# Medicaid RACs to Increase Enforcement Efforts

## Medicaid RACs Set to Increase Audits

Recent efforts by CMS to improve Medicaid audit performance have resulted in procedural changes for Medicaid Integrity Contractors (MICs) and financial incentives for Medicaid Recovery Audit Contractors (Medicaid RACs) to increase their audit efforts and effectiveness.

RACs have long been regarded as “bounty hunters” within the Medicare/Medicaid and healthcare provider communities. These entities essentially *“eat what they kill”*; therefore their profitability ultimately depends on their ability to identify overpayments. RACs receive a percentage of any overpayment recovery they obtain based on contingency fee rates established by each state under the Medicaid RACs final rule, issued September 16, 2011. On June 1, 2011, CMS increased the contingency fee for Medicaid RACs who identify overpayments by Durable Medical Equipment (DME) home health providers by 5%, increasing the Medicaid RAC maximum contingency fee from 12.5% to 17.5%. CMS finally gave notice of this fact on February 24, 2012 when it announced that the Medicaid maximum RAC contingency fee for non-DME claims would remain at 12.5%, while DME claims would be paid at the higher rate of 17.5%. By authorizing this rate change, CMS has given Medicaid RACs additional monetary incentive to focus on DME providers in finding Medicaid overpayments. The result will be even more pressure on DME providers to follow the law. Remember that government contractors have a duty to report and refer suspected fraudulent activity.

For example, DOJ recently indicted a DME provider in South Texas who pled guilty to a felony charge of conspiracy for violating the federal Anti-Kickback Statute:

> “The federal anti-kickback statute prohibits individuals and entities from knowingly and willfully paying or offering to pay, as well as soliciting or receiving remuneration (money or things of value) in return for the referral of patients for medical services or items which are benefits under a federal health care program, such as Medicare or Medicaid. A violation of the statute is a felony offense.”

The DME service provider’s owner now faces up to 5 years in federal prison and a $250,000 fine. DME providers should, at a bare minimum, make sure they have supporting documentation for all ordered equipment and supplies from the referring physician they do business with. This would include diagnostic information, supporting medical tests, and physician orders for medically necessary equipment and supplies. Such documentation is essential to supporting your DME claims in the event of a RAC audit or law enforcement investigation.

**Liles Parker is a full service health law firm, providing assistance and representation with Medicaid and Medicare compliance concerns, government audits and appeals, and other health law matters. Should you have any questions, please contact Richard Pecore at 713-432-4747 for a free consultation.**