HMS Federal Solutions
Region 4 - Recovery Audit Contractor

RAC Claim Reviews & Recovery Audit Process

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Agenda

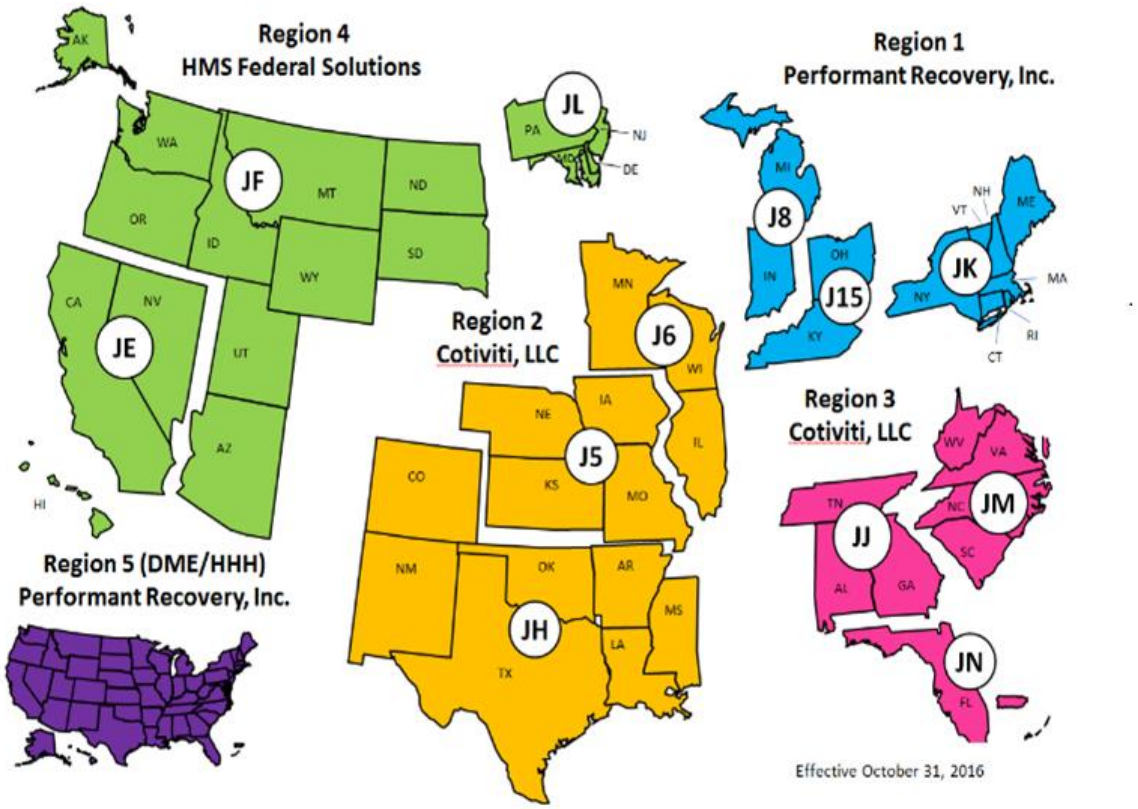
- COVID-19 Program Updates
- Review Types
- Additional Documentation Requests
- Approved New Issues
- Discussion Process
- Provider Portal Overview
- HMS Contact Information
- Open Q&A

RAC Mission Statement

- The RAC Program's mission is to reduce Medicare improper payments through the efficient detection and correction of improper payments.

- CMS' Recovery Auditor Page:
  - CMS Website: https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Recovery-Audit-Program/Index

Medicare Fee for Service RAC Regions – HMS Federal Region 4 RAC



COVID-19 Program Updates

- Effective August 3, 2020, The Centers for Medicare & Medicaid Services (CMS) resumed Medicare Fee-for-Service medical review activities.
- Limiting reviews to Dates of Service preceding March 1, 2020
- Limiting DRG Coding Validation review to exclude COVID-19 diagnosis code B97.29 or U07.1 for Dates of Service on or after January 1, 2020.
- Grant 45-day medical record submission extensions
- CMS-Referred reviews – On Hold
- COVID-19 related updates/FAQs: https://www.cms.gov/files/document/provider-burden-relief-faqs.pdf

Review Types

RAC Review Types

Complex	CMS Required (Complex)	Automated
• Medical records required for claim determination. • Additional Documentation Request (ADR) issued to provider. • ADR applicable to CMS Approved ADR Provider ADR Limits. • Provider has 45-days to submit documentation to RAC. • Clinical review completed within 30 days of receipt of documentation. • Provider has 30-days from the Review Results letter date to file a Discussion with the RAC. • Claim may be submitted to MAC for adjustment on day 31.	• CMS Approved, Referred to RACs for review. • Medical records required for claim determination. • Not subject to/counted towards CMS Approved ADR Limits. • Provider has 45-days to submit documentation to RAC. • Clinical review completed within 30 days of receipt of documentation. • Provider has 30-days from the Review Results letter date to file a Discussion with the RAC. • Claim may be submitted to MAC for adjustment on day 31. • **CMS Required Reviews currently on hold for COVID-19**	• System identified based on Medicare Regulations/Policies and Billing Guidelines. • Does not require review of medical documentation for claim determination. • Informational Letter is issued to the provider as notification of Improper Payment. • Provider has 30-days from the Informational letter date to file a Discussion with the RAC. • Claim may be submitted to MAC for adjustment on day 31.

Additional Documentation Request (ADR) Complex

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Region _4_Recovery Audit Contractor (RAC)

Date:

Reference ID:
Attention:
Address:

NPI:
PTAN:
Phone:
Fax:

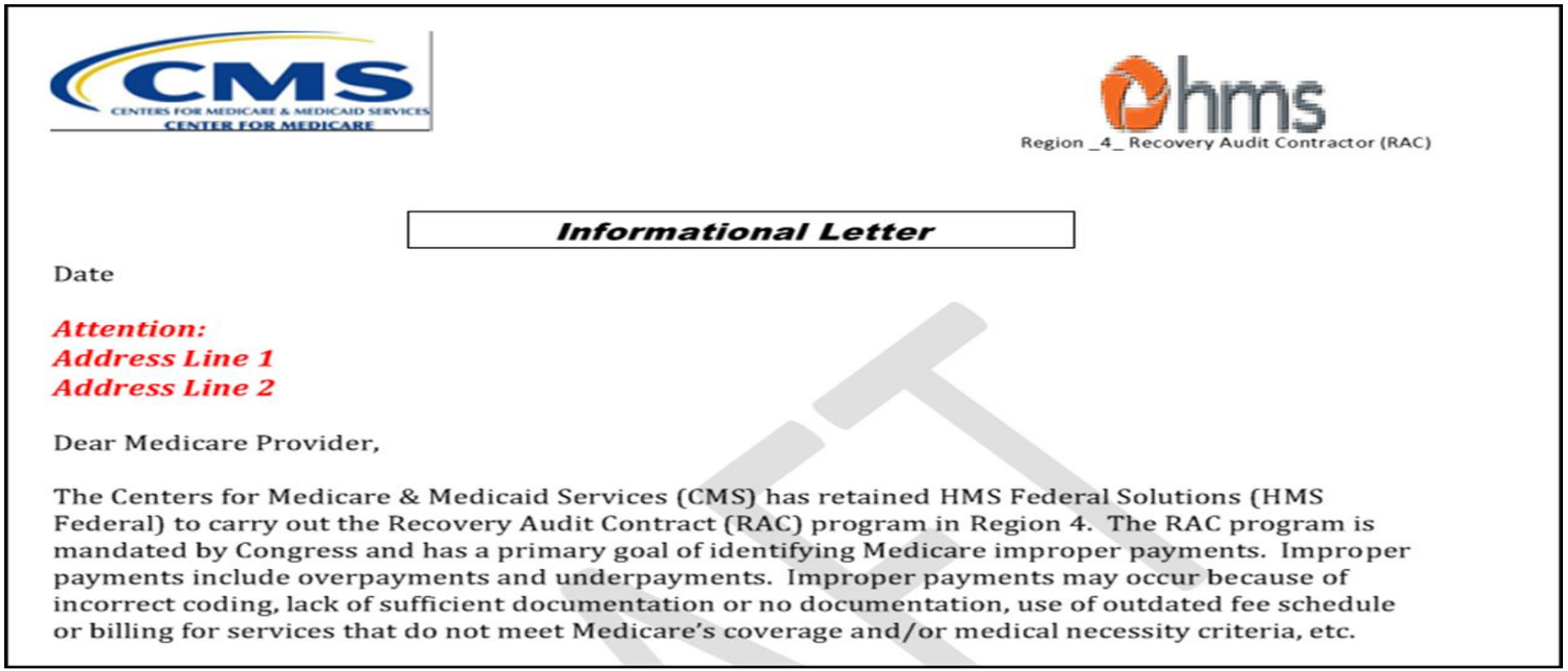
Request Type & Purpose: *Additional Documentation Required and Request for Medical Records*

Dear Medicare Provider/Supplier,

The Centers for Medicare & Medicaid Services (CMS) continually strives to reduce improper payment of Medicare claims.[3] The Recovery Audit Program, mandated by Congress, has been developed to assist in accomplishing this goal.

Reason for Selection
1) Complex review(s) approved by CMS:

Informational Letter



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Region _4_ Recovery Audit Contractor (RAC)

Informational Letter

Date

Attention:
Address Line 1
Address Line 2

Dear Medicare Provider,

The Centers for Medicare & Medicaid Services (CMS) has retained HMS Federal Solutions (HMS Federal) to carry out the Recovery Audit Contract (RAC) program in Region 4. The RAC program is mandated by Congress and has a primary goal of identifying Medicare improper payments. Improper payments include overpayments and underpayments. Improper payments may occur because of incorrect coding, lack of sufficient documentation or no documentation, use of outdated fee schedule or billing for services that do not meet Medicare's coverage and/or medical necessity criteria, etc.

Additional Documentation Request (ADR) Limits

Institutional (Facility) ADR Limits

- The baseline annual ADR limit is one-half of one percent (0.5%) of the provider's paid Medicare claims from a previous 12-month period.
- A provider will have a separate ADR limit for each Type of Bill (TOB).
- ADRs are sent on a 45-day cycle. The baseline ADR Limit is divided by eight (8) to establish the ADR cycle limit, which is the maximum number of claims that can be requested, per TOB, in a single 45-day period.
- Beginning January 1, 2019, providers whose ADR "cycle" limit is less than one, even though their "annual" ADR limit is greater than one (e.g., 1, 2, 3, or 4), will have their ADR cycle limit set at one (1) additional documentation request per 45 days, until their "annual" ADR limit has been reached.
- After three (3) 45-day ADR cycles, CMS will calculate (or recalculate) a provider's Denial Rate, which will then be used to identify a provider's corresponding "Adjusted" ADR Limit.
- Recovery Audit Contractors will have 3-year look-back period, based on the claim paid date, unless otherwise 3 directed by CMS.
- Additional information regarding limits can be found at: Institutional Provider (Facilities) ADR Limits: (https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Recovery-Audit-Program/Downloads/ADR-Limits-Institutional-Provider.pdf)

Additional Documentation Request Limits – Physician/Non-Physician Practitioner

- The limits will be based on the servicing physician or non-physician practitioner's billing Tax Identification Number (TIN), as well as the first three positions of the ZIP code where that physician/non-physician practitioner is physically located.
- ADR limits will be based on the number of individual rendering physicians/non-physician practitioners reported under each TIN/ZIP combination in the previous calendar year.

Group/Office Size	Max # of Requests per 45-days
50+	50
25-49	40
6-24	25
Less than 5	10

- Additional information regarding limits can be found at: Physician/Non-Physician Practitioner ADR Limits (https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Recovery-Audit-Program/Downloads/ADR-Limits-Physician-February-14-2011-.pdf)

Medical Record Submission

- What are my options for sending medical records?
  - Part A Fax: (702) 240-5517
  - Part B Fax: (702) 240-5510
  - Postal Mail
    - Images on CD/DVD or
    - Paper
  - (esMD): Information for submitting imaged documentation via esMD may be found at:
  - ESMD Information for Providers (https://www.cms.gov/Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/ESMD/Information_for_Providers.html)

Medical Record Reimbursement

Will I be reimbursed for the cost of producing medical records?

- $.12 per page for reproduction of PPS provider records, plus first-class postage.
- $.15 per page for reproduction of non-PPS institutions and practitioner records, plus first-class postage.
- Providers (such as critical access hospitals) under a Medicare reimbursement system receive no photocopy reimbursement.
- The maximum reimbursement amount per claim for records received via esMD will not exceed $25.00.
- The maximum reimbursement amount per claim for records not received via esMD will not exceed $15.00.

Region 4 Approved New Issues

New Issue Concept Approvals

- All New Issues must receive CMS approval before the Recovery Auditor may initiate reviews; medical records will not be requested prior to CMS authorization.
- Proposed RAC topics are posted to CMS website for 30-days for provider feedback.
- All CMS Approved New Issues are posted to HMS' Provider Portal 14-days prior to Informational or ADR Letter release
  - Proposed RAC Topics Website: https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Recovery-Audit-Program/Approved-RAC-Topics.html

Automated New Issues

Examples of CMS Approved Automated New Issues

- Outpatient Service Overlapping or During an Inpatient Stay
- Office Visits Billed for Hospital Inpatient
- Automated Inpatient Psych Billed without Source of Admission Equal to “D”

For a full listing of approved new issues and additional information regarding approved new issues including supporting Medicare Regulation references please visit HMS’ website at: New Issues (https://racinfo.hms.com/)

- Approved New Issues may be subject to change

Complex New Issues

Examples of CMS Approved Complex New Issues

- Inpatient Hospital MS-DRG Coding Validation
- Complex SNF Review - Documentation and Medical Necessity
- Comprehensive Cataract Removal
- Implantable Automatic Defibrillators
- Excessive or Insufficient Drug Units Billed

For a full listing of approved new issues and additional information regarding approved new issues including supporting Medicare Regulation references please visit HMS' website at: New Issues (https://racinfo.hms.com/)

- Approved New Issues may be subject to change

Discussion Period Process

Discussion Period Request

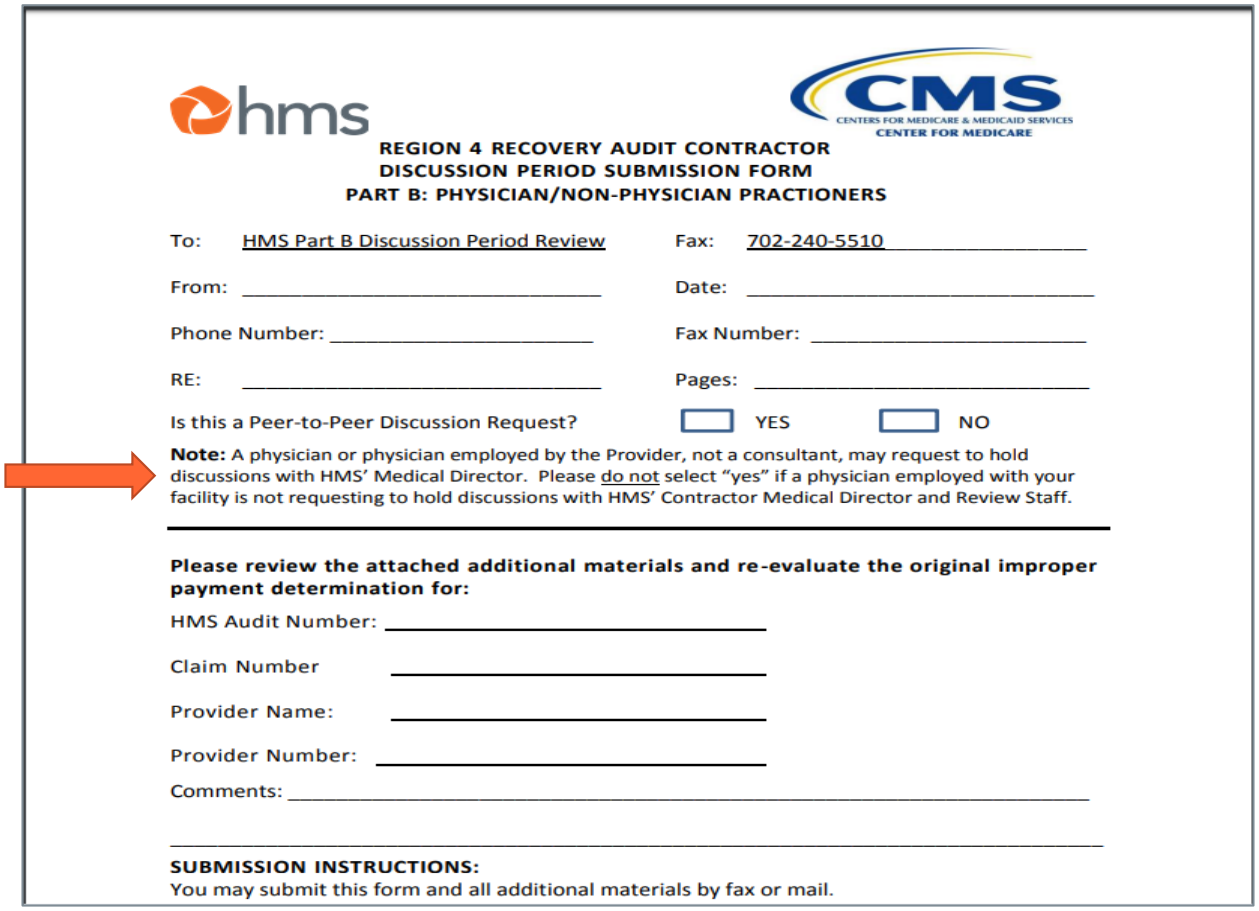
- **The Discussion Period begins with:**
  - Automated Reviews – Informational Letter
  - Complex Reviews – Review Results Letter
- **Discussion Period Process:**
  - Submit completed Discussion Form and supporting documentation to HMS at:
    - Part A Fax: (702) 240-5595
    - Part B Fax: (702) 240-5510
  - Do not bundle discussion period request – Submit one request per claim.
  - Confirmation of receipt of discussion material will be posted to HMS' Provider Portal within 1 business day
  - Discussion documentation is reviewed by a separate independent reviewer
  - Written discussion determination is sent to provider within 30 days and outcome is posted to the provider portal
  - Request Discussion Period Review within 30-days of receipt of improper payment notification letter. Extensions granted upon request.

Discussion Period Continued

Peer-To-Peer Discussion Request

- Opportunity for the rendering physician to discuss the review findings with the Contractor Medical Director (CMD) & Review Staff
- Peer-to-Peer discussion requests can also be submitted by a physician employed by the provider; requesting physician cannot be a consultant
- Submit completed Discussion Form and supporting documentation to HMS
  - Part A Fax: (702) 240-5595
  - Part B Fax: (702) 240-5510
- Contact HMS' Provider Services Department to schedule a peer-to-peer discussion
- Request Discussion Period Review within 30-days of receipt of improper payment notification letter. Extensions granted upon request.

Discussion Fax Form



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REGION 4 RECOVERY AUDIT CONTRACTOR
DISCUSSION PERIOD SUBMISSION FORM
PART B: PHYSICIAN/NON-PHYSICIAN PRACTIONERS

To: HMS Part B Discussion Period Review Fax: 702-240-5510

From: _____ Date: _____

Phone Number: _____ Fax Number: _____

RE: _____ Pages: _____

Is this a Peer-to-Peer Discussion Request? ☐ YES ☐ NO

Note: A physician or physician employed by the Provider, not a consultant, may request to hold discussions with HMS' Medical Director. Please do not select "yes" if a physician employed with your facility is not requesting to hold discussions with HMS' Contractor Medical Director and Review Staff.

Please review the attached additional materials and re-evaluate the original improper payment determination for:

HMS Audit Number: _____

Claim Number _____

Provider Name: _____

Provider Number: _____

Comments: _____

SUBMISSION INSTRUCTIONS:
You may submit this form and all additional materials by fax or mail.

Provider Portal

Provider Portal

- The HMS Provider Portal allows
- providers to:
  - Customize mailing address for ADRs and letters
  - Review all CMS approved new issues
  - View ADR limit by Bill Type
  - Track Additional Documentation Requests
  - Confirm receipt of medical documentation
  - Track review status and outcome
  - Confirm receipt of discussion and correspondence submissions
  - View discussion period outcome
  - View appeal status
  - Track claim closures
  - Obtain copies of ADR, Review Results, Informational and Closure Letters

Customized Contact Information

- How can I customize my mailing address for Region 4 ADRs and correspondence?
- New providers are initially required to complete the Knowledge Based Authentication (KBA) to obtain user credentials
- 2-Factor Authentication required for all established user login attempts
- Portal accepts up to 7 contacts per organization
- Portal User Guides can be found at: https://racinfo.hms.com/Public1/KnowledgeBasedAuthentication.aspx

Customizable Contact Information Page

Manage Contact Information

Provider Table

	Address from Claims Processing Contractor	Contact to Receive Medical Record Request Letters	Contact to Receive Improper Payment Letters
Billing Provider #			
Provider Name			
Affiliation/Ownership			
NPI			
Tax ID			
Contact Name			
Title			
Department			
Address 1			
Address 2			
City			
State			
Zip			
FAX			
Phone			
Extension			
Email			
Previous Provider #			
		Edit Delete	Edit Delete

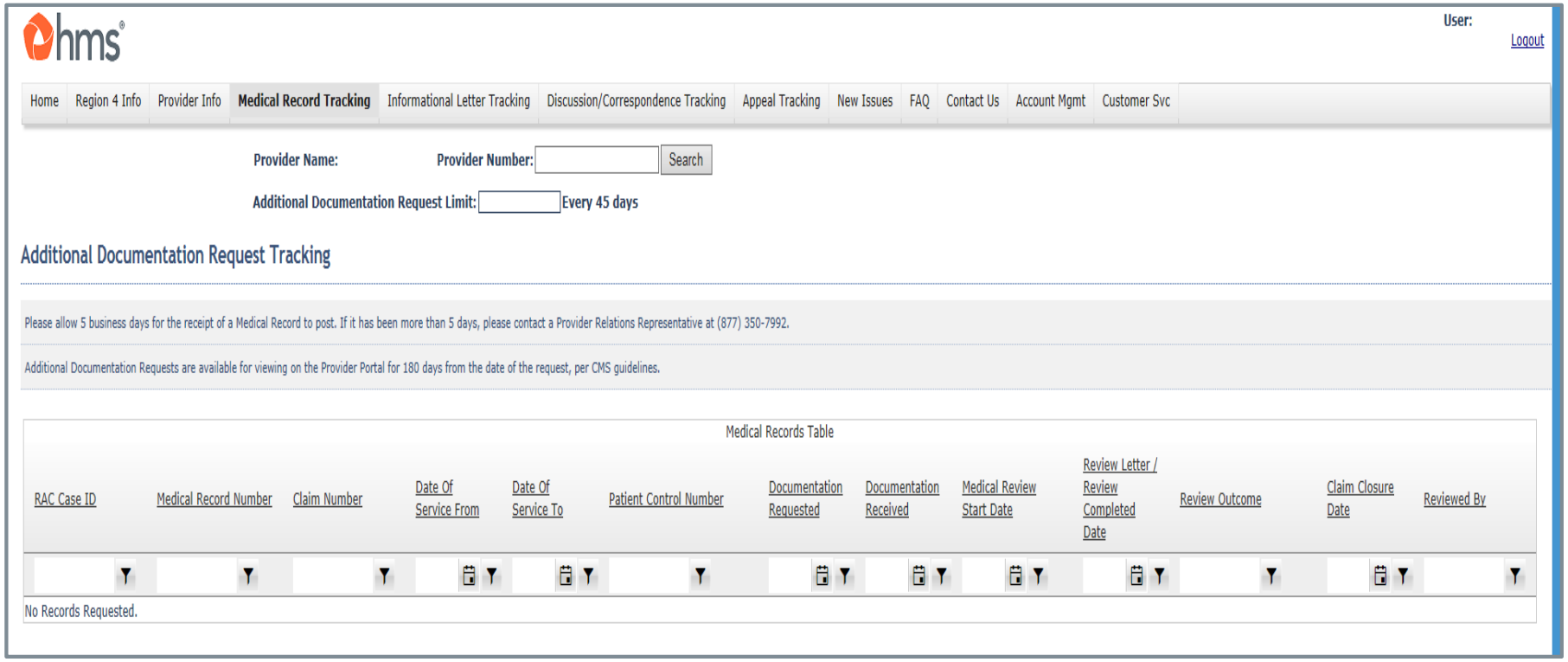
Website Users Add Web User

We request up to 7 contacts, CEO, CFO, Compliance Officer, CMO, IT contact; including 2 additional staff of your choice listed above.

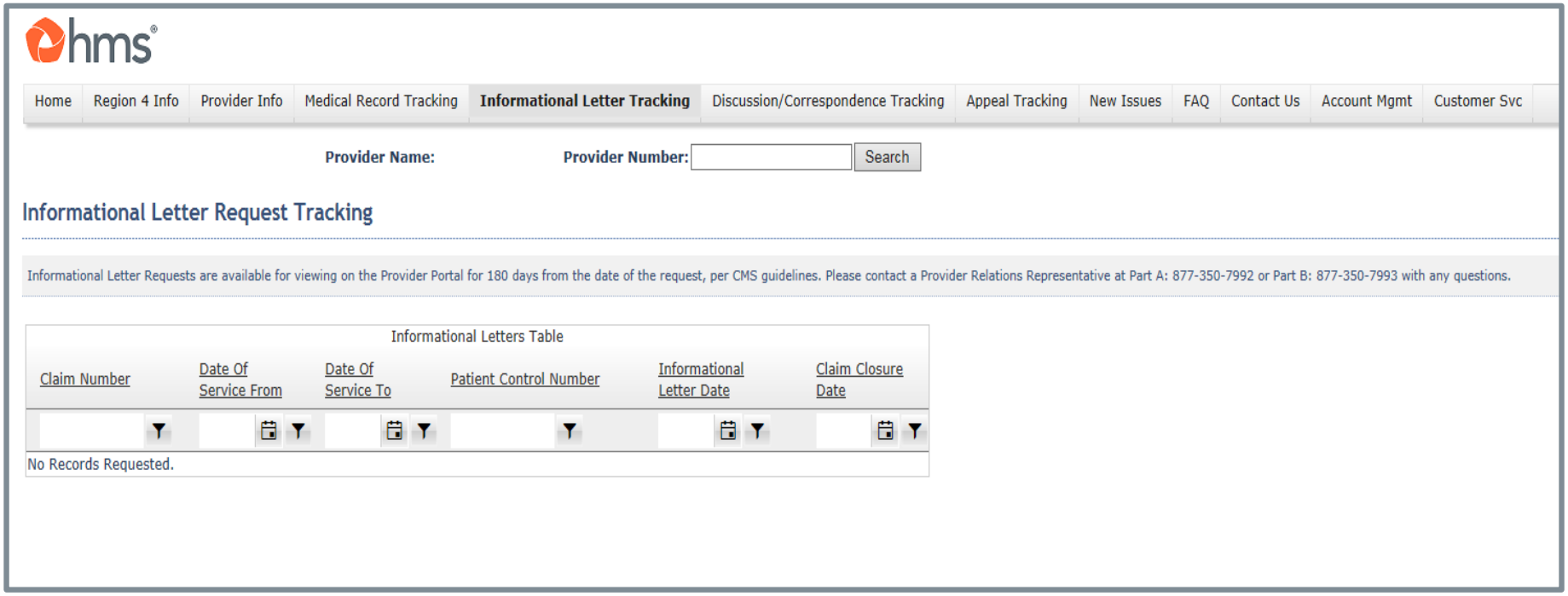
Provider Contact Table

	Contact Name	Title	Department	Email	
Delete					Edit
Delete					Edit

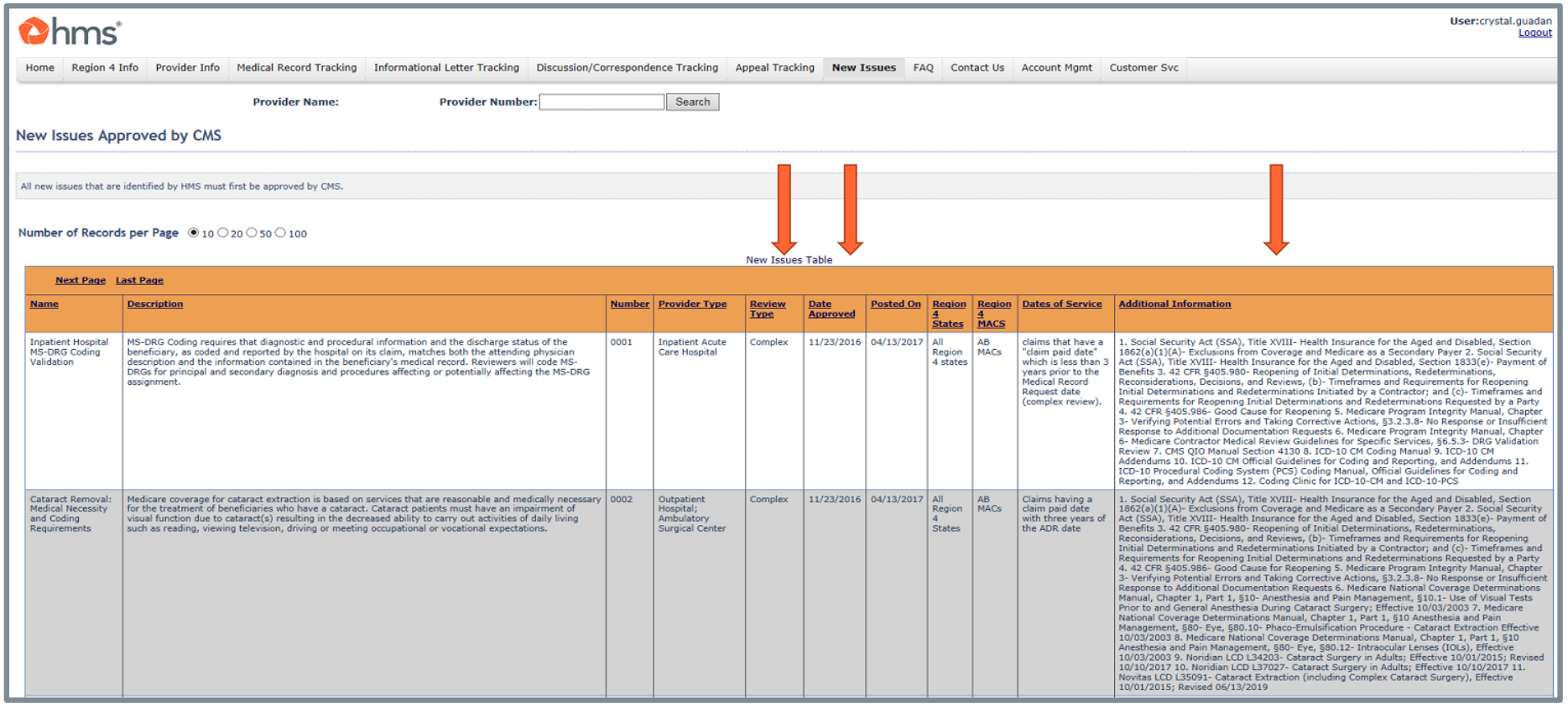
Additional Documentation Request Tracking Page



Informational Letter Tracking



RAC Region 4 CMS Approved New Issues Page



Name	Description	Number	Provider Type	Review Type	Date Approved	Posted On	Region 4 States	Region 4 MACS	Dates of Service	Additional Information
Inpatient Hospital MS-DRG Coding Validation	MS-DRG Coding requires that diagnostic and procedural information and the discharge status of the beneficiary, as coded and reported by the hospital on its claim, matches both the attending physician description and the information contained in the beneficiary's medical record. Reviewers will code MS-DRGs for principal and secondary diagnosis and procedures affecting or potentially affecting the MS-DRG assignment.	0001	Inpatient Acute Care Hospital	Complex	11/23/2016	04/13/2017	All Region 4 states	AB MACs	claims that have a "claim paid date" which is less than 3 years prior to the Medical Record Request date (complex review).	1. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer 2. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits 3. 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party 4. 42 CFR §405.986- Good Cause for Reopening 5. Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §3.2.3.8- No Response or Insufficient Response to Additional Documentation Requests 6. Medicare Program Integrity Manual, Chapter 6- Medicare Contractor Medical Review Guidelines for Specific Services, §6.5.3- DRG Validation Review 7. CMS QIO Manual Section 4130 8. ICD-10 CM Coding Manual 9. ICD-10 CM Addendums 10. ICD-10 CM Official Guidelines for Coding and Reporting, and Addendums 11. ICD-10 Procedural Coding System (PCS) Coding Manual, Official Guidelines for Coding and Reporting, and Addendums 12. Coding Clinic for ICD-10-CM and ICD-10-PCS
Cataract Removal: Medical Necessity and Coding Requirements	Medicare coverage for cataract extraction is based on services that are reasonable and medically necessary for the treatment of beneficiaries who have a cataract. Cataract patients must have an impairment of visual function due to cataract(s) resulting in the decreased ability to carry out activities of daily living such as reading, viewing television, driving or meeting occupational or vocational expectations.	0002	Outpatient Hospital; Ambulatory Surgical Center	Complex	11/23/2016	04/13/2017	All Region 4 States	AB MACs	Claims having a claim paid date with three years of the ADR date	1. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer 2. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits 3. 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party 4. 42 CFR §405.986- Good Cause for Reopening 5. Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §3.2.3.8- No Response or Insufficient Response to Additional Documentation Requests 6. Medicare National Coverage Determinations Manual, Chapter 1, Part 1, §10- Anesthesia and Pain Management, §10.1- Use of Visual Tests Prior to and General Anesthesia During Cataract Surgery; Effective 10/03/2003 7. Medicare National Coverage Determinations Manual, Chapter 1, Part 1, §10 Anesthesia and Pain Management, §80- Eye, §80.10- Phaco-Emulsification Procedure - Cataract Extraction Effective 10/03/2003 8. Medicare National Coverage Determinations Manual, Chapter 1, Part 1, §10 Anesthesia and Pain Management, §80- Eye, §80.12- Intraocular Lenses (IOLs), Effective 10/03/2003 9. Noridian LCD L34203- Cataract Surgery in Adults; Effective 10/01/2015; Revised 10/10/2017 10. Noridian LCD L37027- Cataract Surgery in Adults; Effective 10/10/2017 11. Novitas LCD L35091- Cataract Extraction (including Complex Cataract Surgery), Effective 10/01/2015; Revised 06/13/2019

HMS Contact Information

HMS Contact Information

HMS' Provider Relations Area is the first line of Provider Communication

- Part A Toll Free Number: (877) 350-7992
- Part A Fax Number: (702) 240-5595

- Part B Toll Free Number: (877) 350-7993
- Part B Fax Number: (702) 240-5510

- E-mail Address: racinfo@hms.com
- Address: HMS Federal (HMS)
  9275 West Russell Road,
  Suite 300 – MS 12M
  Las Vegas, NV 89148
- Hours of Operation: 6:00 AM – 5:00 PM (Pacific)

CMS

- **CMS Website:** Recovery Audit Program Page (https://www.cms.gov/research-statistics-data-and-systems/monitoring-programs/medicare-ffs-compliance-programs/recovery-audit-program/)
- **CMS E-mail Address:** RAC@cms.hhs.gov

Helpful Hints

- What can I do to prepare for a RAC Audit?

- Get registered on HMS' Provider Portal
- Customize your contact information
- Review the CMS Approved New Issues posted to HMS' website
- Visit the CMS page for proposed RAC audits
- Monitor HMS' Portal Homepage for Important Announcements and Region 4 Updates

RAC Process Highlights

- As a reminder…

- Additional Documentation Requests (ADRs) are sent on a 45-day cycle.
- ADRs issued for CMS Required Reviews are not subject to ADR Limits.
- Providers have 45 days to submit medical documentation.
- ADR deadline extensions are available upon request.; Contact HMS Provider Relations to inquire.
- Request Discussion Period Review within 30-days of receipt of improper payment notification letter.
- Demand letters are issued by the MAC; Do not send refund checks to HMS.
- Most RAC closures are completed prior to claim adjustment at the MAC.