Statement of Work for the Recovery Audit Contractor Program

I. Purpose

The RAC Program's mission is to reduce Medicare improper payments through the efficient detection and collection of overpayments, the identification of underpayments and the implementation of actions that will prevent future improper payments.

The purpose of this contract will be to support the Centers for Medicare & Medicaid Services (CMS) in completing this mission. The identification of underpayments and overpayments and the recoupment of overpayments will occur for claims paid under the Medicare program for services for which payment is made under part A or B of title XVIII of the Social Security Act.

This contract includes the identification and recovery of claim based improper payments. This contract does not include the identification and/or recovery of MSP occurrences in any format.

This contract includes the following tasks which are defined in detail in subsequent sections of this contract:

1. Identifying Medicare claims that contain underpayments for which payment was made under part A or B of title XVIII of the Social Security Act.

2. Identify and Recouping Medicare claims that contain overpayments for which payment was made under part A or B of title XVIII of the Social Security Act. This includes corresponding with the provider.

3. For any RAC-identified overpayment that is appealed by the provider, the RAC shall provide support to CMS throughout the administrative appeals process and, where applicable, a subsequent appeal to the appropriate Federal court.

4. For any RAC identified vulnerability, support CMS in developing an Improper Payment Prevention Plan to help prevent similar overpayments from occurring in the future.

5. Performing the necessary provider outreach to notify provider communities of the RAC's purpose and direction.

NOTE: The proactive education of providers about Medicare coverage and coding rules is NOT a task under this RAC statement of work. CMS has tasked FIs, Carriers, and MACs with the task of proactively educating providers about how to avoid submitting a claim containing a request for an improper payment.

II. Background

Statutory Requirements

Section 302 of the Tax Relief and Health Care Act of 2006 requires the Secretary of the Department of Health and Human Services (the Secretary) to utilize RACs under the Medicare Integrity Program to identify underpayments and overpayments and recoup overpayments under the Medicare program associated with services for which payment is made under part A or B of title XVIII of the Social Security Act.

CMS is required to actively review Medicare payments for services to determine accuracy and if errors are noted to pursue the collection of any payment that it determines was in error. To gain additional knowledge potential bidders may research the following documents:

- The Financial Management Manual and the Program Integrity Manual (PIM) at www.cms.hhs.gov/manuals
- The Debt Collection Improvement Act of 1996
- The Federal Claims Collection Act, as amended and related regulations found in 42 CFR.
- Comprehensive Error Rate Testing Reports (see www.cms.hhs.gov/cert)
- RAC Status Document (see www.cms.hhs.gov/rac)

Throughout this document, the term "improper payment" is used to refer collectively to overpayments and underpayments. Situations where the provider submits a claim containing an incorrect code but the mistake does not change the payment amount are NOT considered to be improper payments.

III. Transitions from Outgoing RAC to Incoming RAC

From time to time in the RAC program, transitions from one RAC to another RAC will need to occur (e.g., when the outgoing demonstration RACs cease work and the new incoming permanent RACs begin work). It is in the best interest of all parties that these transitions occur smoothly.

The transition plan will include specific dates with regard to requests for medical records, written notification of an overpayment, any written correspondence with providers and phone communication with providers. The transition plan will be communicated to all affected parties (including providers) by CMS within 60 days of its enactment.

IV. Specific Tasks

Independently and not as an agent of the Government, the Contractor shall furnish all the necessary services, qualified personnel, material, equipment, and facilities, not otherwise provided by the Government, as needed to perform the Statement of Work.

CMS will provide minimum administrative support which may include standard system changes when appropriate, help communicating with Medicare contractors, policies interpretations as necessary and other support deemed necessary by CMS to allow the RACs to perform their tasks efficiently. CMS will support changes it determines are necessary but cannot guarantee timeframes or constraints. In changing systems to support greater efficiencies for CMS, the end product could result in an administrative task being placed on the RAC that was not previously. These administrative tasks will not extend from the tasks in this contract and will be applicable to the identification and recovery of the improper payment.

Task 1- General Requirements

A. Initial Meeting with PO and CMS Staff

Project Plan - The RAC's key project staff (including overall Project Director and key sub Project Directors) shall meet in Baltimore, Maryland with the PO and relevant CMS staff within two weeks of the date of award (DOA) to discuss the project plan. The specific focus will be to discuss the time frames for the tasks outlined below. Within 2 weeks of this meeting, the RAC will submit a formal project plan, in Microsoft Project, outlining the resources and time frame for completing the work outlined. It will be the responsibility of the RAC to update this project plan. The initial project plan shall be for the base year of the contract. The project plan shall serve as a snapshot of everything the RAC is identifying at the time. As new issues rise the project plan shall be updated.

The project plan shall include the following:

1. **Detailed quarterly projection by vulnerability issue** (e.g. excisional debridement) including: a) incorrect procedure code and correct procedure code; b) type of review (automated, complex, extrapolation); c) type of vulnerability (medical necessity, incorrect coding…)

2. **Provider Outreach Plan -** A base provider outreach plan shall be submitted as part of the proposal. CMS will use the base provider outreach plan as a starting point for discussions during the initial meeting. Within two weeks of the initial meeting the RAC shall submit to the CMS PO a detailed Provider Outreach Plan for the respective region. The base provider outreach at a minimum shall include potential outreach efforts to associations, providers, Medicare contractors and any other applicable Medicare stakeholders.

3. **RAC Organizational Chart -** A draft RAC Organization Chart shall be submitted as part of the proposal. The organizational chart shall

identify the number of key personnel and the organizational structure of the RAC effort. While CMS is not dictating the number of key personnel, it is CMS' opinion that one key personnel will not be adequate for an entire region. An example of a possible organizational structure would be three (3) key personnel each overseeing a different claim type (Inpatient, Physician, and DME). This is not prescriptive and CMS is open to all organizational structures. A detailed organizational chart extending past the key personnel shall be submitted within two weeks of the initial meeting.

B. Monthly Conference Calls

A minimum of two monthly conference calls to discuss the RAC project will be necessary.

1. On a monthly basis the RAC's key project staff will participate in a conference call with CMS to discuss the progress of the work, evaluate any problems, and discuss plans for immediate next steps of the project. The RAC will be responsible for setting up the conference calls, preparing an agenda, documenting the minutes of the meeting and preparing any other supporting materials as needed.

2. On a monthly basis the RAC's key project staff will participate in a conference call with CMS to discuss findings and process improvements that will facilitate CMS in paying claims accurately in the future. CMS will be responsible for setting up the conference calls, preparing an agenda, documenting the minutes of the meeting and preparing any other supporting materials as needed.

   At CMS' discretion conference calls may be required to be completed more frequently. Also, other conference calls may be called to discuss individual items and/or issues.

C. Monthly Progress Reports

1. The RAC shall submit monthly administrative progress reports outlining all work accomplished during the previous month. These reports shall include the following:

1. Complications Completing any task
2. Communication with FI/Carrier/MAC/DME MAC/DME PSC/PSC
3. Upcoming Provider Outreach Efforts
4. Update of Project Plan
5. Update of what vulnerability issues are being reviewed in the next month
6. Recommended corrective actions for vulnerabilities (i.e. LCD change, system edit, provider education…)

7. Update on how vulnerability issues were identified and what potential vulnerabilities cannot be reviewed because of potentially ineffective policies
8. Update on JOAs
9. Action Items
10. Appeal Statistics
11. Problems Encountered
12. Process Improvements to be completed by RAC

    At CMS discretion a standardized monthly report(s) may be required. If a standardized monthly report is required, CMS will provide the format.

2. The RAC shall submit monthly financial reports outlining all work accomplished during the previous month. This report shall be broken down into eight categories:

    a. Overpayments Collected- Amounts shall only be on this report if the amount has been collected by the FI/Carrier/MAC/DME MAC (in summary and detail)
    b. Underpayments Identified and Paid Back to Provider- Amounts shall only be on this report if the amount has been paid back to the provider by the FI/Carrier/MAC/DME MAC (in summary and detail)
    c. Overpayments Adjusted- Amounts shall be included on this report if an appeal has been decided in the provider's favor or if the RAC rescinded the overpayment after adjustment occurred (in summary and detail)
    d. Overpayments In the Queue- This report includes claims where the RAC believes an overpayment exists because of an automated or complex review but the amount has not been recovered by the FI/Carrier/MAC/DME MAC yet
    e. Underpayments In the Queue- This report includes claims where the RAC believes an underpayment exists because of an automated or complex review but the amount has not been paid back to the provider yet
    f. Number of medical records requested from each provider (in detail)
    g. Number of medical reviews completed within 60 days
    h. Number of reviews that failed to meet the 60 day review timeframe and the rationale for failure to complete the reviews within 60 days

    Reports a, b and c in #3 above shall also be included with the monthly voucher to CMS.

    All reports shall be in summary format with all applicable supporting documentation.

    At CMS discretion a standardized monthly report(s) may be required. If a standardized monthly report is required, CMS will provide the format.

Each monthly report shall be submitted by the close of business on the fifth business day following the end of the month by email to the CMS PO and one copy accompanying the contractor's voucher that is sent to the CMS accounting office.

D. RAC Data Warehouse

CMS will provide access to the RAC Data Warehouse. The RAC Data Warehouse is a web based application which houses all RAC identifications and collections. The RAC Data Warehouse includes all suppressions and exclusions. Suppressions and exclusions are claims that are not available to the RAC for review. The RAC will be responsible for providing the appropriate equipment so that they can access the Data Warehouse.

E. Geographic Region

The claims being analyzed for this award will be claims from providers with originating addresses in Region ____ (or debts associated with claims, as applicable) appropriately submitted to carriers, intermediaries, MACs or DME MACs in Region ____ or Mutual of Omaha.

CMS will have four (4) regions. There will be one (1) RAC in each region. Each RAC will perform recovery audit services for all claim types in that region. A map of the regions can be found in Appendix 2.

Task 2- Identification of Improper Payments

Identification of Medicare Improper payments

The RAC(s) shall pursue the identification of Medicare claims which contain improper payments for which payment was made or should have been made under part A or B of title XVIII of the Social Security Act. RACs are required to comply with Reopening Regulations located at 42 CFR 405.980. Before a RAC makes a decision to reopen a claim, the RAC must have good cause. Additionally, RACs shall ensure that processes are developed to minimize provider burden to the greatest extent possible when Identifying Medicare Improper payments.

A. Improper payments INCLUDED in this Statement of Work

Unless prohibited by Section 2B, the RAC may attempt to identify improper payments that result from any of the following:

- Incorrect payment amounts
  (exception: in cases where CMS issues instructions directing contractors to not pursue certain incorrect payments made)
- Non-covered services (including services that are not reasonable and necessary under section 1862(a)(1)(A) of the Social Security Act),
- Incorrectly coded services (including DRG miscoding)
- Duplicate services

The RAC may attempt to identify improper payments on claims (including inpatient hospital claims)—

- Paid by carriers, intermediaries, MACs and DME MACs with jurisdiction in Region ____

B. Improper payments EXCLUDED from this Statement of Work

The RAC may NOT attempt to identify improper payments arising from any of the following:

1. Services provided under a program other than Medicare Fee-For-Service

For example, RACs may NOT attempt to identify improper payments in the Medicare Managed Care program, Medicare drug card program or drug benefit program.

2. Cost report settlement process

RACs may NOT attempt to identify underpayments and overpayments that result from Indirect Medical Education (IME) and Graduate Medical Education (GME) payments.

3. Claims more than 3 years past the date of the initial determination

The RAC shall not attempt to identify any overpayment or underpayment more than 3 years past the date of the initial determination made on the claim. The initial determination date is defined as the claim paid date. Any overpayment or underpayment inadvertently identified by the RAC after this timeframe shall be set aside. The RAC shall take no further action on these claims except to indicate the appropriate status code on the RAC Data Warehouse. The look back period is counted starting from the date of the initial determination and ending with the date the RAC issues the medical record request letter (for complex reviews) or the date of the overpayment notification letter (for automated reviews).

Note: CMS reserves the right to limit the time period available for RAC review by RAC, by region/state, by claim type, by provider type, or by any other reason where CMS believes it is in the best interest of the Medicare program to limit claim review. This notice will be in writing, may be by email and will be effective immediately.

4. Claim paid dates earlier than October 1, 2007

The RAC program will begin with claims paid on or after October 1, 2007. This begin date will be for all states. The actual start date for a RAC in a state will not change this date. As time passes, the RAC may look back 3 years but the claim paid date may never be earlier than October 1, 2007. In other words the RAC will only look at FY 2008 claims and forward. The RAC will not review claims prior to FY 2008 claim paid dates.

For example, in the state of New York a RAC will be "live" in March 2008. In March 2008, the New York RAC will be able to review claims with paid dates from October 1, 2007- March 2008. In December 2008, the New York RAC will be able to review claims with paid dates from October 1, 2007- December 2008.

Another example, in the state of Pennsylvania a RAC will not be "live" until January 2009 (or later). In January 2009, if the RAC is "live," the RAC in Pennsylvania will be able to review claims from October 1, 2007- January 2009.

5. Claims where the beneficiary is liable for the overpayment because the provider is without fault with respect to the overpayment

The RAC shall not attempt to identify any overpayment where the provider is without fault with respect to the overpayment. If the provider is without fault with respect to the overpayment, liability switches to the beneficiary. The beneficiary would be responsible for the overpayment and would receive the demand letter. The RAC may not attempt recoupment from a beneficiary. One example of this situation may be a service that was not covered because it was not reasonable and necessary but the beneficiary signed an Advance Beneficiary Notice. Another example of this situation is benefit category denials such as the 3 day hospital stay prior to SNF admission.

Chapter 3 of the PIM and HCFA/CMS Ruling #95-1 explain Medicare liability rules. Without fault regulations can be found at 42 CFR 405.350 and further instructions can be found in Chapter 3 of the Financial Management Manual.

In addition, a provider can be found without fault if the overpayment was determined subsequent to the third year following the year in which the claim was paid. Providers may appeal an overpayment solely based on the without fault regulations.
Therefore, the RAC shall not identify an overpayment if the provider can be found without fault. Examples of this regulation can be found in IOM Publication 100-6, Chapter 3, and Section 100.7.

6. Random selection of claims

The RAC shall adhere to Section 935 of the Medicare Prescription Drug, Improvement and Modernization Act of 2003, which prohibits the use of random claim selection for any purpose other than to establish an error rate. Therefore, the

RAC shall not use random review in order to identify cases for which it will order medical records from the provider. Instead, the RAC shall utilize data analysis techniques in order to identify those claims most likely to contain overpayments. This process is called "targeted review". The RAC may not target a claim solely because it is a high dollar claim but may target a claim because it is high dollar AND contains other information that leads the RAC to believe it is likely to contain an overpayment.

NOTE: The above paragraph does not preclude the RAC from utilizing extrapolation techniques for targeted providers or services.

7. Claims Identified with a Special Processing Number

Claims containing Special Processing Numbers are involved in a Medicare demonstration or have other special processing rules that apply. These claims are not subject to review by the RAC. CMS attempts to remove these claims from the data prior to transmission to the RACs.

8. Prepayment Review

The RAC shall identify Medicare improper payments using the post payment claims review process. Any other source of identification of a Medicare overpayment or underpayment (such as prepayment review) is not included in the scope of this contract.

C. Preventing Overlap

1. Preventing overlap with contractor performing claim review and/or responsible for recoveries.

In order to minimize the impact on the provider community, it is critical that the RAC avoids situations where the RAC and another entity (Medicare contractor, PSC, MAC or law enforcement) are working on the same claim.
Therefore, the RAC Data Warehouse will be used by the RAC to determine if another entity already has the provider and/or claim under review. The RAC Data Warehouse will include a master table of excluded providers and claims. This table will be updated on an as needed basis. Before beginning a claim review the RAC shall utilize the RAC Data Warehouse to determine if exclusion exists for that claim. If exclusion exists for that claim, the RAC is not permitted to review that claim. If the exclusion is entered after the RAC begins its review, the RAC and CMS will be notified so that the RAC can cease all activity.

Definition of Exclusions - An excluded claim is a claim that has already been reviewed by another entity. This includes claims that were originally denied and then paid on appeal. Only claims may be excluded. Providers may not be excluded. Exclusions are permanent. This means that an excluded claim will

never be available for the RAC to review.

The following contractors may input claims into the master table for exclusion:

- Part B physician or supplier claims: the carrier or MAC medical review unit for the state.
- Part A claims (other than inpatient PPS hospital claims and long term care hospital claims): the intermediary or MAC medical review unit for the state.
- Part A inpatient PPS hospital claims and long term hospital claims: MAC for the state.
- Durable Medical Equipment, Prosthetics, Orthotics and Supplies: the appropriate DME MAC/PSC medical review unit for that state.
- Comprehensive Error Rate Testing (CERT) Contractor
- CMS RAC Project Officer

2. ***Preventing RAC overlap with contractors, CMS, OGC, DOJ, OIG and/or other law enforcement entities performing potential fraud reviews.***

CMS must ensure that RAC activities do not interfere with potential fraud reviews being conducted by Benefit Integrity (BI) Program Safeguard Contractors (PSCs) or DMERC BI units or with potential fraud investigations being conducted by law enforcement. Therefore, RACs shall input all claims into the RAC Data Warehouse before attempting to identify or recover overpayments. (The master table described above will be utilized.)

Definition of Suppression - A suppressed provider and/or claim is a provider and/or claim that are a part of an ongoing investigation. Normally, suppressions will be temporary and will ultimately be released by the suppression entity.

The following contractors may input providers and/or claims into the master table for suppression:

- Part B physician or supplier claims: the appropriate PSC, OIG, or law enforcement entity
- Part A claims (other than inpatient PPS hospital claims and long term care hospital claims): the appropriate PSC, OIG, or law enforcement entity
- Part A inpatient PPS hospital claims and long term hospital claims: the

appropriate PSC, OIG, or law enforcement entity

- CMS RAC Project Officer
- Durable Medical Equipment, Prosthetics, Orthotics and Supplies: the appropriate PSC, OIG or law enforcement entity

D. Obtaining and Storing Medical Records for reviews

Whenever needed for reviews, the RAC may obtain medical records by going onsite to the provider's location to view/copy the records or by requesting that the provider mail/fax or securely transmit the records to the RAC. (Securely transmit means sent in accordance with the CMS business systems security manual – e.g., mailed CD, MDCN line, through a clearinghouse)

If the RAC attempts an onsite visit and the provider refuses to allow access to their facility, the RAC may not make an overpayment determination based upon the lack of access. Instead, the RAC shall request the needed records in writing.

When onsite review results in an improper payment finding, the RAC shall copy the relevant portions of the medical record and retain them for future use. When onsite review results in no finding of improper payment, the RAC need not retain a copy of the medical record.

When requesting medical records the RAC shall use discretion to ensure the number of medical records in the request is not negatively impacting the provider's ability to provide care. Before contract award CMS will institute a medical record request limit. Different limits may apply for different provider types and for hospitals the limit may be based on size of the hospital (number of beds). The limit would be per provider location and type per time period. An example of a medical record limit would be no more than 50 inpatient medical record requests for a hospital with 150-249 beds in a 45 day time period. CMS may enact a different limit for different claim types (outpatient hospital, physicians, supplier, etc). The medical record request limit may also take into account a hospital's annual Medicare payments.

The medical record request limit may not be superceded by bunching the medical record requests. For example, if the medical record request limit for a particular provider is 50 per month and the RAC does not request medical records in January and February, the RAC cannot request 150 records in March.

All Medical Request letters must adequately describe the good cause for reopening the claim. Good cause for reopening the claim may include but is not limited to OIG report findings, data analysis findings, comparative billing analysis, etc.

The RAC shall develop a mechanism to allow providers to customize their address and point of contact (e.g. Washington County Hospital, Medical Records Dept.,

attention: Mary Smith, 123 Antietam Street, Gaithersburg, MD 20879). By January 01, 2010 all RACs shall develop a web-based application for this purpose. All web-based applications shall be approved by the CMS Project Officer. RACs may visit the CERT Contractor's address customization website at http://www.certcdc.com/certproviderportal/verifyaddress.aspx for an example of a simple but successful system. Each medical record request must inform the provider about the existence of the address customization system.

NOTE: The RAC is encouraged to solicit and utilize the assistance of provider associations to help collect this information and house it in an easily updatable database.

1. ***Paying for medical records***

   a. *RACs shall pay for medical records.*

   Should the RAC request medical records associated with:

   - an acute care inpatient prospective payment system (PPS) hospital (DRG) claim,
   - A Long Term Care hospital claim, the RAC shall pay the provider for producing the records in accordance with the current formula or any applicable payment formula created by state law. (The current per page rate is: medical records photocopying costs at a rate of $.12 per page for reproduction of PPS provider records and $.15 per page for reproduction of non-PPS institutions and practitioner records, plus first class postage. Specifically, hospitals and other providers (such as critical access hospitals) under a Medicare cost reimbursement system, receive no photocopying reimbursement. Capitation providers such as HMOs and dialysis facilities receive $.12 per page. RACs shall comply with the formula calculation found at 42 CFR §476.78(c). RACs shall also ensure compliance with any changes that are made to the formula calculation or rate in future publications of the Federal Register.)

   RACs are required to pay for copying of the inpatient (PPS) and Long Term Care hospital medical records on at least a monthly basis. For example, a RAC may choose to issue checks on the 10th of the month for all medical records received the previous month. All checks should be issued within 45 days of receiving the medical record.

   RACs shall develop the necessary processes to accept imaged medical records sent on CD or DVD beginning immediately, and sent via the 277 Transaction Record starting in 2010. RACs must remain capable of accepting faxed or paper medical records indefinitely.

   RACs shall pay the same per page rate for the production of imaged or electronic medical records. RACs must ensure that providers/clearinghouses

first successfully complete a connectivity and readability test with the RAC system before being invited to submit imaged or electronic records to the RAC. The RAC must comply with all CMS business system security requirements.

b. *RACs <u>may</u> pay for medical records.*

Should the RAC request medical records associated with any other type of claim including but not limited to the facilities listed in PIM 1.1.2, paragraph 2, the RAC may (but is not required to) pay the provider for producing the record using any formula the RAC desires.

2. ***Updating the Case File***

The RAC shall indicate in the case file (See Task 7; section G for additional case record maintenance instructions.)

- A copy of all request letters,
- Contacts with ACs, CMS or OIG,
- Dates of any calls made, and
- Notes indicating what transpired during the call.

<u>Communication and Correspondence with Provider- Database</u>

To assess provider reaction to the RACs and the RAC Program, CMS will complete regular surveys with the provider community. To help determine the universe of providers contacted by a RAC, the RAC will have to supply a listing of all providers to CMS and/or the evaluation contractor. CMS encourages the RAC to utilize an electronic database for all communication and correspondence with the provider. This ensures tracking of all communication and allows for easy access for customer service representatives. This also allows for easy transmission to CMS in the event of an audit or when the listing for the surveys is due. CMS expects the listing to be due no less than twice a year.

3. ***Assessing an overpayment for failing to provide requested medical record.***

Pursuant to the instructions found in PIM 3.10 and Exhibits 9-12, the RAC may find the claim to be an overpayment if medical records are requested and not received within 45 days. Prior to denying the claim for failure to submit documentation the RACs shall initiate one additional contact before issuing a denial.

4. ***Storing and sharing medical records***

The RAC must make available to all ACs, CMS, QICs, OIG, (and others as indicated by the PO) any requested medical record via a MDCN line.

Storing and sharing IMAGED medical records

The RAC shall, on the effective date of this contract, be prepared to store and share imaged medical records. The RAC shall:

- Provide a document management system
- Store medical record NOT associated with an overpayment for 1 year,
- Store medical records associated with an overpayment for duration of the contract,
- Maintain a log of all requests for medical records indicating at least the requester, a description of the medical record being requested, the date the request was received, and the date the request was fulfilled. The RAC Data Warehouse will not be available for this purpose. The RAC shall make information about the status of a medical record (outstanding, received, review underway, review complete, case closed) available to providers upon request. By January 01, 2010 all RACs shall develop a web-based application for this purpose. All web-based applications shall be approved by the CMS Project Officer.

For purposes of this section sharing imaged medical records means the transmission of the record on a disk, CD, DVD, FTP or MDCN line. PHI shall not be transmitted through any means except a MDCN line, postal mail, overnight courier or a fax machine.

Upon the end of the contract, the RAC shall send copies of the imaged records to the contractor specified by the PO.

E. The Claim Review Process

1. *Types of Determinations a RAC may make*

When a RAC reviews a claim, they may make any or all of the determinations listed below.

a. Coverage Determinations

The RAC may find a full or partial overpayment exists if the service is not covered (i.e., it fails to meet one or more of the conditions for coverage listed below).

In order to be covered by Medicare, a service must:

i. Be included in one of the benefit categories described in Title XVIII of the Act;

ii. Not be excluded from coverage on grounds other than 1862(a)(1); and

iii. Be reasonable and necessary under Section 1862(a)(1) of the Act. The RAC shall consider a service to be reasonable and necessary if the RAC determines that the service is:

A. Safe and effective;

B. Not experimental or investigational (exception: routine costs of qualifying clinical trial services with dates of service on or after September 19, 2000 which meet the requirements of the Clinical Trials NCD are considered reasonable and necessary); and

C. Appropriate, including the duration and frequency that is considered appropriate for the service, in terms of whether it is:

- Furnished in accordance with accepted standards of medical practice for the diagnosis or treatment of the patient's condition or to improve the function of a malformed body member;
- Furnished in a setting appropriate to the patient's medical needs and condition;
- Ordered and furnished by qualified personnel;
- One that meets, but does not exceed, the patient's medical need; and
- At least as beneficial as an existing and available medically appropriate alternative.

There are several exceptions to the requirement that a service be reasonable and necessary for diagnosis or treatment of illness or injury. The exceptions appear in the full text of §1862(a) (1) (A) and include but are not limited to:

- Pneumococcal, influenza and hepatitis B vaccines are covered if they are reasonable and necessary for the prevention of illness;
- Hospice care is covered if it is reasonable and necessary for the palliation or management of terminal illness;
- Screening mammography is covered if it is within frequency limits and meets quality standards;
- Screening pap smears and screening pelvic exam are covered if they are within frequency limits;
- Prostate cancer screening tests are covered if within frequency limits;
- Colorectal cancer screening tests are covered if within frequency limits; and
- One pair of conventional eyeglasses or contact lenses furnished subsequent to each cataract surgery with insertion of an interlobular lens.

RACs must be very careful in choosing which denial type to use since beneficiaries' liability varies based on denial type. Benefit category denials take precedence over statutory exclusion and reasonable and necessary denials. Statutory exclusion denials take precedence over reasonable and necessary denials. Contractors should use HCFA Ruling 95-1 and the guidelines listed below in selecting the appropriate denial reason.

Limitation of Liability Determinations
If a RAC identifies a full or partial overpayment because an item or service is not reasonable and necessary, the RAC shall make and document §§1879, 1870, and 1842(l) (limitation of liability) determinations as appropriate. Because these determinations can be appealed, it is important that the rationale for the determination be documented both initially and at each level of appeal. Limitation of Liability determinations do not apply to denials based on determinations other than reasonable and necessary. See PIM Exhibits 14 - 14.3 for further details.

b. Coding Determinations

The RAC may find that an overpayment or underpayment exists if the service is not correctly coded (i.e., it fails to meet one or more of the coding requirements listed in an NCD, local coding article, Coding Clinic, CPT or CPT Assistant.)

c. Other Determinations

The RAC may determine that an overpayment or underpayment exists if the claim was paid twice (i.e., a "duplicate claim"), was priced incorrectly, or the claims processing contractor did not apply a payment policy (e.g., paying the second surgery at 50% of the fee schedule amount).

2. Minor Omissions

Consistent with Section 937 of the MMA, the RAC shall not make denials on minor omissions such as missing dates or signatures.

3. Medicare Policies and Articles

The RAC shall comply with all National Coverage Determinations (NCDs), Coverage Provisions in Interpretive Manuals, national coverage and coding articles, local coverage determinations (LCDs) (formerly called local medical review policies (LMRPs)) and local coverage/coding articles in their jurisdiction. NCDs, LMRPs/LCD and local coverage/coding articles can be found in the Medicare Coverage Data Warehouse http://www.cms.hhs.gov/mcd/overview.asp). Coverage Provisions in Interpretive Manuals can be found in various parts of the Medicare Manuals. In addition, the RAC shall comply with all relevant joint signature memos forwarded to the RAC by the project officer.
RACs should not apply a LCD retroactively to claims processed prior to the effective date of the policy. RAC shall ensure that policies utilized in making a

review determination are applicable at the time the service was rendered except in the case of a retroactively liberalized LCDs or CMS National policy.

The RAC shall keep in mind that not all policy carriers the same weight in the appeals process. For example, ALJs are not bound by LCDs but are bound by NCDs and Rulings.

If an issue is brought to the attention of CMS by any means and CMS instructs the RAC on the interpretation of any policy and/or regulation, the RAC shall abide by CMS' decision.

4. Internal Guidelines

As part of its process of reviewing claims for coverage and coding purposes, the RAC shall develop detailed written review guidelines. For the purposes of this SOW, these guidelines will be called "Internal Guidelines." Internal Guidelines, in essence, will allow the RAC to operationalize carrier and intermediary LCDs and NCDs. Internal Guidelines shall specify what information should be reviewed by reviewers and the appropriate resulting determination. The RAC need not hold public meetings or seek public comments on their proposed internal guidelines. However, they must make their Internal Guidelines available to CMS upon request. Internal Guidelines shall not create or change policy.

5. Administrative Relief from Review in the Presence of a Disaster

The RAC shall comply with PIM 3.2.2 regarding administrative relief from review in the presence of a disaster.

6. Evidence

The RAC shall only identify a claims overpayment where there is supportable evidence of the overpayment. There are two primary ways of identification:

a) Through "automated review" of claims data without human review of medical or other records; and
b) Through "complex review" which entails human review of a medical record or other documentation.

7. Automated Review vs. Complex Review

a. **Automated Review.** Automated review occurs when a RAC makes a claim determination at the system level without a human review of the medical record.

i. <u>Coverage/Coding Determinations Made Through Automated Review</u>
The RAC may use automated review when making coverage and coding determinations only where BOTH of the following conditions apply:

- there is certainty that the service is not covered or is incorrectly coded, AND
- a written Medicare policy, Medicare article or Medicare-sanctioned coding guideline (e.g., CPT statement, CPT Assistant statement, Coding Clinic statement, etc.) exists

When making coverage and coding determinations, if no **certainty** exists as to whether the service is covered or correctly coded, the RAC shall not use automated review. When making coverage and coding determinations, if no written **Medicare policy, Medicare article, or Medicare-sanctioned coding guideline** exists, the RAC shall not use automated review. Examples of Medicare-sanctioned coding guidelines include: CPT statements, CPT Assistant statements, and Coding Clinic statements.)

EXCEPTION: If the RAC identifies a "clinically unbelievable" issue (i.e., a situation where certainty of noncoverage or incorrectly coding exists but no Medicare policy, Medicare articles or Medicare-sanctioned coding guidelines exist), the RAC may seek CMS approval to proceed with automated review. Unless or until CMS approves the issue for automated review, the RAC must make its determinations through complex review.

ii. Other Determinations Made Through Automated Review

The RAC may use automated review when making other determinations (e.g. duplicate claims, pricing mistakes) when there is certainty that an overpayment or underpayment exists. Written policies/articles/guidelines often don't exist for these situations.

b. **Complex Review**. Complex review occurs when a RAC makes a claim determination utilizing human review of the medical record. The RAC may use complex review in situations where the requirements for automated review are not met or the RAC is unsure whether the requirements for automated review are met. Complex medical review is used in situations where there is a high probability (but not certainty) that the service is not covered or where no Medicare policy, Medicare article, or Medicare-sanctioned coding guideline exists. Complex copies of medical records will be needed to provide support for the overpayment.

c. **Summary of Automated vs. Complex.** The chart below summarizes these requirements.

Complex Review (with medical record)	**Automated (without medical record)**	
	Coverage/Coding Determinations	**Other Determinations** (duplicates, pricing mistakes, etc)

Written Medicare policy/article or Medicare-sanctioned coding guidelines exists	No written Medicare policy/article or Medicare-sanctioned coding guidelines exists	Written Medicare policy/article or Medicare-sanctioned coding guidelines exists		No written Medicare policy/article or Medicare-sanctioned coding guidelines exists		Certainty exists	NO Certainty exists
		Certainty exists	NO Certainty exists	Certainty exists	NO Certainty exists		
Allowed	**Allowed** (often called "Individual Claim Determinations")	**Allowed**	**Not allowed**	**Allowed with prior CMS approval** (often called "clinically unbelievable" situations)	**Not allowed**	**Allowed**	**Not allowed**

8. Individual Claim Determinations

The term "individual claim determination" refers to a complex review performed by a RAC in the absence of a written Medicare policy, article, or coding statement. When making individual claim determinations, the RAC shall utilize appropriate medical literature and apply appropriate clinical judgment. The RAC shall consider the broad range of available evidence and evaluate its quality before making individual claim determinations. The extent and quality of supporting evidence is key to defending challenges to individual claim determinations. Individual claim determinations which challenge the standard of practice in a community shall be based on sufficient evidence to convincingly refute evidence presented in support of coverage. The RAC shall ensure that their CMD is actively involved in examining all evidence used in making individual claim determinations and acting as a resource to all reviewers making individual claim determinations.

9. Staff Performing Complex Coverage/Coding Reviews

Whenever performing complex coverage or coding reviews (i.e., reviews involving the medical record), 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. RACs shall maintain and provide documentation upon the provider's request the credentials of the individuals making the medical review determinations. If the provider requests to speak to the CMD regarding a claim(s) denial the RAC shall ensure the CMD participates in the discussion.

10. Timeframes for Completing Complex Coverage/Coding Reviews

RACs shall complete their complex reviews within 60 days from receipt of the medical record documentation. RACs may request a waiver from CMS if an extended timeframe is needed due to extenuating circumstances. If an extended timeframe for review is granted RACs shall notify the provider in writing or via a

web-based application of the situation that has resulted in the delay and will indicate that the Notification of Findings will be sent once CMS approves the RAC moving forward with the review.

11. Re-openings of Claims Denied Due to Failure to Submit Necessary Medical Documentation (remittance advice code N102 or 56900)

In cases where the RAC denies a claim with remittance advice code N102 or 56900 ("This claim has been denied without reviewing the medical record because the requested records were not received or were not received timely.") and the denial is appealed, the appeals department **may, at CMS direction,** send the claim to the RAC for reopening under certain conditions, listed in CMS Pub. IOM 100-04, chapter 34, §10.3. If this occurs, the RAC shall conduct a reopening of claims sent by the appeals department within **30 days** of receipt of the forwarded claim and requested documentation by the RAC. In addition, the RAC shall issue a new letter containing the revised denial reason and the information required by PIM chapter 3, §3.6.5.

F. Activities Following Review

1. Rationale for Determination.

The RAC shall document the rationale for the determination. This rationale shall list the review findings including a detailed description of the Medicare policy or rule that was violated and a statement as to whether the violation resulted in an improper payment.

The RAC shall make available upon request by any other ACs, CMS, OIG, (and others as indicated by the PO) any requested rationale.

Storing and making available IMAGED rationale documents

The RAC shall on the effective date of this contract be prepared to store and share imaged medical records. The RAC shall:

- Provide a document management system that meets CMS requirements,
- Store rationale documents NOT associated with an overpayment for 1 year,
- Store rationale documents associated with an overpayment for the duration of the contract,
- Maintain a log of all requests for rationale documents indicating at least the requester, a description of the medical record being requested, the date the request was received, and the date the request was fulfilled. The RAC Data Warehouse will not be available for this

purpose.

Upon the end of the contract, the RAC shall send copies of the imaged rationale documents to the contractor specified by the PO.

2. Validation Process

a. Validating the Issue

RACs are encouraged to meet with the FIs, carriers, and MACs in their jurisdiction to discuss potential findings the RAC may have identified. The RAC may request that the FI/Carrier/MAC review some claims in order to validate the accuracy of the RAC determination.

b. Validating the Claims at CMS or the RAC Validation Contractor

Once the RAC has chosen to pursue a new issue that requires complex or automated review, the RAC shall notify the PO of the issue in a format to be prescribed by the PO. The PO will notify the RAC which issues have been selected for claim validation (either by CMS or by an independent RAC Validation Contractor). The RAC shall forward any requested information in a format to be prescribed by the PO. The PO will notify the RAC if/when they may begin issuing medical record request letters (beyond the 10 test claims) and demand letters on the new issue. The RAC shall not issue any demand letters on issues that have not approved by CMS. The RAC may request up to 10 medical records when developing a test case for CMS to validate. The RAC shall not issue medical record requests beyond the 10 test claims without prior PO approval. CMS or the RAC Validation Contractor may also evaluate the clarity, accuracy, and completeness of the RAC letter to providers.

3. Communication with Providers about Improper Payment Cases

The RAC may send the provider only one review results per claim. For example, a RAC may NOT send the provider a letter on January 10 containing the results of a medical necessity review and send a separate letter on January 20 containing the results of the correct coding review for the same claim. Instead, the RAC must wait until January 20 to inform the provider of the results of both reviews in the same letter. It is acceptable to send one notification letter that contains a list of all the claims denied for the same reason (i.e. all claims denied because the wrong number of units were billed for a particular drug). In situations in which the RAC identifies two different reasons for a denial, a letter should be sent for each reason identified. For example, if the RAC identified a problem with the coding of respiratory failure and denied several claim(s) because the wrong procedure code and wrong diagnosis codes were billed, the RAC should send two separate letters. The first letter should list all claims in which an improper payment was identified

that contained the wrong procedure code and the second letter should identify those denied because the wrong diagnosis code was billed.

RACs shall ensure that the date a claim was reopened (regardless of the demand letter issue date) is documented and the rationale for good cause when claims are reopened more than 12 months from date of the initial determination. Including this information will lend credibility to RAC documentation if the RAC determination is appealed. RACs shall clearly document the date the claim was reopened and the rational for good cause in the Notification of RAC Review Findings (for initial determinations made by a Part A claims processing contractor), in the demand letter (for initial determinations made by a Part B claims processing contractor) and in all case files.

a. Automated review

The RAC shall communicate to the provider the results of each automated review that results in an overpayment determination. The RAC shall inform the provider of which coverage/coding/payment policy or article was violated. The RAC need not communicate to providers the results of automated reviews that do not result in an overpayment determination. The RAC shall record the date and format of this communication in the RAC Data Warehouse.

b. Complex review

The RAC shall communicate to the provider the results of every complex review (i.e., every review where a medical record was obtained), including cases where no improper payment was identified. In cases where an improper payment was identified, the RAC shall inform the provider of which coverage/coding/payment policy or article was violated. The RAC shall record the date and format of this communication in the RAC Data Warehouse.

c. Contents of Notification of RAC Complex Review Findings Letter

The RAC shall send a letter to the provider indicating the results of the review within 60 days of the exit conference (for provider site reviews) or receipt of medical records (for RAC site reviews). If the RAC need more than 60 days, they are to contact the Project Officer for an extension. Each letter must include:

- Identification of the provider(s) or supplier(s)--name, address, and provider number;
- The reason for conducting the review (See Section SOW 2F-3);
- A narrative description of the overpayment situation: state the specific issues involved which created the improper payment and

any pertinent issues as well as any recommended corrective actions the provider should consider taking;
• The findings for each claim in the sample, including a specific explanation of why any services were determined to be non-covered, or incorrectly coded;
A list of all individual claims including the actual amounts determined to be noncovered, the specific reason for noncoverage, the amounts denied,
• For statistical sampling for overpayment estimation reviews, any information required by PIM, chapter 3, section 3.10.4.4;
• An explanation of the provider's or supplier's right to submit a rebuttal statement prior to recoupment of any overpayment (see PIM Chapter 3, Section 3.6.6);
• An explanation of the procedures for recovery of overpayments including Medicare's right to recover overpayments and charge interest on debts not repaid within 30 days, and the provider's right to request an extended repayment schedule;
• The provider appeal rights information;
• All demand letter requirements listed in Task 4, Section A-Written Notification to Provider.

4. Determine the Overpayment Amount

a. Full denials

A full denial occurs when the RAC determines that:

i. The submitted service was not reasonable and necessary and no other service (for that type of provider) would have been reasonable and necessary, or
ii. No service was provided.

The overpayment amount is the total paid amount for the service in question.

b. Partial denials

A partial denial occurs when the RAC determines that:

i. The submitted service was not reasonable and necessary but a lower level service would have been reasonable and necessary, or
ii. The submitted service was upcoded (and a lower level service was actually performed) or an incorrect code (such as a discharge status code) was submitted that caused a higher payment to be made.
iii. The AC failed to apply a payment rule that caused an improper payment (e.g. failure to reduce payment on multiple surgery cases).

Note: Other situations that are not categorized above should be brought to

the CMS PO's attention before the RAC sends notification to the provider.

In these cases, the RAC must determine the level of service that was reasonable and necessary or represents the correct code for the service described in the medical record. In order to determine the actual overpayment amount, the claim adjustment will have to be completed by the AC. Once the AC completes the claim adjustment, the AC will notify the RAC through the RAC Data Warehouse (or another method instructed by CMS) of the overpayment amount. The RAC shall then proceed with recovery. The RAC can only collect the difference between the paid amount and the amount that should have been paid.

*How the adjustment is completed in the shared system may not necessarily correlate with the RAC contingency amount. For example, a RAC contingency amount could equate to the difference between the full denial and any services determined by CMS to be payable.

c. Extrapolation

Follow the procedures found in PIM 3.10 and Exhibits 9-12, as well as MMA Section 935(a), regarding the use of extrapolation.

d. Recording the Improper Payment Amount in the RAC Data Warehouse

The RAC shall update the RAC Data Warehouse with:

- The improper payment amount for each claim in question;
- Line level claim detail;
- The date of the original demand/notification letter;
- Appeal status;
- Collection detail and/or adjustments due to errors/appeals;
- Any other claim level information found in the RAC Data Warehouse User Guide.

Once an overpayment is identified, the RAC shall proceed with the Recovery of Medicare Overpayments.

G. Potential Fraud

The RAC shall report instances of potential fraud immediately to the CMS PO. (See Task 7 section F on recalled cases)

H. Potential Quality Problems

The RAC shall report potential quality issues immediately to the QIO. The mechanism to report potential quality issues shall be addressed in the JOA between

the RAC and the QIO. If a JOA cannot be reached with a particular QIO, the RAC shall report the potential quality issue to their CMS PO.

I. RAC Medical Director

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.

Relevant Work Experience

- Prior work experience in the health insurance industry, utilization review firm or health care claims processing organization,
- Extensive knowledge of the Medicare program particularly the coverage and payment rules, and
- Public relations experience such as working with physician groups, beneficiary organizations or Congressional offices.

Relevant Educational Experience

- Experience practicing medicine as a board certified doctor of medicine or doctor who is currently licensed.

All clinicians employed or retained as consultants must be currently licensed to practice medicine in the United States, and the contractor must periodically verify that the license is current. When recruiting CMDs, contractors must give preference to physicians who have patient care experience and are actively involved in the practice of medicine. The CMD's duties relevant to the RAC are listed below.

Primary duties include:

- Providing the clinical expertise and judgment to understand LCDs, NCDs and other Medicare policy;
- Serving as a readily available source of medical information to provide guidance in questionable claims reviews situations;
- Recommending when LCDs, NCDs, provider education, system edits or other corrective actions are needed or must be revised to address RAC vulnerabilities;
- Briefing and directing personnel on the correct application of policy during claim adjudication, including through written internal claim review guidelines;
- Keeping abreast of medical practice and technology changes that may result in improper billing or program abuse;

Other duties include:

- Interacting with the CMDs at other contractors and/or RACs to share information on potential problem areas;
- Participating in CMD clinical workgroups, as appropriate; and
- Upon request, providing input to CO on national coverage and payment policy, including recommendations for relative value unit (RVU) assignments.
- Participating in CMS/RAC presentations to providers and associations

To prevent conflict of interest issues, the CMD must provide written notification to CMS within 3 months after the appointment, election, or membership effective date if the CMD becomes a committee member or is appointed or elected as an officer in any State or national medical societies or other professional organizations. In addition, CMDs who are currently in practice should notify CMS of the type and extent of the practice.

J. Assisting CMS in the development of the Medicare Improper Payment Prevention Plan

Through monthly calls, monthly reports and databases the RAC shall assist CMS in the development of the Medicare Improper Payment Prevention Plan. The Medicare Improper Payment Prevention Plan is a listing of all RAC vulnerabilities identified that CMS may need to address through LCDs, NCDs, provider education or system edits.

K. Communication with Other Medicare Contractors

1. Joint Operating Agreement

   The RAC shall be required to complete a Joint Operating Agreement (JOA) with all applicable Medicare contractors (FIs, Carriers, DME MACs, MACs, QIOs, QICs, PSCs…). The JOA shall encompass all communication between the Medicare contractor and the RAC. The JOA shall be a mutually agreed to document that is reviewed quarterly and updated as needed. The JOA shall prescribe 1) agreed upon service levels and 2) notification and escalation mechanisms with CMS involvement.

2. Referrals from CMS

   At CMS discretion, the RAC may receive referrals or "tips" on potential overpayments from CMS, ACs, and OIG or law enforcement. The RAC shall work with the appropriate entities concerning formats and transfer arrangements. The RAC must consider all referrals, but is not required to pursue all referrals.

NOTE: CMS is developing a web-based referral tracking system. This system will be available to all Medicare contractors, to CMS and to the RACs to make and track

referrals. The RACs will be required to review the referral tracking system and to determine if the referral will be reviewed or not. The RAC is not required to act upon any referral. However, the RAC is required to update CMS with the decision and status. The expected timeframe for review and decision is 30-45 days from the referral being entered into the system.

Task 3- Underpayments

The RAC will review claims, using automated or complex reviews, to identify potential Medicare underpayments. Upon identification the RAC will communicate the underpayment finding to the appropriate affiliated contractor. The mode of communication and the frequency shall be agreed upon by both the RAC and the affiliated contractor. This communication shall be separate from the overpayment communications.

After receipt the affiliated contractor will validate the Medicare underpayment. If necessary, the RAC shall share any documentation supporting the underpayment determination with the affiliated contractor. Once the affiliated contractor validates the underpayment occurrence, adjusts the claim and pays the provider, the RAC shall include the amount of the actual underpayment on the next payment invoice. Neither the RAC nor the AC may ask the provider to correct and resubmit the claim.

Once the appropriate affiliated contractor has validated the Medicare underpayment, the RAC will issue a written notice to the provider. This Underpayment Notification Letter shall include the claim(s) and beneficiary detail. A sample letter shall be approved by the CMS Project Officer before issuing the first letter.

For purposes of the RAC program, a Medicare underpayment is defined as those lines or payment group (e.g. APC, RUG) on a claim that was billed at a low level of payment but should have been billed at a higher level of payment. The RAC will review each claim line or payment group and consider all possible occurrences of an underpayment in that one line or payment group. If changes to the diagnosis, procedure or order in that line or payment group would create an underpayment, the RAC will identify an underpayment. Service lines or payment groups that a provider failed to include on a claim are **NOT** considered underpayments for the purposes of the program.

Examples of an Underpayment:

1. The provider billed for 15 minutes of therapy when the medical record clearly indicates 30 minutes of therapy was 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)
2. The provider billed for a particular service and the amount the provider was paid was lower than the amount on the CMS physician fee schedule.

3. A diagnosis/condition was left off the MDS but appears in the medical record. Had this diagnosis or condition been listed on the MDS, a higher payment group would have been the result.

The following will **NOT** be considered an underpayment:

1. The medical record indicates that the provider performed additional services such as an EKG, but the provider did not bill for the service. (This provider type is paid based on a fee schedule that has a separate code and payment amount for EKG)
2. The provider billed for 15 minutes of therapy when the medical record clearly indicates 30 minutes of therapy was provided…however, the additional minutes do not affect the grouper or the pricier. (This provider type is paid based on a prospective payment system that does not pay more for this much additional therapy.)
3. The medical record indicates that the provider implanted a particular device for which a device APC exists (and is separately payable over and above the service APC), but the provider did not bill for the device APC.

Reporting of Underpayments

On a monthly basis the RAC shall submit a report to the PO listing all underpayments the RAC identified during the month. The report shall include the claim number, the provider number, the claim paid date(s), the original amount paid and the reason for the underpayment.

RAC DataWarehouse

Upon submission of the underpayment to the affiliated contractor, the RAC shall input the underpayment into the RAC Database. The RAC shall utilize the RAC DataWarehouse to learn of the payment amount to the provider for invoicing purposes unless other arrangements are made with the affiliated contractor in the JOA.

Provider Inquiries

The RAC will have no responsibility to accept case files from providers for an underpayment case review. If case files are received from providers that were not requested by the RAC, the RAC may shred the record requests. The RAC is under no obligation to respond to the provider.

Medical Record Requests

The RAC may request medical records for the sole purpose of identifying an underpayment. If required, the RAC will pay for all medical record requests, regardless of if an underpayment or overpayment is determined.

Appeal of the Underpayment Determination

The provider does not have any official appeals rights in relation to an underpayment determination. The provider may utilize the RAC rebuttal process and discuss the underpayment determination with the RAC. If the provider disagrees with the RAC that an underpayment exists, the RAC shall defer to the billing provider's judgment and request that the FI or carrier "undo" the underpayment. In addition, the RAC shall forward all supporting documentation, including the validation from the FI or Carrier to the CMS Project Officer or his/her delegate.

Task 4- Recoupment of Overpayments

The RAC(s) will pursue the recoupment of Medicare overpayments that are identified through Task 2. The recovery techniques utilized by the RAC shall be legally supportable. The recovery techniques shall follow the guidelines of all applicable CMS regulations and manuals as well as all federal debt collection standards. Some guidelines specific to CMS include, but are not limited to, 42 CFR, the Debt Collection Improvement Act of 1996, and the Federal Claims Collection Act, as amended. The RAC is required to follow the manual guidelines in the Medicare Financial Management Manual, Chapter 3 & 4, as well as instructions in CMS One Time Notifications and Joint Signature Memorandum unless otherwise instructed in this statement of work or specifically agreed to by the PO.

Adjustment Process

The RAC shall not attempt recoupment or forward any claim to the FI/Carrier/MAC/DME MAC or the applicable CMS Data Center for adjustment if the amount of the overpayment is less than $10.00. Claims less than $10.00 cannot be aggregated to allow for demand.

The RAC shall not forward any claim to the FI/Carrier/MAC/DME MAC or the CMS Data Center for adjustment if the amount of the underpayment is less than $1.00.

The RAC shall not forward claims to the FI/Carrier/MAC/DME MAC for adjustment if the claim is incorrectly coded but the coding error does not equate to a difference in the payment amount. For example, HCPCS code xxxxx requires a modifier for payment. Payment with the modifier is $25.50 per service. Without the modifier payment is $25.50 per service. While the claim without the modifier is incorrect, there is no overpayment or underpayment and the claim shall not be forwarded for adjustment.

Sometimes when the system adjusts the claim for the RAC identified overpayment other lines are adjusted because of system edits. CMS calls these additional lines associated findings. While the RAC did not identify these lines for adjustment, they were initiated because of the RAC adjustment.

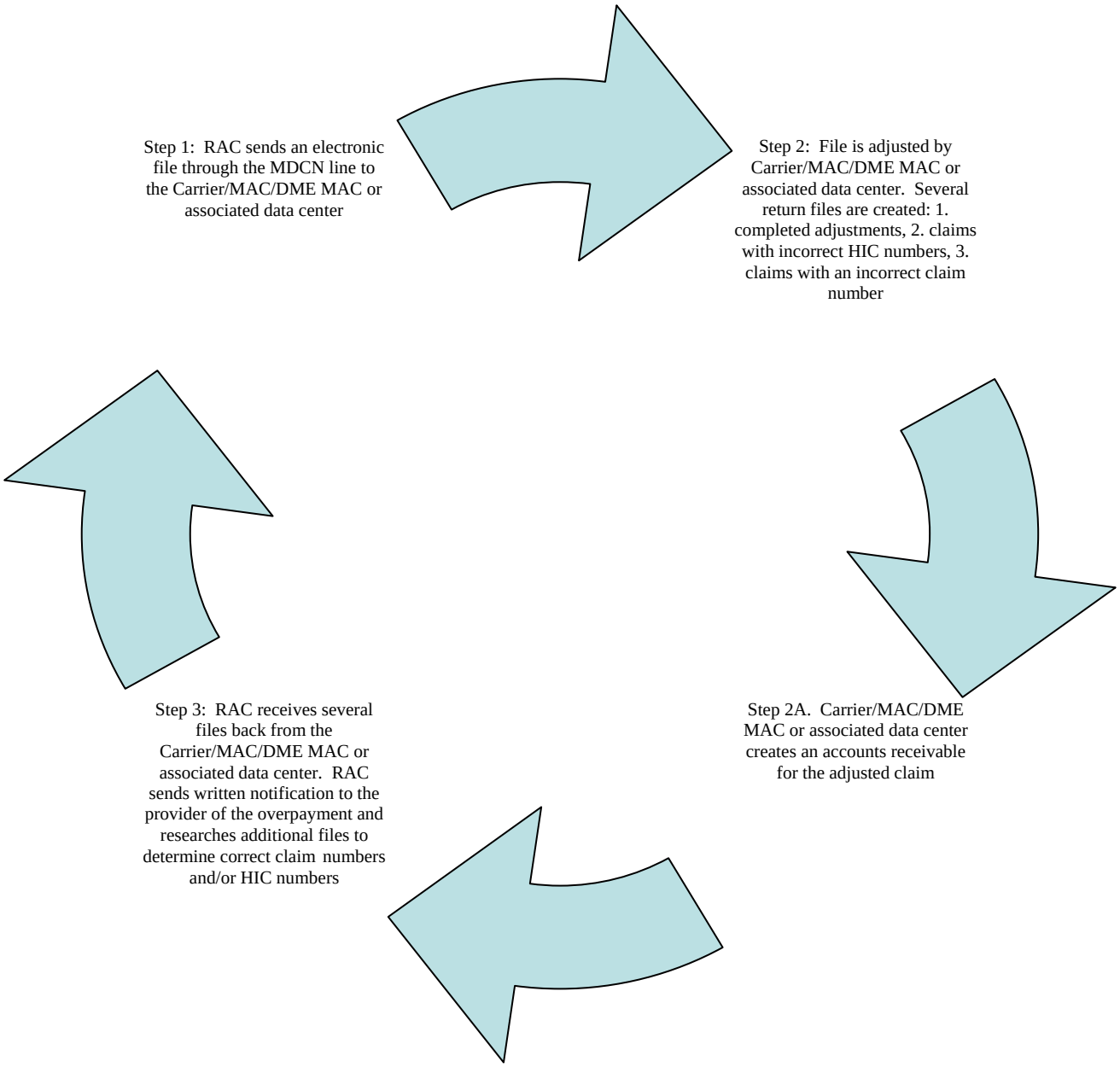
The RAC receives credit for the entire claim adjustment and the RAC shall include these additional lines and denial reason codes on the written notification to the provider. This

is currently only possible for Part B demand letters. However, RACs are still required to have knowledge and an understanding of the associated findings on all Part A claims in the event a provider has a question.

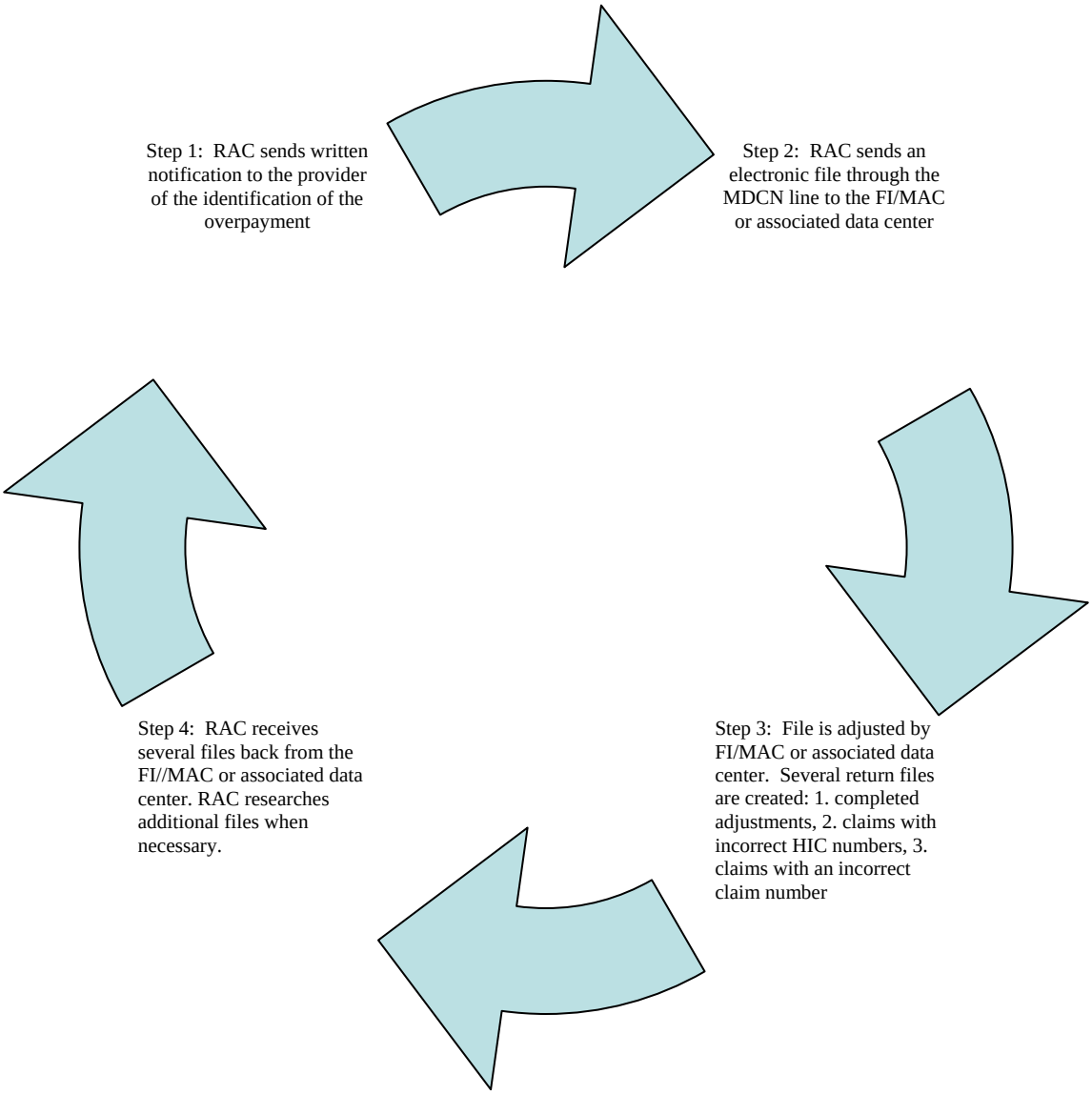
Also, a RAC identified adjustment may trigger the denial of the entire claim because of a known Medicare Secondary Payer occurrence or a known instance of the beneficiary's enrollment in a managed care plan. If an entire claim is denied because of managed care eligibility or a known MSP occurrence the RAC will not receive credit for the denial and will not receive credit for the adjustment identified by the RAC.

When partial adjustments to claims are necessary, the FI/Carrier/MAC/DME MAC shall downcode the claim whenever possible. The RAC will only be paid a contingency payment on the difference between the original claim paid amount and the revised claim paid amount. Some examples include DRG validations where a lower-weighted DRG is assigned, claim adjustments resulting in a lower payment amount, inpatient stays that should have been billed as outpatient, SNF…. If the system cannot currently accommodate this type of downcoding/adjustments, CMS will work with the system maintainers to create the necessary changes. This includes some medical necessity claims.

Part B Adjustment Process



Part A Adjustment Process



In the demonstration each FI/Carrier/DME MAC and the RAC worked collaboratively to

develop methods to automate adjustments. This was successful in some areas and more difficult in others. In areas where automation was difficult backlogs of claims requiring adjustment were created. With expansion of the RAC Program CMS realizes the need for standardization of all reporting and automation. CMS is currently in the process of creating standard system changes to all shared systems (FISS, MCS, and VMS). CMS does not have a completion date for the system changes. Until CMS has complete system changes manual adjustments may be required and it is possible backlogs will occur. While CMS will work with the appropriate FI/Carrier/MAC/DME MAC and the RAC to eliminate the backlog, CMS will not compensate the RAC for claims stuck in the backlog.

A. Written Notification of Overpayment

Part A Process

After identification and validation, if necessary, the RAC shall send written notification of the overpayment to the provider. The written notification shall include all necessary information specified in the Medicare Financial Management Manual, Chapter 4 (unless specifically excluded in this statement of work). The CMS Project Officer shall approve all written notifications to the provider before any letters can be sent.

Part B Process

After the claim is adjusted and an accounts receivable is created, the RAC shall issue a demand letter to the provider. The demand letter shall include all necessary requirements specified in the Medicare Financial Management Manual, Chapter 4, and section 90 (unless specifically excluded in this statement of work). The CMS Project Officer shall approve all demand letters to the provider before any letters can be sent.

CMS is moving toward standardized base letters for use by each RAC. CMS anticipates the standardized base letters will be available by the award of the contract. These letters will be found in the Medicare Financial Management Manual, Chapter 4, and section 100. Use of the standardized base letter will be required; however each RAC will add additional information pertinent to each overpayment identification.

B. Recoupment through Current and/or Future Medicare Payments

Medicare utilizes recoupment, as defined in 42 CFR 405.370 to recover a large percentage of all Medicare provider overpayments. “Recoupment” as defined in 42 CFR 405.370 is the recovery by Medicare of any outstanding Medicare debt by reducing present or future Medicare provider payments and applying the amount withheld to the indebtedness. Overpayments identified and demanded by the RAC will also be subject to the existing withholding procedures. The existing withhold procedures can be found in the Medicare Financial Management Manual, Chapter 4, section 40.1.
Withholding of present and/or future payments will occur by the appropriate Medicare FI/Carrier/MAC/DME MAC. These withhold procedures will be used for all provider overpayments.

Once payments are withheld, the withhold remains in place until the debt is satisfied in full or alternative payment arrangements are made. As payments are withheld they are applied against the oldest outstanding overpayment. The debt receiving the payments may or may not have been determined by the RAC. All payments are first applied to interest and then to principal. Interest accrues from the date of the demand letter and in accordance with 42 CFR 405.378.

The RAC will receive a contingency payment, as stated in the Payment Methodology attachment, for all amounts recovered from withholding of present and/or future payments that are applied to the principal amount identified and demanded by the RAC.

The RAC should not stop recovery attempts strictly because recoupment of the overpayment through current and/or future Medicare payments is being attempted. Outside of the first demand letter and the Intent to Refer demand letter and the offset process, the RAC can determine the recovery methods they choose to utilize. See the Medicare Financial Management Manual, Chapter 4 §20 and §90 for minimum requirements of the Medicare FIs/Carriers/MACs/DME MACs. All recoupment methods shall be explained in detail in the bidder's proposal.

C. Repayment Through Installment Agreements

The RAC shall offer the provider the ability to repay the overpayment through an installment plan. The RAC shall have the ability to approve installment plans up to 12 months in length. If a provider requests an installment plan over 12 months in length the RAC shall forward a recommendation to the appropriate regional office. The regional office will review the case and if the recommended installment plan is over 36 months in length, the regional office will forward the recommendation to Central Office for approval. The RAC shall not deny an installment plan request. However, the RAC may recommend denial. All recommended denials shall be forwarded to the appropriate regional office for review. If necessary the regional office will request Central Office assistance. If an installment plan requires assistance from the Regional or Central Office, the package shall include all documents listed in the Medicare Financial Management Manual, Chapter 4, Section 50.3. When reviewing all installment agreements the RAC shall follow the guidelines in section 1893(f) (1) of the Social Security Act as amended by section 935(a) of the Medicare Prescription Drug, Improvement and Modernization Act of 2003.

The RAC will receive a contingency payment based on the principal amount of each installment payment. As the provider submits monthly payments, the RAC shall receive the applicable contingency payment for the principal amount received.

D. Referral to the Department of Treasury

The Debt Collection Improvement Act of 1996 (DCIA) requires federal agencies to refer eligible delinquent debt to a Treasury designated Debt Collection Center for cross servicing and further collection activities, including the Treasury Offset Program. CMS

is mandated to refer all eligible debt, over 180 days **delinquent**, for cross servicing.

Per DCIA referral criteria, "delinquent" is defined as debt: (1) that has not been paid (in full) or otherwise resolved by the date specified in the agency's initial written notification (i.e., the agency's first demand letter), unless other payment arrangements have been made, or (2) that at any time thereafter the debtor defaults on a repayment agreement.

Debts ineligible for referral include:

- Debts in appeal status (pending at any level);
- Debts where the debtor is in bankruptcy;
- Debts under a fraud and abuse investigation if the contractor has received specific instructions from the investigating unit (i.e., Office of Inspector General or Office of General Counsel, etc.) not to attempt collection;
- Debts in litigation ("litigation" means litigation which involves the federal government as a party; it does not include litigation between the debtor and some party other than the federal government);
- Debts where the only entity which received the last demand letter is the employer and the employer is a Federal agency (MSP debts only);
- Debts where the debtor is deceased;
- Debts where CMS has identified a specific debt or group of debtors as excluded from DCIA referral (MSP debts only);
- Debts where there is a pending request for a waiver or compromise;
- Debts less than $25.00 (for non-MSP this amount is principal only; for MSP this amount is principal and interest);
- Debts of $100 or less where no TIN is available.

The RAC shall issue a written notification to the debtor with the appropriate intent to refer language within a time frame that allows for the RAC to issue an appropriate reply to all timely responses to the "intent to refer" letter before the debt is 130 days **delinquent**. All outstanding debts remaining unresolved and not under a non-delinquent installment agreement must be sent to the affiliated contractor for referral to Treasury on or before they are 130 days delinquent. The intent to refer language can be found in the Medicare Financial Management Manual, Chapter 4, and Section 70. The RAC is required to cease all recovery efforts once the debt is referred to the Department of Treasury. The AC will prepare the case for referral and will notify the RAC, through the RAC Data Warehouse when the debt is referred. Once the overpayment referred is it is no longer the responsibility of the RAC.

E. Compromise and/or Settlement of Overpayment

The RAC shall not have any authority to compromise and/or settle an identified or possible overpayment. If a debtor presents the RAC with a compromise request, the RAC shall forward the overpayment case and all applicable supporting documentation to the CMS PO for direction. The RAC must include its recommendation on the request and justification for such recommendation. If the debt is greater than $100,000, the package must include a completed Claims Collection Litigation Report (CCLR). If the provider

presents the RAC with a settlement offer or a consent settlement request, the RAC shall forward the overpayment case and all applicable supporting documentation to the CMS PO for direction. If CMS determines that a compromise and/or settlement is in the best interests of Medicare, the RAC shall receive a contingency payment for the portion of principal that was recouped, providing that the RAC initiated recoupment by sending a demand letter prior to the compromise and/or settlement offer being received.

F. Voluntary/Self-Reported Overpayments by the Provider

If a provider voluntarily self-reports an overpayment after the RAC issues a demand letter or a request for medical record, the RAC will receive a discounted contingency fee based on the Payment Methodology Scale. In order to be eligible for the contingency fee, the type and dates of service for the self-reported overpayment must be in the RAC's most recently approved project plan.

- If the provider self-reports this kind of case to the RAC, the RAC shall document the case in its files and the RAC Data Warehouse, and forward the check to the appropriate Medicare contractor.

- If the provider self-reports this kind of case to the Medicare contractor, the Medicare contractor will notify the RAC. The RAC will document the case in its files and the RAC Data Warehouses. Timeframes associated with the reporting of the voluntary/self-reported overpayment shall be addressed in the JOA between the RAC and the AC/MAC.

The RAC shall cease recovery efforts for the claims involved in the self-report immediately upon becoming aware (i.e., when the RAC is notified by the Medicare contractor, the provider, etc.)

If a provider voluntarily self-reports an overpayment, and the self-reported overpayment does NOT involve the same types of services for which the RAC had issued a demand letter or a request for medical records, then the RAC is not entitled to a contingency fee amount.

- If the provider self-reports this kind of case to the RAC, the RAC shall forward the check to the appropriate Medicare contractor.

- If the provider self-reports this kind of case to the Medicare contractor, the RAC need take no action.

The RAC may continue recovery efforts since the overpayment the provider self-reported involved a different provider/service combination.

<u>Unsolicited/Voluntary Refunds (by check or claims adjustment, including those due to credit balances</u>)
Occasionally the AC may receive an unsolicited/voluntary refund from a provider. An

unsolicited/voluntary refund is a refund that is submitted to the AC without a demand letter. It is a situation where the provider realizes that a refund is due the Medicare program and refunds the money to the AC. By definition, an unsolicited/voluntary refund (by check or by claims adjustment) must occur before a demand letter is issued. The RAC shall not receive any contingency payment on an unsolicited/voluntary refund.

G. Recoupment During the Appeals Process

The RAC shall ensure that all demand letters initiated as a result of an identified overpayment in Task 2 contain provider appeal rights, where applicable.

If a provider files an appeal with the appropriate entity within the appropriate timeframes, the RAC shall follow all CMS guidance regarding Section 1893(f) (2) of the Social Security Act as amended by section 935(a) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 regarding the limitation on recoupment.

If Section 935(a) is applicable following all CMS guidelines, once the RAC is notified of the appeal request, the RAC shall cease all recovery efforts. If a provider instructs the RAC that it has filed an appeal, the RAC shall cease recovery efforts and confirm the appeal request with the CMS Project Officer or its delegate. After the reconsideration level of the appeal process (completed by the Qualified Independent Contractor (QIC)) is adjudicated (or the first level of appeal if the QIC reconsideration process has not been implemented yet), the RAC shall resume recovery efforts if the decision was not favorable to the provider.

The aging of the provider overpayment for debt referral purposes will cease while recovery efforts are stopped during the appeal process. Interest shall continue to accrue, from the date of the demand letter, throughout the appeals process.

H. Interest

Regulations regarding interest assessment on determined Medicare overpayments and underpayments can be found at 42 CFR 405.378. Interest will accrue from the date of the final determination and will either be charged on the overpayment balance or paid on the underpayment balance for each full 30-day period that payment is delayed. The interest rate in effect on the date of final determination is the rate that will be assessed for the entire life of the overpayment. When payments are received, payments are first applied to any accrued interest and then to the remaining principal balance. Contingency fees are based upon the principal amounts recovered. All payments are applied to interest first, principal second.

I. Customer Service

The RAC shall provide a toll free customer service telephone number in all correspondence sent to Medicare providers or other prospective debtors. The customer service number shall be staffed by qualified personnel during normal business hours from 8:00 a.m. to 4:30 p.m. in the applicable time zone. For example, if the RAC is

conducting the demonstration in California the customer service number shall be staffed from 8:00am to 4:30pm Pacific standard time. After normal business hours, a message shall indicate the normal business hours for customer service. All messages playing after normal business hours or while on hold shall be approved by the CMS Project Officer before use.

The staff answering the customer service lines shall be knowledgeable of the CMS recovery audit program. The staff shall have access to all identified improper payments and shall be knowledgeable of all possible recovery methods and the appeal rights of the provider. If need be, the staff person responsible for that overpayment shall return the call within 1 business day. The RAC shall provide a translator for Spanish speaking providers or other prospective debtors. This translator shall be available within 1 business day of the provider's original call.

The RAC shall utilize a Quality Assurance (QA) program to ensure that all customer service representatives are knowledgeable, being respectful to providers and providing timely follow-up calls when necessary. The QA program shall be described in detail in the proposal.

The RAC shall respond to written correspondence within 30 days of receipt. The RAC shall provide the CMS Project Officer with copies by fax and mailed hard copy, of all correspondence indicating displeasure with the RAC, in the overpayment identification, or in the recovery methods utilized, within ten (10) calendar days of receipt of such correspondence. (If the RAC is not sure how the correspondence will be interpreted, it should forward the correspondence to the CMS PO.)

The RAC shall provide remote call monitoring capability to CMS personnel in Baltimore or the regional offices, if directed by the CMS PO. The RAC phone system must notify all callers that the call may be monitored for quality assurance purposes.

The RAC shall retain a written report of contact for all telephone inquiries and supply it to the CMS PO within 48 hours of it being when requested.

The provider outreach plan should include a component on customer service and should be updated with the project plan, as needed. CMS may stop recovery work in a particular region if evidence leads CMS to believe the customer service plan is not appropriate and/or effective. This "stop order" would be effective until CMS was satisfied with all improvements made in the customer service area.

Task 5- Supporting Identification of Overpayments in the Medicare Appeal Process and/or in the DCIA Process.

Providers are given appeal rights for the majority of Medicare overpayments determined during the post payment review process. If a provider chooses to appeal an overpayment determined by the RAC, the RAC shall assist CMS with support of the overpayment determination throughout all levels of the appeal.

This includes providing supporting documentation (including the medical record) with appropriate reference to Medicare statutes, regulations, manuals and instructions when requested, providing assistance, and representing CMS at any hearings associated with the overpayment when requested by CMS.

Providers shall request an appeal through the appropriate Medicare appeals process. A third party shall adjudicate all appeal requests related to provider overpayments identified by the RAC. This third party may be the current Medicare contractor, a third party contractor identified by CMS, a Qualified Independent Contractor, an Administrative Law Judge, or HHS' Departmental Appeals Board's Medicare Appeals Council. Some recovery claims may eventually be appealed to the appropriate Federal court. If the RAC receives a written appeal request it shall forward it to the appropriate third party adjudicator within one business day of receipt. If the appropriate Medicare contractor is not known, the RAC shall contact the CMS PO within one business day of receipt for assistance. If the RAC receives a verbal request for appeal from a provider, the RAC shall give the provider the telephone number of the appropriate Medicare contractor and inform them that their verbal request does not suspend the permissible time frame for requesting an appeal as set forth in the demand letter.

The appropriate Medicare contractor will notify the RAC and the CMS PO of the appeal request and the outcome of each applicable appeal level. This notification will occur at least one a month.

Additionally the RAC must provide support, as needed, if the debt is disputed outside of the formal administrative appeals process after being returned to the local contractor (or a third party as designated by CMS) for further collection action including referral to the Department of the Treasury for further debt collection activities.

Task 6a- Reporting of Identified, Demanded and Collected Medicare Overpayments and Identified Medicare Underpayments

The RAC will be required on a monthly basis to provide the CMS PO or its delegate with detailed information concerning overpayments and underpayments that have been identified, overpayments that have been demanded and overpayments that have been fully or partially collected. The RAC shall have supporting documentation for all line items on the report. This report will be due no later than the fifth (5^{th}) business day of the following month. Task 1, C.2 contains additional information required in the monthly financial reports.

Data Warehouse Reporting of Possible/Identified Improper Payments

CMS utilizes a Data Warehouse to house information on potential and outstanding improper payments under the RAC realm of responsibility. This Data Warehouse stores outstanding overpayment data, determination dates, principal and interest amounts, the status of the overpayment and allows CMS to prepare detailed and/or summary reports from various data included in the Data Warehouse.

The chart below summarizes when a RAC shall enter data into the Data Warehouse.

RAC chooses claim for potential review- automated or complex	RAC inputs claim into the RAC Data Warehouse- If suppressed or excluded RAC stops work on this claim/line number If not suppressed or excluded RAC continues work
COMPLEX REVIEW or PART A automated review	
RAC requests a medical record	RAC updates a status record with a medical record request
RAC sends a demand letter or a no demand letter*	RAC updates a status record with the demand letter status, no demand letter status and the date of the demand letter
RAC receives the collection amount from the FI	RAC or FI updates a status record with the overpayment amount
	RAC or FI updates a status record with the collection amount
AUTOMATED REVIEW	
RAC sends claims to Carrier or DME MAC for adjustment	
Carrier or DME MAC inform RAC of overpayment amount	RAC or Carrier/DME MAC updates a status record with the overpayment amount
RAC issues demand letter to provider	RAC or Carrier/DME MAC updates a status record with the demand letter status, demand letter date and account receivable number
RAC receives notification from Carrier or DME MAC concerning collection	RAC or Carrier/DME MAC updates a status record with the collection amount and the collection method

* For purposes of the RAC Data Warehouse, a Part A informational letter is a demand letter

A status record should also be input upon notification of an appeal.

RAC Data Warehouse Reporting and RAC Invoices

The RAC Data Warehouse is an integral participant in the success of the RAC project. However, the RAC Data Warehouse can only be successful if the data input into it by the RAC is reliable, timely and valid. In order for a RAC voucher to be paid, all supporting information for the voucher shall be in the RAC Data Warehouse, on the RAC invoice and on the listing received from the Medicare contractor (FI, Carrier, DMAC, MAC, DME MAC) **If a claim is not listed in all three, the claim will be removed from the invoice and not paid. Repeated occurrences could lead to entire invoices not being paid.**

CMS will utilize the following reports from the RAC Data Warehouse:

Part A

1. A report of all Part A collections for the month

2. A report of all Part A adjustments and appeals for the month

3. A report of all Part A underpayments for the month

1 + 3 - 2 = invoice amount

Part B

1. A report of all Part B collections for the month where offset was used.

2. A report of all Part B collections for the month where a check was received.

3. A report of all Part B adjustments and appeals for the month.

4. A report of all Part B underpayments for the month.

1 + 2 + 4 – 3 = invoice

Once available in the RAC Data Warehouse, these reports will be available to each RAC for download. These reports will be by RAC and by contractor number. The total of all reports for the RAC jurisdiction should equal the RAC invoice. Discrepancies must be notated along with supporting documentation.

Inaccurate Information Input into the RAC Data Warehouse

CMS hires a contractor to maintain and enhance the RAC Data Warehouse. Whenever erroneous files are input into the RAC Data Warehouse, CMS has to pay the contractor by the hour to fix the file. All costs attributed to fixing errors input by the RAC will be absorbed by the RAC. CMS will accomplish this by notifying the RAC and by subtracting that amount from the next invoice.

For example: A RAC uploads a file of 30,000 claims and later realizes that the wrong provider type was input. In order to fix the error, CMS must notify the RAC Data Warehouse maintainer to change the provider type or delete the entire file. If this takes 4 hours to complete and the RAC Data Warehouse maintainer is paid $100 per hour, the next invoice for the RAC will have $400 deducted from it for the cost of the error.

CMS has instituted this new process to ensure all RACs understand the importance of the RAC Data Warehouse and take due diligence when inputting information into it and to ensure that CMS can accurately budget for the maintenance of the RAC Data Warehouse.

Task 6b Other Systems Created by RAC

The RAC is free to utilize a subsequent system in addition to RAC Data Warehouse provided by CMS. Any subsequent system shall not take the place of the RAC Data Warehouse.

All reports generated from an alternative system shall be converted to Microsoft Excel 2000 prior to submission to the CMS PO.

Task 7 – Administrative and Miscellaneous Issues

A. Administrative Functions

Once the RAC has identified an overpayment, the RAC shall send the debtor written notification as indicated in Task 4A. This notification shall request that the debtor submit payment in full. Payments shall be sent to the appropriate Medicare FI/Carrier/DME MAC/MAC.

B. Separate reporting

The reporting and data collection/analysis or each of the major tasks must be kept separate and submitted in the appropriate format per Task 1.

C. Payment Methodology

All payments shall be paid only on a contingency fee basis and shall be based on the principal amount of the collection or the amount paid back to a provider (underpayment).

Contingency fees:

- Because interest collected is returned to General Revenue rather than to the Medicare trust funds, a contingency fee shall not be paid on any interest collected.

- The RAC shall not receive any payments for the identification of the improper payments.

- The contingency fee will be determined by the overpayments collected without consideration given to the underpayments identified (i.e. without netting out the underpayments against the overpayments.) Underpayments in a claim are counted separately.

- The RAC shall receive 75% of the agreed upon contingency percentage for

recovery efforts accomplished through the offset process of a Part A claim (processed by the FISS) by a FI/MAC

- The RAC shall receive 50% of the agreed upon contingency percentage for any of the following recovery efforts:
    - Recovery efforts accomplished through the offset process by a carrier/DME MAC or a Part B claim by a MAC.
    - Recovery efforts accomplished through Treasury offset or another collection vehicle after the debt is referred to the Department of Treasury.
    - Recoveries made through a self-disclosure made by a provider in result of a prior RAC identified request for medical records or demand letter. Self-disclosed service and time period must be included in the RAC's project plan.
- If a provider files an appeal disputing the overpayment determination and the appeal is adjudicated in the provider's favor at **ANY** level, the RAC shall repay Medicare the contingency payment for that recovery. Repayment to Medicare will occur on the next applicable invoice.

D. Point of Contact for RAC

The primary point of contact for the RACs shall be the CMS PO or his/her delegate.

E. Data Accessibility

CMS shall provide the RAC with all applicable data files for all claims paid during the specific timeframes of the contract for the appropriate geographic area. The RAC will receive new data updates as they become available. (monthly or quarterly) The data file format, data fields available and user agreements can be found at http://www.cms.hhs.gov/AccesstoDataApplication/www.cms.hhs.gov.

To access data the RAC shall acquire a Medicare Direct Connect Network (MDCN) line. This is a secure line between the RAC and the CMS Data Center. The cost of the MDCN line shall be incurred by the RAC. Anticipated costs range from $1500-$2000 per month. This does not include setup costs. These costs may increase at any time. CMS will provide the applicable points of contact to set up the MDCN line. In addition, the RAC must acquire the appropriate software to enter into the CMS Data Center. Stellant Direct: Connect software is currently being utilized by CMS for this purpose. There is no other alternative software. At this time the price of the Stellant Direct: Connect software is approximately $185,000.00. The RACs are responsible for all costs of the MDCN line and the Stellant Direct: Connect software.

As CMS moves towards utilizing Enterprise Data Centers (EDC) the transmission of data may cease. The RAC may be required to utilize a CMS system in a CMS Data Center to

retrieve extracts of claims.

The RAC shall pay for any charges associated with the transfer of data. This includes, but is not limited to, cartridges, data communications equipment, lines, messenger service, mail, etc. The RAC shall pay for all charges associated with the storage and processing of any data necessary to accomplish the demonstration. The RAC shall establish and maintain back-up and recovery procedures to meet industry standards. The RAC shall comply with all CMS privacy and security requirements. The RAC shall provide all personal computers, printers and equipment to accomplish the demonstration throughout the contract term.

F. Recalled Cases

CMS may determine that a case or a particular uncollectible debt should be handled by CMS staff and may recall the case/debt for that reason. Should CMS recall a case/debt, the RAC shall immediately stop all activities on the case/debt identified by CMS for recall and return the case/debt and all related information to CMS within one (1) business day of the recall request.

The RAC shall receive no payment, except for monies already recouped, for recalled cases.

A BI PSC or BI Unit of a DME MAC may determine that overpayment identification or recoupment action on a case, provider, and geographic region should cease and may recall the case for that reason. Should the BI PSC/unit recall a case, provider, geographic region, the RAC shall immediately stop all activities on the case identified by the BI PSC/unit for recall. The RAC shall receive no payment, except for monies already recouped for recalled cases.
All requests for recall shall be forwarded to the CMS PO for concurrence. CMS and the BI PSC or BI Unit of a DME MAC shall have a valid reason for the recall of the case. If there is a dispute, the CMS PO shall make the final decision concerning the recall of the case.

G. Case Record Maintenance

The RAC shall maintain a case file for every improper payment that is identified, including documentation of subsequent recovery efforts. This file shall include documentation of all processes followed by the contractor including a copy of all correspondence, including demand letters, a telephone log for all conversations with the provider or other individuals or on behalf of the provider or other debtor, and all collection activities (including certified/registered mail receipts, extended repayment agreements, etc). The case file may be electronic, paper or a combination of both. For electronic files, the case file shall be easily accessible and made available within 48 hours of request. At CMS's request or no later than fifteen (15) days after contract termination, the RAC shall return to CMS all case files stored in accordance with CMS instructions. Once an improper payment is determined all documentation shall be kept in the case file. The RAC shall not destroy any supporting documentation relating to the identification or

recovery process.

All case files shall meet the requirements as set by OMB Circular A-130, which can be found at http://www.whitehouse.gov/omb/circulars/a130/a130trans4.html.

H. Recovery Deposits

The demand letters issued by the RAC will instruct debtors to forward their refund checks to the appropriate address at the applicable Medicare contractor (FI/Carrier/DME MAC/MAC). All refund checks shall be payable to the Medicare program. If the RAC receives a refund check, the RAC shall forward the check to the appropriate address. Before forwarding the check, the RAC shall make copies of and otherwise document these payments. A copy shall be included in the appropriate overpayment case file.

I. Support OIG or Other Audits

Should the OIG, CMS or a CMS authorized contractor choose to conduct an audit of the RAC, the RAC shall provide workspace and produce all needed reports and case files within 1 business day of the request.

J. Support Evaluation Contractor

CMS is required to report on the RAC Program annually. To assist with the report, CMS utilizes an independent evaluation contractor. This contractor assists CMS with the analysis of data, completes the provider survey, may assist CMS in monitoring the RACs, and maintains the referral database. Each RAC will have a point of contact for the Evaluation Contractor and each RAC shall assign a point of contact in their organization. At times, the evaluation contractor may request data from each RAC. All requests will be filtered through the CMS PO and should be addressed within 15 days of receipt unless otherwise noted in the request.

K. Public Relations & Outreach

The initial project plan shall include a section covering provider outreach. CMS will announce the use of the RACs in the specified geographic area. All other debtor education and outreach concerning the use of RACs will be the responsibility of the RAC. The RAC shall only educate providers on their business, their purpose and their process. The RACs shall **not** educate providers on Medicare policy. The CMS PO shall approve all presentations and written information shared with the provider, beneficiary, and/or other debtor communities before use. If requested by CMS, the RACs project manager for the CMS contract, at a minimum, shall attend any provider group or debtor group meetings or congressional staff information sessions where the services provided by the recovery audit contractors are the focus.

The RAC is required by January 01, 2010 to develop and maintain a Medicare RAC webpage to communicate to the provider community helpful information (e.g., who to

call for an extension, how to customize the address for a medical record request letter). The Medicare information shall appear on pages that are separate and distinct from any other non-Medicare work the RAC may have. The RAC shall obtain prior PO approval for all Medicare webpage content.

L. Quality Assurance

1. Each RAC shall be required to complete a Statement of Auditing Standards No. 70 (SAS 70) Audit. Each RAC shall be responsible for contracting with an independent and certified public accounting (CPA) firm to perform the audit. The CPA firm will ideally have experience in Medicare operations and must have experience performing SAS 70 Type II audits.

CMS control objectives can be found in IOM Pub. 100-6, Chapter 7. CMS will dictate which control objectives will be applicable to the audit. The scope of the audits will be dictated by CMS and will be determined no later than 180 days after award. A final report from the CPA firm must be submitted to CMS by the end of each award year. Any corrective action plan must be submitted to CMS within 45 days of the issuance of the final report.

Additional general information concerning a SAS 70 audit can be found in IOM Pub. 100-6, Chapter 7.

2. At CMS discretion, CMS may perform a contractor performance evaluation. Advance notice may/may not be given. During the evaluation CMS reviewers will work from a prescribed audit protocol, review actual cases and issue a final report. Any finding from the review will require a corrective action plan.

3. At CMS discretion, CMS may contract with an independent contractor to perform an accuracy audit on a RAC's identifications. At a minimum, this audit would be performed annually.

Task 8 Final Report

The final report shall include a synopsis of the entire contract project. This includes a final report identifying all amounts identified and demanded, all amounts collected and all amounts still outstanding at the end of the demonstration. It shall include a brief listing of all identification methods or other new processes utilized and their success or failure.
The contractor should include any final thoughts on the program, as well as any advantages or disadvantages encountered. From a contractor point of view, the final report should determine if the contract was a success or a failure and provide support for either opinion.

A final report shall be delivered to the CMS PO in the three formats (paper/electronic) as stated below and in the required "electronic" formats to the *fnlrpts@cms.hhs.gov* mailbox:

1) Paper, bound, in the number of copies specified;
2) Paper, unbound, suitable for use as camera-ready copy;
3) Electronic, as one file in Portable Document Format (PDF), as one file in Hypertext 200-word abstract/summary of the final report suitable for submission to the National Technical Information Service. Drafts of all documentation shall be provided to CMS approximately four weeks prior to final deliverable due dates unless otherwise agreed to. CMS staff will review materials and provide comments back to the contractor within 2 weeks, thereby allowing 2 additional weeks for the contractor to make any necessary revisions. All data files and programs created under this project shall be the sole property of CMS and provided to CMS upon request in the appropriate format. They shall not be used for any other purpose other than fulfilling the terms of this contract without the express permission of the contracting officer.

SCHEDULE OF DELIVERABLES

The contract awarder shall provide the necessary personnel, materials, equipment, support, and supplies to accomplish the tasks shown below in the specified time. The contract awarder shall complete the evaluation and report to CMS its findings. All work done under this contract shall be performed under the general guidance of the CMS PO subject to the PO's approval.

Written documents for this project shall be delivered in hard copy to the project officer (2 copies), unless otherwise specified. These documents shall also be delivered to the Project Officer in an electronic version via email. At present, the CMS standard is Microsoft Word 2000 and Microsoft Excel 2000. This is subject to change, and the contractor shall be prepared to submit deliverables in any new CMS standard.

Task Number	Deliverable Number	Deliverable	Due Date (from contract award date)
1.a.	1	Initial Meeting	2 weeks
1.a.	2	Project Plan	4 weeks
1.b.	3	Monthly Conference Calls	Monthly
1.c.	4	Monthly Progress Reports	Monthly
6	5	Financial Report	Monthly
1	6	Vulnerability Report	Monthly
6	7	Training on RAC Data Warehouse	Within 15 days of the start of Task 2
6	8	Case File Transfers	Within 15 days after contract end
9	9	Final Report- Draft	Within 4 weeks of contract end date
9	10	Final Report- Final	Within 8 weeks of contract end date

PAYMENT METHODOLOGY SCALE

1	% When recovery is made through RACs efforts (check sent in by provider in response to demand letters, phone calls…)	_____
2	75% of the contingency fee specified in number 1 above when recovery is made through the offset process by the Medicare fiscal intermediary or MAC (Part A claims only)	
3	50% of the contingency fee specified in number 1 above when recovery is made through the offset process by the Medicare **carrier/DME MAC/MAC** (Part B claims).	
4	50% of the contingency fee specified in number 1 above when recovery is made after the debt is referred to the Department of Treasury	
5	50% of the contingency fee specified in number 1 when a self-disclosure is made by a provider in result of a prior RAC identified request for medical requests or demand letter/ Self disclosed service and time period must be included in the RAC's project plan	
6	100% of the contingency fee specified in number 1 when an underpayment is identified as a result of automated or complex review. Payment occurs after the FI/Carrier/DME MAC/MAC validates the underpayment and determines the actual amount	
7	% When no recovery is made for an overpayment	0%

Appendix 1- Intentionally Left Blank

Appendix 2: Map of Recovery Audit Contract Regions

Map can be viewed here
http://www.cms.hhs.gov/RAC/Downloads/Four%20RAC%20Jurisdictions.pdf