive setting, such as an SNF. The California Hospital Association was concerned with PRG's interpretation of the CMS medical necessity criteria for IRF services (HCFA Ruling 85-2 and CMS Benefit Policy Manual 100-2, Chapter 1, Section 110).

In September 2007, CMS instituted a "pause" in all IRF reviews to allow for an independent review of a sample of denied claims and further discussion with other Medicare contractors on IRF medical record review. It became clear that, with respect to IRF reviews in California, CMS contractors were not consistently applying Medicare policy for IRF services. CMS provided training to contractors reviewing IRF claims in California,[1] and then instructed PRG to re-review all previously denied IRF claims using the medical review methodology described in the training. PRG was then instructed to repay providers for any cases it had reversed.

Table O1 shows data on PRG's IRF re-review, and Table E1 in Appendix E shows that collections resulting from those reviews represented only 6 percent of all collections.

Table O1. PRG IRF Re-reviews

Original number of claims with notification letters sent to providers	5,237
Number of claims reversed by PRG	1,454
Dollars refunded to IRF providers	$14.0 million

Source: PRG-Schultz.

[1]The contractors included the RAC, FI, QIC (second-level appeal contractors), and the CERT Contractor/RAC Validation Contractor.

Appendix P
Service-Specific Examples of Overpayments Identified by the RACs

Table P1. Excisional Debridements (Complex Review, Incorrect Coding)

Claim Facts

- The hospital coder assigned a procedure code of 86.22.
- In the medical record, the physician writes "debridement was performed."
- Coding Clinic 1991Q3 states "Unless the attending physician documents in the medical record that an excisional debridement was performed (definite cutting away of tissue, not the minor scissors removal of loose fragments), debridement of the skin should be coded to 86.26, non excisional debridement of skin… Any debridement of the skin that does not meet the criteria noted above or is described in the medical record as debridement and no other information is available should be coded as 82.26."
- The RAC determined that the claim was INCORRECTLY CODED and issued a repayment request letter for the difference between the payment amount for the incorrectly correctly coded procedure and the payment amount for the correctly coded procedure.

Corrective Actions

- Hospitals can be more careful when submitting claims for excisional debridement.
- Medicare claims processing contractors can remind hospitals about the importance of following the coding clinic guidelines when submitting claims for excisional debridement.

Table P2. Inpatient Rehabilitation (Complex Review, Medically Unnecessary Setting)

Claim Facts

- An Inpatient Rehabilitation Facility (IRF) submitted a claim for inpatient therapy following a single knee replacement
- Medical record indicated that although the beneficiary required therapy, the beneficiary's condition did not meet Medicare's medical necessity criteria for IRF care (HCFA Ruling 85-2 and Medicare Benefit Policy Manual Section 110)
- The RAC determined that the service was MEDICALLY UNNECESSARY for the inpatient setting and issued a repayment request letter for the entire claim. The provider may resubmit the claim for ancillary services that would have been covered had the services been properly provided in an outpatient setting.

Corrective Actions

- Inpatient Rehabilitation Facilities can be more careful when admitting Medicare beneficiaries for inpatient therapy to make sure that the Medicare medical necessity criteria are met.
- Medicare claims processing contractors can remind hospitals about the medical necessity criteria in HCFA Ruling 85-2 and the Medicare Benefit Policy Manual section 110.

Table P3. Wrong Principal Diagnosis (Complex Review, Incorrect Coding)

Claim Facts

- Principal diagnosis on claim did not match the principal diagnosis in the medical record.
- Example: respiratory failure (code 518.81) was listed as the principal diagnosis but the medical record indicates that sepsis (code 038-038.9) was the principal diagnosis.
- The RAC determined that the claim was INCORRECTLY CODED and issued a repayment request letter for the difference between the payment amount for the incorrectly coded services and the amount for the correctly coded services.
- Most common DRGs with this problem:
  - DRG 475 (respiratory system diagoses)
  - DRG 468 (extensive OR procedure unrelated to principal diagnosis)

Corrective Actions

- Hospitals can be more careful when submitting claims for DRG 475 and 468 to ensure that they choose the correct diagnosis to list as principal.
- Medicare claims processing contractors can remind hospitals about the importance of listing the correct principal diagnosis on the claim, especially when billing for DRG 468 and 475.
- Providers and Medicare claims processing contractors can refer to the Federal Register: February 11, 1998 (Volume 63, Number 28) for guidance on the proper coding of nondiagnostic preadmission services.
- Also refer also to the American Hospital Association's definitions of Principal diagnosis and Principal Procedure, found in the ICD-9-CM Official Guidelines for Coding and Reporting.

Table P4. Wrong Diagnosis Code (Complex Review, Incorrect Coding)

Claim Facts

- Hospital reported a principal diagnosis of 03.89 (septicemia)
- Medical record shows diagnosis of urosepsis, not septicemia or sepsis; Blood cultures were negative
- Did not meet the coding guidelines for "septicemia." Changing the diagnosis code to urinary tract infection (UTI) caused the claim to group to a lower DRG
- The RAC determined that the claim was INCORRECTLY CODED and issued a repayment request letter for the difference between the payment amount for the incorrectly coded procedure and the correctly coded procedure.

Corrective Actions

- Hospitals can be more careful when submitting claims for septicemia
- Medicare claims processing contractors can remind hospitals about the importance of listing an accurate principal diagnosis for beneficiaries with a UTI.
- Providers and Medicare claims processing contractors can refer to the Federal Register: February 11, 1998 (Volume 63, Number 28) for guidance on the proper coding of nondiagnostic preadmission services.
- Also refer also to the American Hospital Association's definitions of Principal diagnosis and Principal Procedure, found in the ICD-9-CM Official Guidelines for Coding and Reporting.

Table P5. Neulasta (Automated Review, Medically Unnecessary Services)

Claim Facts

- In the past, the billing code for the drug Neulasta (Pegfilgrastim) indicated that providers should bill 1 unit for each milligram of drug delivered
- Several years ago, CMS changed the definition of the billing code to indicate that providers should bill 1 unit for each vial of drug delivered.
- The hospital billed for 6 units of Neulasta
- The RAC determined that 5 units of service were MEDICALLY UNNECESSARY and issued a repayment request letter for the payment amount for 5 unnecessary vials.

Corrective Actions

- Transmittal 949 clarifies billing for Neulasta. The transmittal can be found at: http://www.cms.hhs.gov/transmittals/downloads/R949CP.pdf.
- Hospitals can be more careful when submitting claims for Neulasta. Hospitals can program their billing computers carefully when CMS changes the definition of a code.
- Medicare claims processing contractors can remind hospitals about the importance of listing the accurate number of "units of service" on a claim, especially when changes to the code definition occur.

Table P6. Colonoscopy (Automated Review, Medically Unnecessary Services)

Claim Facts

- The hospital billed for multiple colonoscopies (45355, 45378, 45380, 45383, 45384, 45385) for the same beneficiary the same day.
- Beneficiaries never need more than one colonoscopy per day.
- The RAC determined that the excessive services were MEDICALLY UNNECESSARY and issued a repayment request letter for the payment amount for the unnecessary services.

Corrective Actions

- Hospitals can be more careful when submitting claims for colonoscopies (45355, 45378, 45380, 45383, 45384, 45385) to ensure they do not bill for more than one per day per beneficiary.
- Medicare claims processing contractors can remind hospitals about the importance of listing the accurate number of "units of service" on a claim.

Table P7. Outpatient Hospital Speech Therapy (Automated Review, Medically Unnecessary Services)

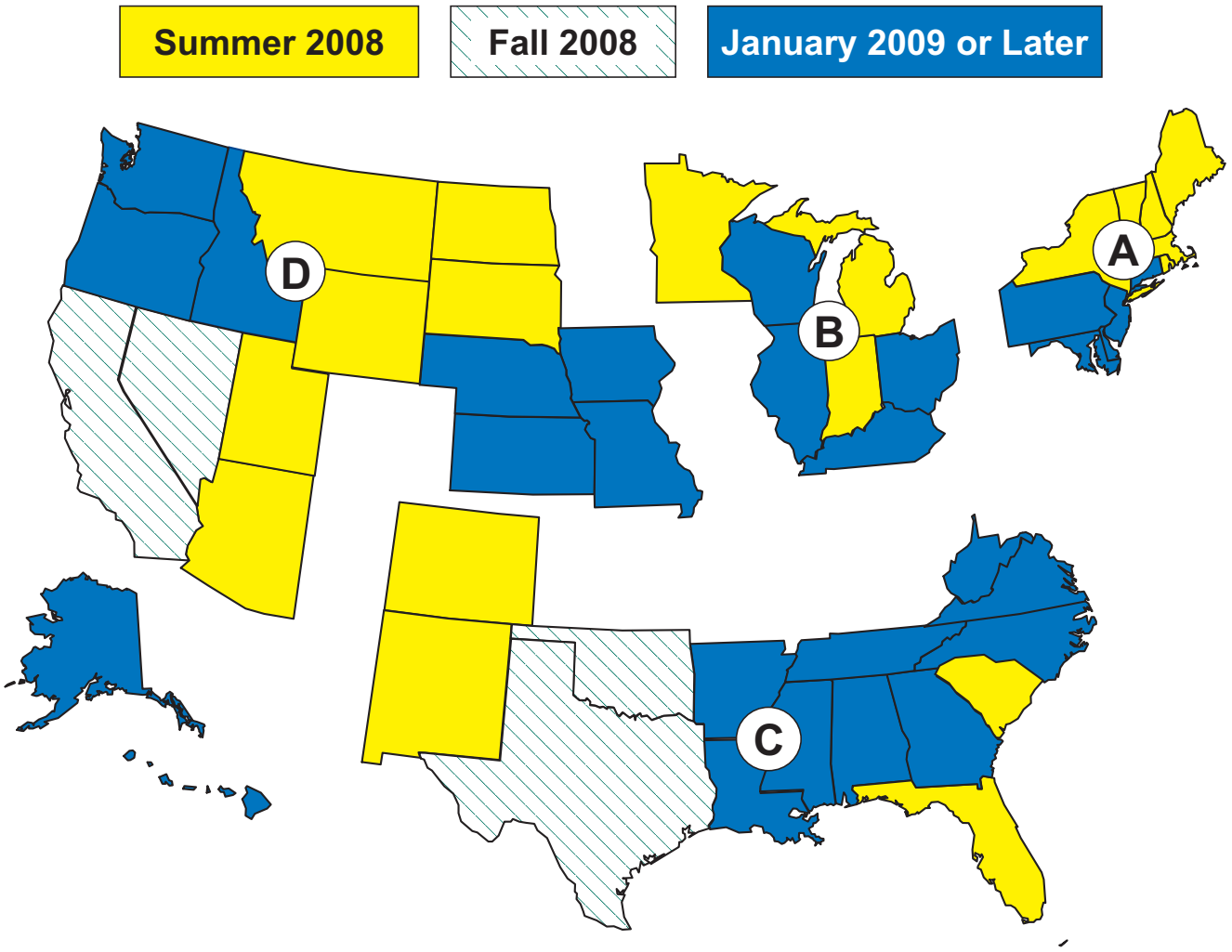
Claim Facts

- The outpatient hospital billed for each 15 minutes of therapy.
- The code definition specifies that the code is per session, not per 15 minutes.
- The units billed exceeded the approved numberof sessions per day.
- The RAC determined that the excessive services billed were MEDICALLY UNNECESSARY and issued a repayment request letter for the payment amount for the unnecessary services.

Corrective Actions

- CMS Claims Processing Manual 100-4, Chapter 5, Section 20.2 clarifies billing for untimed codes. The section be found at: http://www.cms.hhs.gov/manuals/downloads/clm104c05.pdf
- Hospitals can be more careful when submitting claims for therapy services.
- Medicare claims processing contractors can remind hospitals about the importance of listing the accurate number of "units of service" on a claim.

Appendix Q
RAC Expansion Schedule



Appendix R
Key Dates

Table R1. Key Dates

Activity	Date
Congress passes Section 306 of the Medicare Modernization Act requiring the use of RACs	December 2003
CMS announces RAC demonstration	January 2005
CMS releases Requests for Proposals (RFP) for NY, FL, and CA	January 2005
CMS signs contracts for Claim RACs in NY, FL, and CA and MSP RACs in FL and CA	March 28, 2005
RACs begin releasing significant overpayment notifications	January 2006
CMS signs contract for MSP RAC in NY	February 23, 2006
FY 2006 Status Document released	November 16, 2006
Congress passes Section 302 of the Health Care Act of 2006, which requires the RAC program be made permanent and implemented nationally by 2010	December 2006
CMS releases Request for Information and draft Statements of Work for 4 permanent RACs	March 16, 2007
CMS signs contract for demonstration Claim RACs to expand to MA, SC, and AZ	June 2007
RFP for RAC permanent program released	October 19, 2007
Proposals due from bidders wishing to become a permanent RAC	December 17, 2007
FY 2007 Status Document released	February 28, 2008
RAC demonstration ends	March 27, 2008
Release Demonstration Evaluation Report	June 2008 (anticipated)
Award national RAC contracts	TBD
Begin provider outreach in summer 2008 RAC States	TBD

Appendix S
Total Claim Counts

Table S1. Total Claim Counts by Provider Type: Cumulative Through 3/27/08

RAC	Provider Type					All Claims Given to RAC by CMS
	Inpatient Hospital/ Skilled Nursing Facility	Outpatient Hospital	Physician	Ambulance/ Lab/Other	Durable Medical Equipment	
Number of claims						
Connolly	9,448,001	75,848,174	306,148,137	28,346,109	18,296,149	**438,086,570**
HDI	6,595,541	40,272,602	322,008,507	75,020,832	31,616,797	**475,514,279**
PRG	7,018,047	30,321,819	164,230,881	40,556,690	12,211,867	**254,339,304**
All RACs	**23,061,589**	**146,442,595**	**792,387,525**	**143,923,631**	**62,124,813**	**1,167,940,153**
Dollar value of claims						
Connolly	78,560,668,167	15,359,217,915	29,310,787,145	2,121,894,795	2,416,275,452	**127,768,843,473**
HDI	45,118,196,206	9,538,690,860	33,718,039,221	6,747,450,982	4,848,726,851	**99,971,104,120**
PRG	57,720,976,823	7,516,391,317	16,146,066,099	5,612,029,966	2,251,081,856	**89,246,546,061**
All RACs	**181,399,841,195**	**32,414,300,092**	**79,174,892,465**	**14,481,375,743**	**9,516,084,158**	**316,986,493,653**

Source: Self-reported by the RACs.