RAC Audit Underpayments: Does CMS Owe You Money?

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By Lisa A. Eramo, MA

Anxiety—it's the emotion that looms over most patient financial services (PFS) directors and those working in health information management (HIM) when they discover that their organization's claims are subject to a Centers for Medicare and Medicaid Services (CMS) Recovery Audit review. Even when facilities take extra precautions to do the right thing and assign the right code, it is still unsettling to know that auditors are looking over your information with a fine-tooth comb for errors that result in overpayments. And the bigger the overpayment found, the bigger the payoff for the auditor.

But what about underpayments? Aren't Recovery Auditors supposed to be looking for these as well? They are—but the rate at which they discover overpayments is surprising.

Consider Boca Raton Regional Hospital (Boca Raton Medical), a 400-bed nonprofit facility with a 65 percent to 70 percent Medicare population. Since 2011, Recovery Auditors have reviewed more than 6,000 of their claims. Of these, only 31 were determined to have been underpaid.

"I've found that [auditors] throw you an underpayment bone now and then," says Karen Heck, PFS manager of governmental accounts receivable. "They don't focus on them. It doesn't seem fair."

Heck says she feels a .5 percent underpayment rate for their audited claims probably isn't accurate, and that it's likely much higher.

According to the most recent RACTrac survey results from the second quarter 2016, three percent of all Recovery Audit determinations nationwide included an underpayment, while 40 percent included an overpayment.[1] The survey, published by the American Hospital Association, assesses the impact of the Medicare Recovery Audit Contractor (RAC) program on hospitals nationwide.

In its most recent National Recovery Audit Program quarterly newsletter, which includes amounts collected between April 1 and June 30, 2016, CMS stated it identified $24.29 million in underpayments as compared with $75.22 million in overpayments.[2] It did not provide the volume of underpayments as compared with overpayments.

MS-DRGs with the Highest Service-specific Underpayment Rates

The following MS-DRGs may be particularly vulnerable to underpayments. HIM professionals can use this list as a starting point when searching for underpayments in their own organizations.

MS-DRG	Description	Improper payment rate
206	Other respiratory system diagnoses without MCC	14.3%
419	Laparoscopic cholecystectomy without CDE without CC/MCC	6.5%
310	Cardiac arrhythmia and conduction disorders without CC/MCC	5.6%
254	Other vascular procedures without CC/MCC	5.1%
195	Simple pneumonia and pleurisy without CC/MCC	3.9%

Source: Department of Health and Human Services. "Medicare Fee-for-Service 2015 Improper Payments Report, Supplementary Appendices."

Are Underpayments a Priority for Auditors?

The CMS Recovery Audit Statement of Work requires auditors to look for all improper payments, including both under- and overpayments.[3] But experts say this isn't exactly how many of these audits pan out. Instead, hospitals oftentimes face the ugly reality of resource-intensive denials, appeals, and recoupments.

"[Recovery Auditors] are like hunters. They go out and hunt the game. They're looking for places where they can get revenue," says Edward M. Roche, PhD, JD, founder of Barraclough NY, LLC, a litigation support firm that helps healthcare providers fight against statistical extrapolations.

Many believe that Recovery Auditors only pursue overpayments because they're paid a contingency fee of what they recover. This is true—they are paid for identifying overpayments—but they're also paid a fee for identifying underpayments. In a Recovery Auditor publication dispelling myths about the program, CMS states, "The amount of the contingency fee is based on the amount of money from, or reimbursed to, providers. The contingency fee is a percentage of the amount of the improper payment."[4]

A CMS spokesperson confirmed this information, stating that "RACs are paid the same contingency fee for both overpayment and underpayment corrections. For underpayments, the fee is based on the amount paid to the provider."

Three Facts on Underpayments

- An underpayment refers to lines or payment group (i.e., APC, RUG) on a claim that was billed at a low level of payment but should have been billed at a higher level of payment.
- Service lines or payment groups that a provider failed to include on a claim are NOT considered underpayments.
- When an auditor identifies an underpayment, the provider is not required to correct and resubmit the claim.

Source: CMS. "Statement of Work for the Recovery Audit Program."

Many Let Underpayments Slip Out the Door

Frank Cohen, director of analytics and business intelligence at DoctorsManagement, a healthcare consulting firm specializing in physician practice accounting and operations, says underpayments are few and far between. Cohen, who works mostly with physician practices, says he has personally never seen a Recovery Auditor identify a physician underpayment even though he says physicians frequently under-code evaluation and management (E/M) services.

Roche agrees, adding that many providers—including hospitals—down-code proactively to avoid auditor scrutiny. "This isn't correct coding," he says. "This intimidation corrupts the coding process."

In every sampling and extrapolation examined by Barraclough, the auditors have purposefully left out zero-paid claims, Roche says. A zero-paid claim is one that was submitted and entirely denied for causes such as incorrect coding, lack of medical necessity, or a variety of other reasons. "This has the effect of biasing the extrapolation number upwards, because even before the sample is taken, the Recovery Audit Contractor has foreclosed all possibility of finding underpayments," he adds.

However, over time organizations may do their own analysis of claims. "[Providers] will eventually wake up to the fact that they're fighting statistical software that has nothing to do with medical judgment," Roche says. When this happens, he says providers will build their own algorithms to identify potential under- and overpayments so they can correct information in real-time before claims are even submitted.

Underpayments Corrected by CMS by Year

	Number of underpayment claims corrected	Amount returned (millions)
FY 2010	6,813	$16.9
FY 2011	60,561	$141.9
FY 2012	37,410	$109.4

FY 2013	42,611	$102.4
FY 2014	77,760	$173.1
FY 2015	TBD	$81.0
Source: CMS. "Medicare Fee-for-Service Recovery Audit Program – Total Corrections by Fiscal Year."		

Proactively Identifying Underpayments

Rather than rely on Recovery Auditors to identify underpayments, some organizations are taking matters into their own hands. Boca Raton Medical, for example, undergoes an annual coding audit as well as an annual clinical documentation improvement (CDI) audit by an external vendor to proactively identify areas of potential over- and underpayments.

"There are always findings," says Rudy Braccili, Jr., MBA, CRCE, executive director of revenue cycle services at Boca Raton Medical. Although there are pre-bill system edits in place, the hospital doesn't currently perform pre-bill reviews. It may be something that the organization would consider in the future, he adds.

"We have not found a target population that wins the cost-benefit equation to be able to do that. We would only want to do this when we knew that the result would more than pay for the auditing expense," he adds.

Braccili says Boca Raton Medical also works with various vendors that audit its zero-balance claims to determine whether the organization left any money on the table due to a missing modifier, omitted code, incorrect DRG, or a variety of other reasons. These vendors usually discover thousands of dollars annually, which more than pays for the service, he says. Zero-balance claims refers to those that appear to have been paid in full according to the hospital's calculation of the expected reimbursement amount owed. However, complexity of contract rate terms, service bundling varieties, and system limitations sometimes cause miscalculations that result in money potentially left on the table.

"They only get paid a percentage of money that they bring into the organization. That's probably the most cost-effective way to go about [finding underpayments]," Braccili adds.

The following are several ways in which providers can proactively identify underpayments:

1. Audit, audit, and audit again.

Some organizations have the luxury of being able to perform pre-bill audits either internally or with the help of an external vendor. If pre-bill audits aren't realistic, perform retrospective audits to identify areas in which underpayments typically occur within an organization, Cohen says. If within timely filing limits, consider filing a supplemental amended claim to recoup the monies owed, he adds.

Not sure where to focus your audits? These sources can help:

- 2015 CERT report (see sidebar at top of page)
- RACTrac data
- High-risk areas for under-documentation as identified by internal CDI specialists
- PEPPER data—particularly outliers that fall below national averages

Look for trends when auditing. Do underpayments typically relate to a particular diagnosis or principal procedure? Is a specific CC or MCC typically lacking? Is it a documentation problem related to a particular physician?

2. Work with IT to build data mining tools.

Using what Cohen refers to as "supervised learning," data scientists can train computer systems to develop an algorithm that identifies claims with a high probability of being underpaid. Then the organization can process all claims through this algorithm. "An alternative approach would be to use off-the-shelf software that uses statistical algorithms to check groups of claims against best fit patterns," Roche says.

If these tools aren't realistic, focus on audits instead, Cohen says. "Some organizations have the staff and ability to [build these tools]. But most organizations do not employ statisticians, data scientists, and programmers who can build these types of systems. What they do have are a lot of coders and auditors," Cohen says.

3. Follow up with coder, physician, and CDI specialist education.

Use audit results to educate staff about vulnerabilities and how to mitigate risk.

Notes

[1] American Hospital Association. "RACTrac: Exploring the Impact of the RAC Program on Hospitals Nationwide." October 6, 2016.

[2] CMS. "Medicare Fee for Service National Recovery Audit Program Quarterly Newsletter." Second Quarter 2016.

[3] CMS. "Statement of Work for the Recovery Audit Program."

[4] CMS. "Medicare Fee-for-Service Recovery Audit Program Myths." December 17, 2012.

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