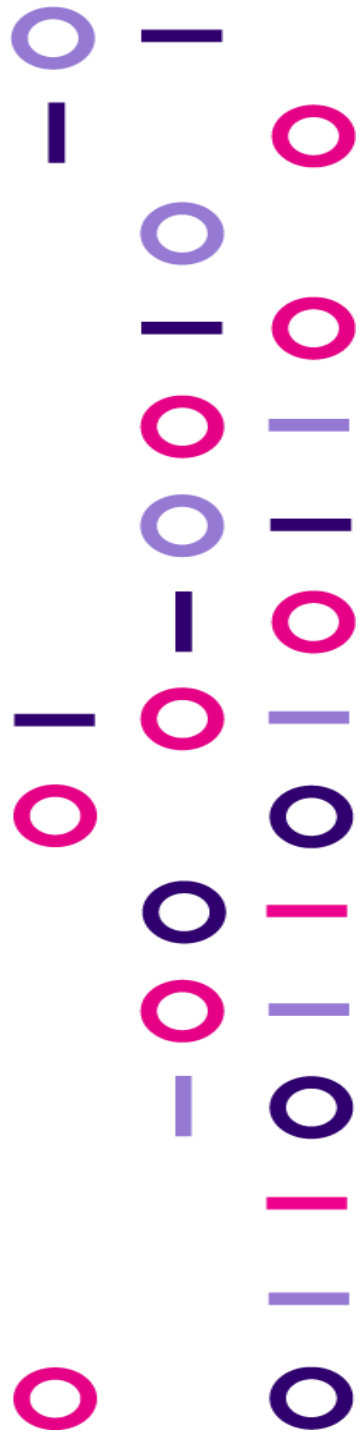




Cotiviti GOV Services Region 4 – Recovery Audit Contractor

RAC Claim Reviews & Recovery Audit Process

January 2022



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All processes and guidelines are undergoing continuous improvement and modification by Cotiviti RAC 4 and CMS. The most current edition of the information contained in this release can be found on the [Region 4 Website](#) and the [CMS website](#).

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RAC Agenda

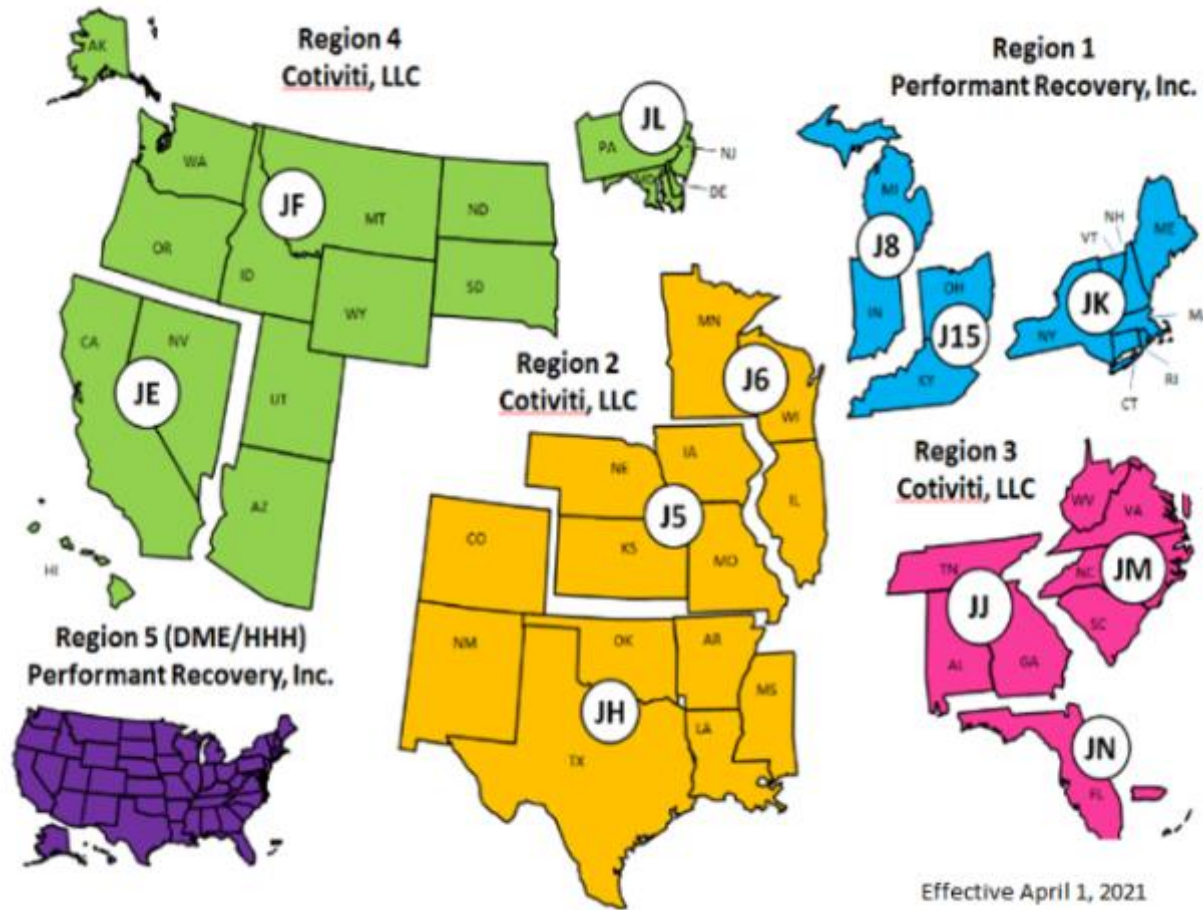
- Region 4 & COVID-19 Updates
- Review Types
- Additional Documentation Requests
- Approved New Issues
- Discussion Process
- Provider Portal Overview & Demo
- Region 4 Contact Information
- Open Q&A

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](#)

Medicare Fee for Service RAC Regions



Region 4 Acquisition

- On April 1, Cotiviti closed on the acquisition of a portion of HMS solutions.
- HMS Federal, the current RAC Region 4 contractor, will now operate as Cotiviti GOV Services.
- HMS solutions have been appropriately rebranded
- Effective 12/1/2021, Region 4 Las Vegas Office was closed. Please continue to follow the guidance in the RAC correspondence letters to ensure timely delivery.
- This change will have no impact in the day-to-day contract administration and audit timelines under CMS' guidance.
- Our Provider Relations Team is also available to address any questions you may have regarding Region 4 Audits.

COVID-19 Key RAC Dates & Reminders

- August 3, 2020 – RACs resumed Medicare Fee-for-Service medical review activities for Dates of Service (DOS) prior to March 1, 2020.
- July 8, 2021 – RACs resume medical reviews for claims with Dates of Service on or after March 1, 2020.
- RACs continue to grant 45-day medical record & discussion period submission extensions upon request
- [CMS COVID-19 related updates & FAQs](#)

RAC Review Types

What are the different types of RAC Review and how can I tell which my office has received a letter for?



RAC Post-Payment Review Types

Complex	CMS Required/Referred (Complex)	Automated
Medical records for claim determination	CMS Approved, Referred to RACs for review.	System identified based on Medicare Regulations, Policies, and Billing Guidelines.
Additional Documentation Request (ADR) issued to provider.	Medical records required for claim determination.	Does not require review of medical documentation for claim determination.
ADR applicable to CMS Approved ADR Limits.	NOT subject to/counted towards CMS Approved ADR Limits.	Informational Letter is issued to the provider as notification of Improper Payment.
Provider has 45-days to submit documentation to RAC.	Provider has 45-days to submit documentation to RAC.	30-Day Discussion Window based on Informational Letter date.
Review completed within 30-days of receipt of records.	Clinical review completed within 30 days of receipt of documentation.	Claim eligible for adjustment on Day - 31
30-Day Discussion Window based on Review Results Letter date.	30-Day Discussion Window based on Review Results Letter date.	NA
Claim eligible for adjustment on Day - 31	Claim eligible for adjustment on Day - 31	NA

Additional Documentation Request (ADR) Letter Sample



Region _X_ 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. The Recovery Audit Program, mandated by Congress, and supported by SSA §1893(f)(7) and SSA §1893(h)(1) and (3), has been developed to assist in accomplishing this goal. Additional information on the RAC Program may be found at: RAC website link or <https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Recovery-Audit-Program>.

Reason for Selection

1) Complex review(s) approved by CMS:

Review Results Informational Letter (Automated Improper Payment Finding)



Review Results - Informational Letter

5/14/2021

HospitalName
Address1
Address2
City, State Zip

Dear Medicare Provider,

The Centers for Medicare & Medicaid Services (CMS) has retained **Cotiviti GOV Services (Cotiviti RAC 4)**, formerly HMS Federal (HMS) to carry out the Recovery Audit Contracting (RAC) program in Region 4. The RAC program is mandated by Congress and supported by SSA §1893(f)(7) and SSA §1893(h)(1) and (3), 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 an outdated fee schedule or billing for services that do not meet Medicare's coverage and/or medical necessity criteria etc.

Your Right to Disagree

If you disagree with our findings, you have the option to submit our Discussion Request Form, which must include evidence to support why you believe the services you provided are covered by Medicare and were properly coded and correctly billed.

- If the additional documentation you provide substantiates a change in our original finding, a review outcome letter will be sent providing the outcome of our review.
- You have thirty (30) days from the date of this Review Results Letter, which is also the date of the Provider Portal notification, to submit the Discussion Period Request in writing. If you require an extension, for submission of the Discussion Period Request please contact us.
- During this period, or during our review of your Discussion Period Request, Cotiviti RAC 4 will not submit the claim(s) for adjustments to your Medicare Administrative Contractor (MAC). After that period expires, the claim(s) identified as improper will be shared with your MAC and they will issue a Demand Letter outlining your appeal rights and repayment options.
- You can find the updated Discussion Request Form including submission instructions at <https://rac4info.cotiviti.com> – including how a Physician or a Physician who is employed by your facility, not a consultant, may request to speak with Cotiviti RAC 4's Medical Director. You may also track the status of your Discussion Period Request via the Provider Portal.

Additional Documentation Request (ADR) Limits

How are ADR limits determined?

How RACs use limits within the program?

Where can you find your office's current ADR limit?



Institutional (Facility) ADR Limits

- 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.
- Separate ADR limits for each Type of Bill (TOB).
- ADRs are sent on a 45-day cycle.
- Beginning January 1, 2019, providers with an "annual" ADR limit is greater than one but a "cycle" limit of less than one, will have their ADR cycle limit set at one (1) additional documentation request per 45 days, until their "annual" ADR limit has been reached.
- CMS calculates (or recalculates) Provider Denial Rates, after three 45-day ADR cycles which will then be used to identify a provider's corresponding "Adjusted" ADR Limit.
- Unless otherwise directed by CMS, RAC has a 3-year look-back period based on the claim paid date.
- **For more information on Part A ADR Limits - Institutional (Facility) ADR Limits**

ADR 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.

- [CMS Physician/Non-Physician Practitioner ADR Limits](#)

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

What are my options for submitting documentation?



NEW! Direct Upload

- Via Cotiviti's Secure Provider Portal
- Authorized Users Only



esMD

- Information for submitting records via esMD can be found on CMS' website
 - [Get Started with esMD](#)



Postal Mail

- Images on CD/DVD
- Paper
- Passwords should be communicated to Provider Services upon submission.



Fax

- Part A Fax: (702) 240-5517
- Part B Fax: (702) 240-5510

Does the RAC reimburse Medical Record Copy Fees?

- \$.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

What is the process for a new issue to be approved for RAC review and how can I identify what new issues Region 4 is actively auditing?



New Issue Concept Approvals

Step 1	Step 2	Step 3	Step 4	Step 5
Concept submission to CMS	CMS Review & Approval	30-Day Provider Comment Period	Approved Concept Issued to RACs.	RAC Post Approved New Issue 14-days Prior to Initiating Reviews.

Top 5 Active Complex Edits

- 1) Excessive or Insufficient Drugs and Biologicals Units Billed – Drug Waste
- 2) Ambulatory Payment Classification Coding Validation
- 3) CMS - RAC Unified Core Complex 3 Stay - SS/SStoCV/
- 4) Skilled Nursing Facility: Medical Necessity and Documentation Requirements
- 5) Endovenous Radiofrequency Ablation and Endovenous Laser Treatment (ERFA and EVLT) for Lower Extremity Varicose Veins

For a full listing of approved new issues and additional information regarding approved new issues including supporting Medicare Regulation references please visit Region 4's website at: [Region 4 New Issue Page](#)

Top 5 Active Automated Edits

- 1) Evaluation and Management Services for Office or Other Outpatient Visit Billed for Hospital Inpatients: Incorrect Coding
- 2) New Patient Visits: Incorrect Coding
- 3) Nursing Facility Services: Excessive Units
- 4) Ophthalmology Codes for New Patient: Incorrect Coding
- 5) Observation Evaluation and Management Services Billed Same Day as Inpatient Admission: Unbundling

For a full listing of approved new issues and additional information regarding approved new issues including supporting Medicare Regulation references please visit Region 4's website at: [Region 4 New Issue Page](#)

Discussion Period Process

What are my options if I don't agree with the RAC decision?



Discussion Period Requests: Standard Process

When does my discussion period window start?

- Automated Reviews – Informational Letter Date
- Complex Reviews – Review Results Letter Date

How do I initiate a discussion period request?

- Submit Discussion Form and supporting documentation to Cotiviti RAC 4 via:
 - Fax: Part A (702) 240-5595 or Part B (702) 240-5510
 - **Secure Provider Portal Upload**

Key Considerations for Discussion Requests

- Do not bundle discussion period requests
- Reviews completed by separate independent reviewers.
- Discussion outcomes issued within 30-days from date of receipt.
- Acknowledged in provider portal within 1-business day of receipt.
- Extensions are available upon request.

Discussion Period Request: Peer-To-Peer (P2P) Process

What is a Peer-To-Peer Discussion?

- Provides an opportunity for the rendering physician to discuss the review findings with the Contractor Medical Director (CMD) & Review Staff.

Who can participate in a P2P discussion period?

- Peer-to-Peer discussion requests can be submitted by a physician or staff employed by the provider; participating physician cannot be a consultant.

How do I request a P2P discussion period?

- Submit completed discussion form and supporting documentation to Cotiviti RAC 4 via:
 - Fax: Part A (702) 240-5595 or Part B (702) 240-5510
 - **Secure Provider Portal Upload**

Key Considerations for Discussion Requests

- Clearly mark P2P box on discussion form.
- Provide point of contact for scheduling.
- 30-day review timeframe must be adhered to.
- Discussion submission extensions are available upon request.

Discussion Fax Form



**REGION 4 RECOVERY AUDIT CONTRACTOR (RAC)
DISCUSSION PERIOD SUBMISSION FORM
PART B: PHYSICIAN/NON-PHYSICIAN PRACTITIONERS**

To: RAC 4 Part Discussion Period Review Fax: _____
From: _____ Date: _____
Phone Number: _____ Fax Number: _____
Email Address: _____ Pages: _____



Is this a Peer-to-Peer Discussion Request? YES NO (I am **not** requesting a teleconference)

Note: A physician or a physician employed by the Provider, **not a consultant**, may request to hold discussions with the RAC 4 Contractor Medical Director (CMD). Please **do not** select "yes" if a physician employed with your facility is **not** requesting to schedule a teleconference with the Contractor Medical Director and Review Staff.

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

Audit Number: _____
Claim Number: _____
Provider Name: _____
Provider Number: _____
Comments: _____

Region 4 Provider Portal

What are the features & benefits of the Region 4 Website and Portal?



The Region 4 Provider Portal Features:

- ✓ **NEW!** Upload Medical and Discussion Documentation
- ✓ 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

Secure Document Uploads

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Home | Region 4 Info | Provider Info | Medical Record Tracking | Informational Letter Tracking | Discussion/Correspondence Tracking | **Documents** | Appeal Tracking

Provider Number: [Search](#)


Documents

Click on the claim number to view/upload documents.

<u>RAC Case ID</u>	<u>Claim Number</u>	<u>Date Of Service From</u>	<u>Date Of Service To</u>	<u>Patient Control Number</u>	<u>Documents Attached</u>	<u>Documents Uploaded</u>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

No Records Found.

Customize Your Contact Information



Home | Region 4 Info | **Provider Info** | Medical Record Tracking | Informational Letter Tracking | Discussion/Correspondence Tracking | Documents | Appeal Tracking

Provider Number: **Search**

Manage Contact Information

Provider Table

Address from Claims Processing Contractor	Contact to Receive Medical Record Request Letters	Contact to Receive Improper Payment Letters
No Provider Selected.		


Website Users

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
No records found.			

Track ADR & Review Status


User

— GOV SERVICES —

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Region 4 Info
Provider Info
Medical Record Tracking
Informational Letter Tracking
Discussion/Correspondence Tracking
Documents
Appeal Tracking
New Issues
FAQ
Contact Us
Account Mgmt
Customer Svc

Provider Number: Search

Additional Documentation Request Tracking

Please allow 5 business days for the receipt of a Medical Record to post. If it has been more than 5 days, please contact a Provider Relations Representative at (877) 350-7992.

Additional Documentation Requests are available for viewing on the Provider Portal for 180 days from the date of the request, per CMS guidelines.

Medical Records Table

RAC Case ID	Medical Record Number	Claim Number	Date Of Service From	Date Of Service To	Patient Control Number	Documentation Requested	Documentation Received	Medical Review Start Date	Review Letter / Review Completed Date	Review Outcome	Claim Closure Date	Reviewed By
<input style="width: 50px;" type="text"/>	<input style="width: 50px;" type="text"/>	<input style="width: 50px;" type="text"/>	<input style="width: 50px;" type="text"/>	<input style="width: 50px;" type="text"/>	<input style="width: 50px;" type="text"/>	<input style="width: 50px;" type="text"/>	<input style="width: 50px;" type="text"/>	<input style="width: 50px;" type="text"/>	<input style="width: 50px;" type="text"/>	<input style="width: 50px;" type="text"/>	<input style="width: 50px;" type="text"/>	<input style="width: 50px;" type="text"/>

No Records Requested.

Track Automated Reviews

COTIVITI
GOV SERVICES

Home | Region 4 Info | Provider Info | Medical Record Tracking | **Informational Letter Tracking** | Discussion/Correspondence Tracking | Documents

Provider Number: **Search**

Informational Letter Request Tracking

Informational Letter Requests are available for viewing on the Provider Portal for 180 days from the date of the request, per CMS guidelines. Please contact a Provider Relations Representative for more information.

<u>Claim Number</u>	<u>Date Of Service From</u>	<u>Date Of Service To</u>	<u>Patient Control Number</u>	<u>Informational Letter Date</u>	<u>Claim Closure Date</u>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

No Records Requested.

View CMS Approved New Issues

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User:crystal.guada

[Logout](#)

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- [Region 4 Info](#)
- [Provider Info](#)
- [Medical Record Tracking](#)
- [Informational Letter Tracking](#)
- [Discussion/Correspondence Tracking](#)
- [Documents](#)
- [Appeal Tracking](#)
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- [FAQ](#)
- [Contact Us](#)
- [Account Mgmt](#)
- [Customer Svc](#)

Provider Number: [Search](#)

New Issues Approved by CMS

All new issues that are identified by Cotiviti RAC 4 must first be approved by CMS.

Number of Records per Page 10 20 50 100

New Issues Table

Next Page Last 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

RAC Process Review & Helpful Hints



Region 4 Contact Information

Provider Relations is the first line of Provider Communication

Toll Free Numbers:

- Part A: 877-350-7992
- Part B: 877-350-7993

Fax Numbers:

Part A: 702-240-5595

Part B: 702-240-551

Address:

Cotiviti RAC 4
C/O Cotiviti-8000
66 East Wadsworth Park Drive
Box 12005
Draper, UT 84020

Hours of Operations:

7:00am – 5:00pm (Pacific)

Email Address:

rac4info@cotiviti.com

Provider Portal:

<https://rac4info.cotiviti.com>

CMS:

[Recovery Audit Program Page](#)

[CMS Approved RAC Topics](#)

[Recovery Audit Program Resource Page](#)

[Email: RAC@cms.hhs.gov](mailto:RAC@cms.hhs.gov)

What can I do to prepare for a RAC Audit?

- **Get Registered!** Create user profile on Region 4 Provider Portal
- Customize your Contacts for ADR & Review Results Letters
- Stay up-to-date on new CMS Approved New Issues
- Regularly visit the CMS page for proposed RAC Audits
- Monitor Region 4's Portal Homepage for Important Announcements and Region 4 Updates

RAC Process Highlights & Reminders

- Additional Documentation Requests (ADRs) are sent on a 45-day cycle.
- Providers have 45-days to submit medical documentation.
- Providers have 30-days to open a discussion period.
- ADR & Discussion deadline extensions are available upon request.
- Demand letters are issued by the MAC; **Do not send refund checks to Cotiviti.**
- Most RAC closures are completed prior to claim adjustment at the MAC.