COMMONWEALTH of VIRGINIA

Department of Medical Assistance Services

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November 1, 2015

MEMORANDUM

TO: The Honorable Charles J. Colgan
Co-Chairman, Senate Finance Committee

The Honorable Walter A. Stosch
Co-Chairman, Senate Finance Committee

The Honorable S. Chris Jones
Chairman, House Appropriations Committee

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

SUBJECT: Report on the Cost Recovery Activities

The 2015-16 Appropriations Act, Item 301 P 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. 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 by November 1 each year.

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

ADMINISTERING MEDICAID AND THE STATE CHILDREN'S HEALTH INSURANCE PROGRAM IN VIRGINIA

DMAS' mission is to provide a system of high quality and cost effective health care services to qualifying Virginians and their families.

The Medicaid program, signed into law by President Lyndon B. Johnson on July 30, 1965, celebrates its 50th year in 2015.

Medicaid is a joint federal and state program authorized under Title XIX of the Social Security Act that provides health and long-term care coverage for specific groups of Virginians with low incomes. In Virginia, Medicaid is administered by the Department of Medical Assistance Services (DMAS) and is jointly funded by Virginia and the federal government. Virginia's federal matching rate, known as the Federal Medical Assistance Percentage (FMAP) is generally 50%, meaning Virginia receives $1 of federal matching funds for every $1 Virginia spends on Medicaid.

Medicaid coverage is primarily available to Virginians who are children in low-income families, pregnant women, elderly, individuals with disabilities and parents meeting specific income thresholds.

All states must follow general federal Medicaid guidelines regarding who is covered, but states set their own income and asset eligibility criteria. Virginia's eligibility criteria are among the strictest in the nation.

VIRGINIA'S MEDICAID PROGRAM
DMAS
INNOVATION · QUALITY · VALUE

Report to the General Assembly on
Contingency Fee-Based Recovery Audit Contractors (RACs)

Report Mandate:

2015-16 Appropriations Act, Item 301 P *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. 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 by November 1 each year.*

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. Section 6411 of the Patient Protection and Affordable Care Act, H.R. 3590 (PPACA), which expanded RAC program to Medicaid, required states to enter into a contract with a Medicaid RAC.

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. Under the Virginia RAC contract, DMAS pays a contingency fee of 9.3% of the actual amounts recovered as a result of RAC audit activities. As noted in the authorizing budget language, RAC recoveries are deposited into a special fund, out of which the contingency fee payments are made to the RAC. Since the initiation of the RAC contract in September 2012, the RAC has evaluated and analyzed DMAS historic data on processed claims to identify potential areas of audit.

As of June 30, 2015, the RAC has audited and completed four DMAS-approved audit proposals and received $291,562.86 in payments from providers based on these audits. Collection activities continue for additional overpayments identified through each of the four audit proposals. The four completed RAC audits and their results are discussed in detail below. Therefore, the contingency fees paid were $27,111.94.

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. The RAC reviewed 4,206 paid claims in DMAS data for which E&M services had been billed. Final overpayment letters for all of these claims were issued to 387 providers. The total recoupment amount to date is $175,616.14.

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. The RAC reviewed 462 paid claims in DMAS data for which New Patient services had been billed. Final overpayment letters for all of these claims were issued to 178 providers. The total recoupment to date is $39,702.11.

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 RAC reviewed 362 paid claims in DMAS data for which DME miscellaneous codes were billed. Final overpayment letters for all of these claims were issued to 10 providers. The total recoupment to date is $16,172.14. After the appeals process is complete, the scenario may be expanded.

4) **Fraud, Waste and Abuse Scenarios** – Data mining identified 9,110 claims with issues including: supplemental codes billed without the appropriate primary procedure; billing separately for services that should have been included under the global surgery code billed; claims lacking a valid "place of service" code based on the service/procedure billed or per Virginia Medicaid Provider manual requirements; and some additional cases related to improper billing of new patient visits. As a result of this data analysis, 9,110 claims from 358 providers were identified that contained overpayments. The total recoupment to date is $60,035.81.