Statement of Work (SOW) for the Part A/B Medicare Fee-for-Service (FFS) Recovery Audit Contractor (RAC) and the National DME/HH+H RAC– Regions 3, 4, and 5

I. Purpose

The Recovery Audit Program's mission is to reduce Medicare improper payments through the efficient detection and correction of improper payments. This statement of work (SOW) includes all tasks and responsibilities associated with the review of Medicare Fee-for-Service (FFS) claims submitted to, and paid by, the Medicare Administrative Contractors (MACs) in the Recovery Audit Contractor (RAC) Region for which this contractor is awarded. The RAC shall review all claim types using CMS-approved review topics. The RAC shall work with the Centers for Medicare & Medicaid Services (CMS), MACs, and any other CMS contractors to effectuate the adjustment of claims, recoup overpayments, pay underpayments, support the appeals process, report the status of all reviews by updating the RAC Data Warehouse (RACDW), and provide monthly reports. All RAC tasks shall be completed in a timely, accurate, and efficient manner, as defined by the CMS RAC COR.

II. Background

Section 1893(h) of the Social Security Act ("the Act") authorized a nationwide expansion of the Recovery Audit Program, and required the Secretary of the Department of Health and Human Services to utilize RACs under the Medicare Integrity Program to identify underpayments and overpayments and recoup overpayments associated with services and items for which payment is made under Part A or B of Title XVIII of the Act. To gain additional knowledge, RACs shall research the following documents:

- The CMS IOM Pub. 100-08, Medicare Program Integrity Manual (PIM)
- The Debt Collection Improvement Act of 1996
- SEC. 31001 - (3)(A)(ii)(c)(6) and (7)(A)(B)
- The Federal Claims Collection Act, as amended and related regulations found in 42 CFR
- Title 42 CFR Subpart D – Medicare Integrity Program Contractors
- Title 42 CFR Subpart E – Medicare Administrative Contractors
- National Coverage Determinations (NCDs) and Local Coverage Determinations (LCDs)
- Comprehensive Error Rate Testing Reports (CERT)
- Recovery Audit Program Status Documents and Reports to Congress available at CMS.gov Medicare Fee-for-Service Compliance Programs
- Sections 508 of the Rehabilitation Act of 1973 (29 U.S.C. 794d) as amended by the Workforce Investment Act of 1998 (P.L. 105-220)
- Health Insurance Portability and Accountability Act of 1996 (Public Law 104-191), Title 2 -- Preventing Health Care Fraud and Abuse; Administrative Simplification; Medical Liability Reform:
    - Subtitle C – Data Collection
    - Subtitle F – Administrative Simplification

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 error (such as an incorrect code, or incorrect/missing modifier), but the payment amount is not

altered by the error, are not considered improper payments for the Medicare FFS Recovery Audit Program.

III. Requirements

A. General Requirements

The primary point of contact (POC) for the RAC for all operational tasks in this SOW or any aspect thereof shall be the CMS RAC COR or their delegate. The CMS Contracting Officer (CO) shall be the primary POC for all contract issues/questions. The RAC shall collaborate with other subject matter experts (SMEs), with CMS RAC COR approval.

Independently and not as an agent of the Government, the RAC shall furnish all the necessary services, qualified personnel, material, equipment, and facilities, not otherwise provided by the Government, as needed to perform all requirements of this SOW.

All documentation created by the RAC and submitted to CMS is subject to the Revised Section 508 of the Rehabilitation Act, as applicable. At the discretion of the CMS RAC COR, 508 compliance may be waived for working documents including draft versions of documents and versions of documents not yet accepted by the CMS RAC COR. For more information, see Appendix B- 508 Standards per the Revised Section 508 of the Rehabilitation Act.

B. Statement on Standards for Attestation Engagements

Each RAC shall be required to complete an annual Statement on Standards for Attestation Engagements Number 18 (SSAE 18 Type II Audit). Each RAC shall be responsible for contracting with an independent and certified public accounting (CPA) firm to perform the audit in accordance with current CMS standards. The CPA firm will ideally have experience in Medicare operations and must have experience performing SSAE 18 Type II audits.

The CMS control objectives can be found in IOM Pub. 100-06, Chapter 7, along with additional general information concerning an SSAE 18 Type II audit. The 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 contract award. The final annual report from the CPA firm must be submitted to CMS by the award anniversary date. Any corrective action plan must be submitted to CMS within 45 calendar days of the issuance of the final report.

C. System Requirements and Data Accessibility

The CMS may make system changes that could result in additional (not previously present) administrative tasks being placed on the RAC. These administrative tasks shall be within the scope of this contract and shall be applicable to the identification and recovery of improper payments. The CMS will provide minimal administrative support for system changes and cannot guarantee implementation timeframes.

The RAC shall be responsible for obtaining the appropriate hardware, software, and telecommunications equipment to undertake and fully complete all the tasks within this SOW. It is the responsibility of the RAC to have available the personnel needed to design, build, and maintain a system, in the appropriate environment, meeting CMS standards, without assistance from CMS. Resources available to the RAC include the CMS Risk Management Handbook (RMH) and the CMS Acceptable Risk Safeguards (ARS) publication. The RAC shall comply with the CMS Security Assessment and Authorization (SA&A) methodology, policies, standards, procedures, and guidelines for contractor facilities and systems. When using or disclosing protected health Information (PHI), the RAC shall comply with the Health Insurance Portability and Accountability Act (HIPAA).

The RAC shall comply with CMS policies and other requirements below, as well as documents referenced within those policies:

1. The CMS Policy for Information Security (PIS), (as amended) – The high-level CMS policy for the CMS Information Security Program.
2. The CMS Policy for the Information Security Program (PISP), (as amended) - Sets the ground rules under which CMS shall operate and safeguard its information and information systems to reduce the risk and minimize the effect of security incidents. This document will subsequently reference the contractor-applicable ARS manual and the RMH, Volumes I, II, and/or III Security Standards and Procedures.
3. The CMS Policy for Investment Management and Governance (as amended) – Establishes the policy for systematic review, selection/reselection, implementation/control, and continual evaluation of IT investments at CMS.
4. Cloud Services - All cloud-specific requirements will be as defined in CMS Information Security, Section 1.3, Cloud-based Services. However, for information identified as Personally Identifiable Information (PII), Protected Health Information (PHI), and/or Federal Tax Information (FTI), the additional security and privacy requirements listed in the ARS manual Implementation Standards (as amended), as applicable to PII, PHI, and/or FTI, shall be applied within cloud-based services.
5. The CMS Information Security website provides a list of applicable security policies and procedures across the program.

A summary of these requirements is listed in the Applicable Laws and Regulations sections of the above listed CMS policies, as well as in the Applicable Laws and Regulations section of the Health and Human Services (HHS) Office of the Chief Information Officer (OCIO) Policy for Information Systems Security and Privacy.

To access CMS data, the RAC shall acquire a secure line between the RAC and the CMS Data Center. The RAC shall acquire the appropriate software to enter into the CMS Data Center. IBM/Sterling Commerce Connect: Direct software is currently being utilized for this purpose. Any alternative CMS software must be approved by the CMS RAC COR. The RAC shall incur all costs associated with the establishment and maintenance of the secure line, as well as license

costs. The RAC shall be responsible for negotiating its own commercial license and costs with the vendor. These costs are not controlled by CMS and may increase at any time.

The RAC shall be required to provide testing to ensure data transfers are secure and successful. After the secure line is established, all testing is completed, and any corrective actions identified as a result of testing have been taken, CMS will provide the RAC with all necessary data files under the terms of this contract for the applicable geographic area. The RAC will receive new data updates monthly. The data file format, data fields available and user agreements are available upon request.

If any problems arise with the transfer of data files, the RAC shall undertake all necessary steps in troubleshooting the cause of the problem. The RAC shall request assistance from CMS only after all steps have been taken to ensure the problem does not originate from the contractor side. If the problem is found to have been caused by CMS, CMS will take steps to re-send the data correctly.

If a newly awarded RAC requires access to National Claims History (NCH) historical claims data files, for the awarded RAC region, the CMS Office of Technology Solutions (OTS) requires the RAC to submit an external hard drive. The external hard drive shall be submitted to the CMS RAC COR. The hard drive shall be capable of storing a minimum of two terabytes of data. A previously used hard drive can be used but must be stripped of any previous data. A RAC that has more than one RAC region is required to provide a separate hard drive for each region.

The CMS will provide approximately three years of historical claims data divided by provider type to each RAC region. The historical claims data files will contain all provider types pertinent and appropriate to the awarded contract. The historical claims data will differ in format from the NCH monthly tap file claims transmissions. The record layouts for the historical claims data files are on the following DESY website www.cms.gov/DESY in folders Version K SAS Copylibs and Version K COBOL Copylibs (The version may be subject to change).

As CMS moves towards utilizing Enterprise Data Centers (EDC), the transmission of data may cease. The CMS will work with the RAC to transition from claims data transmission to claims data extraction. For claims data extraction, the RAC shall be required to utilize a CMS system in a CMS Data Center. An example of the CMS system would be the Integrated Data Repository (IDR).

The RAC shall incur 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 SOW directives.

D. Receiving and Transmitting Medical Records/Documentation

Before requesting documentation, the RAC shall have the ability to receive medical records via esMD. In addition to esMD, the RAC shall accept medical records submitted electronically, (e.g., fax, CD, DVD, or transmitted via electronic submission of medical documentation (esMD)), per the CMS Internet Only Manual (IOM), Program Integrity Manual (PIM), Section 3.2.3.5 - Acceptable Submission Methods for Responses to Additional Document Requests (ADRs).

The RAC shall also accept medical records/documents submitted as (paper) hard copies. Hard copy records shall be scanned into the RAC's secure internal document management system. When scanning, the RAC shall ensure, as much as possible, that the scanned documents maintain appearance, size, form, shading, and fonts of the original documents. After successfully scanning, hard copy records shall be disposed of using CMS records management procedures, as outlined in IOM 100-01 Chapter 7 - Contract Administrative Requirements 30.30.

When transmitting medical records/documentation, the RAC shall use a secure transmittal process. Secure transmittal means sent in accordance with the CMS business systems security manual (e.g., mailed CD, MDCN line, through a clearinghouse, esMD transmittal).

The RAC may use a provider portal designed to accept medical record documentation with CMS Technical Review Board (TRB) approval, see SOW, Task 7, Section C Provider Portal for details.

E. System Security Requirements

The RAC shall establish and maintain backup and recovery of systems in accordance with "CMS Information Security (IS) Application Contingency Plan (CP) Procedures," and "CMS Contingency Planning Tabletop Testing Procedures." The RAC shall comply with all CMS privacy and security requirements. The RAC shall provide all personal computers, printers, and equipment to accomplish the work described herein throughout the contract term.

The RAC shall conduct or undergo an independent evaluation and test of its systems security program in accordance with the CMS Business Partners System Security Manual, IOM Pub.100-17. The RAC's first independent evaluation and test of its systems security program shall be completed prior to the RAC commencing claims review under the contract. Any deficiencies noted as a result of the independent evaluation and test of its systems security program shall be corrected prior to the processing of claims.

The RAC shall conduct, at a minimum, annual vulnerability assessments of its systems, programs, and facility in accordance with the CMS Business Partners System Security Manual, IOM Pub.100-17, Continuous Monitoring:

1. The RAC shall support CMS validation and accreditation of RAC systems and facilities in accordance with CMS' SA&A methodology, through which an organization establishes and demonstrates a sound information security posture for its system.
2. The RAC shall provide annual certification, in accordance with SA&A procedures, that certifies it has examined the management, operational, and technical controls for its systems supporting the RAC function and considers these controls adequate to meet CMS security standards and requirements.
3. The RAC shall ensure security documents are uploaded and security controls are documented timely in the CMS FISMA Control Tracking System (CFACTS). The RAC shall correct any security deficiency, conditions, weaknesses, findings, or gaps identified by all CMS audits, reviews, evaluations, tests, and assessments within the timeframes requested. The RAC shall begin the process to obtain an Authority to Operate (ATO) within 60 calendar days of contract award.
4. While the RAC is working towards obtaining an ATO, the RAC is expected to perform all aspects of the SOW manually, using methods approved by the CMS RAC COR. The quality of the work delivered shall be entirely accurate, complete, and containing no errors. Granting of an ATO is based on the RAC's system meeting/exceeding the minimum Federal, Health & Human Services (HHS), and CMS Security and Privacy policy and standards. The CMS security requirements, policies, procedures, standards, and guidelines are located at CMS Information Security and Privacy Virtual Handbook.

The CMS will take all measures necessary to minimize system security risks, including but not limited to stopping the transmission of NCH data to the RAC, ceasing reviews, and terminating the RAC contract, if necessary.

IV. Personnel Requirements

The RAC shall ensure that the personnel listed below will comprise an adequate structure to perform the tasks outlined in the SOW.

RAC personnel shall be required to undergo a background investigation as outlined with Section III.F.6 of this SOW.

A. Key Personnel

At a minimum, the RAC shall designate a Project Manager (PM), Contractor Medical Director (CMD), Medical Review (MR) Manager, Chief Information Officer (CIO), and Systems Security Officer (SSO) as key personnel.

Key Personnel:
For this SOW, "fully dedicated" means that the individual identified for any key personnel position shall be a full time equivalent (FTE) employee. The PM and CMD may serve as a designated back up, or in an ancillary capacity, on another RAC contract with CMS COR approval; they may not fulfill the role of a primary key personnel on another contract. The primary MR Manager, CIO and SSO may serve in the primary key personnel role, or backup key personnel role, on more than one RAC

contract, with CMS COR approval. Key personnel may not perform duties on any Medicare/non-Medicare contract or commercial line of business, other than a RAC contract, without approval by the CO and CMS RAC COR.

Prior to key personnel changes, the RAC shall send a prospective candidate's resume to CMS reflecting that the candidate meets the requirements of this SOW, along with a proposed transition plan. The key personnel shall be approved by CMS before the transition occurs. All changes to the RAC's organizational chart shall be submitted to the CMS RAC COR within seven business days of the actual change being made.

Backup Key Personnel:
The RAC shall submit a CMS approved contingency plan and designate fully qualified (meets the experience and education requirements for the respective key personnel position) backups for each key personnel role (including a CMS User ID and access to the RACDW). The designated backup personnel shall ensure, to the greatest extent possible, continuity of operations and minimal interruptions in the event of a permanent or temporary departure of key personnel. All backup positions, while serving in the capacity as primary key personnel, must work full-time and are subject to the same rules as Key Personnel provided for above.

1. **Project Manager**
   The PM shall be fully dedicated to this contract and shall act as a central point of contact (POC) with CMS and other stakeholders. The PM shall be available to the CMS RAC COR during normal business hours (9:00 am – 6:00 pm ET). If the PM is not going to be in the office due to vacation, etc., the CMS RAC COR shall be notified, and the PM shall designate a CMS-approved backup person to serve as the central POC with CMS. Anyone serving as a backup for the PM shall be required to answer questions and/or provide data to the same degree that the PM would be able to provide to CMS.

   Primary duties shall include but are not limited to:
   - Coordinate internal resources for the execution of projects.
   - Ensure all projects are delivered on-time and within the scope of the project.
   - Manage changes to the project scope, project schedule, and project deliverables.
   - Perform risk management analysis and implement risk mitigation.
   - Create and maintain comprehensive project documentation.
   - Maintain data integrity and notify CMS of failure to meet SOW requirements immediately upon becoming aware.
   - Ensure staff possess the appropriate credentials to fulfill the SOW requirements.
   - Communicate and disseminate critical project information to CMS and other stakeholders.
   - Coordinate provider outreach opportunities (see Task 15).

- Attend conferences and training as required by CMS.

Project Manager Education
The PM shall possess a bachelor's degree in Accounting, Business, Marketing, Public Administration, or other Healthcare relevant field.

Project Manager Work Experience
The PM shall have at a minimum 5 years of professional work experience in the healthcare industry supporting either Federal Government agencies or Commercial Healthcare market as a PM, project leader, operations manager, technical project manager, or product manager. The PM shall have extensive knowledge of the Medicare program particularly the coverage and payment rules and , preferably with knowledge of CMS FFS Recovery Audit Program.

2. Contractor Medical Director (CMD)
The CMD shall be fully dedicated to this contract. The RAC shall arrange for a CMS-approved alternate CMD when the primary CMD will be unavailable for an extended period, for example 30 calendar days or more. The CMD must be either a Doctor of Medicine or a Doctor of Osteopathy who has Medicare FFS claim experience to oversee medical review. More than one individual's time cannot be combined to meet the one FTE minimum. The CMD must be approved by CMS.

Primary duties include:
- 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.
- Serving as a readily available source of medical information to provide guidance in questionable claim review situations.
- Recommending when LCDs, NCDs, provider education, system edits, or other corrective actions are needed or must be revised to address RAC identified vulnerabilities.
- Overseeing the medical review process and providing the clinical expertise and judgment to understand LCDs, NCDs and other Medicare policy.
- Participating in the appeals process.
- Participating in operational meetings with CMS and CMS stakeholders.

Other duties include:
- Discussing claim review determinations with providers upon request.
- Interacting with the CMDs of other contractors and/or RACs to share information on potential problem areas.
- Participating in CMD clinical workgroups, as appropriate.

- Upon request, providing input to CMS on national coverage and payment policy.
- Participating in CMS/RAC presentations (pre-approved by the CMS RAC COR) to providers and associations.

Please Note: These tasks mentioned are not administrative therefore, non-medical personnel shall not be substituted for the CMD to oversee or perform any of the tasks that involve medical review.

To prevent conflict of interest, the CMD must provide written notification to CMS within three 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. The RAC shall ensure that the CMD does not supervise claims from a provider who was their employer within the previous 12 months.

CMD Work Experience

- Experience practicing medicine as a licensed and board-certified Doctor of Medicine or Osteopathy. When recruiting CMDs, the RAC should give preference to physicians who have patient care experience and are actively involved in the practice of medicine.
- A minimum of three years' experience practicing medicine as a board-certified physician with no previous sanctioning or exclusion from the Medicare program.
- A minimum of two years' prior work experience in the health insurance industry, utilization review firm or another health care claims processing organization.
- Extensive knowledge of the Medicare program particularly the coverage and payment rules.
- Public relations experience such as working with physician groups, beneficiary organizations or Congressional offices.
- The RAC shall annually verify that the CMD's license and board certifications are current.

3. Medical Review (MR) Manager

Each RAC is required to employ a Medical Review (MR) Manager. The MR Manager is responsible for the overall medical review and quality assurance of the RAC review staff and associated processes. The MR Manager shall have broad knowledge of the Medicare program and working knowledge of the CMS FFS Recovery Audit Program requirements and activities. The MR Manager shall be responsible for keeping abreast of regulatory, policy, and coding changes as well as clinical practice and technology changes that may result in improper payments.

Primary duties may include but are not limited to:

- Overseeing the medical review process and providing the clinical expertise and judgment to apply indications for coverage as outlined in Federal regulations and policy.
- Educating and directing personnel on the correct application of CMS-issued review guidelines and edit parameters during the review process.
- Serving as a liaison to the CMD related to claim reviews.
- Overseeing the Inter-Rater Reliability (IRR) process.
- Assuring the timely and accurate completion of the review topic QA processes.
- The RAC shall annually verify that the MR Manager's license is current.

MR Work Experience:
This candidate shall have at least five years of previous medical review experience, with at least three years of management experience.

MR Education and Licensure:
The MR Manager shall have a current Registered Nurse (RN) license in the United States or U.S. Territory. An associate degree in nursing is acceptable.

4. Chief Information Officer (CIO)
The RAC shall appoint a CIO to oversee its compliance with the CMS information security requirements. The CIO may be fully dedicated but it is not a requirement of this contract.

CIO Work Experience
The CIO shall have 5 years combined work experience with at least 3 of those years being in the healthcare industry supporting either Federal Government agencies or commercial healthcare market as the CIO, information technology manager, chief technology officer, information technology manager, or network administrator. The CIO shall have knowledge of the Medicare program, with knowledge of CMS FFS Recovery Audit Program requirements and activities being preferable.

CIO Education
The CIO shall possess an associate degree in information systems, computer science or other related technology field. Relevant work experience in related field of work will be considered in lieu of an associate degree.

Primary duties shall include but are not limited to:
- Learning, documenting, and implementing Federal/CMS security controls.
- Disseminating and implementing IT policy that aligns with CMS requirements.
- Providing interpretation of current policies in response to inquiries or specific incidents.

5. **Systems Security Officer (SSO)**
   The RAC shall designate a SSO to manage the Medicare information security program and ensure the implementation of necessary safeguards. The SSO shall be dedicated to assisting the CIO in fulfilling compliance with the CMS information security requirements. The SSO shall be independent of IT operations. The SSO can be within the CIO organizational domain but cannot have responsibility for operation, maintenance, or development.

   SSO Work Experience
   The SSO shall have 5 years combined work experience with at least 3 of those years being in the healthcare industry supporting either Federal Government agencies or Commercial Healthcare market as the SSO, Information technology specialist, Security engineer, Information security analyst, or Information systems technician. The SSO shall have knowledge of the Medicare program, with knowledge of CMS FFS Recovery Audit Program requirements and activities being preferable.

   SSO Education
   The SSO shall possess an associate degree in information systems, Computer Science, or other related technology field. Relevant work experience in related field of work will be considered in lieu of associate degree.

   The SSO should earn a minimum of 40 hours in continuing professional education credits each year from a recognized national information systems security organization. The educational sessions conducted at the CMS Security Controls Oversight and Update Training (CSCOUT) can be used toward fulfilling the continuing professional education credits.

   Primary duties shall include but are not limited to:
   - Complying with CMS system security policies, procedures, and practices.
   - Responding to security breaches.
   - Providing CMS security system updates.
   - Designating appropriate levels of security clearance to employees.
   - Reporting any identified security vulnerabilities and risks.
   - Perform duties in accordance with IOM Pub. 100-17, the CMS Business Partner System Security Manual (BPSSM).

B. Medical Review Personnel

RAC medical reviewers are required to follow CMS coverage instructions, as well as pertinent coding and billing materials. Coverage criteria may be outlined in statute and/or regulation, and may be

further defined in National Coverage Determinations (NCDs), Local Coverage Determinations (LCDs) and CMS' Manuals

When performing complex reviews, the RAC shall ensure that coverage and medical necessity determinations are only made by licensed RNs or licensed therapists, who have previous medical review experience. The reviewers shall understand Medicare policies (including LCDs and NCDs). Reviews that have been conducted by unqualified or uncredentialed personnel may result in a reversal of findings and/or a corrective action plan.

The RAC shall code the revised principal, secondary diagnosis, or procedures affecting or potentially affecting the MS-DRG assignment to the highest level of specificity per coding guidelines whether it impacts the MS-DRG or not. Clinical validation[1] is prohibited in all RAC reviews.

RACs shall ensure that a licensed medical professional will perform medical record reviews for the purpose of determining medical necessity, using their clinical review judgment to evaluate medical record documentation.
The RAC shall maintain and provide documentation upon the provider's request listing the credentials of the individuals making the medical review determinations. This only includes a reviewer's credentials. The RAC is not required to share names and personal information.

1. Certified Coders

Each RAC is required to employ certified coders to perform complex coding validations. Certified coders are those professionals who earn their certification from an accredited association such as the American Association of Professional Coders (AAPC) or American Health Information Management Association (AHIMA). Certified Coders are obligated to stay current in their profession. This includes continuing education in their respective discipline and keeping abreast of current medical coding updates, compliance rules, and government regulations. Reviews performed by unqualified or uncredentialed personnel[2] are not payable under this contract.

Certified coders may also be Registered Health Information Administrators (RHIA) and Registered Health Information Technicians (RHIT) who have been credentialed by AHIMA in their field of health information. These coders must have at least five years direct coding or billing experience in the specific coding field. The CMS reserves the right to review the credentials of certified coders, RHIA and RHIT at any time under this SOW.

2. Registered Nurses

[1] Clinical validation is a process that involves a clinical review of the medical record to ascertain whether or not the patient truly possesses the conditions that were documented.

[2] Unqualified or uncredentialed personnel are those persons without active certifications or licensures as required in this SOW.

Each RAC is required to employ registered nurses with previous experience in medical record review. Registered nurses are required to have current licenses in nursing in the United States or US Territory. The RAC must ensure that the license is current. The CMS reserves the right to review the credentials of registered nurses at any time under this SOW.

3. Therapists

Each RAC is required to employ licensed therapists (e.g., physical therapist, occupational therapist, and speech-language pathologist) with previous experience in medical record review.

Therapists are required to have current therapy licenses in the United States or US Territory. The RAC must ensure that the license is current. The CMS reserves the right to review the credentials of therapists at any time under this SOW.

4. Other Clinicians

In addition to the required clinicians listed above, the RAC may employ other licensed clinicians to perform medical review. However, only clinicians with current licenses in the United States or US Territories with previous experience in medical record review in their respective disciplines may review medical records for medical necessity. The clinician must understand Medicare policies as well as LCDs and NCDs. The CMS reserves the right to review the credentials of these licensed clinicians at any time under this SOW.

Regardless of license type, all clinicians (including registered nurses, licensed therapists, etc.) must possess three years of previous medical record review experience and at least three years of current and/or relevant clinical experience in a variety of health care settings. Examples include but are not limited to acute care, sub-acute care, long term care, rehabilitative services, home health, skilled nursing, diagnostic services, and outpatient services/settings.

In addition to the CMD, the RAC is encouraged to utilize the expertise of a panel of board-certified clinical specialists, for consultation when performing medical review.

Those personnel that are licensed must have licenses issued by the United States or a US Territory regulatory agency.

C. *Other Personnel*

The Contractor shall ensure adequate staffing levels (i.e. adequate full-time equivalents (FTEs)) and structure, to successfully perform all tasks in the agreed upon timefram es established in this SOW.

V. Statement of Work Tasks

Task 1: Initial Meeting with CMS

The RAC's project staff (including key personnel) shall meet with the CMS RAC COR and appropriate CMS staff within two weeks of the date of award. The initial (Kick Off) meeting shall be in person for key personnel with a virtual/remote option to be approved by CMS RAC COR. During the meeting, the terms and conditions of the specified Regional RAC contract will be discussed. Topics will include, but not be limited to, CMS staff and RAC staff roles and responsibilities outlined in the statement of work, invoice procedures, security requirements, project plan, and any questions or concerns from the RAC for the work being performed under this contract.

The RAC shall submit a list, containing the names and roles, of each RAC staff member who will be in attendance. This list shall be submitted to the CMS RAC COR via email, no less than one week prior to the meeting, unless otherwise directed by the CMS RAC COR.

Task 2: Project Plan

The Project Plan outlines the resources and timeframe(s) for completing all work activities associated with this SOW.

A. Draft Project Plan

Within two weeks after the initial meeting with CMS, the RAC shall submit a draft project plan. The draft project plan will be for the first year of the contract. The draft project plan and all subsequent project plans must be approved by the CMS RAC COR, prior to implementation.

The draft project plan shall include the following:

- Detailed RAC Organizational Chart, identifying the names and titles of all key personnel, first-line management, and all other personnel named within this SOW.
- A list of all clinical certified coders, registered nurses and therapists performing reviews including relevant credentials.
- Contingency plan for dealing with unexpected changes in any key personnel. Contingency plans must be approved by the CMS RAC COR, before implementation.
- Provider Outreach Plan, detailing all potential and planned outreach efforts to associations, individual providers, provider groups, Medicare contractors, and other applicable Medicare stakeholders.
- Customer service plan.
- Appeals Participation Plan, including ALJ hearings.
- Schedule of Deliverables.
- Key Project Milestones:
    - ATO implementation and maintenance;
      CFACTS;
    - Complying with all CMS System Security and Privacy Requirements;

- Annual Trainings;
- Joint Operating Agreements (JOAs) execution:
  - Proposed quarterly projection by:
    - Review topics;
      Type of review (automated, complex, extrapolation);
    - Type of improper payment (medical necessity, incorrect coding, etc.).

B. Subsequent Project Plans

The Project Plan is a living document that, at a minimum, must be included with the monthly progress report (see Task 15). The subsequent project plans shall include the following:

- Detailed RAC Organizational Chart, identifying the names and titles of all personnel named within this SOW.
- Contingency plan for dealing with unexpected changes in any key personnel. Contingency plans must be approved by the CMS RAC COR, before implementation.
- Joint Operating Agreements (JOAs) review and signature due dates.
- Proposed quarterly projections by:
  - review topics;
    type of review (automated, complex, extrapolation);
  - type of improper payment (medical necessity, incorrect coding, etc.).
- Customer service plan.
- Updated ongoing Provider outreach plans.
- Approved new and closed review topics.

Task 3: Identification of Improper Payments on Postpayment Review

The RAC shall perform postpayment review on all Medicare claim types and provider types to identify improper payments, which were made under Part A or Part B. This includes reviews of claims/providers that have a high propensity for error, based on the Comprehensive Error Rate Testing (CERT) program and other CMS analysis.

The RAC shall 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' as defined in 42 CFR 405.986 and shall clearly document the good cause in review proposals and all correspondence related to the review. The RAC shall develop processes to minimize provider burden when identifying Medicare improper payments. The RAC shall ensure edit parameters and claim selection criteria are refined to select only those claims with the greatest probability of being improper and that the number of additional documentation requests do not negatively impact the provider's ability to provide care. The RAC shall perform this analysis prior to requesting records. The CMS has the authority to develop/revise ADR limits at any time. ADR limits will be provided via technical direction, or as otherwise instructed by CMS. ADR limits shall be applied on an annual basis per calendar year, unless otherwise specified by CMS.

All medical record 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 CMS will perform routine evaluations to ensure the RAC is reviewing all claim types as directed. The CMS may impose minimum percentage review requirements by claim type and/or adjust conditional approval limits accordingly. Requirements may be based on improper payment findings in the CERT program or other CMS data analysis.

A. Improper payments included in this SOW

Unless prohibited by Section B below, the RAC may review claims and identify improper payments (overpayments or underpayments) that result from any of the following:

- Incorrect payment amounts.
  - *Exception*: in cases where CMS issues instructions directing contractors not to 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.
- Claims from the following provider types:
  - Inpatient hospital;
    Inpatient psychiatric facility;
  - Outpatient hospital;
    Professional services;
  - Laboratory;
    Ambulance;
  - Skilled Nursing Facility;
    Inpatient Rehabilitation Facility;
  - Critical Access Hospitals;
    Long Term Care Hospitals;
  - Ambulatory Surgical Center;
    Home Health;
  - Hospice;
    Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS);
  - Other (such as Comprehensive Outpatient Rehabilitation Facilities, Rural Health Clinics, and Independent Diagnostic Testing Facilities.

For purposes of the Recovery Audit program, a Medicare underpayment is defined as a single code, although there may be multiple lines, or payment group (e.g. Ambulatory Payment Classification (APC) on a claim that was billed at a higher level of payment but should have been billed at a lower level of payment. The RAC shall review a single code or payment group on a claim, unless otherwise directed by CMS. The RAC may only consider multiple lines of the same code on a claim.

A review may consist of a target claim and a reference claim. A target claim represents the improper payment and is the claim that will be sent to the MAC for adjustment. Regions 3 and 4 target claims exclude HH/H and DMEPOS. Region 5 target claims include only HH/H and DMEPOS. The reference claim may be any claim paid under Part A or Part B of Title XVIII of the Social Security Act. These reference claims may address any claim for any region.

The RAC shall review all provider types listed above.

Any proposed uses of advanced technology, such as artificial intelligence (AI) applied under this SOW shall be reviewed, vetted, and subject to approval by the CMS RAC COR.

B. Improper payments excluded in this SOW

The RAC shall not attempt to identify improper payments (overpayments and underpayments) arising from any of the following:

- **Services provided under a program other than Medicare Fee-For-Service** – For example, the RAC shall not attempt to identify improper payments in the Medicare Managed Care program or Drug Benefit program.
- **Cost report settlement process and Medical Education payments** – The RAC shall not attempt to identify improper payments that result from Indirect Medical Education (IME) and Graduate Medical Education (GME) payments. The RAC shall not review cost report settlements for improper payment identification.
- **Claims more than three years past the initial claim paid date** – The RAC shall not review claims or identify any improper payment more than three years past the initial claim paid date. The look back period is conducted starting from the date of the initial claim paid date and ending with the date the RAC issues the ADR letter (for complex reviews) or the date of the review results letter (for automated reviews). The RAC shall take no further action on these claims except to indicate the appropriate status code in the RACDW and notify CMS RAC COR.
- **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 request medical records from the provider. The RAC shall perform targeted reviews that utilize data analysis techniques in order to identify those claims that most likely contain improper payments. 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 other data analysis suggest that the claim is likely to contain an improper payment.
- **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. The CMS attempts to remove these claims from the data prior to transmission to the RAC.
    - The RAC shall exclude from review claims with a Unique Tracking Number (UTN) to avoid capturing claims subject to prior authorization. For example, providers/suppliers submitting claims subject to prior authorization must include a

valid UTN. The UTN is available on the face of the claim and is therefore visible to the RAC in its respective National Claims History (NCH) data.

- **National Correct Coding Initiative (NCCI) edits** - RACs shall not propose nor conduct any reviews based on (NCCI) edits. In addition, RACs shall not submit any Review Topic proposals that are based on NCCI edits.

The CMS reserves the right to limit the number or time period available for reviews by RAC, state, claim type, provider type, natural disaster, public health emergency (PHE) or any other reason where CMS believes it is in the best interest of the Medicare program to limit claim review. The RAC will be provided written notice containing the effective date of the restrictions outlined.

C. Underpayments

The RAC shall review claims using automated or complex review to identify potential Medicare underpayments. Upon identification, the RAC shall communicate the underpayment finding to the appropriate MAC. The RAC shall not ask the provider to correct and resubmit the claim. The RAC shall obtain approval of the underpayment notification letter template from the CMS RAC COR before issuing the first letter.

For purposes of the Recovery Audit program, a Medicare underpayment is defined as a single code on a claim that was billed at a lower level of payment but should have been billed at a higher level of payment. The RAC shall review each claim line or payment group and consider all possible occurrences of an underpayment in that one code or payment group. If the medical documentation supports changes to the diagnosis, procedure, or order in that line or payment group that would create an underpayment, the RAC shall 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.

1. **Examples of an Underpayment:**
   - The provider submitted a claim for 15 minutes of therapy when the medical record clearly indicates 30 minutes of therapy were provided. Certain HCPCS/CPT codes are measured in 15-minute increments and are called “timed” codes. These services require direct (one-on-one) patient contact. When reporting a 15-minute service, the provider should enter (1) in the field labeled units on the claim form. The provider in this scenario is entitled to (2) units.
   - The provider submitted a claim for a particular service and the amount the provider was paid was lower than the amount on the CMS physician fee schedule.

2. **The following will NOT be considered an Underpayment:**
   - The medical record indicates that the provider performed additional services such as an EKG, but the provider did not submit a claim for the service. (This provider type is paid based on a fee schedule that has a separate code and payment amount for EKG).
   - The provider submitted a claim for 15 minutes of therapy when the medical record clearly indicates 30 minutes of therapy were provided; however, the additional

minutes do not affect the grouper or the pricer. (This provider type is paid based on a prospective payment system that does not pay more for this much additional therapy.)

- 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 submit a claim for the device APC.

Task 4: Obtaining, Storing, Sharing, and Paying for Medical Records

A. Obtaining medical records

The RAC shall not perform onsite visits to review medical records. Medical records shall be obtained through the ADR (Additional Documentation Request) process. The RAC shall accept medical records submitted electronically, (e.g., fax, CD, DVD, or transmitted via electronic submission of medical documentation (esMD), RAC Provider Portal, and submitted as (paper) hard copies). The RAC must have the capability to receive medical records via esMD, prior to sending ADR letters. Although providers are not mandated to electronically store or transmit medical records, the RAC shall possess the technology to accept documents via electronic transmission. The documentation received following the issuance of an ADR or received during a discussion period, shall be stored maintaining as much as possible the document's original appearance including the size, form, color and fonts. The RAC shall comply with all CMS business system security requirements when entering into arrangements regarding the transmission and storage of medical records and other documentation.

Should the RAC receive medical records and/or correspondence in a language other than English, the RAC shall possess the necessary software required to translate the documentation or be required to close the review.

Provider Inquiries (Not Requested by RAC)

The RAC does not have responsibility to randomly accept case files from providers for an improper payment case review. If the RAC receives case files from providers that the RAC did not request, the RAC is under no obligation to respond to the provider, or to reimburse the provider, and the case files shall be disposed of using appropriate records management procedures.

B. Additional Documentation Request Limits

The CMS sets ADR limits for Institutional (Facility) Providers, and Physician/Non-Physician Practitioners. Institutional ADR limits are diversified across all claim types of a facility (e.g., outpatient hospital, physicians, etc.). The methodology for ADR calculations can be found on the CMS RAC website, under the Resources link for download:

- ADR Limits – Supplier – April 1, 2022 (PDF).
- ADR Limits – Physician – February 14, 2011 (PDF).
- ADR Limits - Institutional Provider (Facilities) - May 1, 2022 (PDF).

The CMS has established a method to adjust the ADR limits based on a provider's compliance with Medicare rules. This will result in providers with low denial rates having lower ADR limits, while providers with high denial rates will have higher ADR limits. Denial rates will be assessed by CMS on a regular basis. Adjustments to providers' ADR limits shall only be made by CMS.

If the RAC does not use the entire volume of claims during one 45-calendar day ADR cycle, the unused claims shall not be carried forward into any future ADR cycle. For example, if the medical record request limit for a particular provider is 50 per 45-calendar day period and the RAC does not request medical records in January and February, the RAC cannot request 150 records in March.

The RAC may deny claims where documentation is not submitted. However, the RAC shall initiate at least one additional contact with a provider (through a letter, phone call, email, or fax) before denying the claim. Documentation of the additional outreach shall be available to the CMS RAC COR upon request. The RAC shall allow all providers at least one extension for the submission of additional documentation.

The CMS reserves the right to change the timeframe that providers have to submit additional documentation.

Storing and sharing medical records

The RAC shall make available to CMS, MACs, QICs, OIG, and others, as indicated by the CMS RAC COR, any requested medical record. Records and case files shall be transmitted via a secure line, secure CD, MPLS – Multi-protocol label switching, or another method prescribed by CMS.

The RAC shall, prior to beginning review activity, be prepared to store and share imaged medical records. The RAC shall:

- Have a document management system in place.
- Have the capability to receive and transmit esMD transmissions to providers, CMS, and other Medicare contractors.
- Store medical records NOT associated with an improper payment for one year for QA purposes.
- Store medical records associated with an improper payment as per NARA requirements.
- Maintain a log of all requests for medical records indicating at least the requester, a description of the medical records requested, the date the request was received, and the date the request was fulfilled.

Upon the end of the contract, the RAC shall send copies of the imaged records to the entity specified by the CMS RAC COR.

C. Paying for Medical Records

The RAC shall pay the provider for medical records in accordance with the current guidelines prescribed in the PIM (IOM Pub. 100-08, currently located in section 3.2.3.6), unless otherwise directed by the CMS RAC COR.

Task 5: Claim Review Process

Unless otherwise directed in this SOW, or through TDL from the CMS RAC COR, or through CMS-approved review guidelines, the RAC shall follow all policies in the PIM (IOM Pub.100-08) regarding claim reviews.

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

- Be included in one of the benefit categories described in Title XVIII of the Act.
- Not be excluded from coverage on grounds other than 1862(a)(1).
- 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:
    - Safe and effective.
    - 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
    - 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 as per §1862(a)(1). These exceptions include but are not limited to:

- 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 within frequency limits.
- Prostate cancer screening tests are covered if within frequency limits.
- Colorectal cancer screening tests are covered if within frequency limits.

Timeframes for Completing Reviews

The RAC shall complete complex reviews and notify the providers of the results within 30 calendar days from receipt of the medical record documentation. The RAC may request an extension from CMS, if needed due to extenuating circumstances. If an extended timeframe for review is granted by the CMS RAC COR, the RAC shall notify the provider in writing and via a web-based application (portal), of the delay.

Upon completion of an automated review, the RAC shall inform the provider/supplier of the improper payment no later than 7 business days following the discovery, unless otherwise directed by their CMS RAC COR.

The RAC shall neither issue medical record requests without prior CMS RAC COR authorization, nor issue requests beyond any conditionally approved number of claims.

Types of Reviews

A. Automated Review

PIM 3.3.1.3 defines an automated review as a payment decision made at the system level, using available electronic information, with no manual (human) intervention.

Determinations Made Through Automated Review:
The RAC may use automated review when making coverage and coding determinations only when 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 code set and CPT Coding Clinic guidelines, etc.) exists.

When making 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 code set and CPT Coding Clinic guidelines.

EXCEPTION: If the RAC identifies a “clinically unbelievable” issue (i.e., a situation where certainty of noncoverage or incorrect 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.

Other Determinations Made Through Automated Review:
The RAC may propose the use of automated review when there is certainty that an overpayment or underpayment exist, e.g., duplicate claims, pricing mistakes. Written policies, articles and/or guidelines may not exist for these situations, however, edit parameters may be developed to address those specific circumstances.

B. Complex Review

Complex review occurs when a RAC makes a claim determination utilizing human review of the medical record or other required documentation. Copies of medical records are required to provide support for the improper payment. 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.

The RAC shall provide its review staff with training on the CMS-approved edit parameters and review guidelines. Whenever performing complex reviews, the RAC shall ensure that coverage and medical necessity determinations are only made by licensed RNs or licensed therapists who have previous medical review experience. The reviewers shall understand Medicare policies (including LCDs and NCDs). Reviews that have been conducted by unqualified or uncredentialed personnel may result in a reversal of findings and/or a corrective action plan.

The RAC shall code the revised principal, secondary diagnosis, or procedures affecting or potentially affecting the MS-DRG assignment to the highest level of specificity per coding guidelines whether it impacts the MS-DRG or not. Clinical validation[3] is prohibited in all RAC reviews.

RACs shall ensure that a licensed medical professional will perform medical record reviews for the purpose of determining medical necessity, using their clinical review judgment to evaluate medical record documentation.

Certified coders will perform coding reviews for coding determination. If the RAC utilizes AI software or any type of "crosswalk" to assist with coding reviews, it shall only be considered a resource guide to assist the certified coder with determining the appropriate code.

The RAC shall ensure that no physician, nurse, therapist or certified coder, reviews claims from a provider who was their employer within the previous 12 months.

C. Extrapolation

The RAC may use extrapolation for some claim types when all requirements are met. Extrapolation can be cost effective for low-dollar claims that require complex review and that have a history of having a high error rate. The RAC shall follow the procedures found in the PIM (IOM Pub. 100-8, currently Chapter 8, section 8.4), as well as MMA Section 935(a), regarding the use of extrapolation. The CMS RAC COR must approve the use of extrapolation.

D. Types of Claim Review Determinations

All RAC Claim Review Determinations shall be based solely on the CMS-approved edit parameters and review guidelines associated with the approved review topic. The RAC may find a full or partial overpayment exists if the service/item is not covered.

[3] Clinical validation – is a process that involves a clinical review of the medical record to ascertain whether or not the patient truly possesses the conditions that were documented.

The RAC shall use HCFA Ruling 95-1 and the guidelines listed below in selecting the appropriate denial reason. The selection of denial type determines the beneficiary's liability. Benefit category denials take precedence over statutory exclusion and reasonable and necessary denials. Statutory exclusion denials take precedence over reasonable and necessary denials. When a RAC reviews a claim, the following determinations options are listed below.

1. **Full Denials**
   A full denial occurs when the RAC determines that the overpayment amount is the total paid amount for the service/item in question.

2. **Partial Denials**
   A partial denial occurs when the RAC determines that only part of the claim/claim line paid amount was an overpayment. Examples of when a partial denial may apply is when the submitted service or item was billed and paid using an incorrect code, and/or incorrect number of units, that resulted in a higher payment than should have been received. But, a lower payment, using the correct code, and/or correct number of units, can still be made.

3. **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 limitation of liability determinations as appropriate in accordance with §1879 of the Act. 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 (IOM Pub. 100-08) Chapter 3.6.2.3.

4. **Coding Determinations**
   The RAC may find that an improper payment 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, CPT code set and CPT Coding Clinic guidelines).

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

E. Basis of Determinations

1. **Medicare Policies and Articles**
   - Based on CMS approval the RACs shall comply with the applicable NCDs, local coverage coding determinations (LCD), local coverage articles (LCA), and provisions in

CMS Internet Only Manuals, such as the Claims Processing Manual and the PIM. NCDs, LCDs, and LCAs are located in the CMS Medicare Coverage Database (MCD). Internet Only Manuals are located at CMS.gov.

- The RAC shall comply with all applicable change requests and Technical Direction Letters forwarded to the RAC by the CMS RAC COR. If CMS instructs the RAC on the interpretation of any policy and/or regulation, the RAC shall abide by CMS' decision.
- The RAC shall ensure that policies utilized in making a review determination are applicable at the time the service was rendered.

2. Rationale for Determination

- The RAC shall clearly document the rationale for the review determinations. This rationale shall include 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 ensure the identification of pertinent facts contained in the medical record/documentation to support the review determination. Each rationale shall be specific to the individual claim under review and shall be included in the review results letter sent to the provider.
- The RAC shall make a rationale available upon request to CMS, a MAC, the OIG, and others as indicated by the CMS RAC COR.

3. Other Considerations

The RAC shall comply with relevant instructions in the PIM (IOM Pub. 100-08), as related to the following:

- No medical records/documentation received in response to ADR letter.
- Administrative relief from review in the presence of a disaster.

Task 6: Review Topic Submission and Approval

The RAC shall participate in the CMS review topic submission and approval process. To receive CMS approval for a proposed review topic, the RAC shall submit to CMS a review topic proposal package via email to the CMS RAC COR and the Review Topic Team. There is no limitation on how many proposals the RAC can submit to CMS.

At a minimum, proposals shall contain the following items:

Summary of Issue Potential

The RAC shall analyze the proposed topic to include the total number of claims identified per MAC Jurisdiction when proposed edit parameters/claims selection criteria are applied, the total potential dollar amount of improper payments per MAC Jurisdiction, the range of improper payment amounts per claim, the total number of reviews RAC plans to pursue per quarter, and any other sources used to develop the issue (e.g., CERT, OIG, MAC…)

References

For both automated and complex reviews, the RAC shall include all references used in the development of the edit parameters and review guidelines. The strongest policy references shall be listed first, beginning with:

- Social Security Act.
- The Code of Federal Regulations.
- National Coverage Determinations (NCDs).

Following these, other acceptable references include:

- CMS IOM manuals.
- Local Coverage Determinations (LCDs).
- CMS coding policies.
- CMS technical direction.
- CPT coding clinics.

The RAC shall refrain from including references such as MAC Manuals, OIG reports, Medicare Learning Network articles, etc.

Automated Review

The proposal package shall contain, at a minimum, a completed review topic summary form, references, detailed edit parameters, the edit outcome that describes the objective of the review, and a list containing the codes under review, including the code long descriptors.

Complex Reviews

The proposal package shall contain, at a minimum, a review topic summary form, references, detailed claim selection criteria, the rationale for review, review guidelines, and a code list that contains long descriptors.

The claim selection criteria shall detail how claims are selected for review, for example the lookback periods, HCPCs or CPT codes, claim modifiers, type(s) of bill, place of service, provider type, reason for denial codes for RACDW documentation used, and all applicable exclusions.

The review guidelines shall contain a detailed series of questions that are used to proceed through the review. Each question shall indicate a reference that supports the policy the question addresses. Each question will specify the action taken for each question using reason for denial codes (sub-vulnerability codes), and the action to take on the claim.

The CMS RAC COR will notify the RAC when the review topic is approved. Upon approval, the RAC shall post the review topic on its webpage for a 14-day notification to providers prior to requesting ADRs. The RAC shall not share automated or complex review details without obtaining written consent from CMS. The CMS reserves the right to share any information related to approved review topics with all CMS review entities which may include, but is not limited to, other RACs in Medicare, MACs, the CERT Contractor, or UPICs.

Task 7: Website and Provider Portal

Refer to Appendix B for Section 508 - Accessibility of Information and Communications (ICT) Technology for requirements related to website accessibility and Appendix C for System Security Requirements.

The Medicare FFS Recovery Audit Program information shall appear on pages that are separate and distinct from any other non-Medicare work the RAC may conduct. The RAC shall obtain prior CMS RAC COR approval for all webpage updates.

The RAC shall maintain A) a public facing general website containing information about the RAC program; and) provider portal as a secure web-based application as described below. The RAC shall update the general website and provider portal within five calendar days of any change.

A. Public-facing General Website

The RAC is required to maintain a Medicare FFS RAC website. The RAC shall use the format, language, and features, as determined by CMS.

The general website shall include content and resources to provide information to recovery audit program providers and suppliers. Information to be displayed will include topics such as:

- CMS Approved Review Topics sortable by:
  - Issue name;
    Date of CMS approval;
  - Posting date;
    Applicable MAC jurisdictions;
  - Review type;
    Provider type;
  - Affected code(s);
    Applicable references.
- Medical records submission instructions.
- Medical record submission extension requests.
- Frequently asked questions (FAQs) and answers.
- Audit timelines.
- Links to the MAC and CMS websites.
- Discussion request forms.
- Types of RAC letters and examples.

The CMS may require the RAC to provide other review-specific information in the CMS Approved Review Topics web page and may require implementation of standardized navigation functions, and/or a standardized format for display. The RAC shall wait two weeks

(14 calendar days), after posting a conditionally approved review topic to its website, before starting any reviews of the issue. This applies to all review types.

B. Provider Portal

The RAC shall develop and use a secure web-based application that will allow all provider types to view up-to-date information regarding the status of their RAC reviews, view their ADR limits, and customize their contact information. The RAC shall use a CMS-approved secure process to give providers access to the portal.

The Provider Portal shall, at a minimum, include the following information:

- Provider (provider/practitioner/supplier) address customization:
    - Within the provider portal, the RAC shall implement a secure method for providers to customize their address and points of contact (e.g., Washington County Hospital, Medical Records Dept., attention: Mary Smith, 123 Antietam Street, Gaithersburg, MD 20879).
- The provider's overall ADR limit.
- Dates of all ADR letters.
- The date that the medical documentation was received for each claim being reviewed.
- The date that medical review of the documentation began.
- The date that medical review of the documentation was completed.
- The outcome of the review (overpayment, underpayment, no finding, claim closure).
- Discussion period information.
- Appeals outcomes.

The CMS may require the RAC to provide other provider-specific or claim-specific information on the portal, and may require implementation of standardized functions, and/or a standardized format for display. The CMS will work with the RAC to enhance provider portals, including more uniformity and consistency in the claim status section, as well as display reason statement identifiers where available. The RAC may offer other features, such as medical record upload and various letter download capabilities such as ADRs and Review Results Letters, to improve provider experience with their respective region. All portal upgrades must be approved by the CMS RAC COR prior to implementation.

The RAC shall provide the following information, regarding RAC Provider Portal users, to the CMS RAC COR, upon request:

- First and Last Name.
- Telephone number (including area code).
- Email address.
- National Provider Identifier (NPI) number(s).
- Associated Provider (Facility/Practice/Supplier) Name.
- User's Title/Position at the associated provider.

Task 8: Communication and Collaboration with Other Medicare Contractors

The communication and operating requirements that take place between the RAC and all applicable Medicare contractors (MACs, UPICs, QICs, AdQIC) occur through a Joint Operating Agreement (JOA). The JOA provides clarification of both contractors' roles, responsibilities, and respective duties. The RAC shall initiate all JOAs within 90 calendar days of award. The JOA shall address all communication between the Medicare contractor and the RAC. The JOA shall include timeframes that are mutually agreed upon. During the first year of the contract, the JOA shall be reviewed quarterly, and thereafter shall be reviewed annually as per the agreement and updated as necessary.

The JOA shall include communication processes and timeframes for adjustments, recoupments, appeals, inquiries, and receipt of provider names and addresses.

The RAC shall collaborate with other CMS contractors and partners, as directed by CMS, for the purposes of adjusting improperly paid claims, supporting the appeals process, avoiding duplicative reviews, and referring potential fraud.

The RAC shall share, with the applicable MAC, review guidelines and edit parameters used to identify improper payments and shall participate in conference calls with CMS and other contractors, as necessary.

To assist the Recovery Audit Program, CMS works closely with the RACs and MACs to establish monthly workload limits. The workload limits represent the maximum number of RAC-reviewed claims that the MAC is required to adjust on a monthly basis. The RAC shall communicate workload projections to both CMS and the MACs, at a minimum, on an annual basis. Should the RAC demonstrate a backlog of claims for a MAC and have projections showing the necessity for a sustained higher monthly workload, CMS will consider increasing future workload limits.

A. Communications relating to the claim adjustment

The MAC serves as the conduit to allow the RAC to adjust claims and recoup overpayments. The relationship between the MAC and the RAC is crucial to the success of the Recovery Audit Program. The CMS will occasionally transition the claim processing workload from one MAC to another. Therefore, the JOA between the MAC and RAC shall include procedures related to MAC transitions including blackout periods.

The MAC is responsible for issuing timely demand letters, adjusting claims, applying improper payment adjustments, uploading data into the RACDW when required, and routine customer service and requests from CMS. The MAC is an operational contractor of CMS and does not take direction from the RAC.

Any communication issues with the MAC that cannot be addressed through provisions of the JOA shall be escalated to the CMS RAC COR for additional discussions with the appropriate parties.

The RAC is responsible for identifying improper payments, providing review rationale relating to MAC demand letters, completing in-depth customer service, performing all research required to determine the status of a claim, responding to CMS, and answering all correspondence unless otherwise instructed by CMS. The RAC shall work closely with the MAC to ensure all adjustments are made in a timely and accurate manner. Sharing identified areas of vulnerability within the program for peer review or action is encouraged.

B. Communications relating to appeals
The RAC is expected to work with other CMS contractors, at subsequent levels of re-evaluation, to ensure an accurate and fair adjudication.

If a provider chooses to appeal an improper payment as determined by the RAC, the RAC shall assist CMS with support of the improper payment determination throughout all levels of appeal. This includes providing supporting documentation (including the medical record) with appropriate reference to Medicare statutes, regulations, or manuals.

The RAC shall assist CMS or other contractors at any hearings associated with the improper payment – refer to Task 12.

If the RAC receives a verbal or written request for appeal from a provider, the RAC shall direct the provider to the applicable appeal instructions in the demand letter. The RAC shall forward requests to the appropriate adjudicator, based on the level of appeal, within one business day of receipt.

MAC: The RAC shall foster a relationship with the claims processing contractors to ensure consistent application of the laws and policies surrounding Medicare payment. The RAC shall ensure that the MAC has received the completed appeal case file. The RAC shall work with the MACs to share appeals data, including reasons for RAC finding reversals. The RAC and MACs may also share areas identified as vulnerabilities.

Qualified Independent Contractor (QIC): The RAC will forward new or requested evidence for appeal case files, as necessary.

Administrative Qualified Independent Contractor (AdQIC): The RAC shall work with the AdQIC to ascertain whether QIC level appeals were promoted to the Administrative Law Judge (ALJ), and, if so, which cases the contractors will mutually participate. The AdQIC website assists with the coordination of CMS contractors' participation in ALJ hearings.

Office of Medicare Hearings and Appeals (OMHA): As per Task 12, the RAC may communicate with OMHA on matters regarding the intent to participate or elect party

status, scheduling of hearings, and other similar administrative tasks. All other direct communication is prohibited, unless directed by the CMS RAC COR.

The RAC shall regularly review data provided by appeals contractors to identify ongoing trends or issues of vulnerability that may be applied to current reviews or potential appeals.

C. Communication Regarding Potential Fraud

The RAC shall schedule regular meetings with all UPICs to discuss potential referrals and trends each contractor may have identified. These meetings shall occur, at a minimum, quarterly. Meetings shall include all applicable operational staff as well as the RAC CMD. Informal referrals received from the UPIC or given to the UPIC during these meetings shall be included in the next monthly report to CMS.

The CMS has a Memorandum of Understanding (MOU) with the OIG regarding the referral of potential fraud. If a RAC discovers credible indications of potential fraud, the RAC shall concurrently refer the provider to its CMS RAC COR, and the OIG. The RAC shall include all details relevant to the referral.

If the RAC is contacted by investigative agencies pursuing provider review information (e.g., medical records, review work product, improper payment identification or collection data), the RAC shall refer the investigative agency to the CMS RAC COR for guidance. The CMS RAC COR may then request the information as defined above from the RAC. The RAC shall not discuss law enforcement investigations or information requests from investigative agencies with providers and shall refer any such provider questions to its CMS RAC COR.

E. Referrals

The CMS often receives referrals of potential improper payments from the MACs, UPICS, and Federal investigative agencies (e.g., OIG, DOJ). The CMS may require the RAC to review these claims, or other claims at risk, based on CERT reports, or other CMS data analyses.

Referrals received for RAC review shall utilize CMS-approved review documents.

The RAC will be paid in a manner consistent with the contracted contingency fee for referrals. The review of such referrals is not optional. The CMS will send each notification of referral via a TDL which will detail the provider(s), the CPT/HCPCS(s), applicable approved review topic review(s), and number of reviews to be performed.

The RAC shall include a detailed “Referrals” section to its monthly administrative report.

Referrals are tracked via the RACDW. This system will be available to all Medicare contractors, to CMS, and to the RAC to make and track referrals. The RAC shall be required to review and update the referral tracking system. The expected timeframe for review and decision is 30-45 calendar days from the referral being entered into the system.

F. Support of OIG and 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 one business day of the request.

G. Collaboration with Other Support Contractors
CMS is required to report on the RAC Program annually as per SSA 1993(h)(8). To assist with the report and other requests for information (RFIs), CMS may utilize an independent evaluation contractor to assist CMS with the analysis of data, provider survey, monitoring the RAC, and/or maintaining databases. Each RAC shall identify a point of contact within their organization who will be responsible for responding to such RFIs. Unless otherwise requested, the RAC shall respond to all RFIs, within 15 business days of receipt.

The RAC shall allow the CMS RAC COR, and other interested CMS parties, free access to all hardcopy and electronic documents, office space, IT systems, software and personnel dedicated to tasks performed for this SOW without impediment, for purposes such as contractor performance evaluation, security testing, periodic review, etc. The CMS may request access to any of the aforementioned items without the presence of RAC staff. In cases where contracting staff must be present, the RAC will alert CMS in advance.

Task 9: Activities Following Review

A. Communication with Providers about Improper Payment Findings
Communicating Review Results

One goal of the Medicare FFS RAC program is to provide information to providers that will assist them in submitting their future claims correctly. Accurate and detailed review results are critical to achieving this goal. Review results letters shall provide a detailed level of feedback to the providers regarding coverage and/or coding or payment policy errors related to the improper payment. This detail includes a description of each identified coverage, coding or payment policy error, including what should have been billed by the provider/supplier and how the finding changes the provider/supplier payment.

The RAC shall communicate review results for both automated or complex review, by hard copy letter or fax and through a secure provider portal unless otherwise directed by the CMS RAC COR.

Every letter/notification must include:

- Identification of the provider(s) or supplier(s)--name, address, and provider number.
- The reason for conducting the review.
- When the RAC identifies more than one reason for a denial, the RAC shall include all reasons.

- A narrative description of the improper payment stating the specific issues involved that created the improper payment, including specific coverage, coding or policy citations. The letter must contain specific information such that the provider comprehends the precise reason for the improper payment.
- The information communicated to the provider, whether shared via hard copy or provider portal, shall be identical in format and content, both of which shall be approved by the CMS RAC COR in advance of implementing the letter.

Automated review

The RAC shall only communicate to the provider the results of automated reviews within 7 business days, when an improper payment was identified. The RAC need not communicate to providers the results of automated reviews that do not result in an improper payment determination.

Complex review

The RAC shall communicate review results for complex reviews within 30 calendar days of the receipt of the medical record. If the RAC needs more than 30 calendar days to complete the review, the RAC shall contact the CMS RAC COR to request an extension. The RAC shall communicate to the provider the results of every complex review, including cases where no improper payment was identified.

B. Allowance of a Discussion Period

All providers/suppliers that receive notification of an improper payment (for automated and complex reviews) from the RAC are provided an opportunity to discuss the improper payment determination with the RAC before the claim is sent to the MAC for adjustment. The RAC shall wait 30 calendar days from the date of the review results notification letter before forwarding the claim to the MAC for adjustment. This 30-day period will allow the provider to submit a discussion period request with additional documentation they deem relevant to support the payment of the claim. The RAC is not required to reimburse providers for the additional documentation submitted during the discussion period.

All discussion period requests should be in writing. The RAC shall provide written confirmation (e.g., fax, email) of all discussion requests within one business day of receipt. A determination letter of the discussion results shall be sent to the provider/supplier within 30 calendar days of completion.

Automated Review Discussion Requests

When the RAC receives a discussion request from a provider/supplier, for an automated review that is accompanied by documentation including medical records the RAC is required to honor the request and ensure the medical record is reviewed by the appropriate, qualified personnel.

Complex Review Discussion Requests

When the RAC receives a discussion request from a provider/supplier, for a complex review, the medical record received shall be reviewed by the appropriate, qualified personnel.

Types of discussions:
Peer to peer discussions shall be offered to the provider/supplier. The RAC shall have an escalation process in place for the discussion period when the physician (or a physician employed by the provider) requests to speak to the RAC CMD. The RAC CMD shall be available for that conversation; this is referred to as a peer-to-peer discussion. The intent is for a conversation between the RAC CMD and a physician that directly cared for the beneficiary or a physician that is employed by the provider in the same facility that cared for the beneficiary. This facilitates a physician-to-physician dialog that adds relevant information to the discussion which may support the payment of the claim. Physicians employed as consultants, staff acting as billing administrators or in a non-physician related capacity would not be appropriate for peer-to-peer discussions.

It is expected that the RAC include additional relevant parties during the discussion, including but not limited to clinicians and certified coders depending upon the type of review. For example, in the case of a DRG Coding Validation review discussion, it would be most appropriate for a certified coder to lead the discussion on behalf of the RAC with the support of the RAC CMD.

During the discussion period, it is the RAC's responsibility to review all documents sent by the provider. All documents received at any time during the 30-day discussion period in response to the discussion period request, and those received in response to the original ADR letter, shall be reviewed in totality.

The RAC is not required to accept discussion requests after the 30-day request timeframe has passed. If the claim has already been forwarded to the MAC for adjustment, and the RAC receives a discussion request, the RAC shall immediately notify the provider in writing that the discussion request is invalid.

D. The Claim Adjustment Process
The MAC will pursue the recoupment of Medicare overpayments, identified by the RAC, in accordance with Pub.100-06 Medicare Financial Management Manual, Chapter 3.

Determining the Overpayment or Underpayment Amount
The actual overpayment amount of the claim adjustment is determined by the MAC. Once the claim adjustment is completed, via the file-based mass adjustment process, the MAC will notify the RAC through the RACDW (or another method as instructed by CMS) of the overpayment amount. Only the difference between the paid amount and the amount that should have been paid will be collected.

If the anticipated overpayment amount is less than $25 the RAC should not attempt recoupment, excluding claims reviewed by extrapolation. If the RAC pursues adjustment on a

claim less than $25.00, the RAC shall not receive a contingency fee on any amounts recouped.

If the anticipated underpayment is less than $5 the RAC shall not forward any claim to the MAC or the CMS Data Center for adjustment.

The RAC shall not forward claims to the MAC for adjustment if the claim is incorrectly coded, but the coding error is not expected to equate to a difference in the payment amount. For example, HCPCS code XXXX requires a modifier for payment. Payment with the modifier is $25.50 per service; payment without the modifier is $25.50 per service. While the claim without the modifier is incorrect, there is no improper payment, and the claim shall not be forwarded for adjustment.

There are circumstances when the MAC sends an adjustment through the Shared System that result in adjustments to additional claim lines due to Shared System edits that alter the improper payment. The CMS calls these adjustments “associated findings” that are in addition to the initial findings discovered by the RAC. While the RAC did not identify these lines for adjustment the RAC receives credit for the entire claim adjustment and the MAC will include these additional lines on the demand letter to the provider.

The way a claim is adjusted in the Shared System may not necessarily correlate with the RAC contingency fee. For example, a RAC contingency fee could equate to the difference between the full denial and any services determined by CMS to be payable.

A RAC identified adjustment may trigger the denial of the entire claim because of a known Medicare Secondary Payer (MSP) 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 adjustment.

When partial adjustments to claims are necessary, the MAC will 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.

E. Demand Letters

Demand letters will be issued by the MACs. The demand letters issued by the MAC will instruct providers to forward their refund checks to the appropriate address at the applicable MAC. 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.

F. Reversal of RAC determination

The CMS may determine that it is in the best interest of the Medicare Fee-for-Service Recovery Audit Program to cease work in certain areas. Reversals can be code specific, claim

or provider specific, claim type or provider type specific, jurisdiction specific, or region specific. The reversal instructions issued by CMS will determine any additional actions related to claims in question as well as any contingency fee payments. Any contingency fee payments that require the MAC to readjust the claim as a result of misinterpretation of CMS coverage or payment policy or were outside of CMS' approved parameters will be repaid to CMS.

Reversals could occur for several reasons including additional activity that is occurring by another contractor/entity or lack of adherence by the RAC to any provision of the SOW. Reversals may be indefinite and may require a corrective action plan to resume activity.

G. Compromise and/or Settlement of Overpayment

The CMS has the authority to enter into administrative agreements including individual or group compromises or settlements with providers without requiring the RAC's input. If CMS determines that a compromise and/or settlement of a RAC identified overpayment is in the best interest of Medicare at any time, the payment to the RAC will be adjusted so that the contingency payment is based only on the portion of the overpayment that remains collected or recouped after the administrative agreement, settlement, or compromise.

The CMS will adjust the RAC's invoiceable amounts accordingly due to claim re-adjudication following RAC review, which may result in the take-back of any applicable contingency fees.

H. Potential Quality of Care Problems

Upon medical review, the RAC shall report potential quality of care issues immediately to the CMS RAC COR.

I. Maintaining a Case File

The RAC shall maintain a complete case file for every claim containing an improper payment identified through both complex reviews and automated reviews. All documentation related to a claim review shall be kept in the case file. The RAC shall not destroy any supporting documentation relating to the identification or recovery process.

This file shall include documentation of all processes followed by the RAC, including but not limited to:

- A copy of all correspondence.
- A copy of all ADR and reminder letters.
- A copy of no findings letters.
- A copy of review results letters (for both automated and complex review).
- Any discussion requests (including documentation received) and discussion results letters.
- The date the claim was sent to the MAC for adjustment.
- A copy of the demand letter amount.

- A telephone log for all conversations with the provider or other individuals on behalf of the provider, with notes indicating what transpired during the call.
- Accounts receivable information.
- Contacts with MACs, CMS, or OIG.
- Any appeal requests and decisions.

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. For combined files that are paper and electronic, the entire case file shall be available to be sent to CMS within seven calendar days of the request. Any costs (e.g., materials, shipping) associated with the file transfer to CMS shall be incurred by the RAC. At CMS' request or no later than 15 business days after contract termination, the RAC shall return to CMS all case files stored in accordance with CMS instructions.

All case files shall meet the requirements as set by OMB Circular A-130, which can be found at https://www.whitehouse.gov/omb/information-for-agencies/circulars/

Annual Submission of Case Files to CMS
The RAC shall submit case files to the CMS RAC COR on an annual basis. The RAC shall download all case file documents listed above, in the appropriate formats (e.g., Portable Document Format (PDF), Microsoft Word, etc.), for reviews that occurred during the immediately preceding contract year/period. For example, if the first year of the RAC contract were November 1, 2021 – October 31, 2022, the submitted hard drive(s) would contain case file documents for all activities that occurred during that timeframe.

Case files shall be submitted for all:

- Complex Reviews with "No Findings" letters sent.
- Complex Reviews with Demand Letters sent.
- Automated Reviews with Demand Letters sent.
- Extrapolated Reviews.

Additional details regarding the annual submission of case files shall be provided by the CMS RAC COR via Technical Direction Letter (TDL).

Task 10: Utilizations of the RACDW

The Recovery Audit Contractor Data Warehouse (RACDW) is a database that houses all data pertaining to the operation of claim review with the purpose of correcting improper payments made by their respective MAC. It is also a critical management tool for overseeing Fee For Service (FFS) RAC activity and tracking of collections of overpayments and compensation of underpayments. RACs are required to enter all valid data in a timely manner, as defined in this SOW.

The RAC shall utilize the RACDW as the central repository for all claims information in the Recovery Audit Program. The CMS shall provide access to the RACDW for all applicable RAC staff. This RAC shall continuously update the RACDW with complete and accurate claim information within two business days of claim activity. Timely uploads will assist in preventing interference with law enforcement/fraud investigations and duplicating work on claims that have already been reviewed. The applicable RAC staff shall attend all RACDW conference calls, and participate in all RACDW trainings, as required by CMS.

The RACDW stores claim and provider information, such as provider number, location, dates of service, claim paid amounts, and applicable codes. The RAC shall enter this data by using the current version of the Claims Upload File Format, which shall be provided by the CMS RAC COR.

A. RACDW Required Upload Fields

The following fields, referred to as the date codes, are required by CMS for entry into the RACDW. The RAC shall enter the dates and any other information related to the review of each claim within two business days of the event. Failure to enter these fields within two business days may result in a corrective action plan and loss of contingency fee per claim affected. Date fields will vary based on the type of review, whether complex or automated.

- 01 (Initial selection of record for audit).
- 02 (Request for medical records).
- 03 (Received providers request for extension to submit records).
- 04 (New RAC-assigned deadline for provider to submit records request for extension).
- 05 (Received medical records from provider).
- 06 (RAC asks CMS for extension to complete review).
- 07 (New deadline for RAC to complete review).
- 08 (Improper payment results notification sent to provider).
- 09 (Request for discussion received from provider).
- 10 (Findings sent to AC).
- 11 (Re-adjudicated claim received from AC).
- 12 (Demand letter sent).
- 13 (Claim closed, without review).
- 14 (No findings letter sent).
- 15 (Technical denial determination date).
- 16 (Additional Documentation Received as part of Discussion).
- 17 (Discussion results sent to provider).
- 18 (Provider Self-Adjustment Date).
- 19 (Technical denial notification sent).
- 20 (Received Documentation linked to review).
- 21 (Claim closed after review completion).

Example 1:

When a RAC sends an Additional Documentation Request (ADR) letter to a provider, the RAC shall upload, into the RACDW, a Claims Upload File that includes a Date Code field with "Type of Date" indicator 02 (Request for medical records) and a Date field indicating the date the letter was sent. This upload must occur within two business days from the date the ADR letter was sent.

Example 2:
When a RAC sends an Improper payment results notification to a provider, the RAC shall upload, into the RACDW, a Claims Upload File that includes a Date Code field with "Type of Date" indicator 08 (Improper payment results notification sent to provider) and a Date field indicating the date the notification was sent. This upload must occur within two business days from the date the Improper Payment Results notification was sent. This upload should also include information associated with the improper payment, such as the Denial Reason code, final DRG/ICD/HOPPS/HIPPS/HCPCS code(s), and final Units of Service.

B. Initial Claim Upload
All dates associated with the review process should never pre-date the initial upload date. Any claim that has a date associated with the review process that pre-dates the initial upload date will be flagged as permanently non-invoiceable in the RACDW, and the RAC shall not receive any contingency fee for that claim.

The RAC shall delay sending ADRs until at least 60 calendar days after the claim paid date. This delay is necessary to minimize the likelihood of reviewing a claim that had a prepayment review done by a MAC. Currently, MACs complex reviews are uploaded to the RACDW using a system-generated file. This file is used to exclude the MAC-reviewed claims from potential re-review by a RAC. Therefore, CMS has designated this 60-day wait time to allow ample time for MACs to upload reviews into the RACDW.

C. Preventing Overlap
In order to minimize the impact on the provider community, it is critical that the RAC avoid situations where the RAC and another entity (MAC, UPIC, OIG, or other investigative agencies) are working on the same claim. Only claims that are not suppressed or excluded can be reviewed by the RAC. The RAC shall use the RACDW to determine if another entity already has the provider and/or claim under review. The RACDW will include a master table of suppressed providers and excluded claims that are not eligible for review. After the RAC has uploaded the claim, the RACDW will notify the RAC whether the claim is available for review.

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

- A/B MACs and DME MACs.
- Quality Improvement Organizations (QIO).
- UPICs.
- Investigative Agencies (OIG, FBI, Department of Justice (DOJ)).
- CERT Contractor.

- CMS.

D. 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. Exclusions occur at the claim level. Providers are not be excluded. Exclusions are permanent. This means that an excluded claim will never be available for the RAC to review.

The RAC will be notified to cease all activity if an exclusion is entered after a RAC began its review.

E. Suppressions
A provider's claims can be temporarily removed from RAC review using a suppression. Suppressions are used to minimize provider burden by preventing overlapping reviews when another Medicare contractor or an investigative agency intends to review a claim or provider.

Once a suppression record is entered into the RACDW, CMS will approve or reject that record. Approved suppressions are active for one year from the date of CMS approval. At the end of the year, the suppression will expire and may be extended by the originating entity. The suppression record may also be released at any time during the year by the originating entity or CMS.

When a claim that the RAC has selected for review, is subject to a suppression, the RAC shall immediately cease all activity related to the suppressed claim, regardless of where the RAC is in the review process.

The RAC will receive a notification via the RACDW when a claim under review becomes suppressed. The RAC shall assign, and notify their COR of, a staff member, and backup, to review these notifications daily so that, upon suppression, claims in the review process, shall be closed on the date of notification, as follows:

1. If the review has been completed, but the Review Results Letter (RRL) has not been sent, the RRL shall not be sent;
2. If the RRL has been sent, but the claim has not been sent to the MAC for adjustment, the claim shall not be sent to the MAC for adjustment;
3. If the provider has requested, or is currently participating in, the Discussion Period, the RAC shall notify the provider that claim shall be closed;
4. The RAC shall take no further review or collection actions for suppressed claims.

F. RACDW Reporting of Identified Improper Payments
The RAC shall enter the necessary claim information and/or status updates within two business days of the event. The CMS will provide the specific format after contract award. All updates to the file format shall be shared with the RAC prior to implementation. The RAC shall use the current version of the RACDW claims upload file format.

G. Demand Letter Date and Demand Amounts

The RAC shall be responsible for uploading the finalized adjustment date. The RAC updates the RACDW with the date of MAC demand letter, as well as the demanded amount (negative values for underpayments). Because this information is provided to the RAC from the MAC, this information does not have to be uploaded into the RACDW within two business days of the Demand Letter date but should be entered by the RAC within 10 business days of receiving the information from the MAC.

H. RAC Invoicing

Contingency fee payments will be based on the demand letter finding of the amount collected or paid to the provider.

The contingency fee payment will be determined by the overpayments collected without netting out the underpayments. Underpayments are considered separately.

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 any contingency fee payment that it received for that recovery. Repayment to Medicare will be subtracted from the next applicable invoice.

The RACDW will generate, monthly, pre-filled invoices based on required claims information from the RAC and collection/payment and reversal transactions from the MAC. A RAC may only invoice and be paid for a claim adjustment, when all required data elements, as determined by CMS, have been entered correctly into the RACDW. The existence of a transaction alone does not oblige CMS to pay the contingency fee associated with the claim.

Also, all additional required criteria must be met for a claim to be eligible for invoicing. Additional required criteria include the following:

- Initial Claim Upload date predates all other dates associated with the RAC's review.
- Claim was not excluded from RAC review.
- Claim was not suppressed before date of filing findings with MAC.
- RAC correctly applied approved edit parameters.
- RAC correctly applied approved review guidelines.
- RAC review was completed within approved timeframe(s).
- A collection/payment transaction occurred and was matched to the RAC's review.
- The provider received an unfavorable, or partially favorable, decision at the second (QIC) level of the appeal process, or the provider failed to file a valid timely appeal, at either the first (MAC) level or the second (QIC) level of the appeals process.
- RAC determination was not overturned at any level of appeal.

The CMS regularly reviews invoiced claims to ensure the claims meet all applicable criteria for invoicing. If CMS determines that a claim was included on an invoice and paid in error, CMS will collect the debt by subtracting the payment from the RAC's next invoice, or sending a demand letter, if necessary.

If a RAC has concerns regarding the RACDW generated invoice, the RAC shall contact its CMS RAC COR before submitting the invoice for payment. The RAC may not add to the automatically generated invoices, although the RAC may remove records with appropriate notice to the CMS RAC COR.

The RAC will not be paid a contingency fee until the MAC and QIC level of appeal have been completed and found to be either favorable or partially favorable, to the RAC. Once both appeal levels have been completed and recorded into the RACDW, the RAC may invoice the claim.

In rare and unusual circumstances, CMS may consider a supplemental invoice involving transactions that are not in the RACDW or that failed automated matching; however, such consideration is solely at CMS' discretion. Acceptance of one or more supplemental invoices does not bind CMS to accepting future supplemental invoices.

I. Accuracy Incentive

The CMS expects that the RAC shall have an accuracy rate of at least 95%, as calculated from the results of monthly accuracy audits performed by an independent validation contractor, or by the CMS.

The RACDW will calculate a rolling tally of all accuracy determinations for claims included in the monthly accuracy audits. For each percentage point above 95%, the RAC shall earn an additional 0.2% contingency fee increase. For example, a RAC with a contingency fee of 15% and a 96% accuracy rate would receive an additional 0.2% contingency fee increase, for a total of 15.2%. The adjusted contingency fee will apply to all claims with an improper payment for the applicable timeframe. Accuracy rates and contingency fees will be recalculated every three months.

J. Appeal Affirmation Incentive

The CMS expects that the RAC shall have an appeal affirmation rate of at least 90%, at the first level of appeal.

The appeal affirmation rate will be calculated by the RACDW, using a rolling tally of all affirmed first-level appeals (those with dispositions that are unfavorable to the appellant) for each review topic. For each percentage point above 90%, the RAC shall earn an additional 0.1% contingency fee increase. For example, a RAC with a contingency fee of 15% and a 91% appeal affirmation rate would receive an additional 0.1% contingency fee increase, for a total of 15.1%.

The adjusted contingency fee will apply to all claims with collections or paid underpayments for the applicable timeframe. Appeal overturn rates and contingency fees will be recalculated every three months.

K. Review Timing Incentive

The CMS encourages the RACs to review the newest claims to be the most impactful on provider behavior. Therefore, the review timing incentive will be calculated by the RACDW as follows for **automated reviews:**

- Claims with an Initial Claim Paid Date less than 6 months (183 days) from the date of the review results (Date 08), will receive a **1.5% contingency fee increase.**
  For example, a RAC with a contingency fee of 13%, would receive 14.5% contingency fee for claims reviewed with an Initial Claim Paid Date that is less than 6 months from the date of the review results (Date 08).
- Claims with an Initial Claim Paid Date less than 1 year (365 days) but greater than 6 months (183 days) from the date of the review results (Date 08), will receive a **1% contingency fee increase**.
  For example, a RAC with a contingency fee of 13%, would receive 14% contingency fee for claims reviewed with an Initial Claim Paid Date less than 1 year (365 days) but greater than 6 months (183 days) from the date of the review results (Date 08).

The review timing incentive will be calculated by the RACDW as follows for **complex reviews**:

- Claims with an Initial Claim Paid Date less than 6 months (183 days) from the date of the ADR (Date 02), will receive a **1.5% contingency fee increase.**
  For example, a RAC with a contingency fee of 13%, would receive 14.5% contingency fee for claims reviewed with an Initial Claim Paid Date that is less than 6 months from the date of the ADR (Date 02).
- Claims with an Initial Claim Paid Date less than 1 year (365 days) but greater than 6 months (183 days) from the date of the ADR (Date 02), will receive a **1% contingency fee increase**.
  For example, a RAC with a contingency fee of 13%, would receive 14% contingency fee for claims reviewed with an Initial Claim Paid Date less than 1 year (365 days) but greater than 6 months (183 days) from the date of the ADR (Date 02).

The adjusted contingency fee will apply to claims that meet the above conditions, with collections or paid underpayments, and which meet the invoicing validation rules applied by the RACDW.

Task 11: Quality Assurance and Accuracy Monitoring

Quality assurance and accuracy is verified through four approaches. These include but are not limited to:

- Accuracy Review contractor.
- Inter-Rater reliability (IRR) internal to the RAC.
- Internal CMS review of audit concepts every 6 or 12 months as determined by CMS.
- Contractor Performance Evaluations.

A. Accuracy Reviews

The CMS contracts with an independent validation contractor (RVC) to perform monthly accuracy audits on RAC claim determinations. The RAC shall provide the RVC with the entire case file and all information necessary to complete the audit. The RAC shall provide the case files within seven business days upon the date of request from the RVC. The RAC shall comply with all RVC requests (as instructed through the CMS) and not impede any review processes. The RVC also reviews information that is uploaded into the RACDW by the RAC. Any data that is omitted or entered into the RACDW incorrectly may result in a lower accuracy score. The CMS, MAC, or RVC may also evaluate the clarity, accuracy, and completeness of the RAC letters to providers.

Some accuracy determinations are open to dispute by the RAC. To submit a dispute, the RAC shall follow all guidelines provided by the CMS RAC COR via a technical direction letter (TDL).

B. Inter-Rater Reliability

As part of an Inter-Rater Reliability (IRR) process, the RAC shall evaluate the performance of medical reviewers who perform complex medical record reviews on a monthly basis. The claims shall be randomly selected from all complex reviews with improper payment determinations. The RAC shall implement corrective actions for those reviewers whose IRR is below 90%. New employees shall maintain an IRR of 95% for at least 3 months following their initial training. Both the IRR and corrective action processes shall be detailed in the workplan.

C. CMS/RAC Review Quality Assurance

This task requires the RAC to re-examine approved NI concepts/packages in their entirety regardless of the type of review (automated or complex). Every six months (at a minimum), the RAC shall perform a QA review upon the NI packages that have been conditionally approved for RAC review and accepted by the RAC. This review shall analyze the documents for the appropriateness of policy references, edit parameters/claim selection criteria, review guidelines, and good cause language. The results of the review will be communicated to the CMS RAC COR and the CMS NI Team.

D. Contractor Performance Evaluations (CPE).

The CMS performs quarterly contractor performance evaluations at its discretion. Advance notice may or may not be provided. The CMS will select a focus area for the quarterly evaluations. Any finding from the review may require a corrective action plan.

E. Remedies for Unsatisfactory Performance or Non-compliance
The CMS will take all actions it deems necessary to remedy unsatisfactory performance or non-compliance with any requirements within this SOW.

Actions that CMS may take, at its discretion, include, but are not limited to, the following:

- Rescinding approval (temporarily or permanently) of one, or more, review topics.
- Reduction in the number of conditionally approved reviews.
- Reduction in the number of ADRs that may be sent.
- Requiring the RAC to complete a Corrective Action Plan.
- Limiting the scope of work under the RAC contract.
- Limiting the period of performance of the RAC contract.
- Exercising the administrative/appeals period of the contract early.
- Terminating the RAC contract.

Task 12: Supporting Medicare Third Level of Appeal, in the Office of Medicare Hearings and Appeals (OMHA) and/or in the Debt Collection Improvement Act Process

Providers are given appeal rights for Medicare improper payment determinations during the claim review process. This task addresses the RAC requirements associated with the Third Level of Appeal: Office of Medicare Hearings and Appeals (OMHA) with the Administrative Law Judge.

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.

Third Level of Appeal: Office of Medicare Hearings and Appeals (OMHA)
The RAC shall adhere to all instructions outlined in Pub. 100-08, Program Integrity Manual, Chapter 3.9 to elect its status at the ALJ level. Refer to 42 CFR §405.1010 and 42 CFR §405.1012. In any participation situation (party or participant), the RAC shall be prepared to discuss details related to the facts of each claim under appeal, the relevant coverage policies, and payment requirements, including any clarification required on decisions made earlier in the appeals process. The RAC shall also be prepared to discuss the background on how the claim or provider was selected for review as well as matters related to the extrapolation process, if applicable.

OMHA will send all Notice of Hearings (NOHs) directly to the AdQIC. The AdQIC is tasked with coordinating contractor interest in ALJ hearings; the RAC is required to use the AdQIC Participation Portal to review and elect participation status for Notices of Hearing (NOHs).

Upon receipt of a Notice of Hearing (NOH), the RAC shall review each case to determine its' participation status. Factors to be considered should include, but not be limited to:

- Originator of initial denial.
- Policy implications.
- Improper payment amount.
- Program integrity matters.
- The extent to which a particular issue is, or has been, a recurring issue at the ALJ level of appeal.

Administrative Qualified Independent Contractor (AdQIC): The AdQIC will inform the RAC when QIC level appeals are promoted to the Administrative Law Judge (ALJ), and, if so, which cases the contractors will mutually participate. The AdQIC website assists with the coordination of CMS contractors' participation in ALJ hearings.

The AdQIC will create a record in the AdQIC portal within two calendar days of receipt of the formal NOH from OMHA. This will generate an email notification to the applicable RAC, notifying them that a hearing has been scheduled. Upon receipt of the formal NOH from the AdQIC, the RAC shall log onto the AdQIC website to access the NOH information. The RAC shall make its elections, within five calendar days of the formal NOH e-mail sent date.

A. Electing Party Status in ALJ Hearings

The RAC shall take party status in a minimum of 50% of all appeal cases that reach the ALJ level of appeal. As the medical review contractor who made the improper payment determination subject to appeal, the RAC is given priority to invoke party status.

The election for party status shall be made consistent with the rules at 42 CFR §405.1012, and provided to the ALJ, appellant and all parties identified within five calendar days of the formal NOH e-mail sent date. As a party, the RAC may file position papers, call witnesses and/or cross-examine witnesses of other parties, and/or request discovery, subject to the limitations of 42 CFR §405.1037(b). The RAC shall submit any position paper or additional evidence requested by the ALJ within timeframes established by the ALJ. A copy of any written statements must be provided to the other parties to the hearing at the same time these are submitted to the ALJ. The RAC shall be adequately prepared to respond to questioning by the ALJ or other parties regarding all issues related to the claims under appeal.

B. Electing Participant Status in ALJ Hearings

The RAC shall participate in a minimum of 50% of the remaining cases that reach the ALJ level of appeal for which they have not elected party status.

In accordance with the regulation under 42 CFR Part §405.1010(c) and (d), all contractors' participation as a participant (i.e., non-party) shall be limited to submitting written testimony and/or position papers. The election to participate shall be made consistent with the rules at 42 CFR 405.1010, and be provided in writing to the ALJ, appellant, and all parties identified,

within five calendar days of the formal NOH e-mail sent date. The RAC shall be prepared to respond to questioning by the ALJ (and by the appellant should the ALJ allow cross-examination) regarding all issues related to the claims under appeal.

Because participation status does not include the same rights as full party status, the RAC may not call witnesses, or cross-examine witnesses, of another party. The RAC must coordinate with other contractors in advance to solicit their participation should testimony from the other contractors be necessary.

The RAC shall use form OMHA-105 to elect participation prior to the issuance and/or receipt of a formal NOH. The CMS will provide form updates. As this process is prior to the issuance and/or receipt of a formal NOH, an OMHA adjudicator will not have yet been assigned. In this situation, form OMHA-105 shall be mailed to:

OMHA Central Operations
1001 Lakeside Ave., Suite 930
Cleveland, OH 44114-1158
Attn: CMS and CMS Contractor Elections Mail Stop

If submitting an election to participate in an ALJ Hearing prior to the issuance and/or receipt of formal NOH, the RAC shall also send a copy of form OMHA-105 to the parties who were sent a copy of the notice of reconsideration.

For additional information, please refer to 42 Code of Federal Regulation (CFR) §405.1010(b)(1) and https://www.hhs.gov/about/agencies/omha/index.html .

Task 13: Customer Service and Provider Outreach

The RAC shall maintain a customer service center to provide accurate and timely responses to CMS and provider or stakeholder inquiries. This includes responding to written, telephonic, and electronic inquiries within the appropriate timeframes. The RAC shall also perform any necessary provider outreach, as instructed by CMS.

A. Customer Service

1. The RAC shall provide a toll-free customer service telephone number and email contact in all correspondence sent to Medicare providers or other stakeholders. The customer service phone shall be staffed by qualified personnel during normal business hours from 8:00 a.m. to 4:30 p.m. in each applicable time zone. For example, if the RAC is conducting work in California, the customer service number shall be staffed from 8:00 a.m. to 4:30 p.m. Pacific time. Customer service staff shall be available to providers on all business days except for Federal holidays. 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 RAC COR before use.

2. The RAC shall acknowledge all written correspondence received during normal business hours and after normal business hours (mail, email, and faxed documents) within two business days per the time zone of the respective region with all Federal holidays being excluded. Once the RAC has acknowledged the correspondence, the RAC shall respond to all inquiries within 30 business days.

3. 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. The customer service staff shall return the call within one business day after consultation with the auditor and/or the MR Manager, as appropriate.

4. The RAC shall provide an interpreter for all non-English speaking providers or stakeholders. The RAC shall have resources available for those using teletypewriter (TTY). An interpreter shall be available within one business day of the provider's original call.

5. The RAC shall retain a written report of contact for all telephone inquiries and supply it to the CMS RAC COR within 48 hours of the request. At a minimum, the written report shall include the caller's name, provider name, provider identifier, phone number, date, reason for the call to the RAC, the response to the inquiry, and the outcome of the call, including any follow up contact by the RAC.

6. The RAC shall provide remote call monitoring capability to CMS personnel in Baltimore or CMS regional offices, if directed by the CMS RAC COR. The CMS may monitor RAC calls at any time without prior notification to the RAC. The RAC phone system must notify all callers that the call may be monitored for quality assurance purposes.

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

8. Inquiries regarding the RAC program may occasionally be received, which require a time sensitive response. The deadline for any requested data will be included in the inquiry from CMS.

9. The Project Plan shall include a component on customer service and shall be updated, as needed. The 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 is satisfied with all improvements made in the customer service area.

B. Provider Outreach

The CMS will announce the awardee of the RAC Region, thereafter all other provider education and outreach concerning the RAC program shall be the responsibility of the awarded RAC.

The RAC shall only educate providers on the business, purpose, and processes of the Recovery Audit program. The RAC shall not educate providers on Medicare policy. Provider outreach efforts shall include outreach to stakeholders under the RAC region, covering all eligible provider types. Examples of outreach include, but are not limited to webinars, teleconferences, letters, in-person seminars, or partner events. The RAC may use any combination of outreach methods to reach its regional providers.

The CMS RAC COR shall approve all provider education and outreach presentations and written information shared with the provider, beneficiary, and/or other stakeholder communities 30 calendar days before the implementation. The initial Project Plan shall include a section covering provider outreach.

If requested by CMS, the RAC Project Manager for the CMS contract, at a minimum, shall attend any provider or stakeholder group meetings or Congressional staff information sessions where the service provided by the RAC is the focus.

The RAC shall provide information, in its monthly administrative progress report, on all of its upcoming outreach efforts/sessions. The reported information, for each outreach session, shall include:

- Provider type targeted by the outreach session.
- MAC jurisdiction targeted by the outreach session.
- Date of the scheduled outreach session.
- Method of outreach (webinar, teleconference, etc.) used for the outreach session.
- The date that the provider-related, or state association(s) were informed of the outreach session.

Provider outreach is an ongoing process that will continue throughout the timeframe of the RAC contract which includes the administrative period. The CMS will closely monitor the RAC's outreach efforts, and may revise its provider outreach goals, as necessary, to meet the objectives of the Recovery Audit Program. Any revisions will be provided via TDL.

C. Public Communications

The RAC must receive prior approval from CMS for all RAC press releases. The RAC shall not respond to requests from industry publications, newspapers, and journals for information involving the CMS Recovery Audit Program. These requests shall be forwarded to the CMS RAC COR.

The RAC shall include the CMS RAC COR in all public and Congressional communications regarding the Recovery Audit Program. This includes issues regarding claims, appeals, and

system processes. The one exception are discussions held between the RAC and a provider and/or provider's representative.

Task 14: Conference Calls, Meetings and Travel

A. Conference Calls

The CMS expects the appropriate RAC staff to attend conference calls. Appropriate RAC staff are those who are directly responsible for performing or overseeing the daily RAC operations that are related to the topic(s) on each conference call's agenda. The CMS may also require specific RAC staff to attend other meetings. The CMS RAC COR will notify the RAC in such cases.

Weekly Operational Calls

The RAC shall have a weekly operational call with its respective CMS RAC COR to discuss the progress of work, evaluate any problems, and discuss plans for immediate next steps of the project.

The RAC shall 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.

The RAC shall send agendas for any meeting with CMS to its respective CMS RAC COR no later than two business days in advance. Meeting agendas shall include the name and title of each RAC staff member, and the respective agenda item(s) that have been designated to discuss with CMS. All agenda items shall be as specific as possible.

When addressing IT or CMS systems related agenda topics (including RACDW, CMS Information Systems Security and Privacy Requirements, National Claims History (NCH) data and mainframe discussions, etc.), the RAC CIO, SSO, and/or other RAC IT specialists, who have the ability to provide the background and detailed information to CMS, shall attend all operational calls.

CMS may defer any topics that were not included in the submitted agenda or if the appropriate RAC staff is not available to discuss a particular agenda item, to a future meeting.

Draft meeting minutes shall be produced by the RAC and submitted to its respective CMS RAC COR, for review and approval, within two business days of the meeting. If revisions are necessary, the CMS RAC COR will provide instructions to the RAC on what changes are to be made. Revised meeting minutes shall be submitted to the CMS RAC COR within one business day.

Other Conference Calls

The following are examples of RAC staff deemed appropriate by CMS for various CMS conference calls:

Review Topic Calls
The RAC PM, CMD, and Medical Review (MR) Manager shall attend and participate in all review topic related calls. If a meeting involves discussion of a specific review issue, the RAC shall include (at a minimum) the following information:

- Review topic name.
- Review topic number.
- Detailed question/comment/recommendation including any related reference/data so that the topic can be researched prior to the call.

RAC Validation Contractor (RVC) calls
The RAC shall make available the PM, CMD, and MR Manager for all RVC calls. If a specific claim is scheduled to be discussed, the RAC shall make the actual Medical Reviewer available for discussion.

Overall, at CMS' discretion, all conference calls could be scheduled more frequently, to discuss individual items and/or issues.

B. Meetings/Travel
The CMS expects the appropriate RAC staff to attend meetings. Appropriate RAC staff are those who are directly responsible for performing or overseeing the daily RAC operations that are related to the topic(s) on each meeting's agenda.

The RAC may be required to travel to CMS Central Office in Baltimore, Maryland for the initial meeting with CMS after contract award. In addition, the RAC may be required to attend both the Program Integrity Annual Meeting (five days) and the RAC Operational Meeting (one day) or as otherwise directed.

C. Annual RAC Operational Meeting
The following RAC personnel are required to attend the Annual RAC Operational Meeting:

- Project Manager.
- Contract Medical Director.
- Medical Review Manager.
- Chief Information Officer/System Security Officer.

D. Program Integrity Annual Meeting (PIAM)
PIAM attendance/participation is mandatory for the RAC CMD, the RAC PMs, and the MRM. Aside from mandatory participants, the RAC may be permitted to invite other staff at CMS discretion which will be communicated via technical direction prior to the event. All participants must register if planning to attend all or part of the meeting.

Task 15: Monthly Progress Reports

At a minimum, the RAC shall submit subsequent project plans and the following administrative progress reports outlining all work accomplished during the previous month:

- Monthly Administrative Progress Report.
- Monthly Appeals Report.
- Monthly Review Topics Report.

A standardized report format may be required by the CMS RAC COR. If a standardized monthly report format is required, the CMS RAC COR will provide the format no less than 30 calendar days before the implementation of the format change. Each monthly report shall be submitted by the close of business on the fifth business day following the end of the calendar month; the CMS RAC COR may approve alternative timeframes when necessary. The monthly report shall be sent via secure e-mail to the CMS RAC COR.

A. Monthly Administrative Progress Report

- The RAC shall submit monthly administrative progress reports outlining all work accomplished during the previous month. These reports shall include the following information: All provider outreach efforts upcoming and completed for each section including: Provider type, MAC jurisdiction, date, method of outreach (webinar, teleconference, etc.) used and date provider-related, state association(s) were informed of the outreach session.
- Recommended corrective actions to prevent or reduce improper payments for each review topic. For example: the RAC shall report on LCDs, or other policies, that may be outdated, technically flawed, or have other issues that do not provide optimal support for medical review decisions.
- Update on all JOAs.
- Action items.
- Number of fraud referrals submitted to the CMS RAC COR, for the reporting period.
- Upcoming staff trainings, including webinar/conference call information for CMS RAC COR access.
- Referral Reviews-
    - All review concepts referred to the RAC and the associated review topic number(s), if any;
    - Provider(s) reviewed as the result of a referral;
      Number of reviews to be conducted as part of the referral;
    - Number of reviews completed as part of the referral;
      Outcome(s) of the referred reviews;
    - Status update on any outstanding reviews.
- Constraints with completing any internal RAC task.
- Complications with any contractor, examples are MAC/QIC/AdQIC.

B. Monthly Appeals Report

The RAC shall submit monthly appeals reports. These reports shall be broken down by MAC jurisdiction into the following categories:

- A listing of appeal records requests from the MAC, by review topic number, for the month.
- A listing of appeal records requests from the MAC to which the RAC has responded, by review topic number, for the month.
- A listing of all appeals dispositions, by review topic number and level of appeal, for the month.
- Total number of appeals dispositions, by review topic number, from inception to date.
- A listing of all ALJ hearings (by claim number and review topic number) in which the RAC elected party status.
- A listing of all ALJ hearings (by claim number and review topic number) in which the RAC elected participation status.

C. Monthly Review Topic Report

The RAC shall include a review topic tab in the monthly progress report (spreadsheet). The review topic tab shall include the following, as column headings:

- Review Topic Name.
- Review Topic Number.
- Review Type.
- Review Topic Approval Status (Approved, HOLD, Rescinded).
- Total Number of Reviews Conditionally Approved (total to date).
- Total Number of Reviews Completed (total to date).
- Number of Reviews Completed (in Prior Month).
- Date of Last Quality Assurance (QA) Review for this review topic.
- Date of Last Revision for this review topic.
- Reason for Revision (What changed?).
- Date Revision went into Effect (Effective Date).
- Due Date for Next QA Review.
- Number of Discussion Periods Initiated in Prior Month.
- Number of Discussion Periods Completed in Prior Month.
- Number of Discussion Periods resulting in Overturned Decisions in Prior Month.
- Primary Reason for Overturned Decisions during Discussions in Prior Month.
- Number of Discussion Periods involving Physician to Physician dialog.

Each approved review topic shall have its own row on the report. Under each column heading, the RAC shall include the most recent data related to the column heading. The RAC shall also note the date that the reported data was pulled, and the data source, (e.g. RACDW, or internal RAC system, etc.).

This report shall be supplied in addition to any appeals data or discussion period data that is separately reported. If no reviews have begun for a particular review topic, the RAC shall indicate this with a zero and include an explanation in the appropriate field.

Task 16: Administrative Period (Contract Closeout and Reconciliation)

RAC contracts shall have an 18-month Administrative Period. During the Administrative Period, only provider outreach to communicate contractor changes, contract closeout and reconciliation activities shall occur; active reviews by the incumbent RAC shall not occur. The 18-month Administrative Period is in place for completion of the claim review life cycle, including appeals and potential overturns. The RAC must return any contingency fees for any claim determination that was later overturned during the appeals process.

During the Administrative Period, CMS will continue to:

- Recoup funds from providers on improper payments identified and sent for adjustment during the active recovery auditing (claim review) period.
- Allow the RAC to invoice for contingency fee payments on eligible claims.
- Allow the RAC to support the appeal process.
- Allow CMS to recoup contingency fees from overturned appeals.

To prevent an interruption in claim reviews, the first year of the incoming RAC contract will, in most cases, occur concurrently with the outgoing RAC's Administrative Period. However, outstanding claims and appeals will not transition to the incoming RAC.

The outgoing RAC shall provide CMS with a bi-weekly closeout project status report organized by major closeout tasks. The report shall include a detailed discussion of outstanding issues, deliverables, problem resolution, and risk mitigation/contingency plans as appropriate.

A. Final Report

The final report shall include a synopsis of the entire contract project. This includes a final report identifying all improper payment amounts identified and demanded, all amounts collected and all amounts still outstanding at the end of the contract period. It shall include a brief listing of innovative, new processes utilized during the contract, and their success or failure.

The RAC shall include any final thoughts on the program, as well as any advantages or disadvantages encountered. From a RAC point of view, the final report should determine if the contract was a success or a failure and provide support for either opinion.

The RAC shall deliver the report to the CMS RAC COR. Drafts of all documentation shall be provided to CMS approximately six weeks prior to final deliverable due dates unless otherwise agreed to by CMS. The CMS staff will review materials and provide comments back to the RAC within two weeks, thereby allowing two additional weeks for the RAC to

make any necessary revisions prior to submitting the final versions. 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, as specified by CMS. These shall not be used for any other purpose other than fulfilling the terms of this contract without the express permission of the contracting officer.