Disclaimer

This information release is the property of HMS Federal Solutions (HMS). It may be freely distributed in its entirety but may not be modified, sold for profit or used in commercial documents.

The information is provided “as is” without any expressed or implied warranty. While all information in this document is believed to be correct at the time of writing, this document is for educational purposes only and does not purport to provide legal advice.

All processes and guidelines are undergoing continuous improvement and modification by HMS and CMS. The most current edition of the information contained in this release can be found on the HMS website at https://racinfo.hms.com and the CMS website at http://www.cms.gov

The identification of an organization or product in this information does not imply any form of endorsement. CPT codes, descriptors, and other data only are copyright 2017 American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Agenda

- Meet HMS Federal – RAC Region 4
- Review Types Performed
- Additional Documentation Requests
- Approved New Issues
- Discussion Process
- Provider Portal Overview
- HMS Contact Information
- Open Q&A
The RAC Program’s mission is to reduce Medicare improper payments through the efficient detection and correction of improper payments.

- HDI was the RAC for Region D
- HDI was acquired by HMS in December of 2011
- HMS Federal was awarded the Region 4 RAC Contract on October 31st, 2016
- HMS Federal is a fully owned subsidiary of HMS
HMS Federal’s RAC team includes highly qualified individuals that come together to provide you with the best service possible.

More than nine years of experience with the Medicare Recovery Audit Program.

A complex review team with expertise in Medicare payment rules and regulations for all provider and claims types.

Dedicated Account Management and Provider Relations teams have relevant Medicare claims or billing experience to ensure top quality processes and customer service.
Medicare Fee for Service RAC Regions – HMS Federal Region 4 RAC

Effective October 31, 2016
Review Types Performed
## RAC Review Types

<table>
<thead>
<tr>
<th>Complex Reviews</th>
<th>Automated Reviews</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Medical records required for claim determination</td>
<td>• System identified; Does not require review of medical documentation for claim determination</td>
</tr>
<tr>
<td>• Clinical review completed within 30 days of receipt</td>
<td>• Informational Letter is issued to the provider for notification of improper payment</td>
</tr>
<tr>
<td>• Medical Necessity determinations are made by Registered Nurses or Therapists</td>
<td>• Claims are held for 30 days from the date of the letter to allow the provider to request a discussion</td>
</tr>
<tr>
<td>• Coding determinations are made by certified coders.</td>
<td>period</td>
</tr>
<tr>
<td>• Review Result letter is issued to provider for notification of review outcome</td>
<td>• Claim may be submitted to MAC for adjustment on day 31</td>
</tr>
<tr>
<td>• Claims are held for 30 days from the date of the letter to allow the provider</td>
<td></td>
</tr>
<tr>
<td>to request a discussion period</td>
<td></td>
</tr>
<tr>
<td>• Claim may be submitted to MAC for adjustment on day 31</td>
<td></td>
</tr>
</tbody>
</table>
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)

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, has been developed to assist in accomplishing this goal.

Reason for Selection
1) Complex review(s) approved by CMS:
Additional Documentation Requests
Additional Documentation Requests (ADRs) are sent on a 45-day cycle.

ADRs are issued in accordance with the CMS established annual ADR limit baseline.

Providers have 45-days to respond to request for medical documentation.

Providers are allowed at least one (1) extension for the submission of medical records on each claim.
## Additional Documentation Request Limits

<table>
<thead>
<tr>
<th><strong>Institutional Provider (Facility) Limits</strong></th>
<th><strong>Physician/Non-Physician Practitioner Limits</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>• Baseline annual ADR limit is one half of one percent (0.5%) of the provider's total number of paid Medicare claims from a previous 12 month period</td>
<td>• 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.</td>
</tr>
<tr>
<td>• 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</td>
<td>• 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.</td>
</tr>
<tr>
<td>• Additional information regarding limits can be found at: <a href="https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Recovery-Audit-Program/Downloads/Institutional-Provider-Facilities-ADR-Limits-May-2016.pdf">Institutional Provider (Facilities) ADR Limits</a></td>
<td>• Additional information regarding limits can be found at: <a href="https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/recovery-audit-program/downloads/PhyADR.pdf">Physician/Non-Physician Practitioner ADR Limits</a></td>
</tr>
</tbody>
</table>
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)
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 amount per medical record will not exceed $25.00.
Region 4
Approved
New Issues
New Issue Concept Approvals

- All New Issues must receive CMS approval before the Recovery Auditor may begin initiating reviews; medical records will not be requested prior to CMS authorization.

- CMS may allow the RAC to request a sample of medical records when developing a test case for CMS to validate.

- Upon approval of the new issue concept, CMS will notify the RAC if/when they may begin issuing ADR letters or any subsequent documentation on the new issue.

- HMS posts all approved new issues to the provider portal.
**New Issues Currently in Review**

- Hospital Discharge Day Management Service
- Not a New Patient/ Not a New Patient – Ophthalmology
- Office Visits Billed for Hospital Inpatient
- Visits to Patients in Swing Beds
- Inpatient Psych Billed without Source of Admission Equal to “D”
- Home Services Billed for Hospital Inpatients
- Add-on codes paid without required Primary Code and/or denied Primary Code
- Excessive Units of Hospital Services
- Global vs. PC/TC Split
- Cataracts Billed with Units > 1 or Multiple Claims
- Ambulance during Inpatient Hospital Stay

- Subject to change; current as of 10/1/17.
New Issues Currently in Review

- Inpatient Hospital MS-DRG Coding Validation
- Herceptin (Trastuzumab, J9355) - Multi-Dose Vial Wastage
- Complex SNF Review - Documentation and Medical Necessity
- Vagus Nerve Stimulation

- The full list of current approved Region 4 New Issues including supporting Medicare Regulation references can be found on HMS’ website at: [New Issues](https://racinfo.hms.com/)

Subject to change; current as of 10/1/17
Discussion Period Process
The Discussion Period begins with:

- Automated Reviews – Informational Letter
- Complex Reviews – Review Results/Technical Denial 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
- 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
- Discussion Period requests received more than 30 days from the date of the informational or review results letter date will not be reviewed by the RAC
Peer-To-Peer Discussion Request

- Allows the opportunity for the rendering physician to discuss the review findings with the Contractor Medical Director (CMD)

- 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

- Discussion Period requests received more than 30 days from the date of the informational or review results letter date will not be scheduled for a physician peer-to-peer discussion by the RAC.

- Additional information including the Discussion Fax Form can be found on HMS’ website at: Provider Information (https://racinfo.hms.com/)
Discussion Fax Form

REGION 4 RECOVERY AUDIT CONTRACTOR
DISCUSSION PERIOD SUBMISSION FORM

To: HMS Discussion Period Review
Fax: __________________________

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 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
The HMS Provider Portal allows providers to:

- Customize mailing address for ADRs and letters
- Review all approved new issues
- View overall ADR limit
- Track Additional Documentation Requests
- Confirm receipt of medical documentation
- Track the status and outcome of medical reviews
- Confirm receipt of discussion material and correspondence
- View discussion period information
- View appeal status
- Track claim closures
How can I customize my mailing address for Region 4 ADRs and correspondence?

- New providers are required to complete the Knowledge Based Authentication (KBA) to obtain user credentials.
- 2-Factor Authentication is 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
HMS’ Provider Portal Sign In Page

Knowledge Based Authentication

- Portal Guide For Part A Providers
- Portal Guide For Part B Providers

Please note:
- You are accessing a U.S. Government Information system, which includes: (1) this computer, (2) this computer network, (3) all computers connected to this network, and (4) all devices and storage media attached to this network or to a computer on this network. This information system is provided for U.S. Government-authorized use only.
- Unauthorized or improper use of this system may result in disciplinary action, as well as civil and criminal penalties.
- By using this information system, you understand and consent to the following:
  - You have no reasonable expectation of privacy regarding any communication or data transmitted or stored on this information system. At any time, and for any lawful Government purpose, the Government may monitor, intercept, and search any communication or data transmitted or stored on this information system.
  - Any communication or data transmitted or stored on this information system may be disclosed or used for any lawful Government purpose.

[Provider Type: Select Provider Type]

Provider Sign In
User Name / Hospital Provider Identifier:
Password / What is the letter identification number?

[Please click box to agree]

Sign in
Reset your password?
## Manage Contact Information

<table>
<thead>
<tr>
<th>Billing Provider #</th>
<th>Address From Claims Processing Contractor</th>
<th>Contact to Receive Medical Record Request Letters</th>
<th>Contact to Receive Improper Payment Letters</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider Name</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Affiliation/Ownership</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NPI</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tax ID</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Contact Name</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Title</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Department</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Address 1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Address 2</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>City</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>State</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Zip</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>FAX</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Phone</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Extension</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Email</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Previous Provider #</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- Make both contacts identical

### Website Users

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

<table>
<thead>
<tr>
<th>Contact Name</th>
<th>Title</th>
<th>Department</th>
<th>Email</th>
<th>Edt</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Delete

- Edit
### 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.

<table>
<thead>
<tr>
<th>RAC Case ID</th>
<th>Medical Record Number</th>
<th>Claim Number</th>
<th>Date Of Service From</th>
<th>Date Of Service To</th>
<th>Patient Control Number</th>
<th>Documentation Requested</th>
<th>Documentation Received</th>
<th>Medical Review Start Date</th>
<th>Medical Review Completed Date</th>
<th>Review Outcome</th>
<th>Claim Closure Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

No Records Requested.

Disclaimer: This website contains proprietary, confidential and privileged information and data that may not be copied, reproduced or disseminated, in whole or part, without the prior written consent of HMS.
Discussion and Correspondence Tracking

Please allow 1 business day for the receipt of a Discussion or Correspondence to post. If it has been more than 1 day, please contact a Provider Relations Representative at (877) 350-7992.

Discussion and Correspondence requests are available for reviewing on the Portal for 180 days from the date of receipt, per CMS guidelines.

### Discussion Tracking

<table>
<thead>
<tr>
<th>RAC Case ID</th>
<th>Claim Number</th>
<th>Date Of Service From</th>
<th>Date Of Service To</th>
<th>Patient Control Number</th>
<th>Discussion Received Date</th>
<th>Discussion Determination Date</th>
<th>Discussion Determination Date</th>
<th>Discussion Determination Date</th>
<th>Discussion Determination Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

No Discussion Found.

### Correspondence Tracking

<table>
<thead>
<tr>
<th>RAC Case ID</th>
<th>Claim Number</th>
<th>Date Of Service From</th>
<th>Date Of Service To</th>
<th>Patient Control Number</th>
<th>Correspondence Received Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

No Correspondence Found.
Appeals Tracking Page

Appeal Tracking

The appeal status listed below is the most current appeal status on file at HMS and may not reflect the most current status of your appeal with your Medicare Appeal Contractor.

Appeal statuses are available for review on the Portal for 100 days from the Disposition Date.

<table>
<thead>
<tr>
<th>RAC Case ID</th>
<th>Claim Number</th>
<th>Date Of Service From</th>
<th>Date Of Service To</th>
<th>Patient Control Number</th>
<th>Level of Appeal</th>
<th>Disposition</th>
<th>Disposition Date</th>
</tr>
</thead>
</table>

No Appeal Found.

* Reference

Level of Appeal:
- C = Clinical Reopening
- R = Redetermination
- Q = QIC
- J = ALJ

Disposition:
- A = Affirm Recovery Auditor Decision
- D = Request Dismissed by MAC
- P = Partially Favorable to Provider
- F = Fully Favorable to Provider
- W = Request Withdrawn by Provider
- Z = Remanded Back to Previous Level of Appeal

Disclaimer: This website contains proprietary, confidential and privileged information and data that may not be copied, reproduced or disseminated, in whole or part, without the prior written consent of HMS.
### New Issues Approved by CMS

All new issues that are identified by HMS must first be approved by CMS.

**Number of Records per Page**: 10

<table>
<thead>
<tr>
<th>Name</th>
<th>Number</th>
<th>Provider Type</th>
<th>Review Type</th>
<th>Date Approved</th>
<th>Region 4 States</th>
<th>Region 4 MACs</th>
<th>Region 4 States</th>
<th>Dates of Service</th>
<th>Additional Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Complex Inpatient Hospital MS-DRG Coding Validation</td>
<td>0001</td>
<td>Inpatient Hospital</td>
<td>Complex</td>
<td>11/09/2016</td>
<td>All Region 4 States</td>
<td>AB MACs</td>
<td>AB MACs</td>
<td>dates of service</td>
<td>claims that have a &quot;claim paid date&quot; which is less than 3 years prior to the Demand Letter date (automated review)</td>
</tr>
<tr>
<td>Documentation will be reviewed to determine if Cataract Surgery meets Medicare coverage criteria, meets applicable coding guidelines, and/or is medically reasonable and necessary.</td>
<td>0002</td>
<td>Outpatient Hospital, ASC</td>
<td>Complex</td>
<td>11/09/2016</td>
<td>All Region 4 States</td>
<td>AB MACs</td>
<td>AB MACs</td>
<td>dates of service</td>
<td>claims that have a &quot;claim paid date&quot; which is less than 3 years prior to the Demand Letter date (automated review)</td>
</tr>
</tbody>
</table>

1. CMS Program Integrity Manual Ch. 6, 5.3 A-C DRG Va QIO Manual Section 4130.3, ICD-9 & ICD-10 CM Coding Ha Addendums and Coding Clinic, 5. ICD-9 & ICD-10 CM Office and Reporting
1. CMS NCD 10.1, 2, CMS NCD 80.10, 80.12, 3, Noridian Date 09/16/2013, Revision 09/01/2014, Retirement Date LCD L34203, 5, Novitas LCD L32800, Effective Date 08/9/11/14, Retirement Date 9/30/2015, 6, Novitas LCD L32900.
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 100 – MS 12M
  Las Vegas, NV 89148
- Hours of Operation: 8:00 AM – 4:30 PM (All Region 4 Time Zones)

CMS
- CMS Website: Recovery Audit Program Page
- CMS E-mail Address: RAC@cms.hhs.gov
Helpful Hints

What can I do to prepare for a RAC Audit?

▪ Customize contact information
▪ Review CMS Approved New Issues posted to the website
▪ Monitor the website for announcements and updates
▪ Fax discussion requests
As a reminder…

- Additional Documentation Requests (ADRs) are sent on a 45-day cycle
- Providers have 45 days to submit medical documentation
- Reviews are completed within 30 days of receipt of medical documentation
- Discussion Requests must be received no later than 30 days from the date of the letter
- Claims may be sent to the MAC for adjustment on day 31
Questions?