The Medicare Recovery Audit Contractor (RAC) Program:

Update

to the Evaluation of the

3-Year Demonstration

June 2010

Purpose

The purpose of this report is to update information reported in the Evaluation report released in July 2008, which included information through March 27, 2008. This report provides updated appeals statistics through March 9, 2010. This report includes information related to appeals for RAC claims. This report does not include Medicare Secondary Payer (MSP) issues reviewed in the RAC demonstrations.

Background

In Section 306 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), Congress directed DHHS to conduct a 3-year demonstration using RACs to detect and correct improper payments in the Medicare FFS program. Congress gave CMS the authority to pay each RAC on a contingency fee basis, which is a percentage of the improper payments corrected by the RACs.

CMS designed the RAC Program to:

1) Detect and correct *past* improper payments in the Medicare FFS program; and

2) Provide information to CMS and Medicare contractors that could help protect the Medicare Trust Funds by preventing *future* improper payments thereby lowering the Medicare FFS claims payment error rate.

CMS held a full and open competition to competitively select three RACs for the demonstration. Initially each 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. PRG-Schultz (PRG) was awarded the contract for California, HealthDataInsights (HDI) was awarded the contract for Florida, and Connolly Consulting was awarded the contract for New York. Each jurisdiction was expanded by one State in the summer of 2007 to include Arizona, South Carolina, and Massachusetts.

Updated Appeals of RAC Determinations

From the inception of the RAC demonstration through March 9, 2010, providers chose to appeal 12.7 percent (76,073) of the RAC determinations. Overall, the data indicate that of all the RAC overpayments determinations (598,238), 8.2 percent (48,993) were overturned on appeal (see Table 1). Appendix 1a includes more detailed data on appeals.

Table 1: Provider Appeals of RAC-Initiated Overpayments: Cumulative through 3/9/10, Claim RACs Only

Number of claims with overpayment determinations	598,238
Number of claims where provider appealed	76,073
Number of claims with appeal decisions in provider's favor	48,993
Percentage of appealed claims with a decision in provider's favor	64.4%
Percentage of claims overturned on appeal	8.2%

Source: RAC invoice files, RAC Data Warehouse, and data reported by the Administrative Qualified Independent Contractor (AdQIC) and Medicare claims processing contractors.

There are several data differences between this update and the January 2009 report. Explanations for the data differences are as follows:

- The number of claims with overpayment determinations has increased from 525,133 in the January 2009 report to 598,238, as a result of additional claims being manually included that were not entered into the RAC data warehouse prior to the end of the demonstration. These are claims initiated by the RACs, but adjusted after the end of the demonstration.

- The number of claims where the provider appealed has significantly decreased from the 118,051 reported in January 2009 to 76,073, due to several factors. The previous method of generating this figure counted claims appealed to multiple levels at each level of appeal. The revised method counts an appealed claim once, regardless of the number of levels of appeal. This method provides a far more accurate representation of the percentage of overpayment determinations appealed. Also, appeals reversed by a claims processing contractor when additional documentation was submitted (clerical reopenings), or appeals withdrawn by the provider, are no longer included. Finally, duplicate claims were identified in the previous data, and they have been removed.

- The number of claims with overpayment determinations by PRG decreased from 175,293 to 171,006, due to the fact that duplicate claims included in the previous total have now been removed. (See Appendix 1a)

Appendix 1a

Provider Appeals of RAC-Initiated Overpayments: Cumulative through 8/31/08, RAC Claims, All Claim Types

Claim RAC	Claims with Overpayment Determinations	# appealed (all levels)	% appealed (all levels)	# favorable to provider	% favorable to provider	% of all claims overturned on appeal
Connolly	118,152	8,286	7.0%	5,543	66.9%	4.7%
HDI	309,080	44,778	14.5%	32,628	72.9%	10.6%
PRG	171,006	14,965	8.8%	7,448	49.8%	4.4%
RAC not known[1]	n/a	8,044	n/a	3,374	41.9%	n/a
All RACs	598,238	76,073	12.7%	48,993	64.4%	8.2%

Source: RAC invoice files, RAC Data Warehouse, and data reported by the AdQIC and Medicare claims processing contractors. Includes all completed appeals and some pending appeals. This is because some Medicare claims processing contractors cannot distinguish between pending appeals of RAC determinations and pending appeals of other contractor determinations. These statistics are based on appeals that were known to the AdQIC and Medicare claims processing contractors on or before 3/9/10. Any QIC or ALJ appeals processed by the appeal entities or reported to the Medicare claims processing contractors after that date are not included in these statistics.

[1] This table includes 8,044 appeals that cannot be attributed to a specific RAC. While the payment decision is known, the initiator of the improper payment is not known.