HMS Federal Solutions
Region 4 - Recovery Audit Contractor

RAC Claim Reviews & Recovery Audit Process
Disclaimer

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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

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Agenda

- Review Types
- 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.

• 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
Review Types
## RAC Review Types

<table>
<thead>
<tr>
<th>Complex</th>
<th>CMS Required (Complex)</th>
<th>Automated</th>
</tr>
</thead>
</table>
| • 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. | • 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

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:
Dear Medicare Provider,

The Centers for Medicare & Medicaid Services (CMS) has retained HMS Federal to carry out the Recovery Audit Contractor (RAC) program. The RAC program, mandated by Congress, is aimed at identifying Medicare improper payments.

This notice is to request documentation for the claim(s) shown in the enclosure.

In accordance with 42 USC 1320(c) (5) (A) (3) and §1833 of the Social Security Act, you must provide documentation upon request to support claims for Medicare services. This request is in compliance with the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule, which allows release of information without explicit patient consent for treatment, payment and health care operations.

All documentation should be submitted to HMS Federal according to the enclosed instructions within 45 days of the date of this request. Your response is required even if you are unable to locate the requested documentation.
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 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)
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.

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)

<table>
<thead>
<tr>
<th>Group/Office Size</th>
<th>Max # of Requests per 45-days</th>
</tr>
</thead>
<tbody>
<tr>
<td>50+</td>
<td>50</td>
</tr>
<tr>
<td>25-49</td>
<td>40</td>
</tr>
<tr>
<td>6-24</td>
<td>25</td>
</tr>
<tr>
<td>Less than 5</td>
<td>10</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
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
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
Examples of CMS Approved Automated New Issues

- Outpatient Service Overlapping or During an Inpatient Stay
- Office Visits Billed for Hospital Inpatient
- Add-On Codes Paid Without Required Primary Code and/or Denied Primary Code – by Physician/ASC/Lab and Outpatient Claim
- 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
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
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
- 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

- 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

- 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.
Discussion Fax Form

To: HMS Part B Discussion Period Review
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
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
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
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 transferring or stored on this information system. At any time, and for any lawful Government purpose, the Government may monitor, intercept, and search and seize any communication or data transferring or stored on this information system.
  - Any communication or data transferring 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 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.
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  - Any communication or data transferring or stored on this information system may be disclosed or used for any lawful Government purpose.

(Please click box to agree)

Sign In

Forgot your password?

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# Customizable Contact Information Page

## 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>
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<tr>
<td>Affiliation/Ownership</td>
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<td>NPI</td>
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<td>Tax ID</td>
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<tr>
<td>Contact Name</td>
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<td>Title</td>
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<td>Department</td>
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<tr>
<td>Address 1</td>
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<td>Address 2</td>
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<td>Email</td>
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<tr>
<td>Previous Provider #</td>
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</tbody>
</table>

- Make both contacts identical

## Website Users

We require 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>
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</thead>
<tbody>
<tr>
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</table>

- Add Web User
- Delete

- Edit
Additional Documentation Request Tracking Page

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>Recent Control Number</th>
<th>Documentation Requested</th>
<th>Documentation Received</th>
<th>Medical Review Start Date</th>
<th>Review Letter / Review Completed Date</th>
<th>Review Outcome</th>
<th>Claim Closure Date</th>
<th>Reviewed By</th>
</tr>
</thead>
<tbody>
<tr>
<td>T</td>
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</tbody>
</table>

No Records Requested.
Informational Letter Tracking – NEW!

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 at Part A: 877-350-7992 or Part B: 877-350-7993 with any questions.

<table>
<thead>
<tr>
<th>Claim Number</th>
<th>Date Of Service From</th>
<th>Date Of Service To</th>
<th>Patient Control Number</th>
<th>Informational Letter Date</th>
<th>Claim Closure Date</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>

No Records Requested.
Discussion and Correspondence Tracking Page

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) 300-7992.

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>
</tr>
</thead>
<tbody>
<tr>
<td>T</td>
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<td>T</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>T</td>
<td>T</td>
<td>T</td>
<td>T</td>
<td>T</td>
<td>T</td>
</tr>
</tbody>
</table>

No Correspondence Found.

*Reference

- Upheld = Original improper payment finding upheld.
- Reclassified = After further review of the documentation received, it has been determined that the documentation was not a request for a discussion period. HMS will respond to your inquiry.
- Overturned = Original improper payment finding overturned.
- Dismissed = Discussion Documentation Received Late - Per CMS directive, the Auditor cannot review documentation received on or after the 31st date of the review results letter data for complex reviews and the Informational letter date for automated reviews.
## New Issues Approved by CMS

### Number of Records per Page
- **100**

<table>
<thead>
<tr>
<th>Name</th>
<th>Description</th>
<th>Number</th>
<th>Provider Type</th>
<th>Reviewer Type</th>
<th>Date Approved</th>
<th>Posted On</th>
<th>Region 4 States</th>
<th>Region 4 MACs</th>
<th>Additional Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Complex Inpatient Hospital NS-DRG Coding Validation</td>
<td>NS-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 NS-DRGs for principal and secondary diagnosis and procedures affecting or potentially affecting the NS-DRG assignment.</td>
<td>0001</td>
<td>Inpatient Acute Care Hospital</td>
<td>Complex</td>
<td>11/23/2015</td>
<td>04/15/2017</td>
<td>All Region 4 states</td>
<td>AB MACs</td>
<td>Claims that have a &quot;claim paid date&quot; which is less than 3 years prior to the date of the medical record request (complex review).</td>
</tr>
<tr>
<td>Cataract Removal Medical Necessity and Coding Requirements</td>
<td>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.</td>
<td>0002</td>
<td>Outpatient Hospital / Ambulatory Surgical Center</td>
<td>Complex</td>
<td>11/23/2016</td>
<td>04/15/2017</td>
<td>All Region 4 States</td>
<td>AB MACs</td>
<td>Claims having a &quot;claim paid date&quot; with three years of the KVIR dates.</td>
</tr>
</tbody>
</table>

### CMS Approved New Issues Page

- **Provider Number:** [Search]
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: 7:00 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/Index
- 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
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 may be available; Contact HMS Provider Relations to inquire.
- Discussion Requests received after the 30th day from the date of the letter cannot be reviewed.
- 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.
Thank you for your kind attention

Are there any questions?