American Society of Anesthesiologists®

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RACS: Be In The Know

"What is RAC really?"

Given the immense number of claims submitted to Medicare annually, it is no wonder that most claims are processed without extensive review or medical record assessment. Due to high volume and minimal evaluation, Medicare has become vulnerable to false claims or fraudulent activity. Additionally, its claims processing contractions could issue improper payments for services that do not meet Medicare's coverage and medical necessity criteria. As a result, the Centers for Medicare & Medicaid Services (CMS) implemented the Medicare Recovery Audit Contractor Program (RAC) that is now in effect nationwide. RACs are to protect the Medicare program by identifying and correcting improper Medicare payments and referring potential fraud to CMS[1]. RAC objectives include identifying improper payments by Medicare Administrative Contractors (MACs), conducting post-payment reviews to identify overpayments and underpayments and recouping any overpayments identified[2].

In August 2013, the Department of Health and Human Services (HHS) Office of the Inspector General (OIG) issued a report on Medicare Recovery Audit Contractors and Improper Payments. The report focuses on Medicare Part A and B RAC performances and how CMS addressed their performance in fiscal years (FY) 2010 and 2011.

"I'm not sure this will even affect me."

If you think you are safe from the *RAC attack*, think again. If your practice submits claims to Medicare's fee-for-service program, your claims could be subject to review[3]. RACs are compensated on a contingency fee basis, receiving a percentage of overpayments they recover and restore to CMS[2]. Thus, the program pays for itself and does not require budgetary funding.

The OIG report found that the RACs identified nearly 1.3 billion dollars in improper payments from approximately half the claims they reviewed in 2010 and 2011. Inpatient hospitals, physicians, and medical practitioners accounted for 93 percent of improper payments. The tables below further describe the OIG findings[1]:

OIG RAC Report Findings Overview

Number of Claims Reviewed	2.6 million *(2,608,481)*
Number of Providers	292,000 *(292,265)*
Number of Claims with Improper Payments	1.3 million (~50% of claims reviews) *(1,289,056)*
Total Cost of Improper Payments	$1.3 billion *($1,261,328,388)*
Amount of Improper Payments Returned/Recovered	$903 million *($903 million of the $1.3 billion)*

Improper Payments Returned and Recovered

Amount Recovered from Providers (of $903 million)	$768 million (85%)	
Year	**FY 2010**	**FY 2011**
	$53 million	$715 million
Amount Returned to Providers (of $903 million)	$135 million (15%)	
Year	**FY 2010**	**FY 2011**
	$ 15 million	$120 million

"I won't have that problem. That's what my billing and administrative staff is for."

Anesthesiologists should understand the necessity of reviewing documents and materials prior to claim submission. Even if administrative staff is aware of Medicare's policies, it is essential to spot-audit and work with your billing department to ensure everyone in the practice understands and follows current coding rules. This is especially important since physicians are legally responsible for services billed under their provider identification number. Provided below, you will find the most common reasons for improper payments found in the OIG report[1]:

- Medical services being delivered in inappropriate facilities (32%)
- Providers billing incorrect codes on Medicare claims (25%)
- Providers billing Medicare for Services for deceased beneficiaries
    - CMS recovered $3 million in improper payments for services billed for deceased patients

"Legally responsible? OK, I'm listening…"

As mentioned earlier, auditors are compensated on a contingency fee basis. What does this mean for anesthesiologists? A more technical and conventional approach will be taken towards considering documentation valid or invalid in support of services rendered. The most predominant types of denials in the audit processes include[1]:

1. Payment for items or services that fail to meet Medicare's coverage and medical necessity criteria
2. Payment for items that are incorrectly coded
3. Payment for services where the documentation submitted did not support the ordered service

What Can I Do?

Anesthesiologists should review Chapter 12, Section 50 of the CMS e Claims Processing Manual (http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c12.pdf) to identify the required elements to accurately report anesthesia care. Below is a summary of some of that information.[4]:

Payment at Personally Performed Rate

CMS considers an anesthesia service to be personally performed by an anesthesiologist under any of the following circumstances:

- The physician personally performed the entire anesthesia service alone
- The physician is involved with one anesthesia case with a resident, the physician is a teaching physician
- The physician is involved in the training of physician residents in a single anesthesia case, two concurrent anesthesia cases involving residents or a single anesthesia case involving a resident that is concurrent to another case paid under the medical direction rules
- The physician is continuously involved in a single case involving a student nurse anesthetist
- The physician is continuously involved in one anesthesia case involving a CRNA (or AA)
- The physician and the CRNA (or AA) are involved in one anesthesia case and the services of each are found to medically necessary. Documentation must be submitted by both the CRNA and the physician to support payment of the full fee for each of the two providers. The physician reports the "AA" modifier and the CRNA reports the "QZ" modifier for a non-medically directed case.

Payment at the Medically Directed Rate

CMS considers an anesthesia service to be medically directed occurs if the physician performs the following activities:

- Performs pre-anesthetic examination and evaluation
- Prescribes the anesthesia plan
- Personally participates in the most demanding procedures in the anesthesia plan, including induction and emergence
- Ensures that any procedures in the anesthesia plan that he or she does not perform are performed by a qualified anesthetist
- Monitors the course of anesthesia administration at frequent intervals
- Remains physically present and available for immediate diagnosis and treatment of emergencies
- Provides indicated-post-anesthesia care

For additional information on rules for payment of anesthesia services, please access the manual. In addition, as recommended by CMS, providers should also[3]:

1. Know where previous improper payments have been found
    a. Demonstration findings by the Recovery Auditors: www.cms.hhs.gov/rac
    b. Improper payments found in OIG and CERT reports
        i. OIG Reports: www.oig.hhs.gov/reports.html
        ii. CERT Reports: www.cms.hhs.gov/cert
2. Be knowledgeable in the content of the claims submitted under your provider ID number to avoid an improper payment
    a. Assess claims to confirm compliance with Medicare rules
    b. Appeal the RAC's finding when appropriate necessary
    c. Learn from past experiences by tracking denied claims, identifying patterns, and determining corrective action necessary to avoid improper payments

In conclusion, to avoid becoming entangled in a RAC audit, anesthesiologists need to remain up to date with Medicare. For more geographically specific information, provided below is a table of Medicare Recovery Audit Contractor Regions to allow you to identify the RAC for your region[1]:

"Who is my RAC?"

Region	States	RAC	Website
A	CT, DE, DC, ME, MD, MA, NH, NJ, NY, PA, RI, VT	Performant Recovery Inc. (formerly Diversified Collection Services)	www.dcsrac.com
B	IN, MI, MN, IL, KY, OH, WI	CGI	http://racb.cgi.com
C	AL, AR, CO, FL, GA, LA, MS, NC, NM, OK, SC, TN, TX, VA, WV	Connolly Consulting	www.connollyhealthcare.com/rac
D	AK, AZ, CA, HI, IA, ID, KS, MO, MT, ND, NE, NV, OR, SD, UT, WA, WY	HealthDataInsights	http://racinfo.healthdatainsights.com

For a complete copy of the OIG report, *Medicare Recovery Audit Contractors and CMS's Actions to Address Improper Payments, Referral of Potential Fraud, And Performance*, please visit: http://oig.hhs.gov/oei/reports/oei-04-11-00680.asp

References:

1. OIG. *Medicare Recovery Audit Contractors And CMS's Actions To Address Improper Payments, Referrals Of Potential Fraud, And Performance*. Office Of Inspector General Report. Washington, D.C.: Department of Health and Human Services, 2013. Document.

2. OIG. *Recovery Audit Contractors' Fraud Referrals*. Office of Inspector General Report. Washington, D.C.: Department of Health and Human Services, 2010. Document.

3. CMS. "The Recovery Audit Program and Medicare: The Who, What, When, Where, How, and Why?" 13 May 2013. *Centers for Medicare & Medicaid Services.* Document. 23 October 2013.

4. CMS. "Medicare Claims Processing Manual." 30 May 2013. *Centers for Medicare and Medicaid Services.* Document. 2 November 2013.