



# Medicare's Recovery Audit Contractor (RAC) Program

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Rudy Braccili Jr, MBA, CPAM  
Sr. Director, National Medicare & Medicaid Center

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## Agenda for Today

- **Status of CMS' Permanent RAC Rollout**
- **Changes to Demonstration Project's SOW**
- **Recommended Roles for PFS - Hospital**
- **Tracking RAC Activity**
- **Reporting RAC Activity**

## RAC Demonstration Project

- **3-year Medicare RAC Demonstration Project lasted from March 2005 through March 2008**

### Phase I

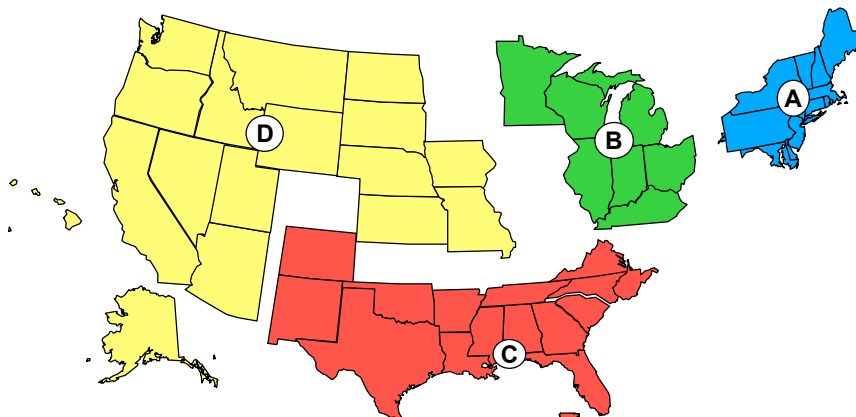
2005: California, Florida & New York F.I.'s

### Phase II

2007: South Carolina, Arizona, Massachusetts & Mutual Of Omaha FI hospitals in any of the 6 demo states, plus original phase I states

## Permanent RAC National Expansion Plans

- CMS competition to hire 4 permanent RACs



## RAC Nation-wide Roll-out Strategy

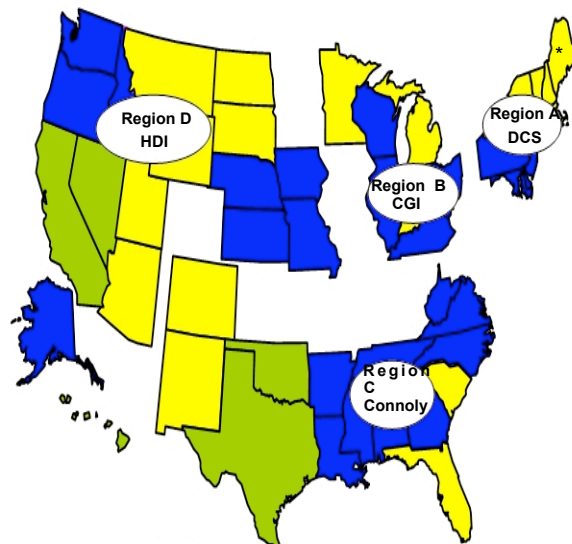
- **Permanent RAC Program**

- Was originally scheduled to begin March 2008

- Was postponed until October 2008 as CMS took longer than anticipated to select permanent RAC vendors

- Postponed again because 2 vendors who were not selected to be RACs (PRG-Schultz, and Viant) filed a formal protest. Protest was settled in early February 2009.

## RAC Nation-wide Roll-out Strategy



March 1, 2009

March 1, 2009

August 1, 2009 or later

## **RAC Nation-wide Roll-out Strategy**

- **For states scheduled to implement on March 1, 2009...**
  - RACs have not yet received claims data from CMS
  - RACs are in the process of scheduling state specific outreach meetings with providers - in cooperation with local state hospital associations and CMS (March – April)
  - Once RACs receive claims data from CMS, they must crunch the data (data mining) to identify areas of high potential payment error. RACs then must seek approval from CMS to audit (April – May)
  - Initial audit letters/requests for medical records are not expected to be received by providers until May - July

## **RAC Vendors by Region**

- Region A: **Diversified Collection Services, Inc.**  
PRG-Schultz, Inc. sub-contractor  
**Northeast U.S. States**
- Region B: **CGI Technologies & Solutions, Inc.**  
PRG-Schultz, Inc. sub-contractor  
**Northern Industrial U.S. States**
- Region C: **Connolly Consulting Associates, Inc.**  
PRG-Schultz, Inc. sub-contractor  
**Southern U.S. States**
- Region D: **Health Data Insights, Inc.**  
Viant Payment Systems, Inc. sub-contractor  
**Mid-western & Western U.S. states**

## RAC Regional CMS Contacts


- Region A: **Diversified Collection Services, Inc.**  
[ebony.brandon@cms.hhs.gov](mailto:ebony.brandon@cms.hhs.gov)
- Region B: **CGI Technologies & Solutions, Inc.**  
[scott.wakefield@cms.hhs.gov](mailto:scott.wakefield@cms.hhs.gov)
- Region C: **Connolly Consulting Associates, Inc.**  
[marie.casey@cms.hhs.gov](mailto:marie.casey@cms.hhs.gov)
- Region D: **Health Data Insights, Inc.**  
[marie.casey@cms.hhs.gov](mailto:marie.casey@cms.hhs.gov)

## RAC Validation Contractor

- **Provider Resources, Inc.** Erie, Pa.
  - Works with CMS to oversee & audit RAC determinations
  - In conjunction with CMS - approves new issues to be targeted by RAC
  - All focus areas must be newly approved for the permanent program.  
Target areas approved during the demonstration project are not carried over to the new program unless newly approved.
- **Vulnerability Reporting**
  - RACs must maintain a website with the approved list of issues they are targeting

## Results of the RAC Demonstration Program

Collections exceeded costs

Overpayments Collected:		\$992.7 m
Less Underpayments Repaid:	-	(\$37.8 m)
Less \$ Overturned on Appeal:	-	(\$46.0 m)
Less PRG IRF Re-review:	-	(\$14.0 m)
Less Costs to Run Demo:	-	(\$201.3 m)
<b>BACK TO TRUST FUNDS</b>		<b>\$693.6 m</b>

Report now available at [www.cms.hhs.gov/RAC](http://www.cms.hhs.gov/RAC)

3/27/05-3/27/08 (Claim RACs & MSP RACs)

## RAC Targets resulting from Demo

- Short stay cases: chest pain, back pain, gastroenteritis
- Cardiac defibrillator surgical procedures – appropriateness of setting
- Major Bowel Procedures
- Discharge Disposition Conflicts with other post-care providers
- Incorrect principal diagnosis
- 3 – day acute qualifying stay for subsequent SNF admission
- Outpatient – Inpatient 3-day (aka 72 hour) overlap rule
- Outpatient # of units exceed maximum allowable (e.g. colonoscopy)

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## Future - Program Expansion Lessons Learned

	Demonstration RACs	Permanent RACs
Look back period (from claim pmt date - date of medical record request)	4 years	3 years
Maximum look back date	None	10/1/2007
Allowed to review claims in current fiscal year?	No	Yes
RAC medical director	Not Required	Mandatory
Coding experts	Optional	Mandatory
Discussion with RAC medical director regarding claim denials if requested	Not Required	Mandatory
Credentials of reviewers provided upon request	Not Required	Mandatory
Vulnerability reporting	Limited	Mandatory
RAC must payback the contingency fee if the claim overturned at...	... <b>first</b> level of appeals	... <b>all</b> levels of Appeal
Web-based application that allows providers to customize address & contact	None	Mandatory by Jan. 1, 2010
External validation process	Not Required	Mandatory



## RAC Overview

- RACs Must Report Potential Fraud and Quality Issues
- Providers Can Repay Overpayments Through Installment Plans up to 12 Months (or Longer with Approval) Settlement Offers will also be considered
- RACs Shall Provide a Toll Free Customer Service Line to All Providers
- Medicare payment retractions resulting from RAC audit will be uniquely identified on the Medicare remit with remark code **N432**
- RAC may not audit a claim that is being audited by another auditing entity e.g. OIG, QIO - RAC data warehouse will prevent this

## Context - CMS Claims Review Entities

### Roles of Various Medicare Improper Payment Review Entities

	Types of Claims	How selected	Volume of Claims	Purpose of Review
QIO	<b>Inpatient Hospitals</b>	All claims where hospital submits an adjusted claim for a higher-weighted DRG  Expedited Coverage Reviews requested by beneficiaries	<b>Very small</b>	To prevent improper payments through DRG upcoding  To resolve discharge disputes between beneficiary and hospital
CERT	<b>All</b>	<b>Randomly</b>	<b>Small</b>	To <b>measure</b> improper payments
MAC	<b>All</b>	<b>Targeted</b>	Depends on number of claims with improper payments for this provider	To <b>prevent future</b> improper payments
RAC	<b>All</b>	<b>Targeted</b>	Depends on number of claims with improper payments for this provider	To <b>detect and correct past</b> improper payments
PSC	<b>All</b>	<b>Targeted</b>	Depends on number of potentially fraudulent claims submitted by provider	To identify <b>potential fraud</b>
OIG	<b>All</b>	<b>Targeted</b>	Depends on number of potentially fraudulent claims submitted by provider	To identify <b>fraud</b>

## RAC Overview

- RACs are authorized to audit Acute Hospital, SNF, IP-Rehab, Long Term Acute Care, Laboratory, Home Health, Physician, DME and Hospice provider types
- Medicare Advantage (HMO), Medicare Part-D (Prescription Drug Benefit), Cost report Settlements, and IME-GME payments are excluded from the RAC program
- RACs will seek to identify potential overpayments made to physicians related to hospital accounts where overpayments have been identified – however this was not the case during the demonstration program

## RAC Overview

- Each RAC must **employ a minimum of one FTE contractor medical director (CMD)** and arrange for an alternate when the CMD is unavailable for extended periods.
- The CMD FTE must be composed of either a **Doctor of Medicine or a Doctor of Osteopathy** who has relevant work and educational experience.
- More than one individual's time cannot be combined to meet the one FTE minimum.
- "...The RAC shall ensure that **coverage/medical necessity determinations are made by RNs or therapists and that coding determinations are made by certified coders.**
- The RAC shall ensure that no nurse, therapist or coder reviews claims from a provider **who was their employer within the previous 12 months.**

## RAC Overview

- A RAC “Black-out” period will exist for providers transitioning from Fiscal Intermediary (FI) to Medicare Administrative Contractor (MAC) during which no RAC activity will take place

## RAC Overview

- **How RACs get paid:**
  - CMS reimburses RACs using a contingency based payment model
  - Payment to the RAC is based on a % of the monies the RAC identifies as overpayments & underpayments
  - Contingency percentages paid to the RAC range from 9% - 12.5% and vary by region. Variation is due to the competitive bid process
  - Program is considered to be “Risk Free” for CMS
  - RACs return contingency fee to CMS if case is overturned on **any level of appeal**

## RAC Overview

- When underpayments to the provider are identified by the RAC, the underpayment amount will be paid to the provider on the Medicare remit. There is no action that the provider must take to obtain the underpaid amount
- When overpayments to the provider are identified by the RAC and the originally paid amount is retracted in total, providers must re-bill the 'adjusted' claim to the FI or MAC in order to receive the corrected payment amount

## RAC Overview

### Examples of Underpayments:

- The provider **billed for 15 minutes of therapy when the medical record clearly indicates 30 minutes of therapy were provided.** (This provider type is paid based on a fee schedule that pays more for 30 minutes of therapy than for 15 minutes of therapy)
- The provider billed for a particular service and the **amount the provider was paid was lower than the amount on the CMS fee schedule.**
- A **diagnosis/condition was left off the claim but appears in the medical record.** Had this diagnosis or condition been listed, a higher payment group would have been the result.

## RAC Review Process

- **RAC sends medical record request for complex reviews**
  - It is not clear for each hospital – **what specific address** will be used. RACs are required to customize addresses as directed by providers in 2010
  - Providers should reach out to the RAC and provide customized correspondence address – however they are not required to oblige until 2010
  - Providers have **45 days to submit** medical record copies
  - Records not received within the required timeframe will be denied and full payment will be retracted
  - Prior to denying due to “records not received” RAC must initiate 1 final contact attempt to provider

## RAC Review Process

- **RAC sends medical record request for complex reviews**
  - RAC must accept **records via fax, paper, CD or DVD**
  - Records will need to be **provided again at each level** of appeal
  - RACs must pay a **\$0.12 cents per page** copy charge and **first class postage** rate for IP records sent
  - RACs **pay copy & postage fees within 45 days** of invoice
  - Hospital is notified of RAC **decision within 60 days**
  - **“Demand letter” is received** when an overpayment is identified with reason for determination.
  - RAC advises **rights of appeal** within the body of each “demand letter”

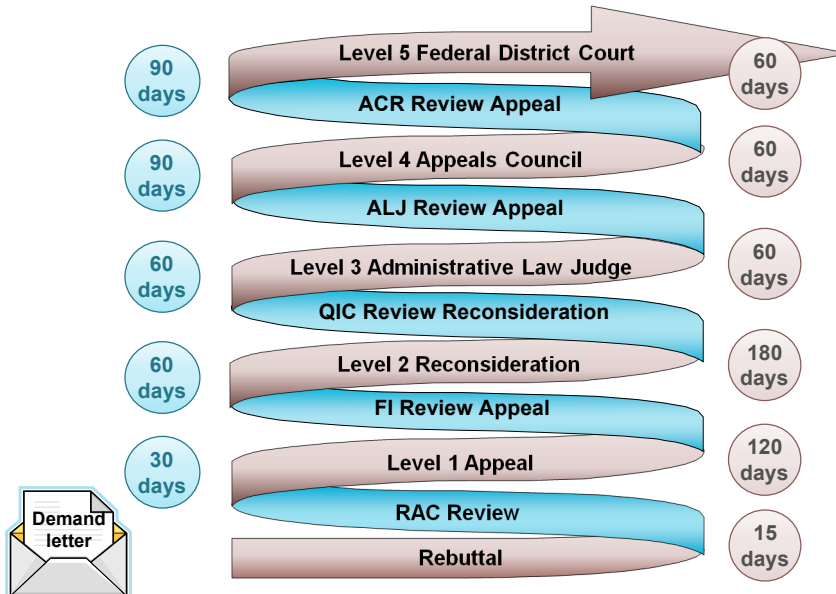
## RAC Review Process

- **CMS Limits the Number of Record Requests**
  - **Inpatient Hospital, Rehabilitation, SNF, Hospice:**  
Ten percent of average monthly Medicare IP claims, with a **200 record maximum, per 45 days**
  - **Outpatient Hospital, Home Health:**  
One percent of average monthly Medicare OP services, with **a 200 record maximum, per 45 days**

## RAC Review Process

- **Hospitals may:**
  - **Agree** with RAC determination – F.I. will “offset” overpayment \$\$ against future claims
  - Submit a **rebuttal** letter (referred to as the “discussion period”) to RAC **within 15 days of notice**, identifying grounds for disagreement. RAC has 30 days to respond. Successful rebuttals will have RAC reverse their decision. Merely filing a rebuttal does not delay payment retraction
  - Engage in **appeal** (5 levels). Interest rate on overpayment accrues and hospital is obligated to pay interest if appeal is ultimately denied.

## RAC Appeals Process



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## RAC Appeals Facts

- **No payment recoupment if level I appeal is filed within 30 days of initial determination.** However providers do have 120 days to file the appeal.
- **No payment recoupment if 2<sup>nd</sup> level appeal is filed within 60 days of level I appeal decision.** However providers do have 180 days to file 2<sup>nd</sup> level appeal.
- Recoupment can occur even with appeal to ALJ – 3<sup>rd</sup> level appeal.
- **All evidence for the appeal** must be submitted by level II unless good cause is shown.
- **Any party** to hearing may request appeal at level 4 or 5.

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## RAC Review Process

- If an appeal at levels I and II is filed fast enough, payment retraction will be deferred. Otherwise retraction will occur within 31 days of demand notice
- However, while the facility is going through the numerous Medicare steps of appeal, **interest will accrue** on the amount that is being disputed. Interest rate is 11.375%
- If the overpayment dispute is overturned at any level of the appeal process, the interest will be removed
- If the overpayment dispute is not overturned, then the interest fee remains on the account

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## Recommended RAC Response

- **Patient Financial Services Role**
  - Provide medical records timely to the RAC when requested
  - File rebuttals/appeals timely (CRC)
  - Consult with hospital professionals when preparing appeals
  - Establish working relationship with RAC single point of contact
  - Involve regulatory & outside counsel in appeal process
  - Track RAC specific patient account activity
  - Monitor RAC related Medicare payment retractions
  - Re-bill Medicare for re-payment as appropriate
  - Refund supplemental payors and Medicare beneficiaries as required
  - Provide RAC financial & clinical reports by facility, state, region, total

## Recommended RAC Response

- **Hospitals' Role**
  - **Forward any RAC correspondence/requests** to PFS
  - **Provide input during the appeal process**
    - Involve P.A. and other hospital-based professionals
    - Provide supporting documentation not present in the record e.g. Physician Advisor medical necessity notes, UR documentation, shadow records
  - **Establish a hospital-based RAC task force** to review RAC audit findings & appeal results, and implement corrective/preventative actions – include:
    - HIM
    - Coding
    - DPS
    - HCO
    - Finance
    - CMO
    - Case Management
    - PFS

## Recommended RAC Response

- **Hospitals' Role**

- Designate a hospital-based RAC Coordinator
  - Chair hospital RAC task force
  - Primary point of contact with PFS & RAC
  - Recommend Case Management Director for this role
- Ensure 100% Interqual review of all Medicare IP admissions
- Engage Physician Advisor when Interqual indicates a potentially “failed” medical necessity case and encourage detailed documentation of the PA review
- Follow-up with SNF - post discharge to ascertain actual level of care provided. Ensure coded discharge disposition matches actual post discharge level of care provided:
  - 03 = skilled level of care      04 = intermediate level of care

## Recommended RAC Response

- **Hospitals' Role**

- Document I.V. therapy start and stop times within the medical record
- Communicate RAC findings and activity to hospital UR committee
- Ensure that services provided to Medicare patients have documentation present in the record describing the medical condition that exists in support of the service – Document – Document – Document!
- Role of HCO: Track RAC issues in Compliance Incident Tracking System (CITS), and Evaluate RAC requests to determine whether any weaknesses need to be corrected

## Recommended RAC Response

- **Hospitals' Role**

- **Provide Physician Outreach Education**

- **Best Practices:**

- Provide each physician with a list of their records that were audited by the RAC along with the outcome of the review
      - Attend physician department meetings to educate physicians
      - Visit physician practices to educate them on:
        - The RAC program
        - The importance of patient status assignment i.e. inpatient vs. observation
        - Clarity around documenting admission orders
        - Medicare's "Inpatient Only Procedures"
        - Provide physicians with contact names and numbers
      - Implement a [Clinical Documentation Improvement Program](#)

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## RAC Tracking Data Components

### Demographics

- Facility
- RAC Audit Letter ID #
- Account No.
- Patient Name (Last Nm, First Nm)
- Medical Record No.
- HIC No.
- Admit Date
- Discharge Date
- Total Charges
- DRG No.

## RAC Tracking Data Components

### RAC Request Data

- Name of RAC Firm
- Date of Initial RAC Letter (**date printed on letter**)
- Date Initial RAC Letter Received by Hospital
- RAC Audit Category (**Dynamic Data**)
  - 1) Request for Records
  - 2) Documentation Supports Services
  - 3) Not Medically Necessary
  - 4) OP Billed as IP
  - 5) Discharge Status Conflict
  - 6) Accounts Not Combined Prior to Billing
  - 7) Incorrect Units Charged

## RAC Tracking Data Components

### RAC Request Data

- Were Records Requested by RAC?
- Date Records were Requested by RAC
- Date Records Are Required by RAC (45 days after date records requested)
- Date Records Sent to RAC by Facility
- # of Pages Sent
- Copy Cost (**\$0.12 per page reimbursed**)
- Postage Cost (**first class rate reimbursed**)
- Total Records Cost Reimbursable by RAC
- Amount of Records Cost Reimbursed by RAC

## RAC Tracking Data Components

### Appeal Data

- Letter of Rebuttal Due Date (**15 days after date of initial RAC Letter**)
  - Date Letter of Rebuttal Sent to RAC by Facility
  - Date Response to Rebuttal Received from RAC
  - Did RAC agree with Rebuttal Letter?
  - Does Hospital Recommend Appeal?
- For each Appeal Level...**
- **Appeal Due Date**
  - **Date Appeal Letter Sent from Hospital**
  - **Date Appeal Response Due back From RAC**
  - **Date Appeal Decision Letter Received**
  - **Appeal Result (Denial Upheld or Denial Overturned)**
  - **Does Facility Recommend Next Level of Appeal**

## RAC Tracking Data Components

### Payment Data

5 Types of Payment Data

#### 1) Original Payment Data

- Original Medicare Pymt Date
- Total Original Medicare Pymt Amt
- Total Original Supp Pymt Amt
- Total Original Pt Pymt Amt
- Grand Total Original Pymts

#### 2) Retraction/Refund Data

- **Medicare Retraction Date**
- **Medicare Retraction Amount**
- **Supplemental Refund Date**
- **Supplemental Refund Amount**
- **Patient Refund Date**
- **Patient Refund Amount**
- **Grand Total Retraction/Refund Amt**

## RAC Tracking Data Components

### Payment Data

#### 3) Re-Payment Data

- Medicare Re-payment Date
- Medicare Re-payment Amt
- Supplemental Re-payment Amt
- Patient Re-Payment Amt
- Grand Total Re-payments

#### 4) Net Payment Results

- **Medicare Net Payment Result**
- **Supplemental Net Payment Result**
- **Patient Net Payment Result**
- **Grand Total Net Payment Result**

## RAC Tracking Data Components

### Payment Data

#### 5) Non-recoverable Net Payments Lost (defined as: Net dollars lost after all appeals exhausted)

- Medicare non-recoverable net dollars lost
- Supplemental non-recoverable net dollars lost
- Patient non-recoverable net dollars lost
- Grand non-recoverable net dollars lost

## RAC Tracking Data Components

### RAC Audit Status

Closed – Entire Original Medicare Payment Retracted

Closed – Original Medicare Payment Increased

Closed – No Change in Medicare Original Payment

Closed – Original Medicare Payment Reduced

Open – Pending outcome

- **Reportable Event?**
- **Comments**

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## Available RAC Reports

- RAC Accounts identified to Date by Audit Category
- RAC Accounts Identified to Date by Audit Status
- RAC Accounts Closed to Date With No Change in Medicare Payment
- RAC Accounts closed to Date with Medicare Payment Decreases
- RAC Accounts Closed to Date with Medicare Payment Increases
- RAC Accounts Pending Final Outcome
- RAC Payment Retractions to Date
- RAC Payment Retractions by Month

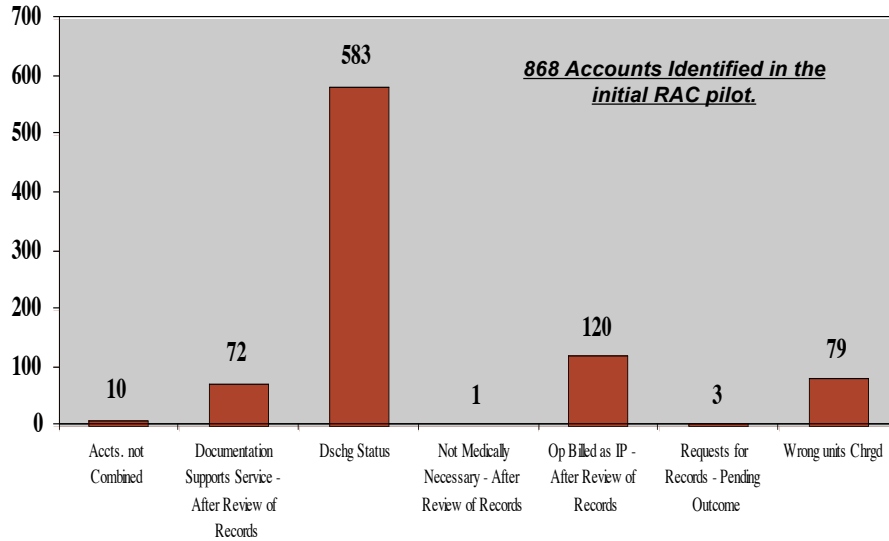
## Available RAC Reports

- RAC Payment [Retractions by Audit Finding](#)
- Grand Total [Non-Recoverable Dollars Lost](#) Due to RAC Audits by Facility
- Grand Total [Non-Recoverable Dollars Lost](#) Due to RAC Audits by Audit Finding
- Total [Accounts Rebutted – By Audit Finding](#)
- Total [Accounts Appealed by Audit Finding](#)
- [Total Accounts Appealed and/or Rebutted](#)
- Level 1 (through 5) Appeal outcomes

## Results from RAC Demonstration Period

- **Martin Memorial Hospital System – Florida**
  - 60% of cases reviewed resulted in “no finding”
  - 40% denied i.e. Medicare overpayment found
    - 70% of all denials were due to medical necessity
    - 16% of denials were overturned at level I appeal
    - 84% of denials were overturned at level II appeal
- **Adventist Health – California**
  - Of total Medicare payments retracted:
    - 38% due to medical necessity
    - 33% due to coding/DRG errors
    - 28% due to IP Rehab medical necessity
    - 2% OP # of units charged
  - \* recovered \$3M in appeals thus far

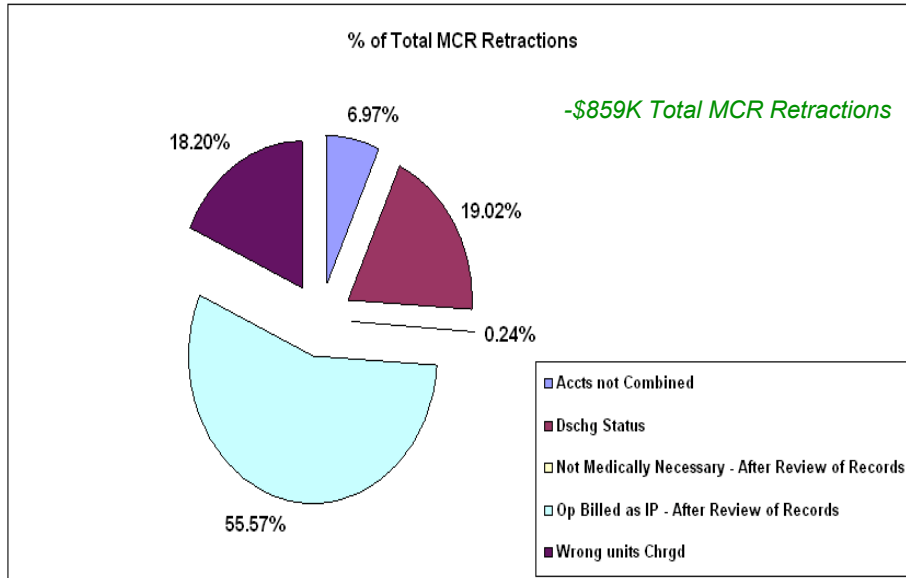
## Tenet – RAC # of Accounts Identified to Date



## Tenet – RAC Medicare Payment Retractions to Date

Facility	Count	Original MCR Payment Amount	Medicare Retraction Amount	Medicare Repayment Amount	Net Medicare Payment Decrease
Coral Gables	2	\$4,987	-\$4,987	\$1,329	-\$3,657
Delray Medical	2	\$3,814	-\$3,814	\$82	-\$3,733
Florida Medical	1	\$1,088	-\$1,088	\$311	-\$777
Good Samaritan	12	\$57,999	-\$57,999	\$13,544	-\$44,455
Hialeah	3	\$13,351	-\$13,351	\$6,386	-\$6,965
Hollywood	0	\$0	\$0	\$0	\$0
North Shore	5	\$18,073	-\$18,073	\$7,858	-\$10,215
North Ridge	4	\$9,012	-\$9,012	\$2,775	-\$6,237
Palm Beach Gardens	0	\$0	\$0	\$0	\$0
Pinecrest	4	\$9,012	-\$6,057	\$3,206	-\$1,851
Palmetto	5	\$16,715	-\$16,715	\$1,718	-\$14,997
St. Mary's	3	\$3,811	-\$3,811	\$3,225	-\$386
West Boca	10	\$10,414	-\$10,414	\$6,756	-\$3,658
Hilton Head Regional Medical Center	50	\$170,075	-\$170,075	\$41,158	-\$128,917
East Cooper Regional Medical Center	25	\$156,289	-\$156,289	\$146,835	-\$9,454
Piedmont Medical Center	72	\$310,203	-\$310,203	\$66,923	-\$243,281
Coastal Carolina	9	\$77,880	-\$77,880	\$52,082	-\$25,798
<b>TOTAL</b>	<b>207</b>	<b>\$862,524</b>	<b>-\$858,569</b>	<b>\$354,188</b>	<b>-\$504,381</b>

## Tenet – Medicare Payment Retractions by Finding



## Tenet – Total Accounts Rebutted and/or Appealed

Facility	# of RAC Accounts	Total Original Payment Amount	REBUTTED ACCTS.		APPEALED ACCTS.		REBUTT. AND/OR APPEALED ACCTS.	
			# of Accounts Rebutted	% of Accounts Rebutted	# of Accounts Appealed	% of Accounts Appealed	# of REBUTT. AND/OR APPEALED ACCTS	% of REBUTT. AND/OR APPEALED ACCTS
Coral Gables	11	\$91,121	1	9.09%	0	0.00%	1	9.09%
Delray Medical	84	\$581,229	5	5.95%	0	0.00%	5	5.95%
Florida Medical	78	\$614,167	30	38.46%	0	0.00%	30	38.46%
Good Samaritan	70	\$399,979	57	81.43%	0	0.00%	57	81.43%
Hialeah	38	\$547,430	11	28.95%	0	0.00%	11	28.95%
Hollywood	5	\$27,107	0	0.00%	0	0.00%	0	0.00%
North Shore	73	\$553,061	20	27.40%	0	0.00%	20	27.40%
North Ridge	23	\$102,093	4	17.39%	0	0.00%	4	17.39%
Palm Beach Gardens	28	\$198,881	0	0.00%	0	0.00%	0	0.00%
Pinecrest	18	\$85,467	0	0.00%	0	0.00%	0	0.00%
Palmetto	22	\$163,144	0	0.00%	0	0.00%	0	0.00%
St. Mary's	51	\$362,416	0	0.00%	0	0.00%	0	0.00%
West Boca	18	\$86,066	0	0.00%	0	0.00%	0	0.00%
Hilton Head Regional Medical Center	106	\$700,954	14	13.21%	29	27.36%	43	40.57%
East Cooper Regional Medical Center	51	\$385,048	26	50.98%	13	25.49%	27	52.94%
Piedmont Medical Center	163	\$907,285	118	72.39%	48	29.45%	119	73.01%
Coastal Carolina	29	\$142,585	0	0.00%	0	0.00%	0	0.00%
<b>TOTAL</b>	<b>868</b>	<b>\$5,948,034</b>	<b>286</b>	<b>32.95%</b>	<b>90</b>	<b>10.37%</b>	<b>317</b>	<b>36.52%</b>

## Key Website & Contact Information

[www.cms.hhs.gov/RAC](http://www.cms.hhs.gov/RAC)

[RAC@cms.hhs.gov](mailto:RAC@cms.hhs.gov)

[www.cms.hhs.gov/RAC/DOWNLOADS/RAC%20EVALUATION%20REPORT.pdf](http://www.cms.hhs.gov/RAC/DOWNLOADS/RAC%20EVALUATION%20REPORT.pdf)

**Questions ?**