Statement of Work for the Recovery Audit Program

I. Purpose

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

The purpose of this contract will be to support the Centers for Medicare & Medicaid Services (CMS) in completing this mission. The identification of underpayments and overpayments and the recoupment of overpayments will occur for claims paid under the Medicare program for services for which payment is made under part A or B of title XVIII of the Social Security Act. The CMS expects that Recovery Auditors review all claim types to assist the Agency in lowering the error rate and in identifying improper payments that have the greatest impact on the Trust Fund.

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

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

1. Identifying Medicare claims that contain underpayments for which payment was made under part A or B of title XVIII of the Social Security Act. This includes the review of **all** claim and provider types and a review of claims/providers that have a high propensity for error based on the Comprehensive Error Rate Testing (CERT) program and other CMS analysis.

2. Identify and Recouping Medicare claims that contain overpayments for which payment was made under part A or B of title XVIII of the Social Security Act. This includes corresponding with the provider. This includes the review of **all** claim and provider types and a review of claims/providers that have a high propensity for error based on the CERT program and other CMS analysis.

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

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

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

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

II. Background

Statutory Requirements

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

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

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

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

III. Transitions Transitions

Outgoing Recovery Auditor to Incoming Recovery Auditor

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

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

Outgoing Claim Processing Contractor to Incoming Claim Processing Contractor and its impact on Recovery Audit Program

At times CMS will transition the claim processing workload from one contractor to another. CMS will review each transition independently taking into account the outgoing and incoming contractor, the impact on the provider community, historical experience and the recovery auditor relationship with the involved contractors to determine the impact on the recovery audit program. The impact may vary from little to no impact to a work stoppage in a particular area for a 3-6 month period of time (or more dependent on the transition). The impact to the recovery audit program will be determined within 60 days of the announcement of the upcoming transition. Each impacted Recovery Auditor will be required to submit a transition plan to CMS for approval. The lack of an approved transition plan will result in a minimum transition time of 6 months.

IV. Specific Tasks

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

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

Task 1- General Requirements

A. Initial Meeting with PO and CMS Staff

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

The project plan shall include the following:

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

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

3. Recovery Auditor Organizational Chart - A draft Recovery Auditor Organization Chart shall be submitted as part of the proposal. The organizational chart shall identify the number of key personnel and the organizational structure of the Recovery Auditor effort. While CMS is not dictating the number of key personnel, it is CMS' opinion that one key personnel will not be adequate for an entire region. An example of a possible organizational structure would be three (3) key personnel each overseeing a different claim type (Inpatient, Physician, and DME). This is not prescriptive and CMS is open to all organizational structures. A detailed organizational chart extending past the key personnel shall be submitted within two weeks of the initial meeting. Any changes to the Recovery Auditor's original organizational chart (down to the first line management) shall be submitted within seven business days of the actual change being made to the Contracting Officer Technical Representative (COTR). First line management is Recovery Auditor specific, and refers to any individuals charged with the responsibility of overseeing audit reviewers, analysts, customer service representatives, and any other staff essential to recovery audit operations. The first line management may or

may not include personnel involved in day-to-day communications with the CMS COTR. This excludes changes to key personnel which shall be communicated immediately to CMS and approved by CMS before the transition occurs.

B. Monthly Conference Calls

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

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

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

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

C. Monthly Progress Reports

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

1. Complications Completing any task
2. Communication with FI/Carrier/MAC/DME MAC/QIC/ADQIC
3. Upcoming Provider Outreach Efforts
4. Update of Project Plan
5. Update of what vulnerability issues are being reviewed in the next month
6. Recommended corrective actions for vulnerabilities (i.e. LCD change, system edit, provider education…)*
7. Update on how vulnerability issues were identified and what potential vulnerabilities cannot be reviewed because of potentially ineffective policies
8. Update on JOAs
9. Action Items
10. Appeal Statistics

11. Problems Encountered
12. Process Improvements to be completed by Recovery Auditor

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

    *The majority of coverage policy in Medicare is defined through Local Coverage Decisions (LCD). Therefore, LCDs typically provide the clinical policy framework for Recovery Auditor medical necessity reviews. If a LCD is out of date, technically flawed, ambiguous, or provides limited clinical detail it will not provide optimal support for medical review decisions.

    The Recovery Auditors will identify and report LCDs that can benefit from central office evaluation and identify their characteristics (out of date, technically flawed, ambiguous, and/or superficial). Identification of these LCDs will improve the integrity of the Medicare program and the performance of the Recovery Auditor program.

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

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

Reports a, b and c in #2 above shall also be included with the monthly voucher to CMS.

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

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

Unless alternative arrangements are approved, each monthly report shall be submitted by the close of business on the fifth business day following the end of the month by email to the CMS COTR and one copy accompanying the contractor's voucher that is sent to the CMS accounting office.

D. RAC Data Warehouse

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

E. Geographic Region

Unless otherwise directed by CMS through technical direction, the claims being analyzed for this award will be all fee-for-service claims processed in Region ___ regardless of the providers' or suppliers' physical locations. Exception: Claims processed by the legacy fiscal intermediary Wisconsin Physician Services (WPS) will be subject to review exclusively by the Recovery Auditor with jurisdiction over the provider's physical location.

Once the legacy workload is transitioned to another intermediary or MAC, in whole or in part, jurisdiction will fall to the Recovery Auditor in the destination region and physical location will become irrelevant.

The incumbent Recovery Auditor, if not also the gaining Recovery Auditor, may no longer review pre-transition claims and shall transfer themt o the new Recovery Auditor or discard them as directed by CMS.

A map of the regions can be found in Appendix 2.

<u>Task 2- Identification of Improper Payments</u>

Identification of Medicare Improper payments

The Recovery Auditors(s) shall pursue the identification of all Medicare claim types which contain improper payments for which payment was made or should have been made under part A or B of title XVIII of the Social Security Act. Recovery Auditors are required to comply with Reopening Regulations located at 42 CFR 405.980. Before a Recovery Auditor makes a decision to reopen a claim, the Recovery Auditor must have good cause and must clearly articulate the good cause in New Issue proposals and correspondence (review results letters, ADR, etc) with providers. Additionally, Recovery Auditors shall ensure that processes are developed to minimize provider burden to the greatest extent possible when Identifying Medicare Improper payments. This may include but is not limited to ensuring edit parameters are refined to selecting only those claims with the greatest probability that they are improper and that the number of additional documentation requests do not impact the provider's ability to provide care. To assist the Recovery Audit Program CMS works closely with the claim processing contractors to establish monthly workload figures. These figures are generated after consultation with the Recovery Auditor. The workload figures are typically modified annually, with the option for modification if necessary. A Recovery Auditor's failure to meet established workload limits repeatedly without notice to the CMS COTR may result in a lessening of future workload limits. Workload limits equate to the number of claims that a claims processing contractor is required to adjust on a monthly basis.

Should the Recovery Auditor demonstrate a backlog of claims for a claims processing contractor, and have projections showing the necessity for a higher sustained minimum monthly workload, the CMS will consider increasing future workload limits.

A. Improper payments INCLUDED in this Statement of Work

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

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

For claims from the following provider types:

- Inpatient hospital
- Outpatient hospital
- Physician/Non-physician practitioner
- Home Health Agency

- Laboratory
- Ambulance
- Skilled Nursing Facility
- Home Health Agency
- Supplier
- Inpatient Rehabilitation Facility
- Critical Access Hospitals
- Long Term Care Hospitals
- Ambulatory Surgical Center
- Other

CMS conducts at a minimum an annual review of recovery auditor activities. In the past the review has been conducted quarterly. If CMS has evidence to believe a recovery auditor is not reviewing all claim/provider types CMS will issue an official warning to the recovery auditor. This notification shall identify the specific claim/provider types failing to be audited, shall include the documentation citations that support the conclusions, and a CMS allotted time frame for Recovery Auditor correction. If the lack of reviews continue CMS will consider recalling specific claim/provider type(s) from one recovery auditor and giving the opportunity to review the claims/providers to another CMS contractor. If this occurs, it will be a permanent change.

B. Improper payments EXCLUDED from this Statement of Work

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

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

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

2. ***Cost report settlement process and Medical Education payments***

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

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

   The Recovery Auditor shall not attempt to identify any overpayment or underpayment more than 3 years past the date of the initial determination made on the claim. The initial determination date is defined as the claim paid date. Any overpayment or underpayment inadvertently identified by the Recovery Auditor after this timeframe shall be set aside. The Recovery Auditor shall take no further

action on these claims except to indicate the appropriate status code on the RAC Data Warehouse. The look back period is counted starting from the date of the initial determination and ending with the date the Recovery Auditor issues the medical record request letter (for complex reviews), the date of the overpayment notification letter (for semi-automated reviews) or the date of the demand letter (for automated reviews). Adjustments that occur after the 3 year timeframe can be demanded and collected, however the Recovery Auditor shall not receive a contingency fee payment.

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

4. Claim paid dates earlier than October 1, 2007

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

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

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

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

The Recovery Auditor shall not attempt to identify any overpayment where the provider is without fault with respect to the overpayment. If the provider is without fault with respect to the overpayment, liability switches to the beneficiary. The beneficiary would be responsible for the overpayment and would receive the demand letter. The Recovery Auditor may not attempt recoupment from a beneficiary. One example of this situation may be a service that was not covered because it was not reasonable and necessary but the

beneficiary signed an Advance Beneficiary Notice. Another example of this situation is benefit category denials such as the 3 day hospital stay prior to SNF admission.

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

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

6. Random selection of claims

The Recovery Auditor 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 Recovery Auditor shall not use random review in order to identify cases for which it will order medical records from the provider. Instead, the Recovery Auditor shall utilize data analysis techniques in order to identify those claims most likely to contain overpayments. This process is called "targeted review". The Recovery Auditor may not target a claim solely because it is a high dollar claim but may target a claim because it is high dollar AND contains other information that leads the Recovery Auditor to believe it is likely to contain an overpayment. A Recovery Auditor may receive provider referrals from other CMS contracting entities and may (upon approval from CMS) perform provider specific reviews. Referrals received for issues that have not yet been approved by the new issue approval process for the Recovery Auditor within that region must still comply with new issue approval process prior to audit initiation.

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

7. Claims Identified with a Special Processing Number

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

8. Prepayment Review

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

C. Preventing Overlap

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

In order to minimize the impact on the provider community, it is critical that the Recovery Auditor avoids situations where the Recovery Auditor and another entity (Medicare contractor, ZPIC/PSC, MAC or law enforcement) are working on the same claim.
Therefore, the RAC Data Warehouse will be used by the Recovery Auditor to determine if another entity already has the provider and/or claim under review. The RAC Data Warehouse will include a master table of excluded suppressed providers and excluded claims that will be updated on a regular basis. Before beginning a claim review the Recovery Auditor shall utilize the RAC Data Warehouse to determine if exclusion exists for that claim. Recovery Auditors are not permitted to review suppressed or excluded claims. The Recovery Auditor will be notified to cease all activity if a suppression is entered after the recovery auditor begins its review; exclusions entered after recovery auditor reviews begin shall be handled individually based on the timing of the other review.

Definition of Exclusions - An excluded claim is a claim that has already been reviewed by another entity. This includes claims that were originally denied and then paid on appeal. Only claims may be excluded. Providers may not be excluded. Exclusions are permanent. This means that an excluded claim will never be available for the Recovery Auditor to review.

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

- Fiscal Intermediaries, A/B MACs and DME MACs
- Quality Improvement Organizations (QIO)

  Program Safeguard Contractors/Zone Program Integrity Contractors
- Comprehensive Error Rate Testing (CERT) Contractor
- CMS Recovery Auditor COTR

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

CMS must ensure that Recovery Auditor activities do not interfere with potential fraud reviews/investigations being conducted by other Medicare contractors or law enforcement. Therefore, Recovery Auditors shall input all claims into the RAC Data Warehouse before attempting to identify or recover overpayments. (The master table described above will be utilized.)

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

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

- PSCs/ZPICs, OIG, DOJ or other law enforcement
- CMS Recovery Auditor COTR

The CMS Recovery Auditor COTR may also issue a Technical Direction Letter (TDL) that suppresses claims. Immediately upon receipt of such letter the Recovery Auditor shall stop all work that could possibly affect the claims identified in the TDL, and make system and process changes to implement the suppression before resuming work.

D. Obtaining and Storing Medical Records for reviews

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

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

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

When requesting medical records the Recovery Auditor shall use discretion to ensure the number of medical records in the request is not negatively impacting the provider's ability to provide care. Before contract award CMS will institute a medical record request limit. Different limits may apply for different provider types and for hospitals the limit may be based on size of the hospital (number of beds). The limit would be per provider location and type per time period. An example of a medical record limit would be no more than 50 inpatient medical record requests for a

hospital with 150-249 beds in a 45 day time period. CMS may enact a different limit for different claim types (outpatient hospital, physicians, supplier, etc). The medical record request limit may also take into account a hospital's annual Medicare payments.

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

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

The Recovery Auditor shall develop a mechanism to allow providers to customize their address and point of contact (e.g. Washington County Hospital, Medical Records Dept., attention: Mary Smith, 123 Antietam Street, Gaithersburg, MD 20879). By January 01, 2010 all Recovery Auditors shall develop a web-based application for this purpose. All web-based applications shall be approved by the CMS Project Officer. Recovery Auditors may visit the CERT Contractor's address customization website at http://www.certcdc.com/certproviderportal/verifyaddress.aspx for an example of a simple but successful system. Each medical record request must inform the provider about the existence of the address customization system.

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

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

   a. *Recovery Auditors <u>shall</u> pay for medical records.*

      Should the Recovery Auditor request medical records associated with:

      - an acute care inpatient prospective payment system (PPS) hospital (DRG) claim,
      - A Long Term Care hospital claim, the Recovery Auditor shall pay the provider for producing the records in accordance with the current formula or any applicable payment formula created by state law. (The current per page rate is: medical records photocopying costs at a rate of $.12 per page for reproduction of PPS provider records and $.15 per page for reproduction of non-PPS institutions and practitioner records, plus first class postage. Specifically, hospitals and other providers (such as critical access hospitals) under a Medicare cost reimbursement system, receive no photocopying reimbursement. Capitation providers such as HMOs and dialysis facilities receive $.12 per page. Recovery Auditors shall comply with the formula calculation

found at 42 CFR §476.78(c). Recovery Auditors shall also ensure compliance with any changes that are made to the formula calculation or rate in future publications of the Federal Register.)

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

Recovery Auditors shall develop the necessary processes to accept imaged medical records sent on CD or DVD beginning immediately. Recovery Auditors must remain capable of accepting faxed or paper medical records indefinitely.

Recovery Auditors shall pay the same per page rate for the production of imaged or electronic medical records. Recovery Auditors must ensure that providers/clearinghouses first successfully complete a connectivity and readability test with the Recovery Auditor system before being invited to submit imaged or electronic records to the Recovery Auditor. The Recovery Auditor must comply with all CMS business system security requirements.

At its discretion, CMS may institute a maximum payment amount per medical record. Prior to becoming effective, this change would be communicated to the provider community.

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

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

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

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

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

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

To assess provider reaction to the Recovery Auditors and the Recovery Audit

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

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

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

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

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

Storing and sharing IMAGED medical records

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

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

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

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

E. The Claim Review Process

1. *Types of Determinations a Recovery Auditor may make*

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

a. Coverage Determinations

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

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

i. Be included in one of the benefit categories described in Title XVIII of the Act;
ii. Not be excluded from coverage on grounds other than 1862(a)(1); and
iii. Be reasonable and necessary under Section 1862(a) (1) of the Act. The Recovery Auditor shall consider a service to be reasonable and necessary if the Recovery Auditor determines that the service is:
    A. Safe and effective;
    B. Not experimental or investigational (exception: routine costs of qualifying clinical trial services with dates of service on or after September 19, 2000 which meet the requirements of the Clinical Trials NCD are considered reasonable and necessary); and
    C. Appropriate, including the duration and frequency that is considered appropriate for the service, in terms of whether it is:
        - Furnished in accordance with accepted standards of medical practice for the diagnosis or treatment of the patient's condition or to improve the function of a malformed body member;
        - Furnished in a setting appropriate to the patient's medical needs and condition;
        - Ordered and furnished by qualified personnel;
        - One that meets, but does not exceed, the patient's medical need; and

- At least as beneficial as an existing and available medically appropriate alternative.

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

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

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

Limitation of Liability Determinations

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

b. Coding Determinations

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

c. Other Determinations

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

2. Minor Omissions

Consistent with Section 937 of the MMA, the Recovery Auditor shall not make denials on minor omissions such as missing dates or signatures if the medical documentation indicates that other coverage/medical necessity criteria are met. Any questions regarding whether a claim shall be denied for a minor omission shall be directed to the COTR.

3. Medicare Policies and Articles

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

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

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

4. Internal Guidelines

As part of its process of reviewing claims for coverage and coding purposes, the Recovery Auditor shall develop detailed written review guidelines. For the purposes of this SOW, these guidelines will be called "Review Guidelines."

Review Guidelines, in essence, will allow the Recovery Auditor to operationalize CMS policies to ensure consistent and accurate review determinations. Review Guidelines shall are a step-by-step approach to ensuring coverage requirements are met and to assist the reviewers in making logical decisions based on the information in the supporting documentation. The Recovery Auditor need not hold public meetings or seek public comments on their proposed review guidelines. However, they must make their Review Guidelines available to CMS upon request. Review Guidelines shall not create or change policy. In the absence of CMS policy Review Guidelines shall be developed using evidence-based medical literature to assist reviewers in making a determination.

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

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

6. Evidence

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

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

7. Automated Review vs. Complex Review

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

i. Coverage/Coding Determinations Made Through Automated Review

The Recovery Auditor may use automated review when making coverage and coding determinations only where BOTH of the following conditions apply:

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

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

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

ii. Other Determinations Made Through Automated Review

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

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

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

<table>
<tr><th colspan="2" rowspan="2">Complex Review
(with medical record)</th><th colspan="5">Automated
(without medical record)</th></tr>
<tr><th colspan="4">Coverage/Coding Determinations</th><th rowspan="2">Other Determinations
(duplicates, pricing mistakes, etc)</th></tr>
<tr><td rowspan="2">Written Medicare policy/article or Medicare-sanctioned coding</td><td rowspan="2">No written Medicare policy/article or Medicare-sanctioned coding</td><td colspan="2">Written Medicare policy/article or Medicare-sanctioned coding guidelines exists</td><td colspan="2">No written Medicare policy/article or Medicare-sanctioned coding guidelines exists</td><td rowspan="2">Certainty exists</td><td rowspan="2">NO Certainty exists</td></tr>
<tr><td>Certainty</td><td>NO</td><td>Certainty</td><td>NO</td></tr>
</table>

guidelines exists	guidelines exists	exists	Certainty exists	exists	Certainty exists		
Allowed	**Allowed** (often called "Individual Claim Determinations")	**Allowed**	**Not allowed**	**Allowed with prior CMS approval** (often called "clinically unbelievable" situations)	**Not allowed**	**Allowed**	**Not allowed**

8. Semi-Automated Review

Semi-Automated Review is a two-part review. The first part is the identification of a billing aberrancy through an automated review using claims data. This aberrancy has high indexes of suspicion to be an improper payment. The second part includes a Notification Letter that is sent to the provider explaining the potential billing error that is identified. The letter also indicates that the provider has 45 days to submit documentation to support the original billing. If the provider decides not to submit documentation, or if the documentation provided does not support the way the claim was billed, the claim will be sent to the Medicare claims processing contractor for adjustment and a demand letter will be issued. However, if the submitted documentation does support the billing of the claim, the claim will not be sent for adjustment and the provider will be notified that the review has been closed. This type of review is to be used in which a clear CMS policy does not exist but in most instances the items and services as billed would be clinically unlikely or not consistent with evidence-based medical literature.

The Recovery Auditor is not required to reimburse providers for the additional documentation submitted for semi-automated reviews.

9. Individual Claim Determinations

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

10. Staff Performing Complex Coverage/Coding Reviews

Whenever performing complex coverage or coding reviews (i.e., reviews involving the medical record), the Recovery Auditor shall ensure that coverage/medical necessity determinations are made by RNs or therapists and that coding determinations are made by certified coders. The Recovery Auditor shall ensure that no nurse, therapist or coder reviews claims from a provider who was their employer within the previous 12 months. Recovery Auditors shall maintain and provide documentation upon the provider's request the credentials of the individuals making the medical review determinations. This only includes a reviewer's credentials. Names and personal information are not required to be shared. If the provider requests to speak to the CMD regarding a claim(s) denial the Recovery Auditor shall ensure the CMD participates in the discussion.

11. Timeframes for Completing Complex Coverage/Coding Reviews

Recovery Auditors shall complete their complex reviews within 60 days from receipt of the medical record documentation. Recovery Auditors may request a waiver from CMS if an extended timeframe is needed due to extenuating circumstances. If an extended timeframe for review is granted Recovery Auditors shall notify the provider in writing or via a web-based application of the situation that has resulted in the delay and will indicate that the Notification of Findings will be sent once CMS approves the Recovery Auditor moving forward with the review. Unless granted an extension by CMS, Recovery Auditors shall not receive a contingency fee in cases where more than 60 days have elapsed between receipt of the medical record documentation and issuance of the review results letter.

12. DRG Validation vs. Clinical Validation

DRG Validation is the process of reviewing physician documentation and determining whether the correct codes, and sequencing were applied to the billing of the claim. This type of review shall be performed by a certified coder. For DRG Validations, certified coders shall ensure they are not looking beyond what is documented by the physician, and are not making determinations that are not consistent with the guidance in Coding Clinic.

Clinical validation is a separate process, which involves a clinical review of the case to see whether or not the patient truly possesses the conditions that were documented. Clinical validation is beyond the scope of DRG (coding) validation, and the skills of a certified coder. This type of review can only be performed by a clinician or may be performed by a clinician with approved coding credentials.

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

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

14. Allowance of a Discussion Period

All providers receiving a demand letter and/or review results letter from the recovery auditor are availed an opportunity to discuss the improper payment with the recovery auditor. The recovery auditor can have an escalation process in plan for the discussion period, however if the physician (or a physician employed by the provider) requests to speak to a physician, that request must be acted upon. The request for a discussion period shall be utilized to determine if the provider has other information relevant to the payment of the claim. All discussion requests should be in writing and shall be responded to by the recovery auditor within 30 days of receipt, unless the recovery auditor is notified by the affiliated contractor of a provider initiated appeal. If during the discussion period the recovery auditor is notified by the contractor that the provider initiated the appeals process, the recovery auditor shall immediately discontinue the discussion period and send a letter to the provider that the recovery auditor cannot continue the discussion period once an appeal has been filed.

If the recovery auditor modifies the original improper payment identification, written notification shall be sent to the provider so that the provider can share it with the appropriate appeal entity if necessary. If the claim has already been forwarded to the MAC for adjustment, the recovery auditor shall immediately notify the MAC that the claim no longer requires adjustment or needs to be re-adjusted.

F. Activities Following Review

1. Rationale for Determination.

The Recovery Auditor shall clearly document the rationale for the determination. This rationale shall list the review findings including a detailed description of the Medicare policy or rule that was violated and a statement as to whether the violation resulted in an improper payment. Recovery auditors shall ensure they are identifying pertinent facts contained in the medical record to support the review determination. Each rationale shall be specific to the individual claim under review.

The Recovery Auditor shall make available upon request by any other ACs, CMS,

OIG, (and others as indicated by the PO) any requested rationale.

Storing and making available IMAGED rationale documents

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

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

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

2. Validation Process

a. Validating the Issue

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

b. Validating the New Issues at CMS or the RAC Validation Contractor

Once the Recovery Auditor has chosen to pursue a new issue that requires semi-automated, complex or automated review, the Recovery Auditor shall notify the PO of the issue in a format to be prescribed by the COTR. The PO will notify the Recovery Auditor which issues have been selected for claim validation (either by CMS or by an independent RAC Validation Contractor). The Recovery Auditor shall forward any requested information in a format to be prescribed by the PO. The PO will notify the Recovery Auditor if/when they may begin issuing medical record request letters (beyond the 10 test claims) and demand letters on the new issue. The Recovery Auditor shall not issue any demand letters on issues that

have not approved by CMS. The Recovery Auditor may request up to 10 medical records when developing a test case for CMS to validate. The Recovery Auditor shall not issue medical record requests beyond the 10 test claims without prior PO approval. CMS or the RAC Validation Contractor may also evaluate the clarity, accuracy, and completeness of the Recovery Auditor letter to providers.

Upon approval to review the issue the recovery auditor shall post the issue name, description, posting date, state applicable provider type and any relevant HCPCS code or DRG code to the Recovery Auditor website. A separate page on the website shall be dedicated to new issues. By June 01, 2011, the new issue listing shall be sortable by at a minimum provider type. Additional sort methodologies could include post date, state and claim type.

Upon approval of the new issue by CMS, CMS reserves the right to share new issues with all CMS review entities which may include, but is not limited to, other recovery auditors in Medicare and Medicaid, MACs, CERT contractor, and ZPICs.

3. Communication with Providers about Improper Payment Cases

The Recovery Auditor shall strive to send the provider only one review results per claim. For example, a Recovery Auditor shall try NOT to send the provider a letter on January 10 containing the results of a medical necessity review and send a separate letter on January 20 containing the results of the correct coding review for the same claim. Whenever possible, the Recovery Auditor shall wait until January 20 to inform the provider of the results of both reviews in the same letter. However, if both issues are not yet approved by CMS for widespread review, the Recovery Auditor may issue one review results letter and reserve the right to conduct another review in the future. Prior to completing an additional, different review the Recovery Auditor shall notify the provider. The Recovery Auditor shall not request the additional documentation again but shall afford the provider the opportunity to submit additional documentation for the new review. The time period for submission shall be the same as an original additional documentation request.

It is acceptable to send one notification letter that contains a list of all the claims denied for the same reason (i.e. all claims denied because the wrong number of units were billed for a particular drug). In situations in which the Recovery Auditor identifies two different reasons for a denial, a letter should be sent for each reason identified. For example, if the Recovery Auditor identified a problem with the coding of respiratory failure and denied several claim(s) because the wrong procedure code and wrong diagnosis codes were billed, the Recovery Auditor should send two separate letters. The first letter should list all claims in which an improper payment was identified that contained the wrong procedure

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

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

a. Automated review

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

b. Complex review

The Recovery Auditor shall communicate to the provider the results of every semi-automated and complex review, including cases where no improper payment was identified. In cases where an improper payment was identified, the Recovery Auditor shall inform the provider of which coverage/coding/payment policy or article was violated. The Recovery Auditor shall record the date and format of this communication in the Recovery Auditor Data Warehouse.

c. Contents of Notification of Recovery Auditor Complex Review Findings Letter

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

- Identification of the provider(s) or supplier(s)--name, address, and provider number;
- The reason for conducting the review (See Section SOW 2F-3);

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

4. Determine the Overpayment Amount

a. Full denials

A full denial occurs when the Recovery Auditor determines that:

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

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

b. Partial denials

A partial denial occurs when the Recovery Auditor determines that:

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

Note: Other situations that are not categorized above should be brought to the CMS PO's attention before the Recovery Auditor sends notification to the provider.

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

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

c. Extrapolation

Recovery auditors are encouraged to use extrapolation for some claim types when all requirements are met. Extrapolation may be cost effective for low dollar claims that require complex review that have a history of having a high error rate. Recovery auditors shall follow the procedures found in PIM 3.10 and Exhibits 9-12, as well as MMA Section 935(a), regarding the use of extrapolation. The use of extrapolation shall be approved for each issue prior to beginning.

G. Potential Fraud

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

H. Potential Quality Problems

The Recovery Auditor shall report potential quality issues immediately to the appropriate CMS COTR.

I. Recovery Auditor Medical Director

Each Recovery Auditor must employ a minimum of one FTE contractor medical director (CMD) and arrange for an alternate when the CMD is unavailable for extended periods. The CMD FTE must be composed of either a Doctor of Medicine or a Doctor of Osteopathy who has relevant work and educational experience. More than one individual's time cannot be combined to meet the one FTE minimum.

Relevant Work Experience

- Prior work experience in the health insurance industry, utilization review firm or health care claims processing organization,

- Extensive knowledge of the Medicare program particularly the coverage and payment rules, and

- Public relations experience such as working with physician groups, beneficiary organizations or Congressional offices.

Relevant Educational Experience

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

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

Primary duties include:

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

Other duties include:

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

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

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

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

K. Communication with Other Medicare Contractors

1. Joint Operating Agreement

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

   The MAC serves as the conduit to allow the recovery auditor to adjust claims and recoup overpayments. The relationship between the MAC and the recovery auditor is crucial to the success of the program. CMS has the following expectations with the MAC/recovery auditor relationship:

   -The MAC is a contractor of CMS and does not take direction from the recovery auditor.
   -Any communication issues with the MAC shall be brought to the attention of the recovery auditor COTR at CMS so additional discussions with the appropriate parties can be held.

-The MAC is responsible for adjusting the claims, applying recoupments, uploading the RAC Data Warehouse when required and routine customer service and requests from CMS.
The Recovery Auditor is responsible for identifying improper payments, issuing demand letters timely and uploading the dates/amounts of those letters to the RAC Data Warehouse, completing in depth customer service, performing all research required to determine the status of a claim, answering CMS and answering all correspondence unless otherwise instructed by CMS.

2. Referrals from CMS

CMS often gets referrals of potential improper payments from claim processing contractors, program integrity contractors, external entities and OIG. At CMS discretion, CMS may choose to forward the referral (provider, claims, issue…) to the Recovery Auditor for the Recovery Auditor's consideration. When a direct referral comes to the Recovery Auditor from CMS, CMS reserves the right to enact the Payment Methodology Scale B.

The largest source of referrals for which Payment Methodology Scale B will be enacted will be improper payments identified and recouped by the Recovery Auditor from an OIG report that was referred to the Recovery Auditor by CMS after June 30, 2010. Referrals will be given to the Recovery Auditors via a Technical Direction Letter (TDL). The TDL will include all information deemed necessary by CMS but may include a pre-approval of the issue, language for the Recovery Auditor's new issue section of the website and edit parameters and/or review methodologies. This is not an all inclusive listing of possible inclusions in the TDL. If necessary, CMS may require the Recovery Auditors CMD and staff presence on a conference call with the OIG for explanation purposes. Recovery Auditors shall ensure they report the issue as an OIG referral on the New Issue form and shall follow the rest of the requirements in the Recovery Auditor SOW regarding demand, collection, and reporting.

Outside of OIG reports the enactment of Payment Methodology Scale B will occur individually and will be communicated to the Recovery Auditors in writing, by email and/or Technical Direction.

Each referral sent to the Recovery Auditors by CMS will require a decision by the Recovery Auditor within 30 calendar days. The decision point will be if the Recovery Auditor intends to pursue the issue in its jurisdiction and when. Upon acceptance of the issue the Recovery Auditor will have to track the progress and report back to CMS periodically. Once the web-based referral tracking system is in place the tracking will take place in it. Until then, the tracking shall occur in the Recovery Auditor's monthly report to the PO. Specific tracking guidance will be shared with the Recovery Auditors at the time of the first referral.

If the Recovery Auditor chooses to not review the issue in their jurisdiction, CMS reserves the right to give the issue to another contractor. This could be another Recovery

Auditor not associated with your jurisdiction that is responsible only for referrals from CMS.

NOTE: CMS is developing a web-based referral tracking system. This system will be available to all Medicare contractors, to CMS and to the Recovery Auditors to make and track referrals. The Recovery Auditors will be required to review the referral tracking system and to determine if the referral will be reviewed or not. The Recovery Auditor is not required to act upon any referral. However, the Recovery Auditor is required to update CMS with the decision and status. The expected timeframe for review and decision is 30-45 days from the referral being entered into the system.

3. Referrals from the CERT program

Annually CMS releases the CERT program error rate. CMS will share claim type specific information with the recovery auditors for their review If CMS has evidence to believe a recovery auditor is not reviewing all claim/provider types with a high error rate as determined by CMS, CMS will issue an official warning to the recovery auditor. This notification shall identify the specific claim/provider types failing to be audited, shall include the documentation citations that support the conclusions, and a CMS allotted time frame for Recovery Auditor correction. If the lack of reviews continue CMS will consider recalling specific claim/provider type(s) from one recovery auditor and giving the opportunity to review the claims/providers to another CMS contractor. If this occurs, it will be a permanent change.

Task 3- Underpayments

The Recovery Auditor will review claims, using automated or complex reviews, to identify potential Medicare underpayments. Upon identification the Recovery Auditor will communicate the underpayment finding to the appropriate affiliated contractor. The mode of communication and the frequency shall be agreed upon by both the Recovery Auditor and the affiliated contractor. If necessary, the Recovery Auditor shall share any documentation supporting the underpayment determination with the affiliated contractor.

Neither the Recovery Auditor nor the AC may ask the provider to correct and resubmit the claim, although the Recovery Auditor shall issue an Underpayment Notification Letter including the claim(s) and beneficiary detail.

A sample letter shall be approved by the CMS COTR before issuing the first letter.

For purposes of the Recovery Auditor program, a Medicare underpayment is defined as those lines or payment group (e.g. APC, RUG) on a claim that was billed at a low level of payment but should have been billed at a higher level of payment. The Recovery Auditor will review each claim line or payment group and consider all possible occurrences of an underpayment in that one line or payment group. If changes to the diagnosis, procedure or order in that line or payment group would create an underpayment, the Recovery Auditor will identify an underpayment. Service lines or payment groups that a provider

failed to include on a claim are **NOT** considered underpayments for the purposes of the program.

Examples of an Underpayment:

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

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

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

Provider Inquiries (Not requested by Recovery Auditor)

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

Medical Record Requests

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

Appeal of the Underpayment Determination

The normal appeal process is available to providers for all underpayment determinations.

Task 4- Recoupment of Overpayments

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

Adjustment Process

The Recovery Auditor shall not attempt recoupment or forward any claim to the FI/Carrier/MAC/DME MAC or the applicable CMS Data Center for adjustment if the anticipated amount of the overpayment is less than $10.00 unless the recovery auditor is choosing to review the claims using extrapolation. Claims less than $10.00 cannot be aggregated to allow for demand unless extrapolation is used and if inadvertently demanded the Recovery Auditor shall not receive a contingency fee on any amounts recouped.

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

The Recovery Auditor shall not forward claims to the FI/Carrier/MAC/DME 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 xxxxx requires a modifier for payment. Payment with the modifier is $25.50 per service. Without the modifier payment is $25.50 per service. While the claim without the modifier is incorrect, there is no overpayment or underpayment and the claim shall not be forwarded for adjustment.

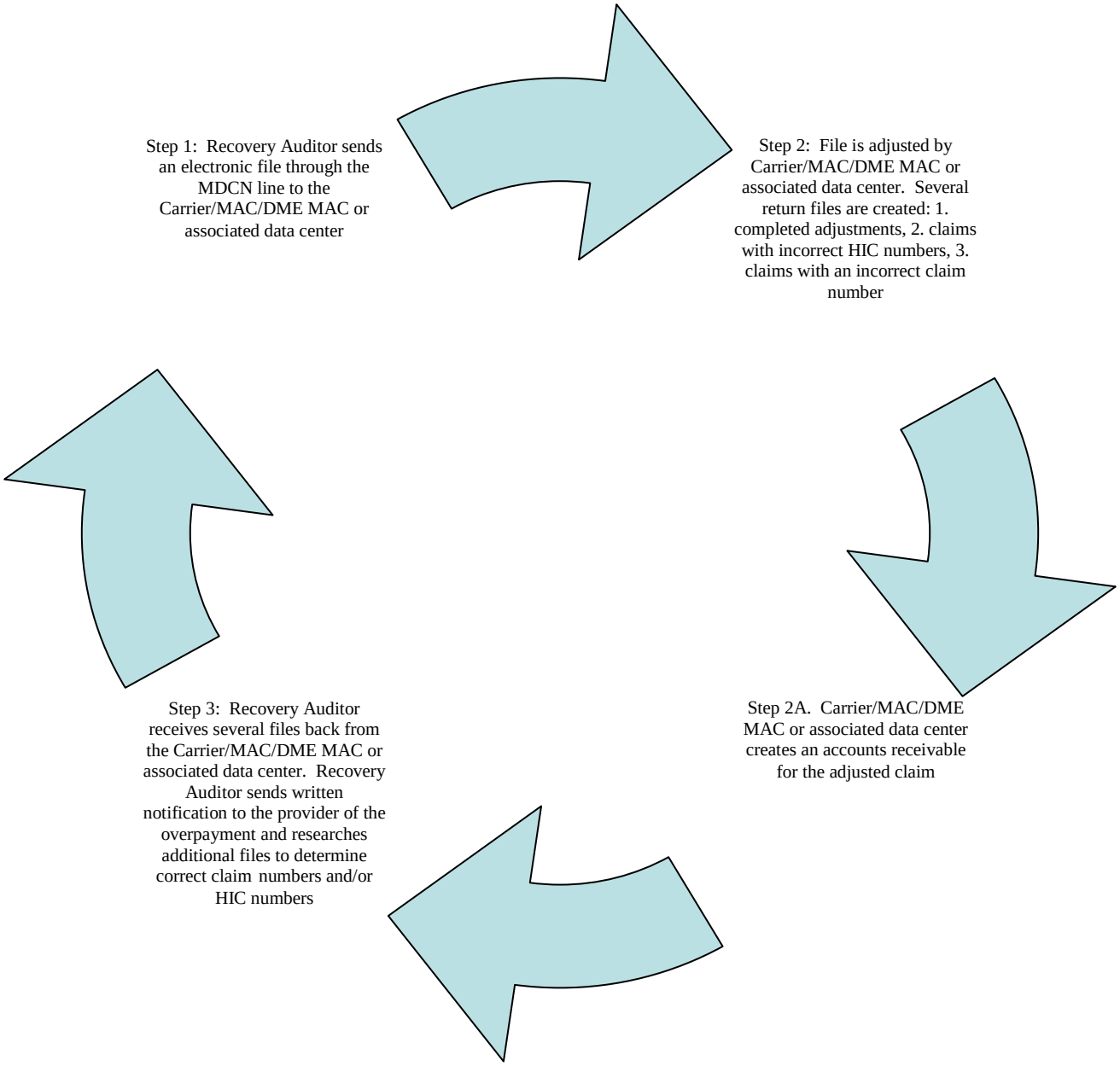
Sometimes when the system adjusts the claim for the Recovery Auditor identified overpayment other lines are adjusted because of system edits. CMS calls these additional lines associated findings. While the Recovery Auditor did not identify these lines for adjustment, they were initiated because of the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

The Recovery Auditor receives credit for the entire claim adjustment and the Recovery Auditor shall include these additional lines and denial reason codes on the written notification to the provider.
Also, a Recovery Auditor identified adjustment may trigger the denial of the entire claim because of a known Medicare Secondary Payer occurrence or a known instance of the

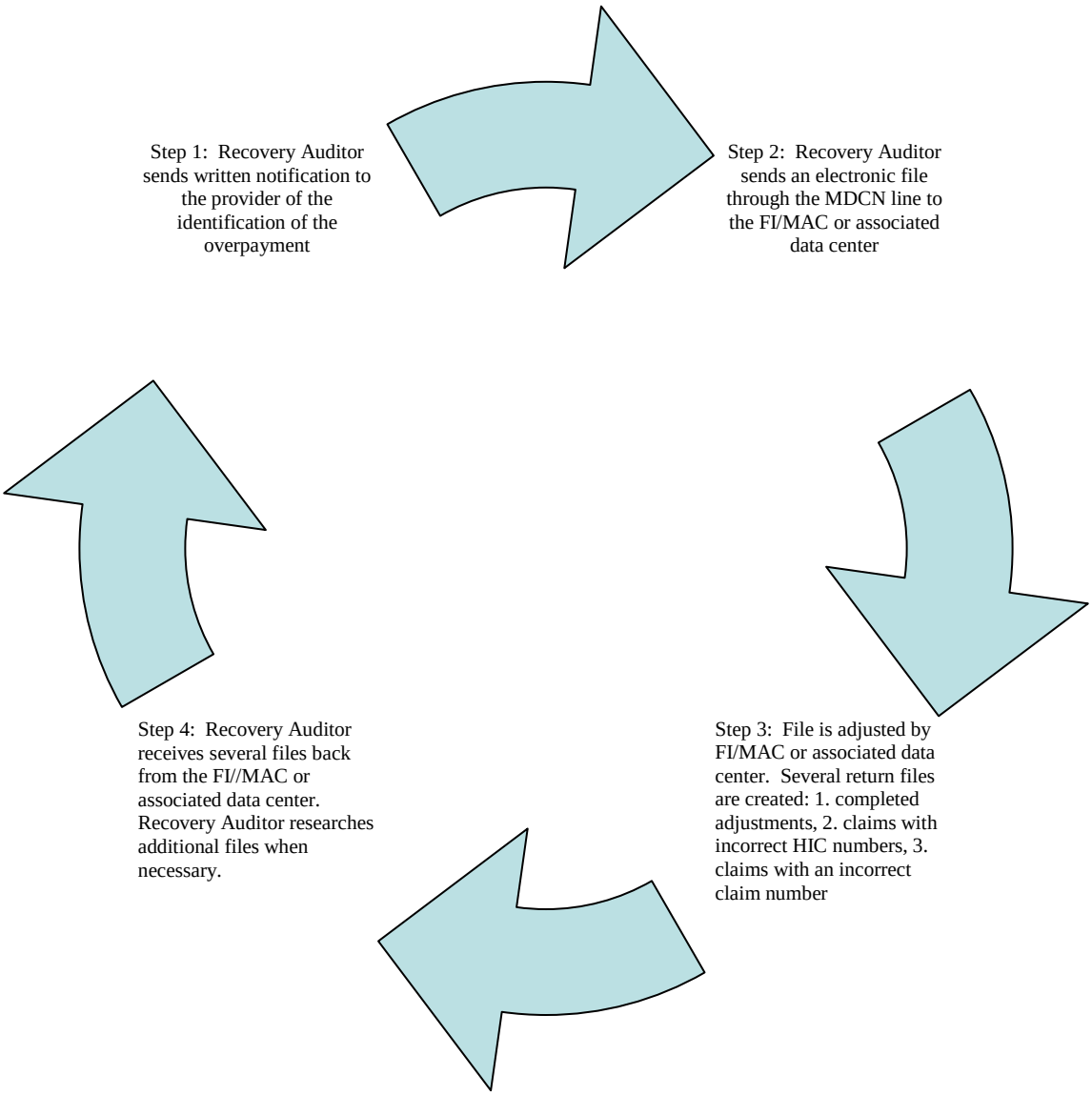
beneficiary's enrollment in a managed care plan. If an entire claim is denied because of managed care eligibility or a known MSP occurrence the Recovery Auditor will not receive credit for the denial and will not receive credit for the adjustment identified by the Recovery Auditor.

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

Part B Adjustment Process



Part A Adjustment Process



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

A. Written Notification of Overpayment

After the claim is adjusted and an accounts receivable is created, the Recovery Auditor shall issue a demand letter to the provider. Since the accounts receivable and demand letter begins interest accrual, includes appeal rights and begins recoupment timeframes it is imperative that the demand letter be dated the same day as the accounts receivable date. The Recovery Auditor is responsible for issuing the demand letter on the same date as the accounts receivable is received from the MAC and is responsible for ensuring the MAC is notifying the Recovery Auditor timely of the accounts receivable creation. Failure to issue demand letters timely will result in the suspension of all recovery audit activity in a jurisdiction/region. The recovery auditor is responsible for ensuring they are receiving timely and accurate information from the MAC. The demand letter shall include all necessary requirements specified in the Medicare Financial Management Manual, Chapter 4, and section 90 (unless specifically excluded in this statement of work). The CMS COTR shall approve a sample of all demand letters prior to use.

B. Recoupment through Current and/or Future Medicare Payments

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

Once payments are withheld, the withhold remains in place until the debt is satisfied in full or alternative payment arrangements are made. As payments are withheld they are applied against the oldest outstanding overpayment. The debt receiving the payments may or may not have been determined by the Recovery Auditor. All payments are first

applied to interest and then to principal. Interest accrues from the date of the demand letter and in accordance with 42 CFR 405.378.

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

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

C. Repayment Through Installment Agreements

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

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

D. Referral to the Department of Treasury

The Debt Collection Improvement Act of 1996 (DCIA) requires federal agencies to refer eligible delinquent debt to a Treasury designated Debt Collection Center for cross servicing and further collection activities, including the Treasury Offset Program. CMS is mandated to refer all eligible debt, over 180 days **delinquent**, for cross servicing.

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

Debts ineligible for referral include:

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

The Recovery Auditor shall refer all debt to the claim processing contractor within a time frame that allows for the claim processing contractor to issue the "intent to refer" letter before the debt is 130 days **delinquent**. The Recovery Auditor is required to cease all recovery efforts once the debt is referred to the Department of Treasury. Once the overpayment referred is it is no longer the responsibility of the Recovery Auditor.

E. Compromise and/or Settlement of Overpayment

The Recovery Auditor shall not have any authority to compromise and/or settle an identified or possible overpayment. If a debtor presents the Recovery Auditor with a compromise request, the Recovery Auditor shall forward the overpayment case and all applicable supporting documentation to the CMS PO for direction. The Recovery Auditor must include its recommendation on the request and justification for such recommendation. If the debt is greater than $100,000, the package must include a completed Claims Collection Litigation Report (CCLR). If the provider presents the Recovery Auditor with a settlement offer or a consent settlement request, the Recovery Auditor shall forward the overpayment case and all applicable supporting documentation to the CMS PO for direction. If CMS determines that a compromise and/or settlement is in the best interests of Medicare, the Recovery Auditor shall receive a contingency payment for the portion of principal that was recouped, providing that the Recovery

Auditor initiated recoupment by sending a demand letter prior to the compromise and/or settlement offer being received.

F. Voluntary/Self-Reported Overpayments by the Provider

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

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

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

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

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

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

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

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

<u>Unsolicited/Voluntary Refunds (by check or claims adjustment, including those due to credit balances</u>)
Occasionally the AC may receive an unsolicited/voluntary refund from a provider. An unsolicited/voluntary refund is a refund that is submitted to the AC without a demand letter. It is a situation where the provider realizes that a refund is due the Medicare program and refunds the money to the AC. By definition, an unsolicited/voluntary refund (by check or by claims adjustment) must occur before a demand letter is issued.

The Recovery Auditor shall not receive any contingency payment on an unsolicited/voluntary refund.

G. Recoupment During the Appeals Process

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

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

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

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

H. Interest

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

I. Customer Service

The Recovery Auditor shall provide a toll free customer service telephone number in all correspondence sent to Medicare providers or other prospective debtors. The customer service number shall be staffed by qualified personnel during normal business hours from 8:00 a.m. to 4:30 p.m. in the applicable time zone. For example, if the Recovery Auditor is conducting the work in California the customer service number shall be staffed from 8:00am to 4:30pm Pacific standard 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 Project Officer before use.

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

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

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

The Recovery Auditor shall respond to all discussion requests within 30 days of receipt. The incoming discussion request and the written reply as well as any supporting documentation shall be included in the case file.

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

The Recovery Auditor shall retain a written report of contact for all telephone inquiries and supply it to the CMS PO within 48 hours of it being when requested. At a minimum, the written report shall include the provider name, phone number, date and reason for the call to the Recovery Auditor, the response to the inquiry, and the outcome of the call.

The Recovery Auditor shall respond to all email inquiries within 2 business days of receipt. (Friday after 5:00 pm- Monday 6:00 am and all federal holidays are excluded) This includes requests from CMS as well as inquiries from providers and other external entities.

The provider outreach plan should include a component on customer service and should

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

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

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

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

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

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

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

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

The Recovery Auditor will be required on a monthly basis to provide the CMS PO or its

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

Data Warehouse Reporting of Possible/Identified Improper Payments

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

1) RAC chooses claim for potential review (automated or complex) and uploads required elements to the RAC Data Warehouse. If the claim is suppressed or excluded (initially or at any point in the review) the RAC stops work immediately.

2a) COMPLEX REVIEW: RAC updates the Data Warehouse with the medical record request date, date of provider's extension request and revised due date (if applicable), date of receipt, date of RAC's request for review period extension and revised date granted by CMS (if applicable), results letter sent date and date claim sent to the MAC/EDC for adjustment (if applicable).

2b) AUTOMATED REVIEW: RAC updates the Data Warehouse with date claim sent to the MAC/EDC for adjustment.

2c) SEMI-AUTOMATED REVIEW: RAC updates the Data Warehouse with the advisory letter date and (as applicable) the date of provider's extension request and revised due date, date of records receipt, date of RAC's request for review period extension and revised date granted by CMS, results letter date and date claim sent to the MAC/EDC for adjustment.

3) Recovery Auditor receives the improper payment amount and receivable/payable information from the FI/carrier/MAC/DME MAC/EDC. The Recovery Auditor receives such information for the purpose of conducting their audit operations, and shall not be held responsible for updating the RAC Data Warehouse with payment information but shall be responsible for uploading the date the finalized adjustment was received from the claims processing contractor.

4) Recovery Auditor updates the Data Warehouse with the date of its demand letter or no demand letter, as well as the demanded amount (negative values for underpayments).

RAC Data Warehouse Reporting and Recovery Auditor Invoices

The RAC Data Warehouse is an integral participant in the success of the Recovery Auditor project. However, the Recovery Auditor Data Warehouse can only be successful if the data input into it by the Recovery Auditor is reliable, timely and valid. The RAC Data Warehouse shall produce pre-filled invoices based on claims information from the Recovery Auditor linked to collection/payment and reversal transactions from the Medicare contractors. Contingency rates will be automatically applied based on transaction type codes reported by the claim processing contractors.

Recovery Auditors may not add to the automatically generated invoices, although they may remove records with appropriate notice to their COTR.

CMS may consider supplemental invoices with transactions that are not in the RAC Data Warehouse or that failed automated matching, but such consideration is solely at the discretion of CMS. Acceptance of one or more supplemental invoices does not bind the Agency to accepting future supplemental invoices.

Inaccurate Information Input into the RAC Data Warehouse

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

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

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

Task 6b Other Systems Created by Recovery Auditor

The Recovery Auditor is free to utilize a subsequent system in addition to RAC Data

Warehouse provided by CMS. Any subsequent system shall not take the place of the RAC Data Warehouse.

All reports generated from an alternative system shall be converted to appropriate Microsoft Excel version requested by the CMS COTR.

Task 7 – Administrative and Miscellaneous Issues

A. Administrative Functions

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

B. Separate reporting

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

C. Payment Methodology

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

Contingency fees:

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

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

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

- The Recovery Auditor shall receive 75% of the agreed upon contingency percentage for recovery efforts accomplished through the offset process of a Part A claim (processed by the FISS) by a FI/MAC

- The Recovery Auditor shall receive 50% of the agreed upon contingency percentage for any of the following recovery efforts:

- ❖ Recovery efforts accomplished through the offset process by a carrier/DME MAC or a Part B claim by a MAC.

- ❖ Recovery efforts accomplished through Treasury offset or another collection vehicle after the debt is referred to the Department of Treasury.

- ❖ Recoveries made through a self-disclosure made by a provider in result of a prior Recovery Auditor identified request for medical records or demand letter. Self- disclosed service and time period must be included in the Recovery Auditor's project plan.

- If a provider files an appeal disputing the overpayment determination and the appeal is adjudicated in the provider's favor at **ANY** level, the Recovery Auditor shall repay Medicare the contingency payment for that recovery. Repayment to Medicare will occur on the next applicable invoice.

D. Point of Contact for Recovery Auditor

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

E. Data Accessibility

CMS shall provide the Recovery Auditor with all applicable data files for all claims paid during the specific timeframes of the contract for the appropriate geographic area. The Recovery Auditor will receive new data updates as they become available. (monthly or quarterly) The data file format, data fields available and user agreements are available upon request. To access data the Recovery Auditor shall acquire a Medicare Data Communications Network (MDCN) line. This is a secure line between the Recovery Auditor and the CMS Data Center. The cost of the MDCN line shall be incurred by the Recovery Auditor. Anticipated costs range from $1500-$2000 per month. This does not include setup costs. These costs may increase at any time. CMS will provide the applicable points of contact to set up the MDCN line. In addition, the Recovery Auditor must acquire the appropriate software to enter into the CMS Data Center. IBM/Sterling Commerce Connect:Direct software is currently being utilized by CMS for this purpose. There is no other alternative software. At this time the price of the IBM/Sterling Commerce Connect:Direct software is approximately $185,000.00. The Recovery Auditors are responsible for all costs of the MDCN line and the software.

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

The Recovery Auditor shall pay for any charges associated with the transfer of data. This includes, but is not limited to, cartridges, data communications equipment, lines, messenger service, mail, etc. The Recovery Auditor shall pay for all charges associated

with the storage and processing of any data necessary to accomplish the demonstration. The Recovery Auditor shall establish and maintain back-up and recovery procedures to meet industry standards. The Recovery Auditor shall comply with all CMS privacy and security requirements. The Recovery Auditor shall provide all personal computers, printers and equipment to accomplish the work described herein throughout the contract term.

F. Recalled Cases

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. Should CMS initiate a recall , the Recovery Auditor shall immediately stop all activities included in the recall.

Recalls could occur because of additional activity that is occurring by another contractor/entity or lack of adherence by the Recovery Auditor of any provision of the Statement of Work. Recalls are indefinite and may require a corrective action plan to resume activity. Recalls can be claim or provider specific, claim or provider type specific, jurisdiction specific, or regional specific. Unless instructed by CMS through technical direction, demands previously issued will still continue to be recouped and the Recovery Auditor will receive a contingency fee, if appropriate.

G. Case Record Maintenance

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

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

H. Recovery Deposits

The demand letters issued by the Recovery Auditor will instruct debtors to forward their refund checks to the appropriate address at the applicable Medicare contractor (FI/Carrier/DME MAC/MAC). All refund checks shall be payable to the Medicare

program. If the Recovery Auditor receives a refund check, the Recovery Auditor shall forward the check to the appropriate address. Before forwarding the check, the Recovery Auditor shall make copies of and otherwise document these payments. A copy shall be included in the appropriate overpayment case file.

I. Support OIG or Other Audits

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

J. Support Evaluation Contractor

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

K. Public Relations & Outreach

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

The Recovery Auditor is required by January 01, 2010 to develop and maintain a Medicare Recovery Auditor webpage to communicate to the provider community helpful information (e.g., who to call for an extension, how to customize the address for a medical record request letter). The Medicare information shall appear on pages that are separate and distinct from any other non-Medicare work the Recovery Auditor may have. The Recovery Auditor shall obtain prior PO approval for all Medicare webpage content.

L. Quality Assurance

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

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

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

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

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

Every six (6) months (at a minimum) recovery auditors shall review their approved issues to ensure compliance with the most recent CMS policy changes. Any changes to a new issue and the policy used to make the review determinations shall be submitted to the COTR for approval before beginning reviews. The COTR and associated staff shall then review such changes to issues and/or policy and issue guidance to the recovery auditors within a 30 day approval period.

Task 8 Final Report

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

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

1) Paper, bound, in the number of copies specified;
2) Paper, unbound, suitable for use as camera-ready copy;
3) Electronic, as one file in Portable Document Format (PDF), as one file in Hypertext

200-word abstract/summary of the final report suitable for submission to the National Technical Information Service. Drafts of all documentation shall be provided to CMS approximately four weeks prior to final deliverable due dates unless otherwise agreed to. CMS staff will review materials and provide comments back to the contractor within 2 weeks, thereby allowing 2 additional weeks for the contractor to make any necessary revisions. All data files and programs created under this project shall be the sole property of CMS and provided to CMS upon request in the appropriate format. They shall not be used for any other purpose other than fulfilling the terms of this contract without the express permission of the contracting officer.

SCHEDULE OF DELIVERABLES

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

Written documents for this project shall be delivered in hard copy to the project officer (2 copies), unless otherwise specified. These documents shall also be delivered to the Project Officer in an electronic version via email. At present, the CMS standard is Microsoft Word 2007 and Microsoft Excel 2007. This is subject to change, and the contractor shall be prepared to submit deliverables in any new CMS standard.

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

Appendix 1- Intentionally Left Blank

Appendix 2: Map of Recovery Audit Contract Regions