Additional Documentation Limits for all Medicare providers (except suppliers and physicians)
(As of November 10, 2010)

In response to feedback from the RACs, providers/suppliers and their associations, CMS has modified the additional documentation request limits for the RAC program. These limits will be set by each RAC (CMS) and will establish a cap per campus on the maximum number of medical records that may be requested per 45-day period. A campus unit (defined below) may consist of one or more separate facilities/practices under a single organizational umbrella; each limit will be based on that unit's prior calendar year Medicare claims volume.

1. Limits will be based on the servicing provider/supplier's Tax Identification Number (TIN) and the first three positions of the ZIP code where they are physically located. Using TINs will reduce the total number of limits that would have been imposed per organization under the previous draft policy, which was based on National Provider Identifiers, while factoring in ZIP codes will promote equitability for regional or national organizations. For example:

    - Provider A has TIN 123456789 and two physical locations in ZIP codes 12345 and 12356; the two locations would qualify as a single campus unit for additional documentation limit purposes.

    - Provider B has TIN 123456780 and is physically located in 12345 as well as 21345. This provider would be considered as two distinct entities for additional documentation purposes, and each location would have its own additional documentation limit.

    Please note that the definition of a campus for RAC documentation request limits differs significantly from the definition in 42 CFR 413.65(a)(2) used to determine eligibility for provider-based billing.

2. Limits will be set at 1% of all claims submitted for the previous calendar year, divided into eight periods (45 days). Although the RACs may go more than 45 days between record requests, in no case shall they make requests more frequently than every 45 days. A provider's limit will be applied across all claim types, including professional services. Note: FY 2010 limits are based on submitted claims, irrespective of paid/denied status and/or individual lines, although interim/final bills and RAPs/final claims shall be considered as a unit. For example:

    - Provider C billed 156,253 claims last year. The provider's additional documentation limit would be (156253 *.01)/8= 195.31, or 195 additional documentation requests per 45 days.

    - Provider D billed 50,000 inpatient claims, 75,000 outpatient claims, 20,000 SNF covered stays, 20,000 home health episodes of care, 250,000 physician claims, 10,000 inpatient rehab claims and 1.000 hospice claims. The total number of claims for this provider would equal 426,000. The provider's additional documentation limit would

be (426000*.01)/8= 532.5. The provider's additional documentation limit would be 532 additional documentation requests every 45 days, if there were no cap in place (see below).

While respecting a provider's overall limit, the RAC may exercise discretion in the exact composition of an additional documentation request. For example, the RAC may request inpatient records up to the full limit even though the provider's inpatient business may only be a small portion of their total claim volume.

3. Beginning November 2, 2010, the cap will be 300 additional documentation requests per 45 days for all providers (excluding physicians and suppliers).

4. In addition, CMS may give the RACs permission to exceed the cap. Permission to exceed the cap must receive CMS approval and may occur by CMS or by the RAC requesting permission to exceed the cap. Affected providers will be notified in writing.

Questions concerning this update can be directed to RAC@cms.hhs.gov.