COMMONWEALTH of VIRGINIA

Department of Medical Assistance Services

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January 10, 2014

MEMORANDUM

TO: The Honorable Walter A. Stosch
Chairman, Senate Finance Committee

The Honorable Lacey E. Putney
Chairman, House Appropriations Committee

FROM: Cynthia B. Jones
Director, Virginia Department of Medical Assistance Services

SUBJECT: Report on the Cost Recovery Activities

The 2013 Appropriation Act, Item 307 Q states:

> *The Department of Medical Assistance Services shall have the authority to pay contingency fee contractors, engaged in cost recovery activities, from the recoveries that are generated by those activities. All recoveries from these contractors shall be deposited to a special fund. After payment of the contingency fee any prior year recoveries shall be transferred to the Virginia Health Care Fund. Beginning November 1, 2011, and each year thereafter, the Director, Department of Medical Assistance Services shall report to the Chairmen of the House Appropriations and Senate Finance Committees the increase in recoveries associated with this program as well as the areas of audit targeted by contractors.*

Should you have any questions or need additional information, please feel free to contact me at (804) 786-8099.

CBJ/

Enclosure

pc: The Honorable William A. Hazel, Jr., MD, Secretary of Health and Human Resources

Department of Medical Assistance Services
Annual Report to the General Assembly

Report on Contingency Fee-Based Recovery Audit Contractors (RACs)

November 2013

Report Mandate

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Background

Recovery Audit Contractor (RAC) is a term used to describe auditing firms who review medical claims for over- and under-payments and are paid a contingency fee based on actual recoveries resulting from their audits. Starting in 2005, the federal government began to utilize RACs to audit Medicare claims, expanding the program nationwide in 2010. Over this period of time, RAC audits uncovered over $900 million in overpayments in the Medicare program. The success of the Medicare RACs resulted in the inclusion of Section 6411 of the Patient Protection and Affordable Care Act, H.R. 3590 (PPACA), which expands the current RAC program to Medicaid, requiring states to enter into a contract with a Medicaid RAC.

RAC Activities in Virginia

Virginia's FY 2011-2012 budget bill (Item 297 VVVV) authorized the Virginia Department of Medical Assistance Services (DMAS) to employ RAC auditors and pay them a contingency fee based on the recoveries generated by their audit activities. DMAS issued a Request for Proposals (RFP) in March 2012 for qualified and innovative health care auditing firms to provide RAC services for Virginia's Medicaid program. In July 2012, DMAS awarded this contract to Health Management Systems (HMS) for the three-year period (with the opportunity for three additional one-year renewals after the initial contract period).

Under this contract, DMAS pays HMS a contingency fee of 9.3% of the actual amounts recovered as a result of their RAC audit activities. In addition, in accordance with federal law, DMAS will also pay HMS the same 9.3% contingency fee for underpayments identified during their audit activities. While HMS identifies overpayments through auditing, recovery of overpayments is conducted by DMAS. While federal law permits extrapolation of overpayments identified through RAC audits[*], DMAS chose not to extrapolate due to concerns about ensuring a statistically-valid sample and provider relations.

Federal regulations require States to coordinate the audit activities of their RACs with other State auditing activities to ensure that the RAC does not audit claims that have already been audited or that are currently being audited by another entity. In order to coordinate RAC activities with other audits conducted by DMAS staff and contractors, DMAS makes the final determination on the types of audits and providers on which HMS RAC activities will focus.

RAC First Year Audit Activities

Upon the initiation of the RAC contract in September 2012, HMS evaluated and analyzed DMAS historic data on processed claims to identify potential areas of audit. After completion of the review in November 2012, HMS proposed for DMAS approval a total of twenty-four potential audits to conduct during the contract year. In order to ensure that audits could be completed in short order, HMS focused on audits that would not require desk or on-site reviews. Instead, these audit proposals generally focused on claims that appeared to have been paid improperly, based on the information contained in the claim file.

As of June 30, 2013, HMS has moved forward on three DMAS-approved audit proposals. DMAS has provisionally approved two additional audit proposals, which are currently being further reviewed to ensure that the claims have not already been subject to a previous audit. Two other audit proposals were deemed not viable due to a limited number of potentially improper claims. The remaining 17 proposals are in various stages of development and refinement.

The three RAC audits that have been approved by DMAS are as follows: (1) Pulmonary Diagnostic Procedures and Evaluation & Management Services; (2) New Patient Visits; and (3) Billing of Miscellaneous Durable Medical Equipment (DME) Codes. These audits are discussed in detail below.

1) Pulmonary Diagnostic Procedures and Evaluation & Management (E&M) Services – This audit examined claims for pulmonary diagnostic procedures to identify physicians who had improperly billed for E&M services on the same day. HMS

[*] Extrapolation is a process used to apply the results of an audit performed on a sample of claims to the universe of claims submitted by a provider. For example, if through an audit, payment for ten percent of the sampled claims were found to be made in error, DMAS would recover ten percent of all claims submitted by that provider during the audited period, not just ten percent of the sampled claims.

found 4,206 paid claims for which services had been improperly billed. The total amount identified for recoupment was $315,000. Final overpayment letters were issued to 387 providers in August 2013.

2) New Patient Visits – This audit examined claims for new patient visits, which are billed at a higher rate than regular office visits. According to American Medical Association guidelines, a patient can only be considered a new patient once every three years. HMS identified potential recovery of $43,000 from 482 claims in which providers appeared to have violated this rule.
3) Billing of Miscellaneous Durable Medical Equipment (DME) Codes – This audit examined claims for DME services/supplies/items that utilized a generic miscellaneous code rather than the category-specific codes that DMAS has directed providers to use. The current review is a pilot focusing on 10 providers with about $641,000 in potential overpayments. HMS began requesting records to perform complex medical record reviews of providers identified under this audit in July 2013. The review may be expanded based on the results of the pilot.

Summary

While much of the RAC's first year involved analyzing data to identify potential areas of audit, three DMAS-approved audits have been initiated. HMS expects to identify in excess of $1 million in total overpayments from these audits. As of the end of the first contract year, DMAS has received $24,851.23 in payments from providers based on audits conducted under the RAC contract. As noted in the authorizing budget language, these funds will be deposited into a special fund, out of which the contingency fee payments will be made to the RAC. During the second year of this contract, DMAS and HMS will work together to approve and move forward with pending audit proposals, and HMS will continue to identify new areas in which to focus audits.