Recovery Auditing in Medicare Fee-For-Service

for Fiscal Year 2016

FY 2016 Report to Congress as Required by

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Executive Summary

The Medicare Fee-for-Service (FFS) Recovery Audit Program is authorized under Section 1893(h) of the Social Security Act (the Act). Section 1893(h)(8) requires the Secretary to "annually submit to Congress a report on the use of recovery audit contractors" and that "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…" This report satisfies that requirement for fiscal year 2016 (October 1, 2015 through September 30, 2016).

The mission of the Recovery Audit Program is to identify and correct overpayments made on claims for health care services provided to beneficiaries, to identify underpayments to providers, and to provide information that allows the Centers for Medicare & Medicaid Services (CMS) to implement corrective actions that will prevent future improper payments.

CMS oversees several different Recovery Audit Programs, such as those for Medicare FFS and Medicare Part D. States oversee their own Medicaid Recovery Audit Programs in accordance with federal guidelines set by CMS. This report focuses only on the Medicare FFS Recovery Audit Program. Information on the other Recovery Audit Programs is reported separately in CMS's Annual Report to Congress on the Medicare and Medicaid Integrity Programs.

Medicare FFS Recovery Audit Program

The Medicare FFS program consists of a number of payment systems and uses a network of contractors to process more than one billion claims each year submitted by more than one million healthcare providers, including hospitals; physicians; skilled nursing facilities (SNFs); labs; ambulance companies; and durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) suppliers.[1] These contractors, called Medicare Administrative Contractors (MACs), process claims, make payments to providers in accordance with the Medicare statute and regulations, and review claims and educate providers on how to submit accurately coded claims that meet Medicare requirements.

CMS uses several types of contractors to verify that claims are paid based on Medicare requirements. One type of contractor used is a Recovery Audit Contractor (RAC). A RAC's primary task is to review Medicare claims data and supporting medical documentation to determine if a claim was appropriately paid. Section 1893(h)(3) of the Act required that the Secretary expand the FFS Recovery Audit Program nationwide by January 2010. Prior to this, the Recovery Audit Program operated as a demonstration in six states from March 2005 to March 2008. The national FFS Recovery Audit Program was established in early 2009 after conducting a full and open competition. At that time, four contracts were awarded for four distinct regions. Each RAC is responsible for identifying overpayments and underpayments in a geographically defined area. In addition, the RACs are responsible for identifying common billing errors, trends, and other Medicare payment issues for CMS.

[1] For the purposes of this report, we use the term "provider" to refer to any provider or supplier who bills FFS Medicare.

In Fiscal Year (FY) 2016, Medicare FFS RACs collectively identified and corrected 380,229 claims with improper payments that resulted in $473.92 million in improper payments being corrected. The total corrections identified include $404.46 million in overpayments collected and $69.46 million in underpayments repaid to providers (see Table 1). This represents a 7.5% increase from program corrections in FY 2015, which were $440.69 million.

In FY 2016, the Medicare FFS Recovery Audit Program returned a net of $214.09 million to the Medicare Trust Funds. This represents a 50% increase from returned dollars in FY 2015, which were $141.87 million. These savings take into consideration the costs of the program, including contingency fees, administrative costs, and amounts overturned on appeal. However, these savings do not take into account program costs and administrative expenses incurred at the third and fourth levels of appeal (the Office of Medicare Hearings and Appeals (OMHA) and the Medicare Appeals Council within the Departmental Appeals Board (DAB), respectively), as these components do not receive Recovery Audit Program funding for those appeals.

The results of audits performed by the RACs help CMS to identify program vulnerabilities and take appropriate corrective actions to prevent future improper payments. CMS hosts regular meetings with the RACs, MACs, and CMS staff to discuss best practices, particular vulnerabilities, and future corrective actions, including CMS educational articles, local and national system edits, and additional review by other CMS contractors. CMS continues to analyze the results of the Recovery Audit Program to determine what corrective actions can be implemented to help reduce improper payments in the future.

CMS continues to make improvements to the Recovery Audit Program to help reduce provider burden, verify the accuracy of RAC determinations, and promote transparency within the program. All RACs have increased their use of the Electronic Submission of Medical Documentation (esMD) system to facilitate the electronic transmission of medical documentation and help eliminate the costly and time-consuming need for providers to mail paper records for medical review. CMS is increasing collaboration between the RACs and the MACs on many program elements, such as data sharing and reporting, policy and coverage interpretation, appeals, and general operational issues and improvements. CMS is continuing to make improvements to the RAC Data Warehouse, the repository for all RAC review activity, and currently requires RACs and other review contractors to use the Data Warehouse to prevent another review contractor from selecting a previously reviewed claim. The RAC Data Warehouse has been successful in preventing duplicate reviews of the same claim among all of CMS's review contractors.

In FY 2016, CMS also worked with the RACs to encourage further involvement in the appeals process, specifically at the Administrative Law Judge (ALJ) level of appeal, which is administered by OMHA.[2] RAC involvement in ALJ appeals aids in contractor and provider education because it presents a forum for discussion, assists in identifying erroneous billing practices for providers, and assists in identifying policies that may need clarification. The RACs, in turn, gain a greater understanding of ALJ decision making and what sorts of determinations are likely to be either upheld or overturned on appeal, increasing

[2] The new RAC contracts, awarded on October 31, 2016, require RACs to take party status in a minimum of 50% of cases at the ALJ level of appeal and to participate in a minimum of 50% of the remaining cases. In addition, HHS published a final rule in January 2017 that limits how many CMS contractors can elect party status for a hearing; however, this does not change this RAC contract requirement.

the future accuracy of claim determinations. The RACs are involved in appeals meetings between other CMS review entities, such as MACs and Zone Program Integrity Contractors (ZPICs), and CMS appeals contractors, such as the Qualified Independent Contractors (QICs) and the Administrative QIC (AdQIC), to discuss trends in appeals and best practices for drafting position papers for use at ALJ hearings.

Introduction

Background

Faced with increasing national health expenditures and a growing beneficiary population, the importance and challenges of safeguarding the Medicare program are greater than ever.

CMS uses a comprehensive strategy to prevent and reduce improper payments. Each year, CMS publishes a national improper payment rate for Medicare FFS, Part C, Part D, Medicaid, and the Children's Health Insurance Program (CHIP) in accordance with the *Improper Payments Information Act of 2002 (IPIA)*, as amended by the *Improper Payments Elimination and Recovery Act of 2010 (IPERA)* and the *Improper Payments Elimination and Recovery Improvement Act of 2012 (IPERIA)*.[3]

As part of its efforts under the IPIA, CMS implemented the Comprehensive Error Rate Testing (CERT) program to measure improper payments in the Medicare FFS program. Among other data sources, CMS uses the CERT program's results to direct future work by the Medicare FFS Recovery Audit Program and the MACs.[4] The MACs process claims, make payments to providers in accordance with Medicare requirements, and review claims and educate providers on how to submit accurately coded claims that meet Medicare guidelines. In addition, each MAC is required to complete an Improper Payment Reduction Strategy (IPRS) that includes jurisdictional-level strategies to reduce improper payments. These plans include the standard additional review and clarification of local and national policies, as well as new and innovative ideas for reducing improper payments. Additional provider education, widespread or targeted, is included, as well as clarifications and modifications to local coverage policies. These plans have proven to be successful in helping to reduce each MAC's improper payment rate.

The ZPICs take a variety of actions to detect and deter fraud, waste, and abuse in the Medicare program, which include conducting interviews and site visits, implementing appropriate administrative actions (e.g., prepayment edits, payment suspensions, revocations), and performing program integrity reviews of medical records and documentation. While the MACs and other contractors also perform medical review to make coverage or coding determinations, ZPICs perform program integrity-directed medical review with a focus specifically toward fraud detection and investigation. The ZPICs look for possible falsification of documents that may lead to identification of provider or supplier overpayments. While several Medicare contractors are responsible for reviewing Medicare claims, CMS has processes in place to make sure the work is collaborative and not duplicative.

The RAC Data Warehouse was developed to serve as the primary source of data for the Medicare FFS Recovery Audit Program. CMS uses the Data Warehouse to prevent RACs and other review entities from reviewing claims that were previously subjected to medical record review by another review entity, such as a MAC, or that are currently under review by law enforcement. All review contractors are instructed to upload the claims they are reviewing into the Data Warehouse. Contractors are then instructed to check the Data Warehouse for any existing activity on the claims under consideration for review prior to beginning those reviews. A claim that has been reviewed by one contractor is not available to another

[3] Additional information about the Medicare FFS improper payment rate can be found at go.cms.gov/CERT
[4] Effects of RAC reviews may not be immediately realized in the Medicare FFS improper payment rate, due to differences in the RAC look-back period and the CERT reporting period.

contractor for review, absent potential fraud. CMS is continuously working to improve the collaboration between review contractors to promote accurate and efficient reviews of Medicare claims, while reducing provider burden and ensuring beneficiary access to health care services.[5]

Improper Payments in Medicare

Claims submitted to Medicare are screened by thousands of system edits prior to payment. However, given the volume of claims submitted to Medicare on a daily basis, CMS is not able to perform medical review for every claim prior to payment. Instead, CMS must rely on both prepayment review (after receipt of the claim but before payment) and post-payment review (after receipt and payment of the claim) of a subset of submitted claims. Overall, CMS manually reviews less than 0.3 percent of submitted claims each year through auditing programs, including those claims reviewed under the Recovery Audit Program, to identify and correct improper payments.

The most common reasons for improper payments are the following[6]:

- Payment is made for services where the documentation submitted does not support the ordered service,
- Payment is made for services that do not meet Medicare's coverage and medical necessity criteria, or
- Payment is made for services that are incorrectly coded.

It is important to note that while all payments made as a result of fraud are considered "improper payments," not all improper payments constitute fraud.

Statutory Authority for RACs

The Medicare FFS Recovery Audit Program began as a demonstration required in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003.[7] The demonstration was conducted from March 2005 to March 2008 in six states to determine if RACs could effectively be used to identify improper payments for claims paid under Medicare Part A and B. This demonstration allowed for additional review of Medicare claims by utilizing RACs on a contingency fee basis to identify and investigate claims with calculated risk.

> *The Recovery Audit Program demonstration established RACs as a successful tool in the identification and prevention of improper Medicare payments.*

Section 1893(h) of the Act, which authorized the Medicare FFS Recovery Audit Program expansion nationwide by January 2010, requires an annual Report to Congress, including information on the

[5] CMS is currently working towards implementing the Unified Case Management system for all review contractors including the RACs, which will serve as a central repository of review contractor medical review data.
[6] Additional information on improper payment findings can be found starting on Pg. 191 of the HHS Agency Financial Report (AFR) at: https://www.hhs.gov/sites/default/files/fy-2016-hhs-agency-financial-report.pdf
[7] For more information on the Recovery Audit Program demonstration, see the Recovery Audit Program website section on "Historical Programs"

performance of such contractors on identifying underpayments and overpayments and recouping overpayments, and an evaluation of the comparative performance of such contractors and savings to the program. This report satisfies that requirement.

The Use of RACs

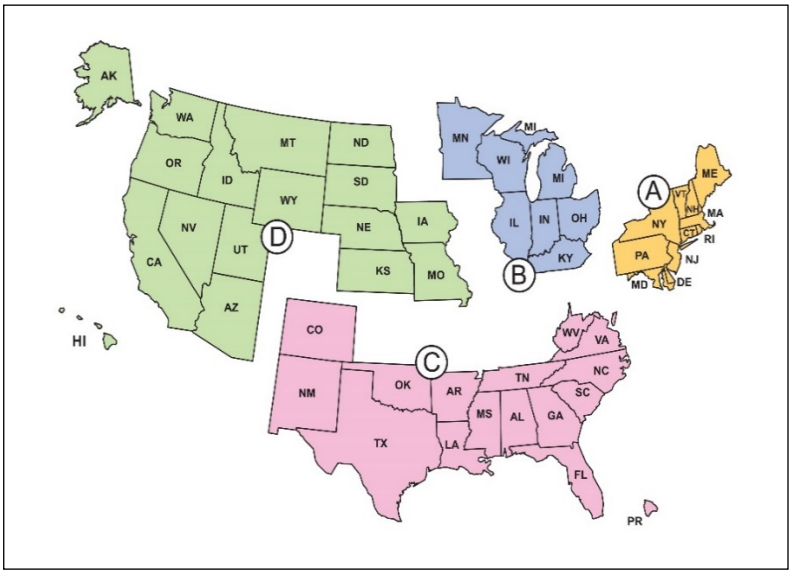
The Recovery Audit Program is an important component in CMS's multifaceted strategy to reduce improper payments and pay claims accurately. CMS established the Recovery Audit Program in early 2009 and fully implemented the program by September 2010. Each RAC is responsible for identifying overpayments and underpayments in a geographically defined area. In addition, the RACs are responsible for identifying for CMS common billing errors, trends, and other Medicare payment issues. RACs are unique and distinct from other contractors due to their ability to conduct widespread post-payment review on a contingency fee basis.

The RACs in each region in FY 2016 were:

- Region A: Performant Recovery
- Region B: CGI
- Region C: Cotiviti
- Region D: HealthDataInsights (HDI)

Figure 1 depicts each of the four Recovery Audit Program regions in FY2016.

Figure 1



How RACs are Paid

As required by Section 1893(h) of the Act, RACs are paid on a contingency fee basis. The amount of the contingency fee is a percentage of the improper payment recovered from, or reimbursed to, providers. The RACs negotiate their contingency fees at the time of the contract award. The base contingency fees range from 10.4 - 14.4 percent for all claim types, except DME. The contingency fees for DME claims

range from 15.4 – 18.9 percent. The RAC must return the contingency fee if an improper payment determination is overturned at any level of appeal.

Recovery Audit Review Process

The RACs review Medicare FFS claims on a postpayment basis using the same Medicare policies and regulations as other Medicare contractors. CMS limits the claims eligible for RAC review to those that were paid within the past three years.[8] The RAC improper payment correction process is similar to that used by other Medicare contractors and is as follows:

Review

RACs follow three review processes to identify improper payments: automated, semi-automated, and complex.

- **Automated**: These reviews use claims data analysis to identify improper payments.
- **Semi-Automated**: Similar to automated, these reviews are initiated with data analysis; however, providers may submit supporting documentation to substantiate the claim.
- **Complex**: These reviews require a review of the supporting medical records to determine whether there is an improper payment. The reviewer must be a qualified health care coder or clinician based on the type of review being undertaken.

Notification

After the RACs identify an improper payment, the RACs then notify the provider of the overpayment or underpayment. For automated and semi-automated reviews, the RACs send informational letters that describe the rationale for the improper payment determination. For claims that underwent a complex review, RACs are required to send review results letters with more detailed rationales, indicating the specific reason for the improper payment determination. Review results letters also include references to applicable polices and information within the medical documents to inform providers about how to avoid similar payment errors in future Medicare billing practices.

After notification of an improper payment, providers may request a discussion with the RACs regarding their claim determinations. As part of the contract modification signed by all RACs in early FY 2016, CMS required the RACs to wait 30 days before sending the claim to the MAC for adjustment to allow for a discussion request.[9]

> *The discussion period offers providers the opportunity to submit additional documentation to substantiate their claims and allows the RACs to review the additional information without the provider having to file an appeal.*

If the RAC reverses its claim determination, it will stop the claim from being adjusted or work with the MAC to reverse the adjustment if it has already occurred. However, providers may not simultaneously

[8] RAC program enhancements implemented in December 2015 limit the look-back period for patient status reviews to 6 months so long as the claim was submitted within 3 months of the date of service.
[9] This requirement is also included in the new RAC contracts that were awarded in FY 2017.

initiate a discussion and an appeal. The RACs will stop the discussion period if they are notified of a pending appeal.

In the case of an underpayment, the provider is notified via a letter describing the underpayment and the payment process. In the case of an overpayment, the provider receives a demand letter requesting repayment of the specific amount. The demand letter includes the accompanying rationale for the determination and instructs providers on the repayment and appeal processes, which initially flow from the remittance advice. The MACs have full responsibility of issuing demand letters related to RAC-initiated overpayments. This streamlines all adjustment correspondence and activities to enhance the timeliness of demand notifications.

Collection and Repayment

The MACs are responsible for the collection efforts of overpayments and payment of underpayments identified by the RACs. The recoupment of an overpayment may be offset against future payments from CMS if payment is not received within the specified timeframe. The provider may also apply for an extended repayment schedule. Typically, recoupment from future payments begins 41 days after the adjustment/date of the demand letter. In the event a valid appeal is received, recoupment is delayed during the first two levels of appeal.

Appeals

Providers who disagree with a RAC's improper payment determination may utilize the multilevel administrative appeals process under Section 1869 of the Act. Recovery Audit Program appeals follow the same appeal process as other Medicare claim determinations. The levels of appeal for FY 2016 are described below.[10]

Redetermination:

Performed by MACs, the request for redetermination must be received by the MAC within 120 calendar days of the date a party receives the initial (or revised initial) determination, and written notice of the redetermination is generally expected to be mailed or otherwise transmitted by the MAC within 60 calendar days of receipt of the request for redetermination.

Reconsideration:

Performed by Qualified Independent Contractors (QICs), the request for reconsideration must be filed with the QIC within 180 calendar days of the date the party receives the Medicare Redetermination Notice. The QICs generally are expected to mail or otherwise transmit notice of the reconsideration within 60 calendar days of receipt of the request for reconsideration. If a QIC reconsideration is not issued within the applicable adjudication period, the appellant may choose to escalate the appeal to the ALJ if certain conditions are met.

[10] Appeals regulations were revised effective March 20, 2017 and the procedures may differ in some respects from those effective in FY 2016.

Administrative Law Judge (ALJ):

ALJ hearings require a minimum amount in controversy ($150 for Calendar Year (CY) 2016), and a request for a hearing must be filed within 60 calendar days of the date the party receives the reconsideration notice. Generally, ALJs are expected to issue a decision, dismissal order, or remand to the QIC within 90 calendar days of the date the request for hearing is received. If an ALJ decision is not issued within the applicable adjudication period, the appellant may choose to escalate that appeal to the Medicare Appeals Council if certain conditions are met. Due to an overwhelming number of hearing requests, OMHA has not been able to meet the 90-day time-frame for adjudication in some cases, resulting in a backlog of pending appeals at OMHA.[11]

Medicare Appeals Council within the DAB (the Appeals Council):

A request for review by the Appeals Council must be filed within 60 calendar days after receipt of the ALJ decision or dismissal, and the Appeals Council generally is expected to issue a decision, dismissal order, or remand order to the ALJ within 90 calendar days of receipt of the request for review. If an Appeals Council decision is not issued within the applicable adjudication period, the appellant may choose to escalate the appeal to Federal district court if certain conditions are met. Due to an overwhelming number of Council review requests, the Council has not been able to meet the 90-day timeframe for adjudication in some cases, resulting in a backlog of pending appeals at the Council. There is no minimum amount in controversy at this level.[12]

Judicial Review (Federal District Court Review):

Appeals to Federal district court must be filed within 60 calendar days of the date a party receives notice of the Appeals Council's decision, but the federal court does not have a deadline to issue its decisions. For CY 2016, the minimum amount in controversy was $1,500.

[11] See the website for the Office of Medicare Hearings and Appeals for more information.
[12] Appeals must still meet the AIC at OMHA in order to reach the DAB.

Procurement

CMS released revised Requests for Proposals (RFPs) on November 6, 2015. The revised SOW contained many of the Recovery Audit Program enhancements CMS announced in December 2014 and updated in November 2015.[13] So as not to further delay the implementation of these important program enhancements, CMS included several of the enhancements in the contract modifications extending the RACs' active recovery auditing work through July 31, 2016. These included reducing the complex review timeframe from 60 days to 30 days; implementing a 30-day discussion period before sending a claim to the MAC for adjustment; requiring additional information to be included in the RACs' provider portals; and requiring the review of all claim and provider types, as well as certain topics upon CMS referral.

On October 31, 2016, CMS awarded the next round of Medicare FFSRAC contracts to:

Region 1 – Performant Recovery, Inc.

Region 2 – Cotiviti, LLC

Region 3 – Cotiviti, LLC

Region 4 – HMS Federal Solutions

Region 5 – Performant Recovery, Inc.

The RACs in Regions 1-4 will perform postpayment review to identify and correct Medicare claims that contain improper payments (overpayments or underpayments) that were made under Part A and Part B, for all provider types other than DMEPOS and Home Health/Hospice. The Region 5 RAC will be dedicated to the postpayment review of DMEPOS and Home Health/Hospice claims nationally. These awards continue the implementation of many of the Recovery Audit Program enhancements designed to reduce provider burden, enhance program oversight, and increase transparency in the program.

[13] https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Recovery-Audit-Program/Downloads/Recovery-Audit-Program-Enhancements11-6-15-Update-.pdf.

Key Program Components

CMS has identified five key factors for measuring the success of the Recovery Audit Program: increasing accuracy, implementing effective and efficient program operations, maximizing transparency, minimizing provider burden, and developing robust provider education. In addition, communication with key stakeholders is essential to the program's success, as it seeks to identify problems and develop solutions early and to discuss those issues with all parties.

Increasing Accuracy

CMS has implemented several elements to verify RAC accuracy in identifying improper payments.

> *All new review topics for potential audits are approved by CMS before the RACs begin widespread review.*

This occurs through a CMS Recovery Audit Review Plan Team that is comprised of CMS policy and coverage staff and clinicians. This allows the appropriate CMS personnel to approve what the RACs are reviewing (including all automated, semi-automated, and complex reviews), and ensures that the RACs have the correct interpretation of the policies used in their audit methodologies. During these team meetings, coverage and policy experts review whether the RACs proposed review approach is consistent with current guidelines. These discussions sometimes reveal that certain guidelines may be outdated or no longer clinically appropriate and may lead to CMS updating certain coverage or billing guidelines to align with more current practices. One example of updated guidelines from previously identified vulnerabilities are those related to inpatient hospital patient status reviews. In 2013, Final Rule 1599-F clarified and modified CMS's policy regarding when inpatient hospital admissions are payable under Medicare Part A. These discussions can also help CMS identify system edits to install to prevent improperly billed claims from being paid in the first place. More recently, CMS implemented a systems change to better identify DMEPOS claims that overlap with a Part A hospital stay.

RACs are required to have at least one full time Contractor Medical Director (CMD) on staff and to arrange for an alternate when the CMD will be unavailable for extended periods. The use of CMDs has proven to be a valuable addition to the program, as they provide clinical expertise during, and oversight of, the medical review process. The CMD is required to be involved in the overall processes of medical review and quality assurance to make sure that policies are being followed and accurate review decisions are being made. The CMD participates in policy discussions with CMS and other Medicare contractors and offers corrective actions to address the improper payment findings. These physicians also engage in frequent discussions with providers, which allows for greater education. Several RACs have added additional full-time or part-time CMDs to provide greater clinical guidance and assistance to staff, providers, and CMS. RACs also sometimes utilize additional clinical resources that are not dedicated to the Recovery Audit Program.

To verify the accuracy of each RAC's claim determinations, CMS uses an independent validation contractor to review a monthly random sample of claims on which a RAC has made an improper payment determination.

The Recovery Audit Validation Contractor (RVC) establishes an annual accuracy score for each RAC. The RVC employs policy experts and clinicians, and presents CMS with an independent decision regarding the sample. The accuracy score represents how often the RACs were accurately determining overpayments or underpayments based on the RVC's review.

In FY 2016, each RAC had an overall accuracy score of 91 *percent or higher for claims adjusted from August 2015 through July 2016.*

The RVC is also tasked with conducting special studies of RAC findings. In FY 2016, the RVC performed 3 special studies on claims reviewed by the RACs. CMS uses these studies to further focus on certain claim types and audit areas that may require more analysis. Including both the accuracy and special study reviews, the RVC reviewed 4,767 claims as part of its oversight activities. CMS uses the results from the RVC in its assessment of each RAC's performance. The accuracy rates and special study results are part of each RAC's Contractor Performance Assessment Rating System (CPARS) overall performance rating for the year. These results are available to all federal agencies and are included in each RAC's performance evaluations, which are used in subsequent contract award considerations. Poor performance may result in negative performance evaluations and a possible termination of the RAC's work.

Implementing Effective and Efficient Program Operations

CMS works to make the Recovery Audit Program as efficient and effective as possible by minimizing provider impact and administrative cost.

One of the keys to improving efficiencies is continued communication among all stakeholders. CMS provides several opportunities for discussion among contractors to address operational issues and concerns that may impede program efficiency. CMS continues to support these communication opportunities and hosts regularly scheduled conference calls for the RACs and MACs to discuss ongoing issues. Increased contractor relations have resulted in more streamlined claim processing, changes in the operational process to allow for more efficient communications, and contractor sharing of identified program vulnerabilities for potential review.

CMS also continues to improve the RAC Data Warehouse to track greater audit detail and information.

The Data Warehouse was developed to serve as the primary source of data for the Medicare FFS Recovery Audit Program and was initially designed to prevent RACs and other review contractors from reviewing claims that were previously subjected to medical record review by another review entity, such as a MAC, or that are currently under review by law enforcement. CMS has implemented several systems changes to allow for more reporting of MAC and ZPIC reviews, including both prepayment and postpayment data.

CMS requires other review contractors to check the Data Warehouse to avoid selecting a previously reviewed claim for further review. CMS is planning future changes to continuously improve our ability to prevent review of the same provider or same issue by two different review contractors at the same time.

CMS continues to improve the Data Warehouse functionalities to allow more data collection and data storage, and to automate the process of data collection as much as possible. CMS and the Data Warehouse users also engage in regular communication dedicated to Data Warehouse operational issues.

CMS is continuing to use the esMD program to allow providers to electronically submit documentation. In an increasingly electronic medical record environment, this eliminates the costly and time-consuming need for providers to mail hard-copy records for contractor review. In FY 2016, all RACs continued to be voluntary participants in the esMD program.

Maximizing Transparency

In order to promote transparency, CMS posts improper payment corrections information, including overpayments and underpayments, on a quarterly basis on its website.[14] CMS also posts the RAC statement of work and educational articles aimed at preventing future improper payments. The individual RAC websites contain all of the topics approved for review, called "issues," with search functions to improve the ease of provider navigation.

RACs are required to use web portals to allow providers to review claim status information and track the progress of their audits. RACs have expanded their use of the portals to include demand letter information and review rationales for their improper payment determinations. Some RACs also use the portal to deliver messages to the provider communities in their region about specific audits, such as details about an audit that may have been stopped, discussion period instructions, and other information that may be helpful to providers as they respond to a request for additional documentation. As part of the contract modification signed by all RACs in early FY 2016, CMS required the RACs to include additional statuses on their provider portals, including dates associated with reviews, as well as appeal levels and outcomes.

CMS meets regularly with national, state, and local provider and supplier associations, as well as other interested stakeholders, to discuss operational concerns about the Recovery Audit Program. New ideas and improvements are often discussed at these meetings, and CMS values the input of the associations and the providers on the aspects of the program.

Minimizing Provider Burden

CMS is sensitive to the concerns of the provider and supplier communities and continues to work with these communities to reduce the burden of the review process. CMS has imposed additional documentation request limits on the number of medical records a RAC may request in a 45-day timeframe. CMS has amended the limits so that requests must be spread across several different provider types, as opposed to requesting only one type of record for a practice/facility. In November 2015, CMS refined the Additional Document Request (ADR) limits to be proportional to all types of bills for which a facility is paid, and adjustable based on a provider's compliance with Medicare rules. These revised limits were effective in January 2016. The limits established continuity and helped providers prepare for potential audits, as well as encouraged the RACs to select only those claims with the highest risk of

[14] This information is posted at go.cms.gov/RAC under the "Recent Updates" download section.

improper payment. CMS continues to analyze provider billing data in an effort to further refine the calculation of the ADR limits.

As previously discussed, all RACs accept esMD submissions to minimize provider and supplier burden associated with medical documentation requests. The acceptance of esMD helps minimize the time necessary to respond to RAC requests and offers another alternative for providers to safely and quickly transport the documentation.

Each RAC has a customer service center with representatives available to address provider concerns. They are required to have a quality assurance program to verify that all customers receive professional and knowledgeable assistance with timely follow-up when necessary. Personnel are required to return telephone calls within 1 day, respond to electronic inquiries within 2 days, and respond to written requests within 30 days. The RACs are also available to address any Recovery Audit Program questions dealing with claim adjustments, recoupment, and appeals.

In addition to efforts in the Recovery Audit Program, CMS works across the agency to minimize provider burden. These efforts include ensuring that claims reviewed by one entity are not reviewed by another contractor again, unless there is a concern of potential fraud. CMS has implemented a standardized documentation request letter for review contractors to use. CMS works to prevent multiple review entities, such as RACs, MACs, and ZPICs from reviewing the same providers and the same topics at the same time.

CMS is exploring additional options to help providers navigate through the audit process. Initiatives include enhancing CMS websites with consolidated contractor information, standardizing medical review timeframes, and standardizing results letters to providers.

CMS understands that additional staffing is often required to address RAC requests and is constantly working to improve processes to allow providers to respond to requests without increasing administrative burden or having a negative impact on beneficiary care.

Developing Robust Provider Education

The Recovery Audit Program identifies areas for potential improper payments and offers an opportunity to provide feedback to providers on future improper payment prevention. CMS encourages collaboration between RACs and MACs to discuss improvements, areas for possible review, and corrective actions that could prevent improper payments. Educational efforts include articles or bulletins providing narrative descriptions of the claim errors identified and suggestions for their prevention, as well as information regarding system edits for errors that can be automatically prevented at the onset. These efforts are described more in the Corrective Action section of this report.

In addition, CMS has partnered with state and national hospital associations to provide periodic updates via conferences, webinars, and teleconferences. These forums serve as an opportunity for CMS to gain the insight of the provider community, as well as provide feedback from the program to providers.

FY 2016 Results

Performance of the RACs

In FY 2016, the RACs identified and corrected $473.92 million in improper payments. There were $404.46 million collected in overpayments and $69.46 million in identified underpayments paid back to providers (see Table 1). This represents a 7.5% increase from program corrections in FY 2015, which were $440.69 million.

Table 1

Table 1: CORRECTIONS BY RAC

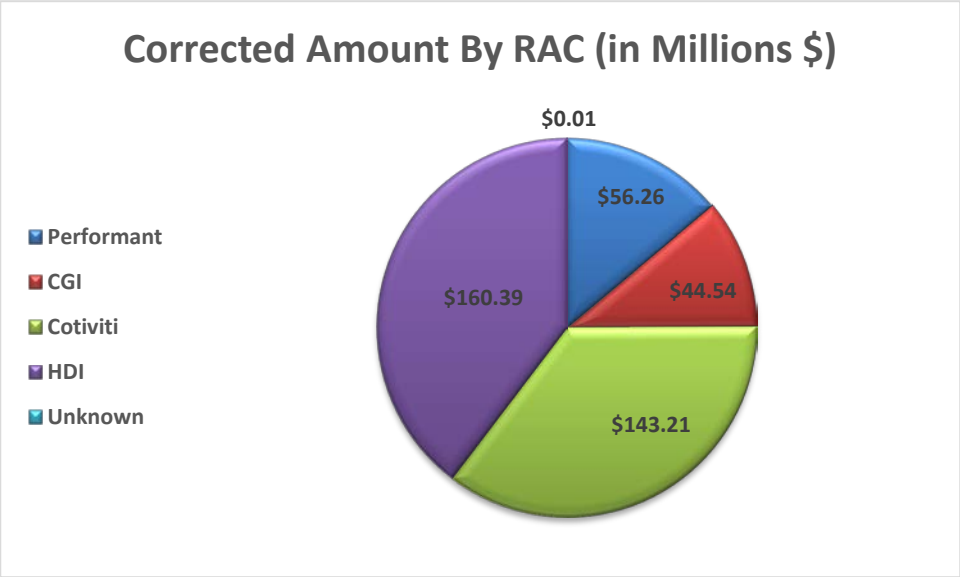
	Overpayments Collected		Underpayments Restored		Total Corrected	
RAC	**No. of Claims**	**Amount Collected**	**No. of Claims**	**Amount Restored**	**No. of Claims**	**Amount Corrected**
Performant	72,681	$56,259,974.80	6,258	$9,582,298.15	78,939	$65,842,272.95
CGI	63,866	$44,544,053.62	1,096	$3,402,728.33	64,962	$47,946,781.95
Cotiviti	69,385	$143,213,553.28	25,781	$38,461,475.66	95,166	$181,675,028.94
HDI	134,099	$160,389,190.28	6,492	$18,007,417.08	140,591	$178,396,607.36
Unknown[15]	565	$56,657.91	6	$5,606.16	571	$62,264.07
Total	***340,596***	***$404,463,429.89***	***39,633***	***$69,459,525.38***	***380,229***	***$473,922,955.27***

Evaluation of the Comparative Performance of the RAC's

The Region C RAC, Cotiviti, corrected the largest dollar amounts of overpayments and restored the largest dollar amount of underpayments. Cotiviti corrected 42% of the total amount of improper payments for the Recovery Audit Program with $181.7 million in total corrections (see Figure 2). HDI, the Region D RAC, corrected $178.4 million. The Region A RAC, Performant, corrected $65.8 million. The Region B RAC, CGI, corrected $47.9 million.

[15] Due to changing MAC workload numbers, these claims could not be attributed to a specific RAC in the Data Warehouse. No RAC has been paid contingency fees for the correction of these claims.

Figure 2



Savings to the Medicare Program

The Recovery Audit Program returned a net $214.09 million (see Table 2) to the Medicare Trust Funds in FY 2016 after taking into consideration the costs of administering the Recovery Audit Program within CMS, underpayments paid to providers, contingency fees, and appeal reversals. From the $404.46 million in overpayment collections, CMS spent $59.94 million to operate the Recovery Audit Program, of which $39.12 million were contingency fees paid to RACs and $20.82 million were administrative. Administrative costs include processing appeals at the first two levels, adjusting claims, support contractors, and oversight of the program. These amounts do not take into account costs incurred at the third and fourth levels of appeal (Office of Medicare Hearings and Appeals (OMHA) and the Medicare Appeals Council within the Departmental Appeals Board (DAB), respectively), as these components do not receive Recovery Audit Program funding for those appeals.

Table 2

Amount Returned to the Medicare Trust Funds (in Millions)

Over-payments Collected	-	Under-payments Restored	-	Amount Over-turned on Appeal	-	RAC Contingency Fees	-	CMS Administration Costs	=	Amount Returned to Medicare Trust Funds
$404.46	-	***$69.46***	-	***$60.97***	-	***$39.12***	-	***$20.82***	=	***$214.09***

Note: CMS administration costs include adjusting claims, processing appeals, supporting contractors, and CMS full time equivalents.

This equates to a Return on Investment (ROI) of $4.57:1. The ROI for FY 2015 was $2.48:1. The Recovery Audit Program ROI is calculated as the savings from Recovery Audit Program activities divided by the costs of Recovery Audit Program activities. Savings are defined as overpayments collected minus underpayments paid out to providers and minus overpayments overturned on appeal. Costs are defined as contingency fees paid to RACs plus CMS administrative costs. Savings and costs are calculated based on the time period in which funds were recovered or expended, not based on when actions like overpayments, underpayments, and appeals were identified.

Compared to overall FFS expenditures, the amount collected by RACs is relatively small. RACs collected less than 1 percent of the over $41 billion in improper payments identified by CERT in FY 2016 and less than 0.1 percent of the over $374 billion that Medicare paid in benefits in FY 2016.

CMS believes that these collections have additional industry impacts.

Additional Analysis

RACs did not perform any patient status reviews on inpatient hospital claims with dates of admission in FY 2016; however, 63 percent of overpayments collected (more than $278 million) continued to come from inpatient hospital claims, including coding validation reviews.

The RACs performed more automated reviews (over 63 percent) than complex reviews and semi-automated reviews, but the vast majority of the improper payments collected came from complex reviews (over 85 percent).

Additional results and analysis of Recovery Audit Program data can be found in our companion Appendices document. These Appendices are released as a separate document for FY 2016 and are available for download on the Recovery Audit Program website at https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Recovery-Audit-Program.

Appeals

Beneficiaries and providers generally have the right to appeal Medicare coverage or payment determination through Section 1869 of the Act.

CMS strives to lower the appeal rate, which in turn reduces the administrative costs of the program, as well as provider burden.

Throughout the four levels of the administrative appeals process, 135,492 appeal decisions were rendered for claims with overpayments identified by the RACs in FY 2016. Claims may have had initial overpayment determinations made prior to FY 2016. Appealed claims may be counted multiple times if the claim had appeal decisions rendered at multiple levels during FY 2016. For example, if a claim was

appealed to the first level and received a decision in FY 2016, then appealed to the second level and received a decision in FY 2016, both decisions are counted. Of the total appeals decided, 56,724 decisions, or 41.9% percent were overturned with decisions in the provider's favor.

Table 3

Recovery Audit Program Appeal Decisions by Claim Type – All Administrative Levels

Claim Type	Appeal Decisions Made	Appeals Dismissed	Claims Remanded	Appeal Decisions Overturned	% of Appeal Decisions Overturned
Part A	112,194	211,330	365	41,944	37.5%
Part B	21,267	1,994	1	13,873	65.2%
DME	2,279	1,238	0	907	39.8%
Total	***135,492***	***214,562***	***366***	***56,724***	***41.9%***

Determinations are overturned for a variety of reasons including:

- Appeals entities above level two are bound by the Medicare statute, Medicare regulations, National Coverage Determinations (NCDs), and CMS rulings. ALJs are required to provide substantial deference to CMS manuals and Local Coverage Determinations (LCDs) when they are applicable to a particular case, but are not bound by them. By contrast, RACs are required to make their claim decisions based on all CMS policies, including CMS manuals and LCDs. This may create discrepancies between the ALJ decisions and the RAC determinations.[16]
- In many Part B denials, providers can easily correct and resubmit some claims after the overpayment determination. For example, they can add a missing modifier to the claim that makes it payable.
- On appeal, providers often produce additional documentation that was not provided to the RACs at the time they made their original overpayment determination. RACs allow providers multiple attempts to provide documentation supporting their claim prior to issuing a notification letter. However, sometimes a provider only produces documentation after receiving an overpayment determination and subsequently filing an appeal.

The receipt of an appeal and the reversal of a RAC decision do not necessarily mean the RAC was incorrect in its determination regarding the claim as it was billed. Automated and semi-automated reviews are often denied correctly. However, as noted above, the provider can correct billing errors during the appeals process by adding a modifier, correcting the number of units of service, providing additional documentation, or modifying the claim so that it follows CMS policy for payment. In these cases, the RAC was correct in its original determination. CMS believes these corrections should be reported as a

[16] OEI-02-10-00340 - Improvements Are Needed At The Administrative Law Judge Level of Medicare Appeals

separate category and continues to improve data sharing and reporting capabilities between contractors to try to account for these corrections.

CMS has made changes to the review approval process to even further improve the RACs' identifications, as well as the overturn rate of appeals. CMS now requires the MACs to validate the RACs' proposed review methodology and policy interpretations for their particular jurisdictions to minimize incorrect findings. While the review approval process should minimize these occurrences, CMS works quickly to resolve the issues so the provider can avoid the burden of the appeals process when issues do occur.

In FY 2016, RACs continued to increase their participation in ALJ hearings. Appeals involvement by RACs further provides for contractor and provider education, as it presents an additional forum for discussion and clarification of coverage and billing policies, and identification of incorrect billing practices by the provider. Hearing participation also presents an opportunity for the RACs to clarify any policy questions the ALJ(s) may have during the hearing process and helps to identify CMS policies in need of further clarification.

Corrective Actions

The development of corrective actions to prevent and correct improper payments is an agency-wide collaborative effort. Improper payments can occur due to a lack of sufficient documentation, lack of medical necessity, and incorrect coding.

A vulnerability is defined as a claim type or series of related claim types that pose a financial risk to the Medicare FFS program due to the claim type's susceptibility to improper payments. Some payment vulnerabilities can be prevented through national claims processing system edits. These edits can deny a claim or send an electronic message to the MACs to manually review a claim. Providers have the right to appeal a claim that is denied by national claims processing system edits. The MACs also develop edits for their local claim processing systems based on identified improper payments in their jurisdiction. Additionally, CMS developed the National Correct Coding Initiative (NCCI) to promote national correct coding methodologies and to control improper coding that leads to inappropriate payment of Part B claims. The NCCI program consists of Procedure-To-Procedure (PTP) edits[17] and Medically Unlikely Edits (MUEs).[18] All NCCI edits are updated quarterly.

However, not all payment vulnerabilities can be corrected through system edits. Such issues may need to be corrected through provider education, prepayment review, post-payment review, or changes in CMS policy. CMS is also implementing new techniques for preventing and correcting improper payments, such as prior authorization, which requires that all relevant coverage, coding, and clinical documentation requirements be met before the item or service is provided to the beneficiary and before the claim is submitted for payment.

To ensure that the agency is coordinating its approach and focusing resources on the payment vulnerabilities that contribute the most to the improper payment rate, CMS developed the Program Integrity Board. This Board is a cross-agency board that meets regularly to discuss issues contributing to the Medicare FFS improper payment rate. As part of the Program Integrity Board, integrated project teams are created to focus more thoroughly on certain payment vulnerabilities.

As an example, one integrated project team is focused on home health. The home health integrated project team was the first project team created, as a result of the high improper payment rate for home health claims identified in the FY 2014 Medicare FFS improper payment rate. The team recommended courses of action, including policy clarifications, a home health probe and educate process, additional widespread provider education, and consideration of demonstration projects. Additional integrated project teams have been created for therapy, as well as general documentation improvement, which affects many different provider and claim types.

[17] PTP edits prevent inappropriate payment for billing code pairs that should not be reported together by the same provider for the same beneficiary for the same date of service.

[18] MUEs prevent payment for an inappropriate number/quantity of the same service on a single day. An MUE for a Healthcare Common Procedural Coding System (HCPCS)/Current Procedural Terminology (CPT) code is the maximum number of units of service under most circumstances reportable by the same provider for the same beneficiary on the same date of service.

MAC Corrective Actions for RAC-Identified Vulnerabilities

CMS has established a process for MACs to implement corrective actions for program vulnerabilities based on RAC reviews. CMS identifies all areas of review with more than $500,000 in RAC corrections as vulnerabilities. Each quarter, CMS sends all review topics that reach this payment threshold for the first time to the MACs. The MACs then report on any action they have taken to prevent or correct these payment vulnerabilities. Because they have limited resources with which to implement their IPRS, MACs prioritize the areas that are most susceptible to improper payments in their jurisdiction, and this data analysis helps MACs make such a determination. The MACs then focus on those areas that would benefit most from corrective actions, such as local system edits. CMS does not instruct the MACs on which system edits to implement. Payment vulnerabilities based on MAC LCDs require local system edits. These policies are individualized and can differ with each MAC. MACs can also choose to do additional prepayment or post-payment reviews, as well as provider education.

Additional Corrective Actions for Vulnerabilities

CMS works to address RAC-identified vulnerabilities promptly to prevent future improper payments. National system edits are based on national coverage determinations and policies. It is possible that claims processing edits are already in place for some vulnerabilities but need to be re-evaluated for effectiveness, while other edits have been implemented more recently, but the effects of the edit have not yet been realized.

Below is a summary of examples of actions that have been taken to address payment vulnerabilities that were previously identified and that cannot be corrected through system edits:

- CMS implemented the Prior Authorization of Power Mobility Devices (PMDs) Demonstration. Since implementation, CMS has observed a decrease in expenditures for PMDs in the demonstration states and non-demonstration states. Based on claims processed from the inception of the pilot on September 1, 2012 through April 30, 2016, monthly expenditures for the PMD codes included in the demonstration decreased from $12 million in September 2012 to $2.7 million in April 2016 in the original 7 demonstration states; $10 million in September 2012 to $2.3 million in April 2016 in the 12 additional expansion states; and $10 million in September 2012 to $2.9 million in April 2016 in the non-demonstration states. CMS believes many national suppliers have adjusted their billing practices nationwide and are now complying with CMS policies based on their experiences with prior authorization in the demonstration states. To assist providers with submitting prior authorization requests, CMS developed data elements for an Electronic Clinical Template for PMDs. For more information, please visit the PMD Electronic Clinical Template website.

- CMS implemented two models to test whether prior authorization in Medicare FFS helps reduce expenditures, while maintaining or improving access to and quality of care for certain non-emergent services. CMS believes using a prior authorization process will help ensure services are provided in compliance with applicable Medicare coverage, coding, and payment rules before services are rendered and claims are paid.

  - In December 2014, CMS implemented a prior authorization model for repetitive, scheduled non-emergent ambulance transport occurring on or after December 15, 2014 in New Jersey, Pennsylvania, and South Carolina. Pursuant to section 515 of MACRA, CMS expanded the prior authorization model for repetitive, scheduled non-emergent ambulance transports effective January 1, 2016 to five additional states (Delaware, Maryland, North Carolina, Virginia, and West Virginia) and the District of Columbia.
  - CMS implemented a prior authorization model for non-emergent hyperbaric oxygen therapy in Illinois, Michigan, and New Jersey. Providers in Michigan began submitting prior authorization requests on March 1, 2015 for treatments occurring on or after April 13, 2015, and providers in Illinois and New Jersey began submitting prior authorization requests on July 15, 2015 for treatments occurring on or after August 1, 2015.

- CMS contracted with a Supplemental Medical Review Contractor (SMRC) to perform nationwide medical reviews focused on vulnerabilities identified by CMS internal data analysis, the CERT program, professional organizations, and federal oversight agencies, such as the Office of Inspector General (OIG). The purpose of the SMRC is to perform and/or provide support for a variety of tasks aimed at lowering improper payment rates and increasing efficiencies of the medical review functions primarily for the Medicare FFS program. Having a centralized medical review resource that can perform large volume medical review nationally allows for a timely and consistent execution of medical review, activities, and decisions. The SMRC evaluates medical records and related documents to assess compliance with Medicare's coding, coverage, billing and payment requirements and identify claims improperly paid.
- In FY 2016, the SMRC performed post-payment reviews on services provided in skilled nursing and inpatient rehabilitation facilities, physician and chiropractic services, and bone marrow and stem cell transplant procedures. The SMRC selects claims, performs research and/or data analysis, and conducts reviews in a manner that minimizes provider and supplier burden. Reviewing these claims allows recoupment of overpayments that would otherwise represent significant losses to the Medicare Trust Funds. The results of these reviews are used to help CMS improve provider billing accuracy through additional provider education and outreach.

- CMS has issued reports on FFS facility billing practices for 8 facility types in FY 2016. Program for Evaluating Payment Patterns Electronic Reports (PEPPERs) are available for Short-term and Long-term Acute Care Hospitals, Critical Access Hospitals, Inpatient Psychiatric Facilities, Inpatient Rehabilitation Facilities, Hospices, Partial Hospitalization Programs, Skilled Nursing Facilities, and Home Health Agencies. PEPPER is a comparative data report that summarizes a provider's Medicare claims data statistics for target areas often associated with Medicare improper payments due to billing, MS-DRG coding and/or admission necessity issues. Target areas are determined by CMS. PEPPERs can be used to compare data statistics over time to identify changes in billing practices, pinpoint areas in need of auditing and monitoring, identify potential DRG under- or over-coding problems, and identify target areas where length of stay increased. PEPPERs can assist hospitals and

facilities achieve CMS's goal of reducing and preventing improper payments. For more information, please visit the PEPPER website.

- CMS has issued 130,585 Comparative Billing Reports (CBRs) on billing practices in FY 2016. CBRs contain data-driven tables and graphs with an explanation of findings that compare providers' billing and payment patterns to those of their peers located in their state and across the nation. To protect privacy, CMS issues each agency CBR confidentially and provides only summary billing information. No patient or case-specific data is included. CMS believes CBRs are a tool to help providers better understand Medicare billing rules and improve the level of care for patients. The MACs post CBR topics under the review section of their websites.

- CMS has issued 4 Quarterly Provider Compliance Newsletters, providing detailed information on 15 complex review findings identified by the Medicare FFS RACs in FY 2016. CMS has received positive feedback from provider associations regarding the value of these documents and plans to continue their issuance. For more information, these articles are available at the MLN Provider Compliance website.

CMS contractors also post MLN Matters articles to their websites, as well as other educational material relevant to CMS policy and LCDs for their jurisdictions.

For more information, please review national policy guidance at the Medicare Coverage Database.

Continuous Improvement

CMS is committed to working with the RACs, the provider and supplier communities, and other stakeholders to continuously improve the RAC program and refine ongoing operations.

RACs continue to participate, and encourage providers to participate, in the esMD program, which facilitates the paperless transmission of electronic medical records. Provider participation varies across RACs but is as high as 40 percent of all documentation submitted to Performant (Region A).[19]

The esMD program promotes both efficiency and organization, while reducing provider burden and administrative costs.

CMS encourages the RACs and MACs to meet to discuss program issues and potential improvements. CMS hosts regular teleconference meetings with both contractors to address operational issues. RACs also meet regularly with the MACs in their region to discuss issues specific to their operations. In addition, CMS facilitates additional communication on appeals, medical review, policy interpretation, and other areas as needed. By nurturing contractor collaboration, CMS hopes to:

- Promote uniform policy application;
- Limit inaccurate identifications by the RACs based on different interpretations of policies;
- Limit unnecessary appeals to reduce provider burden and costs; and
- Ensure review topics are not being reviewed by more than one Medicare FFS review contractors to further reduce provider and supplier burden.

CMS continues to encourage RACs to expand their review strategies to include different types of providers, including a statement of work (SOW) change that emphasizes the review of claim types with high improper payment rates.

At times, CMS will refer issues of potential improper payments to the RACs for their review. These referrals may come from MACs and ZPICs, or external entities such as the OIG and Government Accountability Office (GAO). These referrals will typically include uniform review rationale and website language, as well as standard claim selection criteria and edit parameters so that all RACs are reviewing the claims consistently. These referrals are optional for the RACs, and should a RAC choose not to accept a particular issue, CMS retains the right to give those claims to a different RAC for review. RACs do receive an increased contingency fee on the OIG referrals that result in improper payment correction.

CMS regularly evaluates the RACs' performance and adherence to the requirements in their SOWs. Staff members go on location to observe medical reviewers, Information Technology systems, and customer service areas. When onsite visits are not possible, CMS conducts desk audits on claims to confirm that all aspects of the review process were completed correctly and accounted for in the Data Warehouse.

[19] This data is self-reported by the RACs.

Regular meetings with MACs, provider groups, and other stakeholders are also monitored for additional contractor oversight. If there are any findings in these evaluations, CMS notifies the RAC and requires a corrective action plan. The results of these regular evaluations are consolidated annually in the CPARS for an overall performance rating for the year. These results are available to all federal agencies. CMS believes that regular contractor oversight is essential to the success of the Recovery Audit Program.

Program Enhancements

In December 2015, CMS implemented several enhancements to the existing RAC contracts. These enhancements reduce provider burden by allowing providers more time for discussions with the RACs and MACs regarding improper payment findings and the ability to submit additional documentation to the RACs without the need to file an appeal. These enhancements include:

- RACs will have 30 days to complete complex reviews and notify providers of their findings, instead of 60 days. This provides more immediate feedback to the provider on the outcome of their reviews. RACs will continue not to receive a contingency fee for those complex reviews that are not completed within the required timeframe.

- RACs must wait 30 days to allow for a discussion request before sending the claim to the MAC for adjustment. Providers will not have to choose between initiating a discussion and an appeal and can be assured that modifications to the improper payment determination will be made prior to the claim being sent for adjustment.

- RACs must confirm receipt of a provider's discussion request or other written correspondence within three business days.

- CMS will work with RACs to enhance their provider portals, including more uniformity and consistency in the claim status section, as well as display reason statement identifiers where available.

- CMS will require the RACs to broaden their review topics to include all claim/provider types, and will be required to review certain topics based on a referral, such as an OIG report.

- In the upcoming RAC contracts, each RAC will be required in to take part status in a minimum of 50% of all appeal cases that reach the ALJ level and will be required to participate in a minimum of 50% of the remaining cases that reach the ALJ level. This required level of involvement in the appeals process will foster more consistent communications between the RACs and the ALJs.