

Editorial:

Physicians Beware: Medicare RAC Attacks Coming

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Heart attacks, brain attacks, and now RAC attacks. Medicare's recovery audit contractor (RAC) program, the "bounty hunter program," is now a permanent entity.

As the Medicare program is facing \$34 trillion in unfunded liabilities,¹ it is clear that government has promised more in Medicare benefits than taxpayers can afford long-term.

Although physicians currently face a 21 percent cut in Medicare fees in 2010, government is looking to take more money back from physicians via aggressive "bounty hunting" to help slow the financial demise of the Medicare program.

Those physicians who are holding out for a "fix" in the flawed Medicare SGR (sustainable growth rate) payment formula should know that if a "fix" is implemented, it will likely come at the cost of the adoption of a DRG-like system of payment for outpatient encounters (episodes of care). The adoption of a DRG-like system of payment for outpatient encounters will, of course, ensure that patients who present to the physician's office will be given the same type of treatment that patients receive in the hospital under the DRG (diagnosis related group) payment system.

Medicare is a giant Ponzi scheme that, like all such schemes, is destined for collapse. Despite repeated warnings of impending financial collapse by AAPS, the former head of the Government Accountability Office (GAO), the former Secretary of the Department of Health and Human Services, and the chairman of the Federal Reserve, the giant Medicare Ponzi scheme continues, and soon will take on the additional costs of the retiring baby boom generation.

Aggressive RAC attacks are anticipated, and physicians will be targeted for substantial repayments in the coming years.

Legislative History

Section 306 of the Medicare Prescription Drug Improvement and Modernization Act of 2003 authorized a 3-year RAC demonstration project. The demonstration program began in March 2005 and ended on Mar 27, 2008.

Section 302 of the Tax and Health Care Act of 2006 authorized the creation of a permanent RAC program to be expanded to all states by 2010. Legislation provided that payment to private contractors (bounty hunters) be made on a contingent basis for overpayments. However, as provided in Section (1)(B)(ii) of the law, payments to RACs "may be made in such amounts as the Secretary may specify for identifying underpayments...."²

On Oct 6, 2008, CMS awarded contracts to four RACs, each covering four RAC jurisdictions of the country. A map showing the CMS schedule for RAC expansion to all of the states is posted on the CMS website.³ The names and addresses of the four RACs are also posted.⁴ Bounty-hunter contingency fees for 2009 are as follows: Region A—12.45%; Region B—12.50%; Region C—9.0%; Region D—9.49%.⁴

In November 2008, an automatic stay stopped all work for all RACs, pending a determination by the GAO concerning protests filed by two companies that bid unsuccessfully on RAC contracts. Under the Competition and Contracting Act of 1984, the GAO must provide a decision within 100 days—due in early February 2009.⁵

Results of the 3-Year RAC Demonstration

Although purportedly designed to detect improper payments, both overpayments and underpayments, the RAC Demonstration program was heavily biased toward finding only overpayments from the outset. None of the RACs chosen by CMS had any experience in identifying underpayments or any software available to detect underpayments.⁶ Also, although RAC bounty hunters received a contingency fee for detecting overpayments, CMS did not provide any financial incentive for RACs to find underpayments until the spring of 2006.⁶ Thus over the 3-year demonstration period, bounty hunters recovered \$992.7 million in overpayments while finding only \$37.8 million in underpayments. Medicare RACs raked in \$187 million in bounties during the 3-year period, making bounty hunting extremely lucrative for the bounty hunters.²

The initial RAC program was limited to only three states, California, Florida, and New York, all chosen for their high Medicare utilization rates. In the summer of 2007, each RAC jurisdiction was expanded to include an additional state—Massachusetts, South Carolina, and Arizona.

Recovery of overpayments increased over the 3-year period, most dramatically in fiscal year 2007 (see Appendix C in the CMS report)² and in the second quarter of 2008 (see Figure 4, p 17: Overpayments Collected by Quarter: Claim RACs Only).² As the demonstration program focused primarily on hospitals, 85 percent of overpayments collected were from hospitals while only 2 percent were from physicians (see Figure 5, p 19: Overpayments Collected by Provider Type).² The average overpayment amounts recovered for hospitals were \$12,157 per claim and \$483,774 per provider per year, and for physicians, \$140 per claim and \$372 per provider per year (see Appendix I, CMS report).² It is estimated that approximately 50,054 physicians, primarily specialists and physicians in large groups, were audited during the demonstration period.⁷ All physicians in all states will be vulnerable to RAC attacks under the permanent RAC program.

RACs utilize proprietary data-mining software to search claim data for improper payments.² Like Medicare fiscal intermediaries, RACs use two types of reviews—automatic reviews (via data-mining software) and complex reviews (requiring providers to produce medical records for in-depth analysis).

Incorrect coding of pharmaceutical injectables, excessive/multiple units, Neulasta (medically unnecessary), vestibular function testing, and duplicate claims were among the most common reasons found for physician overpayments.²

Over the demonstration period, only 14 percent of RAC determinations were appealed by all providers (Part A and B), and

only 4.6 percent were overturned on appeal.² The appeals rate for physicians varied between 6.3 percent and 22 percent, with an overturn rate between 3.1 percent and 9.6 percent.²

Numerous complaints arose from California physicians during the demonstration period, including complaints of overaggressive recovery efforts by RACs and instances in which some physicians were reportedly forced to make repayments for claims previously adjudicated.⁷ In May 2007, nearly half of the California congressional delegation wrote to CMS to complain about lack of CMS oversight of the RACs.⁷ During the demonstration period, CMS created a RAC Data Warehouse to automate and oversee the RAC program. The Fraud Fighter Program (Program Safeguard Contractors—established in 2006) and law enforcement agencies have full access to the RAC Data Warehouse.²

CMS estimates that the Claims RAC Demonstration cost 20 cents for each dollar collected.² However, as is typical of many administrative cost calculations provided by CMS, the cost borne by the targets of RAC audits was not determined. The CMS evaluation report stated: “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” (p. 14).²

Medicare Advantage Plans (Medicare HMOs), hospice, and home health services were exempt from RAC attacks during the demonstration period, and they will continue to be exempt during the permanent RAC program.

Although contingency fees for bounty hunters were not disclosed to the public during the demonstration period, CMS has disclosed contingency fees for the permanent RAC program and has indicated that the contingency fees apply to detection of both overpayments and underpayments.⁸

Changes Made in Permanent RAC Program

The permanent RAC program will limit the look-back period to 3 years with an earliest look-back date of Oct 1, 2007. RACs will be required to hire a medical director and coding experts. An external validation process is also mandatory. The reason for a review must now be listed on RAC letters requesting medical records for review, and on letters demanding refunds of overpayments (previously RACs could simply demand repayment and were not required to provide a reason).² The number of medical records a RAC can request from physicians is also limited, based on a sliding scale. Medical record request limits (number of records requested per 45 days) for 2009 are as follows: solo physicians (10), groups of two to five physicians (20), groups of six to 15 physicians (30), and groups of more than 16 physicians (50).

Responding to a RAC Attack

Physicians must respond to a RAC’s request for medical records within 45 calendar days of the request. If a physician decides to appeal an adverse RAC determination, the physician has 120 days to file an appeal with the fiscal intermediary that originally processed the Medicare claim. The minimum claim amount that RACs can review is \$10, and RACs can review evaluation and management (E&M) services. Of note, RACs will receive a full contingency fee for overpayments based on extrapolated claims. Physicians also need to be aware that permanent RACs will work in cooperation with Program Safeguard Contractors (Fraud Fighter Program) and the OIG (Office of Inspector General), and recovery of overpayment by a RAC will

not prohibit the U.S. Attorney General from prosecuting a physician for fraud and abuse.

What Can Physicians Expect?

Although hospitals will continue to be a focus for Medicare bounty hunters, as hospitals produce high-dollar Medicare claims, physicians can expect to be increasingly targeted for RAC attacks. Physicians in large groups, specialists, and physicians who perform high-dollar amount surgeries and/or procedures will likely be targeted.

As in the demonstration program, physicians who provide injectable pharmaceuticals in their office will likely continue to be targeted, as will “outliers,” particularly those physicians who have a large volume of higher level E&M codes. Physicians who order a high volume of durable medical equipment, prosthetics, and orthotics (e.g. oxygen, diabetic test strips, motorized wheelchairs/scooters) can expect to receive more letters requesting validation of claims.

It is also likely that as RAC attacks expand, and more data are collected, RACs will figure out a dollar amount such that solo physicians and small groups, which cannot afford anti-RAC attack software and web services (currently being offered to hospitals), will decide not to appeal because the expense of appealing will be more than the requested amount.

Physicians who adopt electronic health records (EHRs) will be facilitating RAC attacks by making more data available for RACs to mine, at low cost, using their proprietary data-mining software. Physicians using EHRs will be in a constant and costly race to upgrade their software so as to comply with ever changing Medicare rules and regulations that make physicians vulnerable to attack.

The end result for physicians will be increasing expense associated with treating Medicare patients in an environment of shrinking payments.

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