

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
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Office of Media Affairs

FACT SHEET

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CMS ANNOUNCES NEW RECOVERY AUDIT CONTRACTORS TO HELP IDENTIFY IMPROPER MEDICARE PAYMENTS

Background

The Centers for Medicare & Medicaid Services (CMS) has taken the next steps in the agency's comprehensive efforts to identify improper Medicare payments and fight fraud, waste and abuse in the Medicare program by awarding contracts to four permanent Recovery Audit Contractors (RACs) designed to guard the Medicare Trust Fund.

In the Tax Relief and Health Care Act of 2006, Congress required a permanent and national RAC program to be in place by January 1, 2010. The national RAC program is the outgrowth of a successful demonstration program that used RACs to identify Medicare overpayments and underpayments to health care providers and suppliers in California, Florida, New York, Massachusetts, South Carolina and Arizona. The demonstration resulted in over \$900 million in overpayments being returned to the Medicare Trust Fund between 2005 and 2008 and nearly \$38 million in underpayments returned to health care providers.

The goal of the recovery audit program is to identify improper payments made on claims of health care services provided to Medicare beneficiaries. Improper payments may be overpayments or underpayments. Overpayments can occur when health care providers submit claims that do not meet Medicare's coding or medical necessity policies. Underpayments can occur when health care providers submit claims for a simple procedure but the medical record reveals that a more complicated procedure was actually performed. Health care providers that might be reviewed include hospitals, physician practices, nursing homes, home health agencies, durable medical equipment suppliers and any other provider or supplier that bills Medicare Parts A and B.

Recovery Audit Contractors

The new RACs are:

- **Diversified Collection Services, Inc. of Livermore, California**, in Region A, initially working in Maine, New Hampshire, Vermont, Massachusetts, Rhode Island and New York.

- **CGI Technologies and Solutions, Inc. of Fairfax, Virginia**, in Region B, initially working in Michigan, Indiana and Minnesota.
- **Connolly Consulting Associates, Inc.** of Wilton, Connecticut, in Region C, initially working in South Carolina, Florida, Colorado and New Mexico.
- **HealthDataInsights, Inc. of Las Vegas, Nevada**, in Region D, initially working in Montana, Wyoming, North Dakota, South Dakota, Utah and Arizona.

Additional states will be added to each RAC region in 2009.

The new RACs were selected under a full and open competition. The RACs will be paid on a contingency fee basis on both the overpayments and underpayments they find. The selection of the new contractors was based on a best value determination for the Federal government that included a sound technical approach for the level and quality of claim analysis and detail to exceptional customer service, conflict of interest reviews and lowest contingency fee.

Provider Education Activities

As part of preparing Medicare providers for the RAC program as it is phased in nationally, CMS will continue working closely with national and state medical, hospital and nursing home associations to strengthen relationships to be more proactive and anticipate the needs and concerns of health care providers. Before work begins, the RACs will hold Town Hall type meetings in each state with health care providers and CMS staff and representatives from the RACs in October and November. Health care providers can get more information about these meetings and the date the program will begin in their states by checking the CMS RAC Web site www.cms.hhs.gov/RAC/Downloads/RAC%20Expansion%20Schedule%20Web.pdf.

CMS is also using lessons learned from the RAC demonstration to make improvements in the permanent RAC program. For example, the program will be more transparent by listing the types of issues undergoing review on each of the RACs' Web sites. Each RAC will also employ a full-time medical director to help in the review of claims.

Soon after outreach efforts are made this month and in November, some health care providers in the states that are part of the first phase may begin to receive either requests for medical records or a letter requesting that an overpayment be repaid for their claims that were submitted to and paid for by Medicare. To prepare for the start of the program, health care providers should consider conducting an internal assessment to ensure that submitted claims meet the Medicare rules. Other steps that providers should take include:

- Identifying where improper payments have been persistent by reviewing the RACs' Web-sites and identifying any patterns of denied claims within their own practice or facility.
- Implementing procedures to promptly respond to RAC requests for medical records.
- If the provider disagrees with the RAC determination, filing an appeal before the 120-day deadline.
- Keeping track of denied claims and correcting these previous errors.
- Determining what corrective actions need to be taken to ensure compliance with Medicare's requirements and to avoid submitting incorrect claims in the future.

CMS will continue to monitor the efforts of the RACs to ensure they are providing sufficient information and undertaking outreach activities to reach all the health care providers in their regions so no provider feels unreasonably burdened.

For more information on the Permanent RAC Program and to view the evaluation report on the three-year RAC demonstration, visit: <http://www.cms.hhs.gov/RAC>.

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