

Department of Health and Human Services

**OFFICE OF  
INSPECTOR GENERAL**

**RECOVERY AUDIT CONTRACTORS'  
FRAUD REFERRALS**



Daniel R. Levinson  
Inspector General

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OEI-03-09-00130



# E X E C U T I V E S U M M A R Y

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## OBJECTIVES

To determine the extent to which:

1. recovery audit contractors (RAC) referred cases of potential fraud to the Centers for Medicare & Medicaid Services (CMS) during the demonstration project, and
2. CMS provided training to RACs regarding fraud identification and referral during the demonstration project and in the permanent program.

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## BACKGROUND

CMS contracts with RACs to identify improper payments of Medicare Part A and Part B claims. RACs conduct postpayment reviews to identify overpayments and underpayments and recoup any overpayments they identify. RACs receive payment based on the amount of improper payments identified.

CMS conducted a 3-year RAC demonstration project from March 2005 through March 2008 that was designed to (1) detect and correct past improper payments in the Medicare fee-for-service program and (2) provide information to CMS and to the Medicare claims processing contractors that could help protect the Medicare trust funds by preventing future improper payments. The demonstration covered California, Arizona, Florida, South Carolina, New York, and Massachusetts. Three RACs participated in the demonstration project and identified more than \$1.03 billion in Medicare improper payments. After the demonstration period, CMS awarded contracts to four companies that will serve as RACs in the permanent program.

RACs are not responsible for reviewing claims for fraudulent activity; however, they are responsible for referring to CMS any instances of potential fraud that are identified during their reviews. This is the first indepth study of the RACs' role in referring cases of potential fraud.

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## FINDINGS

**Between 2005 and 2008, RACs referred two cases of potential fraud to CMS.** Only one RAC reported referring two cases of potential fraud involving specific providers to CMS during the 3-year demonstration project. However, CMS reported that it received no specific provider referrals from RACs during the demonstration project. While it did not

## E X E C U T I V E   S U M M A R Y

make formal referrals to CMS, another RAC notified CMS of numerous claims it identified involving improper payments. The third RAC did not refer any cases of potential fraud to CMS during the demonstration project.

**During the demonstration project, CMS did not provide any formal training to RACs regarding the identification and referral of potential fraud; however, CMS did provide the permanent RACs with a presentation about fraud.** CMS did not provide RACs in the demonstration with formal training regarding the identification and referral of potential fraud. CMS did provide the permanent RACs with a presentation about fraud, which discussed the need for the RACs to be knowledgeable about fraud in Medicare, the definition of fraud, and examples of potential Medicare fraud. CMS is planning to provide the permanent RACs with further education and training on the identification of potential fraud. In addition, two of the three RACs reported providing informal training to their staff regarding the identification and referral of potential fraud.

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### RECOMMENDATIONS

During the 3-year demonstration project, RACs identified over \$1 billion in improper payments, yet referred only two cases of potential fraud to CMS. Because RACs do not receive their contingency fees for cases they refer that are determined to be fraud, there may be a disincentive for RACs to refer cases of potential fraud.

RACs are required to refer any cases of potential fraud that they identify; however, they must be able to identify fraud to refer it. Having a RAC staff that is knowledgeable about fraud and trained to identify fraud will increase awareness and detection of potential fraud during the claims review process. CMS did not provide RACs in the demonstration project with formal training on how to identify fraud. However, CMS did provide the permanent RACs with a presentation about fraud.

Therefore, we recommend that CMS:

**Conduct followup to determine the outcomes of the two referrals made during the demonstration project.**

**Implement a database system to track fraud referrals.**

**Require RACs to receive mandatory training on the identification and referral of fraud.**

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## **AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE**

CMS concurred with all three of our recommendations. In regard to our first recommendation, CMS stated that it researched the two cases identified by the RAC for potential referral and determined they should be referred to the Office of Inspector General (OIG) for further development. CMS is in the process of forwarding the two cases to OIG. OIG will review these cases and determine what actions need to be taken.

CMS concurred with our second recommendation and stated that it is in the process of developing a system to track the RAC claims review process.

Finally, in response to our third recommendation, CMS stated that it has already provided two training sessions to the RACs and is in discussion with OIG and the Department of Justice on additional training. The OIG training session was scheduled for January 2010.

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## OBJECTIVES

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## BACKGROUND

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 directed the Secretary of the U.S. Department of Health and Human Services (the Secretary) to undertake a demonstration project to assess the use of RACs under the Medicare Integrity Program in (1) identifying underpayments and overpayments, and (2) recouping overpayments (for services for which payment was made under Part A or Part B of Title XVIII of the Social Security Act).<sup>1</sup> The demonstration project lasted 3 years (March 2005 through March 2008) and provided CMS with information about the feasibility and merits of applying recovery audit principles and methods to the Medicare program.

The Tax Relief and Health Care Act of 2006 directed the Secretary to expand the RAC program nationally by January 2010.<sup>2</sup> In October 2008, CMS awarded contracts to four companies that serve as the RACs for the permanent program. At the time of data collection for this report, the permanent RACs were conducting provider outreach and beginning to phase in their review of providers but were not fully operational.

RACs are not responsible for reviewing claims for fraudulent activity. CMS contracts with program safeguard contractors (PSC) and Zone Program Integrity Contractors (ZPIC) to perform benefit integrity

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<sup>1</sup> The Medicare Prescription Drug, Improvement, and Modernization Act of 2003, P.L. 108-173, Title III § 306.

<sup>2</sup> The Tax Relief and Health Care Act of 2006, P.L. 109-432 § 302(a), Social Security Act § 1893(h), 42 U.S.C. § 1395ddd(h).

functions including fraud detection.<sup>3</sup> However, in the course of reviewing claims for improper payments, RACs may come across instances where the overpayment appears to involve fraudulent activity. RACs are responsible for referring these instances of potential fraud to CMS.<sup>4</sup>

The RAC program is unique because RACs operate on a contingency fee basis, unlike any other Medicare contractor. While RACs are not responsible for identifying fraud, they are responsible for referring any cases of potential fraud to CMS. RACs do not receive contingency fees for these cases when they are determined to be fraud. Thus, there may be a disincentive for RACs to refer cases of potential fraud.

This is the first indepth study of the RACs' role in referring cases of potential fraud. Specifically, this study examined the role of the demonstration RACs in referring cases of potential fraud. It also focused on training that the demonstration RACs and the permanent RACs received from CMS regarding the identification and referral of potential fraud.

### **Recovery Audit Contractor Demonstration Project**

The 3-year RAC demonstration project was conducted from March 2005 through March 2008 and was designed to (1) detect and correct past improper payments in the Medicare fee-for-service program, and (2) provide information to CMS and to the Medicare claims processing contractors that could help protect the Medicare trust funds by preventing future improper payments.<sup>5</sup>

CMS awarded the first RAC contracts in March 2005. Initially, the States with the highest Medicare utilization rates—California, Florida, and New York—were selected for the demonstration. In the summer of 2007, CMS expanded the demonstration to Massachusetts, South Carolina, and Arizona. The companies selected for the demonstration were:

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<sup>3</sup> PSCs and ZPICs are CMS's fraud, waste, and abuse detection contractors. CMS is in the process of transferring PSC functions to the ZPICs and expects all ZPICs to be operational in 2010.

<sup>4</sup> CMS, *Statement of Work for the Recovery Audit Contractor Program*, November 7, 2007, p. 24.

<sup>5</sup> CMS, *The Medicare Recovery Audit Contractor (RAC) Program: An Evaluation of the 3-Year Demonstration*, June 2008, p. 11. Available online at <http://www.cms.hhs.gov/RAC/Downloads/RAC%20Evaluation%20Report.pdf>. Accessed on February 2, 2009.

## I N T R O D U C T I O N

- PRG-Schultz (California, Arizona<sup>6</sup>),
- HealthDataInsights (Florida, South Carolina), and
- Connolly Consulting (New York, Massachusetts).

CMS compensated RACs through contingency fees, which were a percentage of the amount of improper payments RACs corrected. Contingency fees included fees paid to RACs for detecting and collecting overpayments plus the fees paid for detecting and refunding underpayments. CMS and RACs negotiated these contingency fees, which ranged from 18 to 38 percent during the demonstration.

*RAC responsibilities.* CMS tasked RACs with identifying, through postpayment review, Medicare Part A or Part B claims with underpayments or overpayments.<sup>7</sup> Improper payments could include noncovered services, incorrectly coded services, duplicate services, and incorrect payment amounts. For each overpayment identified, RACs were to attempt recoupment.

*Claims review process.* Using claims data from 2001 through 2007, RACs were responsible for identifying claims containing improper payments. RACs used their own proprietary software to perform automated reviews to identify claims that contained improper payments. RACs also conducted more complex medical reviews on claims. In conducting claim reviews, RACs had to comply with Medicare policies, regulations, national coverage determinations, local coverage determinations, and manual instructions.

CMS excluded a number of claim types from review by the RACs. These exclusions included:

- claims for hospice and home health services,
- payments made to providers under a CMS-conducted demonstration,
- claims previously reviewed by another Medicare contractor,
- claims involved in a potential fraud investigation, and

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<sup>6</sup> While contractually Arizona was added to PRG-Schultz's jurisdiction in July 2007, no Arizona claims were reviewed before the end of the RAC demonstration.

<sup>7</sup> CMS, *Statement of Work for the Recovery Audit Contractors Participating in the Demonstration (Non-Medicare Secondary Payer)*, No. 40700NMSPB, p. 1.

- potentially miscoded physician evaluation and management claims.<sup>8</sup>

Appeals. Providers were able to appeal RAC overpayment determinations. There are five levels in the Medicare Part A and Part B appeals process: (1) redetermination by a carrier, Fiscal Intermediary (FI), or Medicare Administrative Contractor; (2) reconsideration by a Qualified Independent Contractor; (3) hearing by an Administrative Law Judge; (4) review by the Medicare Appeals Council; and (5) judicial review in the U.S. District Court.<sup>9</sup>

Appeals affected RACs' ability to retain contingency fees. Once RACs were notified by CMS of an appeal request, they were required to cease all recovery attempts. CMS required RACs to pay back the contingency fee if the appeal was favorable to the provider at the redetermination level. Subsequent appeals after the redetermination level did not affect the RACs' ability to retain the contingency fee.

RAC Data Warehouse. CMS gave RACs access to the RAC Data Warehouse to facilitate the activities of the RACs, CMS, FIs, carriers, Durable Medical Equipment Regional Carriers (DMERC), Quality Improvement Organizations (QIO), PSCs, and law enforcement agencies.<sup>10</sup> The RAC Data Warehouse was designed for numerous coordinating, tracking, and reporting functions.

RACs were prohibited from reviewing claims that had been flagged by other Medicare contractors and law enforcement agencies in the RAC Data Warehouse. Therefore, before beginning any claim reviews, RACs were required to compare their list of claims to be reviewed against the flagged claims in the RAC Data Warehouse. Flagged claims are those that have been previously medically reviewed, settled, or are currently under investigation. Claims can be flagged by CMS, FIs, carriers, DMERCs, QIOs, PSCs, and law enforcement agencies.

Potential fraud referrals. Fraud detection was not part of the scope of work for demonstration RACs. However, RACs were responsible for referring claims they determined to be potentially fraudulent to the CMS Project

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<sup>8</sup> CMS, *The Medicare Recovery Audit Contractor (RAC) Program: An Evaluation of the 3-Year Demonstration*, p. 13.

<sup>9</sup> CMS, *Original Medicare (Fee-for-Service) Appeals: Overview*. Available online at <http://www.cms.hhs.gov/OrgMedFFSAppeals/>. Accessed on March 11, 2009.

<sup>10</sup> CMS, *RAC Data Warehouse User's Guide*, version 3.0, p. 4.

Officer.<sup>11</sup> The CMS Project Officer would then forward the referrals to the Program Integrity Group at CMS for further review and determination to refer to the PSC and/or law enforcement. CMS prohibited RACs from reviewing or taking further action on these claims. Further, RACs could not collect their contingency fee for claims they referred and that CMS determined to be fraud. However, if CMS determined that a referral did not involve potential fraud, the RAC was allowed to proceed with reviewing the claim.

*Outcome of the demonstration project.* During the 3-year demonstration project, RACs identified more than \$1.03 billion in Medicare improper payments, 96 percent (\$980 million) of which were overpayments collected from providers. The remaining 4 percent (\$37.8 million) were underpayments that were repaid to providers.<sup>12</sup> Of the overpayments, 85 percent (\$828.3 million) were collected from inpatient hospital facilities.<sup>13</sup>

During the demonstration project, providers appealed 22.5 percent of the RAC overpayment determinations. Overall, 7.6 percent of all overpayment determinations were overturned on appeal.<sup>14</sup>

The total cost of the demonstration project was \$201.3 million—or about 20 cents for each dollar collected.<sup>15, 16</sup> CMS paid RACs a total of \$187.2 million in fees over the duration of the demonstration. Medicare

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<sup>11</sup> The demonstration project statement of work provides for referrals to be made to PSCs; however, CMS directed demonstration RACs to make fraud referrals to the CMS Project Officer instead. Further, RACs were not given a specific format or method by which to make the referrals to CMS. CMS, *Statement of Work for the Recovery Audit Contractors Participating in the Demonstration (Non-Medicare Secondary Payer)*, p. 14.

<sup>12</sup> CMS, *The Medicare Recovery Audit Contractor (RAC) Program: An Evaluation of the 3-Year Demonstration*, p. 15.

<sup>13</sup> *Ibid.*, p. 19.

<sup>14</sup> CMS, *The Medicare Recovery Audit Contractor (RAC) Program: Update to the Evaluation of the 3-Year Demonstration*, January 2009, p. 4. Available online at <http://www.cms.hhs.gov/RAC/Downloads/AppealUpdatethrough83108ofRACEvalReport.pdf>. Accessed on February 2, 2009.

<sup>15</sup> CMS, *The Medicare Recovery Audit Contractor (RAC) Program: An Evaluation of the 3-Year Demonstration*, p. 14.

<sup>16</sup> The demonstration project also included Medicare Secondary Payer (MSP) RACs. These RACs were responsible for identifying and recovering MSP nonbeneficiary Group Health Plan-based overpayments. The total costs provided in this paragraph include MSP RACs. We did not include MSP RACs in our review.

claims processing contractors' costs were an additional \$8.7 million, and other expenses were \$5.4 million.<sup>17</sup>

### **Recovery Audit Contractor Permanent Program**

Section 302 of the Tax Relief and Health Care Act of 2006 requires that the RAC program be implemented nationally by 2010. In March 2007, CMS began conducting a full and open competition to award four permanent RAC contracts.<sup>18</sup> Each RAC is responsible for identifying overpayments and underpayments in one of four regional jurisdictions.

In October 2008, CMS announced its selection of the following companies as RACs:

- Region A (Maine, New Hampshire, Vermont, Massachusetts, Rhode Island, New York): Diversified Collection Services (DCS), Inc., of Livermore, California;
- Region B (Michigan, Indiana, Minnesota): CGI Technologies and Solutions (CGI), Inc., of Fairfax, Virginia;
- Region C (South Carolina, Florida, Colorado, New Mexico): Connolly Consulting Associates, Inc., of Wilton, Connecticut; and
- Region D (Montana, Wyoming, North Dakota, South Dakota, Utah, Arizona): HealthDataInsights (HDI), Inc., of Las Vegas, Nevada.

Shortly after the RAC selections were announced, two unsuccessful bidders filed protests with the Government Accountability Office (GAO). As a result, CMS was required to impose an automatic stay in the contract work of the four RACs. As required under provisions of the Competition and Contracting Act of 1984, GAO had 100 days to issue its decision in the matter. On February 4, 2009, settlement was reached and the imposed stay was lifted. As a result, PRG-Schultz, Inc., will serve as a subcontractor to DCS, CGI, and HDI in Regions A, B, and D; and Viant Payment Systems, Inc., will serve as a subcontractor to Connolly Consulting in Region C.

By the end of 2009, CMS had fully implemented the RAC program and expanded it to all States.

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<sup>17</sup> CMS, *The Medicare Recovery Audit Contractor (RAC) Program: An Evaluation of the 3-Year Demonstration*, p. 3.

<sup>18</sup> CMS, *Recovery Audit Contractors: Overview*. Available online at [http://www.cms.hhs.gov/RAC/01\\_Overview.asp#TopOfPage](http://www.cms.hhs.gov/RAC/01_Overview.asp#TopOfPage). Accessed on February 9, 2009.

Changes to the RAC program. Based on lessons learned during the demonstration project, several changes were made to improve the RAC program.<sup>19</sup> Changes included the following:

- RACs must pay back the contingency fee if the claim is overturned at any level of appeal, not just the redetermination level.
- The look-back period for reviewing claims was reduced from 4 years to 3 years, and RACs cannot review any claims prior to October 1, 2007.<sup>20</sup>
- RACs must report identified vulnerabilities monthly to CMS.

Potential fraud referrals. CMS made no changes to the fraud referral process for the permanent RACs. RACs must continue to report claims that they determine to be potentially fraudulent to the CMS Project Officer and do not receive their contingency fee for referrals determined to be fraud. As in the demonstration, RACs are allowed to continue reviewing these claims if CMS determines that the claims do not involve potential fraud.

### **Oversight of Recovery Audit Contractors**

RACs are overseen by CMS's Division of Recovery Audit Operations, part of the Provider Compliance Group within the Office of Financial Management. Each RAC has a CMS lead Project Officer and one or two co-Project Officers that are assigned to the task order.

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## **METHODOLOGY**

### **Scope**

We focused our data collection on the three RACs that participated in the 3-year demonstration project (March 2005 through March 2008). We also collected information from CMS regarding its oversight of the RACs during the demonstration project and permanent program.

We did not collect information from the four permanent RACs because they had not begun reviewing claims at the time of this study.

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<sup>19</sup> CMS, *The Medicare Recovery Audit Contractor (RAC) Program: An Evaluation of the 3-Year Demonstration*, p. 25.

<sup>20</sup> The look-back period is the amount of time between the medical record request date and the claim payment date (i.e., RACs cannot ask for medical records more than 3 years after a claim was paid).

### **Data Collection and Analysis**

From each of the three demonstration RACs, we requested information regarding each case of potential fraud that was referred to CMS during the demonstration project. The type of information we requested included: provider name, provider identification number, date of referral, to whom the referral was sent, whether acknowledgment of the referral was received, method of sending the referral, type of potential fraud identified, type of claim, and provider type. We also requested all documentation pertaining to each referral. From this information, we determined the number and type of referrals that each RAC made to CMS during the demonstration project.

Additionally, we asked RACs to provide us with information about policies and procedures regarding the referral of potential fraud that they had in place during the demonstration. We also asked about training that they received from CMS regarding the identification and referral of cases of potential fraud. We reviewed and summarized RAC responses to each of these questions to determine the extent to which RACs received training from CMS regarding fraud identification and referral during the demonstration project.

From CMS, we requested information about the referrals of potential fraud that it received from the RACs during the demonstration project. Specifically, we asked CMS to provide us with the following information for each referral received: provider name, provider identification number, date of referral, name of RAC that sent the referral, whether CMS sent the RAC a confirmation of receipt for the referral, type of claim, whether the referral was forwarded for further review or investigation, and the outcome of the referral. We also requested all documentation pertaining to each referral. We compared this information to the information we received from the RACs.

We also asked CMS to provide us with information on its policies and procedures for addressing referrals of potential fraud as well as training that it provided to RACs in identifying and referring cases of potential fraud. We reviewed CMS's responses to determine the extent to which it provided RACs with training on fraud identification and referral.

### **Standards**

This study was conducted in accordance with the "Quality Standards for Inspections" approved by the Council of the Inspectors General on Integrity and Efficiency.

## ► FINDINGS

### **Between 2005 and 2008, RACs referred two cases of potential fraud to CMS**

Two cases of potential fraud involving specific providers were referred by RACs to CMS during

the 3-year demonstration project. The two cases were referred by one RAC and were sent by letter directly to the CMS Project Officer. However, in response to our information request, CMS reported that it received no specific provider referrals from RACs during the demonstration project. CMS also reported that it did not track the outcomes of referrals it received from RACs.

The two referrals involved rehabilitation service providers and both involved suspected alterations of medical records after the services were rendered. According to the RAC referral letters sent to CMS, the RAC had no contact with the providers in reference to the allegations and continued to complete its complex and/or automated, postpayment review of the providers. If CMS had determined that the referrals were potentially fraudulent, the RAC should have ceased its review of these claims.

While another RAC did not make any formal fraud referrals to CMS, it indicated that it notified CMS of multiple claims involving millions of dollars in improper payments to physician practices for Intravenous Immune Globulin (IVIG) treatments in Florida. CMS directed the RAC to close down its review of these claims. The RAC reported that CMS then referred these IVIG claims to the PSC and/or law enforcement to develop cases against numerous providers throughout Florida. During this time, CMS decided to exclude claims from physician practices as well as claims from durable medical equipment suppliers in three southern counties of Florida from further RAC review.

The third RAC had no potential fraud referrals during the demonstration project.

### **During the demonstration project, CMS did not provide any formal training to RACs regarding the identification and referral of potential fraud; however, CMS did provide the permanent RACs with a presentation about fraud**

During the demonstration project, the RACs were routinely invited by CMS to participate in a number of conferences and meetings where fraud issues were discussed, but no formal training

was provided to the RACs. In response to our information request

## F I N D I N G S

regarding RAC training, CMS stated, “In order to determine if recovery auditors could work in Medicare, CMS purposely did not provide formal training to the RACs. The RACs needed to prove to Medicare and the provider community that they could work in the Medicare environment. Significant CMS intervention would have clouded the result.”<sup>21</sup>

However, in October 2008, CMS gave a presentation regarding Medicare fraud to the permanent RACs participating in the permanent program. The presentation discussed the definition of fraud, examples of potential Medicare fraud, and the need for the RACs to be knowledgeable about fraud in Medicare.

CMS told us it is planning to provide RACs in the permanent program with further education and training on the identification and referral of potential fraud.

**Although CMS did not provide formal training to the RACs during the demonstration project, two RACs reported providing informal training to their own staff regarding the identification and referral of potential fraud**

One RAC noted that its Executive Vice President has experience in Medicare fraud as a result of previously working for CMS, where he was responsible for benefit integrity functions. The identification of potential fraud was regularly discussed at staff meetings, improper payment query meetings, and other meetings where the Executive Vice President participated and provided advice and counsel to staff. In addition, this RAC held monthly conference calls with its Project Officer to discuss operational issues, including potential fraud issues.

Another RAC reported that auditors were advised to refer cases to upper management when concerns were prompted by questionable billing patterns or the nature of the medical documentation. These concerns resulted in further examination of the claims data, additional medical review, and referrals to CMS.

The other RAC did not provide its staff with training regarding the identification or referral of potential fraud.

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<sup>21</sup> Response received on June 22, 2009, from CMS Director for the Division of Recovery Audit Operations and CMS Director for the Division of Benefit Integrity Management Operations in CMS.

## ► R E C O M M E N D A T I O N S

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During the 3-year demonstration project, RACs identified over \$1 billion in improper payments. Yet, RACs referred only two cases of potential fraud to CMS during this time. Because RACs do not receive their contingency fees for cases they refer that are determined to be fraud, there may be a disincentive for RACs to refer cases of potential fraud.

RACs are required to refer any cases of potential fraud that they identify; however, they must be able to identify fraud to refer it. Having a RAC staff that is knowledgeable about fraud and trained to identify it will increase awareness and detection of potential fraud during the claims review process. However, CMS did not provide RACs in the demonstration project with formal training on how to identify and refer fraud, although CMS did provide the permanent RACs with a presentation about fraud.

Therefore, we recommend that CMS:

**Conduct followup to determine the outcomes of the two referrals made during the demonstration project**

CMS indicated that it received no provider-specific referrals from the RACs during the demonstration project. However, one RAC submitted copies of two provider-specific referrals that were sent to the CMS Project Officer during the demonstration project. CMS should determine the outcome of these referrals.

**Implement a database system to track fraud referrals**

We recommend that CMS develop a database system to track fraud referrals it receives from RACs.

**Require RACs to receive mandatory training on the identification and referral of fraud**

Although RACs are not responsible for identifying fraud, having more training in detecting fraudulent activity could assist RACs in identifying potential fraud that they might encounter during their reviews. CMS should ensure that the permanent RACs receive training on how to identify cases of potential fraud. Furthermore, CMS should develop guidelines to assist the RACs in determining when to refer cases of potential fraud for further investigation.

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**AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL  
RESPONSE**

CMS concurred with all of our recommendations. In addition, CMS stated that the RACs' primary focus is the identification and correction of improper payments, not identification of potential fraud. However, since fraudulent payments could potentially be identified in the RACs' improper payment reviews, their reviews also serve to identify instances of potential fraud. CMS also stated that if RACs identified potential fraud during the demonstration, their statement of work required them to forward these cases to CMS and CMS would determine if further referral to the program safeguard contractors or other law enforcement was warranted. We recognize that RACs are not responsible for identifying potential fraud; however, we believe that there may be a disincentive for RACs to refer cases of potential fraud because they do not receive their contingency fees for cases determined to be fraud.

CMS concurred with our first recommendation and stated that it had researched the two cases identified by the RAC for potential referral and determined they should be referred to the Office of Inspector General (OIG) for further development. CMS is in the process of forwarding the two cases to OIG. OIG will review these cases and determine what actions need to be taken.

CMS concurred with our second recommendation and stated that it is in the process of developing a system to track the RAC claims review process. This will include new issues approved for review, as well as corrective actions taken and referrals to and from a RAC. The referrals will include potential fraud referrals and will require closure so that feedback can be given when necessary.

CMS also concurred with our third recommendation and stated that it has already provided two training sessions to the RACs and is in discussion with OIG and the Department of Justice on additional training. The OIG training session was scheduled for January 2010.

The full text of CMS's comments is provided in the Appendix.

▶ A P P E N D I X

**Agency Comments**



DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

*Administrator*  
Washington, DC 20201

**DATE:** JAN 05 2010

**TO:** Daniel R. Levinson  
Inspector General

**FROM:** Charlene Frizzera */S/*  
Acting Administrator

**SUBJECT:** Office of Inspector General (OIG) Draft Report: "Recovery Audit Contractors' Fraud Referrals" (OEI-03-09-00130)

Thank you for the opportunity to review and comment on the OIG's draft report, "Recovery Audit Contractors' Fraud Referrals." The Centers for Medicare & Medicaid Services (CMS) appreciates the time and resources the OIG has invested to review the Recovery Audit Contractor (RAC) fraud referrals during the RAC demonstration.

Section 306 of the Medicare Modernization Act required CMS to establish the RAC demonstration. Its purpose was to determine if recovery auditors could identify improper payments paid by the Medicare fee-for-service program. CMS awarded three contracts in 2005 to three unique contractors to identify claims-based Medicare fee-for-service improper payments, conducting the demonstration first in California, New York, Florida and then later in Massachusetts, South Carolina and Arizona. The RAC demonstration succeeded in correcting more than \$1 billion in improper Medicare payments. About 96 percent of these improper payments were overpayments, a fraction of which was used to pay for the program and the rest was returned to the Medicare Trust Fund.

It is important to note that the RACs were not tasked with identifying potential fraud under the demonstration, nor is identifying fraud a key role as the program is launched nationally. The RACs' primary focus is the identification and correction of improper payments. Since fraudulent payments could potentially be identified in the RAC's improper payment reviews, their reviews also serve to identify instances of potential fraud. However, if the RACs did identify potential fraud in the demonstration, their Statement of Work (SOW) required them to forward the case to CMS and then CMS would determine if further referral to the Program Safeguard Contractors (PSCs) or other law enforcement was warranted. Two potential referrals were received from the RACs and CMS determined that they warranted additional follow-up and will refer them to the OIG for further development. Thus, as the RAC continues to perform the functions of its SOW, potential fraud may be uncovered and referral to the appropriate entity will take place.

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In addition, during the RAC demonstration, CMS took steps to ensure that the RACs did not impede upon any open fraud investigations and/or audits. Therefore, CMS created a RAC Data Warehouse which provided notice to the RACs on claims that were excluded from review. Law enforcement, PSC and claim processing contractors also had access to the RAC Data Warehouse.

Implementation of the permanent RAC program was required by the Tax Relief and Health Care Act of 2006 which mandated the use of RACs nationwide by January 2010. In October 2008, CMS awarded four contracts to four unique contractors to perform recovery audit services to identify Medicare fee-for-service improper payments. As of October 2009, CMS had successfully completed implementation of the national RAC program. While the RAC program's goal is to identify and correct improper payments and prevent improper payments from occurring in the future, CMS now requires the RACs to have Joint Operating Agreements (JOAs) with the PSCs and/or Zone Program Integrity Contractors (ZPICs). The agreement primarily focuses on the development of the relationship between the RACs and PSCs/ZPICs and the development of a formal and informal referral process between the entities for cases that may indicate fraud

In addition, CMS is in the process of developing a system to track the RAC claims review process. This would include tracking new issues approved for review, as well as referrals to and from a RAC and any corrective actions taken as a result of the identification. This system will also allow CMS to track potential fraud referrals and provide feedback when necessary.

Finally, in the national RAC program, CMS has been proactive in its efforts to provide education and training to the RACs. Two of the sessions included specific presentations relevant to the identification of potential fraud. In addition, the OIG has agreed to conduct a special training on the identification of potential fraud for the RACs in January 2010. CMS has also reached out to the Department of Justice (DOJ) to provide additional training for the RACs and has offered to create ad hoc reports for law enforcement when needed.

While the mission of the RAC program is to identify and correct Medicare fee-for-service improper payments and prevent future improper payments, CMS appreciates the cooperation it has received from other governmental entities and looks forward to continued collaboration with law enforcement, which will strengthen the government's ability to protect the Medicare Trust Fund for its beneficiaries.

Our detailed comments on the report recommendations follow.

**OIG Recommendation**

Conducts follow up to determine the outcomes of the two referrals made during the demonstration project.

**CMS Response**

The CMS concurs. CMS has researched the two cases identified by the RAC for potential referral and has determined they should be referred to the OIG for further development. CMS is in the process of forwarding the two cases to the OIG.

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**OIG Recommendation**

- Implement a database system to track fraud referrals.

**CMS Response**

The CMS concurs. The CMS is in the process of developing a system to track the RAC claims review process. This includes new issues approved for review, as well as corrective actions taken and referrals to and from a RAC. The referrals will include potential fraud referrals and will require closure so that feedback can be given when necessary.

**OIG Recommendation**

- Require RACs to receive mandatory training on the identification and referral of fraud.

**CMS Response**

The CMS concurs. The CMS has provided two sessions to the RACs and is in discussion with OIG and DOJ on additional sessions. The OIG session is scheduled for January 2010.



## **A C K N O W L E D G M E N T S**

This report was prepared under the direction of Robert A. Vito, Regional Inspector General for Evaluation and Inspections in the Philadelphia regional office, and Linda M. Ragone, Deputy Regional Inspector General.

Maria Schepise Johnson served as the project leader for this study. Central office staff who contributed include Scott Manley.

# *Office of Inspector General*

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