Statement of Work (SOW) for the Part A/B Medicare Fee-for-Service Recovery Audit Contractor (RAC) – Region 1

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SOW for the RAC Region 1

I. Purpose

The Recovery Audit Program's mission is to reduce Medicare improper payments through the efficient detection and correction of improper payments. The purpose of this statement of work (SOW) includes all tasks and responsibilities associated with the review of Medicare Fee-for-Service (FFS) claims submitted to, and paid by, the A/B Medicare Administrative Contractors (MACs) in RAC Region 1 (see map in the Appendices section). This excludes Durable Medical Equipment, Prosthetics, Orthotics, and Supply (DMEPOS) claims and Home Health/Hospice (HH/H) claims. The RAC shall review all applicable claim types submitted to an A/B MAC through the appropriate review methods and work with the Centers for Medicare & Medicaid Services (CMS) and MACs to effectuate the adjustment of claims, recoupment of overpayments, payment of underpayments, support the appeals process and reporting the status of all reviews by updating the RAC Data Warehouse (RACDW) and providing monthly reports in a timely, accurate, and efficient manner.

II. Background

Section 1893(h) of the Social Security Act authorized a nationwide expansion of the Recovery Audit Program, and required the Secretary of the Department of Health and Human Services to utilize RACs under the Medicare Integrity Program to identify underpayments and overpayments and recoup overpayments associated with services and items for which payment is made under Part A or B of Title XVIII of the Social Security Act. The CMS is required to actively review Medicare payments for services to determine accuracy and, if errors are identified, to pursue the collection of any payment made in error. To gain additional knowledge, offerors may research the following documents:

- The CMS IOM Program Integrity Manual (PIM) at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS019033

- The Debt Collection Improvement Act of 1996
  - SEC. 31001 - (3)(A)(ii)(c)(6) and (7)(A)(B)

- The Federal Claims Collection Act, as amended and related regulations found in 42 CFR
  - Title 42 CFR Subpart D – Medicare Integrity Program Contractors
  - Title 42 CFR Subpart E – Medicare Administrative Contractors

- National Coverage Determinations (NCDs) and Local Coverage Determinations (LCDs) (see https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx)

- Comprehensive Error Rate Testing Reports (see https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/CERT/CERT-Reports)

- Recovery Audit Program Status Documents and Reports to Congress (see https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Recovery-Audit-Program/Resources)

- Health Insurance Portability and Accountability Act of 1996 (Public Law 104-191), Title 2 -- PREVENTING HEALTH CARE FRAUD AND ABUSE; ADMINISTRATIVE SIMPLIFICATION; MEDICAL LIABILITY REFORM
    - Subtitle C – Data Collection
    - Subtitle F – Administrative Simplification

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 error (such as an incorrect code, or incorrect/missing modifier), but the payment amount is not altered by the error, are not considered improper payments for the Medicare FFS Recovery Audit Program.

III. Requirements

i. General Requirements

The SOW is subject to Sections 504 and 508 of the Rehabilitation Act of 1973 (29 U.S.C. 794d) as amended by the Workforce Investment Act of 1998 (P.L. 105-220). All documentation created by the contractor and submitted to CMS is subject to Sections 504 and 508 Compliance for Communications as applicable. At the discretion of the CMS RAC COR, 508 compliance may be waived for working documents including draft versions of documents and versions of documents not yet accepted by the COR. For more information, see Appendix D "508 Standards per the Revised Section 508 of the Rehabilitation Act".

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 all requirements of this SOW.

CMS will provide minimum administrative support, which may include standard system changes when appropriate, help communicating with Medicare contractors, policy interpretations as necessary and other support deemed necessary by CMS to allow the RAC to perform their tasks accurately and efficiently. The 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 additional administrative tasks being placed on the RAC that were not previously present. These administrative tasks will be within the scope of this contract and will be applicable to the identification and recovery of improper payments.

ii. System Requirements and Data Accessibility

The RAC shall be responsible for obtaining the appropriate hardware, software, and telecommunications equipment to undertake and fully complete all the tasks within this SOW. It is the responsibility of the RAC to have available the personnel needed to design, build, and maintain a system, in the appropriate environment, meeting CMS standards, without assistance from CMS. Resources available to the RAC include the CMS Risk Management Handbook (RMH) and the CMS Acceptable Risk Safeguards (ARS) publication. The RAC shall comply with the CMS Security Assessment and Authorization (SA&A) methodology, policies, standards, procedures, and guidelines for Contractor facilities and systems. When using or disclosing protected health Information (PHI), the RAC shall be in compliance with the Health Insurance Portability and Accountability Act (HIPAA).

RACs shall comply with CMS policies and other requirements below, as well as documents referenced within those policies:

- CMS Policy for Information Security (PIS) (as amended) – The high level CMS policy for the CMS Information Security Program, and is available at http://www.cms.gov/Research-Statistics-Data-and-Systems/CMS-Information-Technology/InformationSecurity.
- CMS Policy for the Information Security Program (PISP) (as amended) - Sets the ground rules under which CMS shall operate and safeguard its information and information systems to reduce the risk and minimize the effect of security incidents. This document will subsequently reference the Contractor-applicable ARS manual and the RMH, Volumes I, II, and/or III Security Standards and Procedures, and is available at http://www.cms.gov/Research-Statistics-Data-and-Systems/CMS-Information-Technology/InformationSecurity.
- CMS Policy for Investment Management and Governance (as amended) – Establishes the policy for systematic review, selection/reselection, implementation/control, and continual evaluation of IT investments at CMS, and is available at http://www.cms.gov/Research-Statistics-Data-and-Systems/CMS-Information-Technology/ITInvestman/index.html.
- Cloud Services - All cloud-specific requirements will be as defined in Section 1.3, Cloud-based Services. However, for information identified as Personally Identifiable Information (PII), Protected Health Information (PHI), and/or Federal Tax Information (FTI), the additional security and privacy requirements listed in the ARS manual Implementation Standards (as amended), as applicable to PII, PHI, and/or FTI, shall be applied within cloud-based services.
- The CMS Information Security website at http://www.cms.gov/Research-Statistics-Data-and-Systems/CMS-Information-Technology/InformationSecurity provides a list of applicable security policies and procedures across the program.

  A summary of these requirements are listed in the Applicable Laws and Regulations sections of the above listed CMS policies, as well as in the Applicable Laws and Regulations section of the Health and Human Services (HHS) Office of the Chief Information Officer (OCIO) Policy for Information Systems Security and Privacy,

available at http://www.hhs.gov/ocio/policy/index.html.

To access CMS data, the RAC shall acquire a secure line between the RAC and the CMS Data Center. The RAC shall acquire the appropriate software to enter into the CMS Data Center. IBM/Sterling Commerce Connect:Direct software is currently being utilized for this purpose. There is no other alternative software. The RAC shall incur all costs associated with the establishment and maintenance of the secure line, as well as license costs. The RAC will be responsible for negotiating their own commercial license and cost with the vendor. These costs are not controlled by CMS and may increase at any time.

The RAC may be required to provide testing to ensure data transfers are secure and successful. After the secure line is established, any testing is completed, and any corrective actions identified as a result of testing have been taken, CMS will provide the RAC with all necessary data files under the terms of this contract for the applicable geographic area. The RAC will receive new data updates on a monthly basis. The data file format, data fields available and user agreements are available upon request.

If any problems arise with the transfer of data files, the RAC shall undertake all necessary steps in troubleshooting the cause of the problem. The RAC shall request assistance from CMS only after all steps have been taken to ensure the problem does not originate from the contractor side. If the problem is found to have been caused by CMS, CMS will take steps to re-send the data correctly.

If a newly awarded RAC requires National Claims History (NCH) historical claims data files, for the awarded RAC region(s), the CMS Office of Technology Solutions (OTS) requires the RAC to submit an external hard drive. The external hard drive shall be submitted to the CMS RAC COR. The hard drive shall be capable of storing a minimum of two (2) terabytes of data. A previously used hard drive can be used, but must be stripped of any previous data. A RAC that has more than one RAC region is required to provide a separate hard drive for each region.

CMS will provide approximately three years of historical claims data divided by provider type to each RAC region. The historical claims data files will contain all provider types, including inpatient, carrier, skilled nursing facility, home health, and durable medical equipment, as appropriate to the awarded contract. The historical claims data will differ in format from the NCH monthly tap file claims transmissions. The record layouts for the historical claims data files are on the following DESY website www.cms.gov/DESY in folders Version K SAS Copylibs and Version K COBOL Copylibs. (The version may be subject to change.)

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

The RAC shall incur 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 RAC shall pay for all charges associated with the storage and processing of any data necessary to accomplish SOW directives.

Receiving and Transmitting Medical Records/Documentation

Although providers are not mandated to electronically store or transmit medical records, the RAC shall possess the technology to accept documentation via electronic transmission. The RAC shall accept medical records submitted electronically, e.g. fax, CD, DVD, or transmitted via electronic submission of medical documentation (esMD). Before additional documentation requests (ADRs) may be sent, the RAC shall have the capability to receive medical records via esMD.

The RAC shall also accept medical records/documents submitted as (paper) hard copies. Hard copy records shall be scanned into the RAC's secure internal document management system. When scanning, the RAC shall ensure, as much as possible, that the scanned documents maintains appearance, size, form, shading, and fonts of the original documents. After successfully scanning, hard copy records shall be disposed of using appropriate records management procedures.

When transmitting medical records/documentation, the RAC shall use a secure transmittal process. Secure transmittal means sent in accordance with the CMS business systems security manual – e.g., mailed CD, MDCN line, through a clearinghouse, esMD transmittal.

iii. System Security Requirements

The RAC shall establish and maintain back-up and recovery of systems in accordance with "CMS Information Security (IS) Application Contingency Plan (CP) Procedures" and "CMS Contingency Planning Tabletop Testing Procedures[1]." The RAC shall comply with all CMS privacy and security requirements. The RAC shall provide all personal computers, printers, and equipment to accomplish the work described herein throughout the contract term.

The RAC shall conduct or undergo an independent evaluation and test of its systems security program in accordance with the CMS Business Partners System Security Manual, 100-17. The Contractor's first independent evaluation and test of its systems security program shall be completed prior to the Contractor commencing claims payment under the contract. Any deficiencies noted as a result of the independent evaluation and test of its systems security program shall be corrected prior to the processing of claims.

The RAC shall conduct, at a minimum, annual vulnerability assessments of its systems, programs, and facility in accordance with the CMS Business Partners System Security Manual, 100-17, Continuous Monitoring.

- The RAC shall support CMS validation and accreditation of Contractor systems and facilities in accordance with CMS' SA&A methodology, through which an organization

[1] http://www.cms.gov/Research-Statistics-Data-and-Systems/CMS-Information-Technology/InformationSecurity/Information-Security-Library.html

establishes and demonstrates a sound information security posture for its system.

- The RAC shall provide annual certification, in accordance with SA&A procedures, that certifies it has examined the management, operational, and technical controls for its systems supporting the RAC function and considers these controls adequate to meet CMS security standards and requirements.

- The RAC shall ensure security documents are uploaded and security controls are documented timely in the CMS FISMA Control Tracking System (CFACTS). The RAC shall correct any security deficiency, conditions, weaknesses, findings, or gaps identified by all CMS audits, reviews, evaluations, tests, and assessments within the timeframes requested. The RAC shall begin the process to obtain an Authority to Operate (ATO) within 60 days of contract award.

- While the RAC is working towards obtaining an ATO, they are expected to perform all aspects of the SOW manually, using methods approved by the CMS RAC COR. The quality of the work delivered shall be entirely accurate, complete, and containing no errors. Granting of an ATO is based on the RAC's system meeting/exceeding the minimum federal, Health & Human Services (HHS), and CMS Security and Privacy policy and standards. The CMS security requirements, policies, procedures, standards, and guidelines are located at CMS Information Security and Privacy "Virtual Handbook" at: http://www.cms.gov/InformationSecurity as well as the Information Security and Privacy Library at: https://www.cms.gov/Research-Statistics-Data-and-Systems/CMS-Information-Technology/InformationSecurity/Information-Security-Library.html.

CMS will take all measures necessary to minimize system security risks, including stopping the transmission of NCH data to the RAC, ceasing reviews, and terminating the RAC contract, if necessary.

IV. Personnel Requirements

The RAC shall ensure that the key personnel and additional personnel listed below will comprise an adequate structure to perform the tasks outlined in the SOW. The CMS COR has the right to waive any of the below requirements at their discretion for the key personnel requirements listed below, in order to benefit the government.

RAC personnel shall be required to undergo a background investigation commensurate with the *Homeland Security Presidential Directive (HSPD) 12* position-sensitivity levels for the Personal Identity Verification (PIV) card required to access, develop, or host and/or maintain a Federal information system(s). All RAC employees shall comply with the conditions established for their designated position sensitivity level prior to performing any work under this contract. Additional information regarding PIV card credentialing shall be communicated by the CMS RAC COR.

i. Key Personnel

At a minimum, the RAC shall designate a Project Manager, Contractor Medical Director (CMD), Chief Information Officer (CIO) and Systems Security Officer (SSO) as key personnel. The RAC may designate additional key personnel at its discretion.

The RAC shall submit a CMS approved contingency plan and designate fully qualified (meets the required experience and education requirements) backups for each key personnel role (including a CMS User ID and access to the RACDW) . The designated backup personnel shall ensure, to the greatest extent possible, continuity of operations and minimal interruptions in the event of an unexpected departure of key personnel. All backup positions, while working in the backup capacity, may be a part-time RAC employee, but must work full-time while serving in a key personnel position.

The key personnel specified in this contract are considered to be essential to work performance. At least 30 days prior to the contractor voluntarily diverting any of the specified individuals to other programs or contracts the RAC shall notify the CMS RAC COR and Contracting Officer (CO) and shall submit a justification for the diversion or replacement and a request to replace the individual. The request must identify the proposed replacement and provide an explanation of how the replacement's skills, experience, and credentials meet or exceed the requirements of the contract. If the employee of the contractor is terminated for cause or separates from the contractor voluntarily with less than thirty days' notice, the RAC shall provide the maximum notice practicable under the circumstances. The RAC shall not divert, replace, or announce any such change to key personnel without the written consent of the CMS RAC COR. The contract will be modified to add or delete key personnel as necessary to reflect the agreement of the parties.

"For this SOW, "fully dedicated" means that the individual identified for the position shall be a Full Time Equivalent (FTE) employee. Fully dedicated key personnel may work on another RAC Region contract, in a "back-up" capacity only." This individual may not perform duties on any Medicare/non-Medicare contract or commercial line of business without approval by the CMS CO.

Project Manager

The Project Manager shall be fully dedicated to this contract and shall act as a central point of contact with CMS and other stakeholders. The Project Manager shall be available to the CMS RAC COR during normal business hours (8:00 – 5:00 pm ET). If the Project Manager is not going to be in the office due to vacation, etc., the CMS RAC COR will be notified at least one day in advance. In such cases, the Project Manager will designate a "back-up" person to serve as the central point of contact with CMS. Anyone serving as a back-up for the Project Manager will be required to have the ability to answer questions and/or provide data to the same degree that the Project Manager would be able to provide to CMS.

Work Experience

The Project Manager shall have 10 or more years of previous work experience, with at least three years' experience as a project manager, preferably with large, complex projects. The Project Manager shall have knowledge of the Medicare program, with knowledge of CMS FFS Recovery Audit Program requirements and activities being preferable.

Education

The Project Manager shall possess a bachelor's degree from an accredited institution, plus a master's degree from an accredited institution or substitution of four (4) additional years of related work experience in lieu of the master's degree.

Contractor Medical Director (CMD)

The CMD shall be fully dedicated to this contract. The RAC shall arrange for an alternate CMD when the prime CMD will be unavailable for an extended period. The CMD must be either a Doctor of Medicine or a Doctor of Osteopathy who has relevant work and educational experience to oversee the review of Medicare FFS claims. More than one individual's time cannot be combined to meet the one FTE minimum. The CMD must be approved by CMS.

Primary duties include:

- 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;
- Serving as a readily available source of medical information to provide guidance in questionable claim review situations;
- Recommending when LCDs, NCDs, provider education, system edits or other corrective actions are needed or must be revised to address RAC identified vulnerabilities;
- Overseeing the medical review process and providing the clinical expertise and judgment to understand LCDs, NCDs and other Medicare policy;

Other duties include:

- Discussing claim review determinations with providers upon request;
- Interacting with the CMDs of other contractors and/or RACs to share information on potential problem areas;
- Participating in CMD clinical workgroups as appropriate;
- Upon request, providing input to CMS on national coverage and payment policy;
- Participating in CMS/RAC presentations (approved by the CMS RAC COR) to providers and associations.

To prevent conflict of interest issues, the CMD must provide written notification to CMS within three 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.

Work Experience

- A minimum of 3 years' experience practicing medicine as a board-certified physician with no previous sanctioning or exclusion from the Medicare program.
- Prior work experience in the health insurance industry, utilization review firm or another health care claims processing organization.

- Extensive knowledge of the Medicare program particularly the coverage and payment rules.
- Public relations experience such as working with physician groups, beneficiary organizations or Congressional offices.

Education and Licensure

Experience practicing medicine as a board-certified Doctor of Medicine or Osteopathy or Doctor who is currently licensed to practice medicine. The RAC shall periodically verify that the CMD's license is current. When recruiting CMDs, the RAC should give preference to physicians who have patient care experience and are actively involved in the practice of medicine.

Chief Information Officer (CIO)

The RAC shall appoint a CIO to oversee its compliance with the CMS information security requirements. The CIO may oversee lines of business, other than this contract.

Work Experience

The CIO shall possess knowledge of and extensive practical experience in information technology (IT) practices, including security controls, in large organizations and significant managerial or other practical involvement relating to IT management.

Systems Security Officer (SSO)

The RAC shall designate a principal (i.e., primary) SSO qualified to manage the Medicare information security program and ensure the implementation of necessary safeguards. The Contractor's Systems Security Officer (SSO) may oversee other lines of business, other than this contract.

The SSO shall be dedicated to assisting the CIO in fulfilling compliance with the CMS information security requirements. The SSO shall be organizationally independent of IT operations. The SSO can be within the CIO organizational domain but cannot have responsibility for operation, maintenance, or development. The SSO will perform duties in accordance with IOM Pub. 100-17, see https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS019466 the CMS Business Partner System Security Manual (BPSSM).

Work Experience

The SSO shall possess three years of practical experience in information technology (IT) systems security policies, procedures and practices to manage security administrative duties in large organizations.

ii. Medical Review Personnel

Certified Coders

Each RAC is required to employ certified coders to perform complex coding validations. Certified coders are those professionals who earn their certification from an accredited association such as the American Association of Professional Coders (AAPC) or American Health Information Management Association (AHIMA). Health care professionals are obligated to stay current in their profession. This includes continuing education in their respective discipline and keeping abreast of current medical coding updates, compliance rules, and government regulations.

Certified Coders may also be Registered Health Information Administrators (RHIA) and Registered Health Information Technicians (RHIT) who have been credentialed by AHIMA in their field of health information. These coders must have at least five years direct coding or billing experience in the specific coding field. That is, an RHIT or RHIA who will be reviewing DRG Validation must have experience in coding or billing DRGs for at least five years before performing coding review for the RAC. The CMS reserves the right to review the credentials of certified coders, RHIA and RHIT at any time under this SOW.

Registered Nurses

Each RAC is required to employ registered nurses with previous experience in medical record review. Registered nurses are required to have current licenses in nursing in the United States. The RAC must ensure that the license is current. The CMS reserves the right to review the credentials of registered nurses at any time under this SOW.

Therapists

Each RAC is required to employ Therapists (e.g. physical therapist, occupational therapist, and speech-language pathologists) with previous experience in medical record review. Therapists are required to have current therapy licenses in the United States. The RAC must ensure that the license is current. The CMS reserves the right to review the credentials of Therapists at any time under this SOW.

Other Clinicians

In addition to the required clinicians listed above, the RAC may employ other clinicians to perform medical review. However, only licensed clinicians with previous experience in medical record review may review medical records for medical necessity. The clinician must have an understanding of Medicare policies as well as LCDs and NCDs.

Regardless of license type, all clinicians (including Registered Nurses, Therapists, etc.) must possess three (3) years previous medical record review experience and at least three (3) years of current and/or relevant clinical experience in a variety of health care settings. Examples include but are not limited to: acute care, sub-acute care, long term care, rehabilitative services, home health, skilled nursing, diagnostic services, and outpatient services/settings.

Also, in additional to the CMD, the RAC is encouraged to utilize the expertise of a panel of board-certified clinical specialists, for consultation when performing medical review.

iii. Other Personnel

o..Customer Service Program Manager

The Customer Service Program Manager: possess a history of providing effective oversight of customer service staff. The Customer Service Program Manager will have a focus on handling customer inquiries/questions and the education of these customers. The scope of the education provided is limited to only that of the RAC processes. RACs are prohibited from providing education on the interpretation of Medicare and/or payment policy.

a. Systems Analyst

The Systems Analyst is primarily responsible for an organization's current computer systems, procedures, and design information systems solutions to help the organization operate more efficiently and effectively. The Systems Analyst may be a part-time position. The professional shall possess a bachelor's degree in an IT related field from an accredited institution, and at least five (5) years of related work experience. In lieu of a bachelor's degree an additional three (3) years of related work experience may substituted.

b. System Administrator

The System Administrator is primarily responsible for the upkeep, configuration, and reliable operation of computer systems. The System Administrator may be a part-time position. The professional shall possess a bachelor's degree in an IT related field from an accredited institution, and at least five (5) years of related work experience. In lieu of a bachelor's degree an additional three (3) years of related work experience may substituted.

c. Application Developer

The Application Developer is primarily responsible for designing, developing, and programming successful software. The Application Developer may be a part-time position. The professional shall possess a bachelor's degree in an IT related field from an accredited institution, and at least five (5) years of related work experience. In lieu of a bachelor's degree an additional three (3) years of related work experience may substituted.

d. 508 Compliance Officer

The 508 Compliance Officer possesses a bachelor's degree from an accredited institution. In absence of a bachelor's degree, on the job experience may be substituted for the required education on a year-for-year basis.

Any changes to the RAC's organizational chart (down to the first line management) shall be submitted to the CMS RAC COR within seven (7) business days of the actual change being made. First line management is RAC specific and refers to any individuals charged with the oversight responsibility of audit reviewers, analysts, customer service representatives, and any other staff essential to recovery audit operations. The first line management may include personnel involved in daily communications with the CMS RAC COR. This direction

excludes changes to key personnel, which shall be communicated immediately to and approved by CMS before the transition occurs.

V. Specific Tasks to Be Performed

i. Task 1: Initial Meeting with CMS

The RAC's project staff (including key personnel, the Project Manager, CMD, CIO and SSO) shall meet at CMS in Baltimore, Maryland with the CMS RAC COR and appropriate CMS staff within two weeks of the date of award to discuss the project plan. During the meeting, the terms and conditions of the Region 1 RAC contract will be discussed. Topics will include: CMS staff and RAC staff roles and responsibilities, invoice procedures, security requirements, and other CMS expectations for the work being performed under this contract, and answer any questions or concerns from the RACs.

The following RAC personnel are required to attend the Initial Meeting:

- Project Manager
- Contract Medical Director
- Medical Review Manager
- Chief Information Officer/System Security Officer

Each RAC shall submit a list, containing the names, and roles, of each RAC staff member who will be in attendance. This list shall be submitted to the CMS RAC COR via email, no less than one week prior to the meeting unless otherwise directed by the CMS RAC COR.

ii. Task 2: Project Plan

The Project Plan outlines the resources and timeframe(s) for completing all work activities associated with this SOW.

Draft Project Plan

Within two weeks after the initial meeting with CMS, the RAC shall submit a draft project plan. The draft project plan will be for the base year of the contract. The draft project plan and all subsequent project plans must be approved by the CMS RAC COR, prior to implementation.

The draft project plan shall include the following:

- Detailed RAC Organizational Chart, identifying the names and titles of all key personnel, essential personnel, first-line management, and all Medical Review Personnel.
- Contingency plan for dealing with unexpected changes in any key personnel or Essential Personnel. Contingency plans must be approved by the CMS RAC COR, before implementation.
- Provider Outreach Plan, detailing all potential and planned outreach efforts to associations, individual providers, provider groups, Medicare contractors, and other applicable Medicare stakeholders.

Subsequent Project Plans

The Project Plan is an evolving document that must be updated quarterly. It is the RAC's responsibility to update the project plan as new review topics are approved. The subsequent project plans shall include the following:

- Detailed RAC Organizational Chart, identifying the names and titles of all key personnel, essential personnel, first-line management, and all Medical Review Personnel.
- Contingency plan for dealing with unexpected changes in any key personnel or Essential Personnel. Contingency plans must be approved by the CMS RAC COR, before implementation.
- Proposed quarterly projections by: a) review topics[2]; b) type of review (automated, complex, extrapolation); c) type of error (medical necessity, incorrect coding, etc.)
- Joint Operating Agreements (JOAs) review and signature due dates.

iii. Task 3: Identification of Improper Payments on Postpayment Review

The RAC shall perform postpayment review on all Medicare claim types and provider types to identify improper payments (overpayments or underpayments), which were made under Part A or Part B (excluding HH/H and DMEPOS) of Title XVIII of the Social Security Act. This includes review of claims/providers that have a high propensity for error, based on the Comprehensive Error Rate Testing (CERT) program and other CMS analysis.

The RAC shall comply with Reopening Regulations located at 42 CFR 405.980. Before a RAC makes a decision to reopen a claim, the RAC must have good cause and shall clearly document the good cause in review proposals and correspondence (review results letters, ADRs, etc.) to providers. Additionally, the RAC shall develop processes to minimize provider burden to the fullest 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 negatively impact the provider's ability to provide care. The RAC shall perform this analysis prior to requesting records. CMS has the authority to create/revise ADR limits at any time. ADR limits will be provided via technical direction or as otherwise instructed by CMS.

At its discretion, CMS may impose minimum percentage review requirements by claim type. Requirements may be based on improper payment findings in the CERT program or other CMS data analysis. The CMS will perform routine evaluations to ensure the RAC is reviewing all claim types as directed.

To assist the Recovery Audit Program, CMS works closely with the claim processing contractors to establish monthly workload figures. The workload figures are typically modified annually, with the option for further modification, as necessary. Workload limits equate to the number of claims that a claims processing contractor is required to adjust on a monthly basis. Should the RAC demonstrate a backlog of claims for a claims processing

[2] All proposed and approved RAC Topics are posted to the Medicare Fee-for-Service Recovery Audit Program webpage.

contractor, and have projections showing the necessity for a sustained higher monthly workload, the CMS will consider increasing future workload limits.

A. Improper payments included in this SOW

Unless prohibited by Section B or Section C below, the RAC may attempt to identify improper payments (overpayments or underpayments) 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
- Laboratory
- Ambulance
- Skilled Nursing Facility
- Inpatient Rehabilitation Facility
- Critical Access Hospitals
- Long Term Care Hospitals
- Ambulatory Surgical Center
- Other (such as Comprehensive Outpatient Rehabilitation Facilities, Rural Health Clinics, and Independent Diagnostic Testing Facilities; excluding DMEPOS, Home Health and Hospice)

The RAC shall review all provider types listed above. The CMS conducts periodic evaluations of the RAC's performance. If the CMS RAC COR determines the RAC is not effectively reviewing all claim/provider types during these evaluations, CMS will consider official contract action.

B. Improper payments excluded in this SOW

The RAC may **not** attempt to identify improper payments (overpayments and underpayments) arising from any of the following:

- **Services provided under a program other than Medicare Fee-For Service –** For example, the RAC shall **not** attempt to identify improper payments in the Medicare Managed Care program or drug benefit program.

- **Cost report settlement process and Medical Education payments –** The RAC shall **not** attempt to identify underpayments and overpayments that result from Indirect Medical Education (IME) and Graduate Medical Education (GME)

payments. The RAC shall not review cost report settlements for overpayment/underpayment identification.

- **Claims more than three (3) years past the date of the initial determination –** The RAC shall **not** attempt to identify any overpayment or underpayment more than **three years** past the date of the initial determination made on the claim. The initial determination date is defined as the claim paid date documented in the Common Working File (CWF). Any overpayment or underpayment inadvertently identified by the RAC after this timeframe shall be set aside. The RAC shall take no further action on these claims except to indicate the appropriate status code in the RACDW. The look back period is conducted starting from the date of the initial determination and ending with the date the RAC issues the medical record request letter (for complex reviews) or the date of the overpayment notification letter (for automated reviews).

- **Random selection of claims** – The RAC 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[3]. Therefore, the RAC shall not use random review in order to identify cases for which it will request medical records from the provider. Instead, the RAC shall utilize data analysis techniques in order to identify those claims most likely to contain overpayments. This process is called "targeted review". The RAC 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 RAC to believe it is likely to contain an overpayment.

- **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 RAC. CMS attempts to remove these claims from the data prior to transmission to the RAC.

  For example: Providers/suppliers submitting claims subject to prior authorization must include a valid Unique Tracking Number (UTN). The UTN is available on the face of the claim and is therefore, visible to the RAC in their respective National Claims History (NCH) data. RACs shall exclude from review claims with the UTN present in order to avoid capturing claims subject to prior authorization.

The CMS reserves the right to limit the number of reviews or the time period available for review by RAC, state, claim type, provider type, or 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 (includes e-mail) and will be effective immediately.

[3] Per instruction in the Program Integrity Manual (PIM), random sampling may be used for the purposes of estimating overpayments (i.e. extrapolation).

C. Underpayments

The RAC shall review claims using automated, or complex, review to identify potential Medicare underpayments. Upon identification, the RAC will communicate the underpayment finding to the appropriate MAC. The RAC shall not ask the provider to correct and resubmit the claim. The RAC shall obtain approval of the underpayment notification letter language from the CMS RAC COR before issuing the first letter.

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

1. **Examples of an Underpayment:**
   - The provider billed for 15 minutes of therapy when the medical record clearly indicates 30 minutes of therapy was provided. (Certain HCPCS/CPT codes are measured in 15 minute increments and are called "timed" codes. These services require direct (one-on-one) patient contact. When reporting a 15-minute service, the provider should enter "1" in the field labeled units on the claim form. The provider in this scenario is entitled to 2 units.)
   - 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.
   - 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.

2. **The following will NOT be considered an Underpayment:**
   - 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.)
   - 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.)
   - 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.

3. **Provider Inquiries (Not Requested by RAC)**
   The RAC does not have responsibility to randomly accept case files from providers for an underpayment case review. If the RAC receives case files from providers that they did not request, the RAC is under no obligation to respond to the provider, and

shall be disposed of using appropriate records management procedures.

iv. Task 4: Obtaining, Storing, Sharing, and Paying for Medical Records

A. Obtaining medical records

The RAC shall not perform onsite visits. Instead, the RAC shall request the needed medical records in writing, using an Additional Documentation Request (ADR) Letter.

The RAC shall accept medical records submitted electronically, e.g. fax, CD, DVD, or transmitted via electronic submission of medical documentation (esMD), and submitted as (paper) hard copies. Although providers are not mandated to electronically store or transmit medical records, the RAC shall possess the technology to accept documents via electronic transmission. The documentation received following the issuance of an ADR or received during a discussion period, shall be stored properly, while maintaining as much as possible the document's original appearance including: size, form, color and fonts. Should the RAC received medical records and/or correspondence in a language other than English, the RAC shall possess the necessary software required to translate the documentation or be required to close the review.

The RAC shall comply with all CMS business system security requirements when entering into arrangements regarding the transmission of medical records and other documentation.

Before ADRs may be sent to providers that use esMD, the RAC shall have the capability to receive medical records via esMD.

Additional Documentation Request Limits

The CMS sets ADR limits for Institutional (Facility) Providers, Physician/Non-physician Practitioner, and DMEPOS Suppliers. Institutional ADR limits are diversified across all claim types of a facility (e.g. outpatient hospital, physicians, etc.). Current limits can be found in the Downloads Section of the CMS Recovery Audit Program website at the following URL: https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Recovery-Audit-Program/Resources

The CMS will establish a method to adjust the ADR limits based on a provider's compliance with Medicare rules. This will result in providers with low denial rates having lower ADR limits, while providers with high denial rates will have higher ADR limits. Denial rates will be assessed by CMS on a regular basis. Adjustments to providers' ADR limits shall only be made by CMS.

The ADR 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 45-day period and the RAC does not request medical records in January and February, the RAC cannot request 150 records in March.

The RAC may deny claims where documentation is not submitted; however, the RAC shall initiate at least one additional contact with a provider (through a letter, phone call, portal notification, or any other acceptable method) before denying the claim. The RAC shall allow all providers at least one extension for the submission of additional documentation.

ADR limits will be incrementally applied, per CMS instruction, to new providers under review. This will ensure that a provider who has not received previous ADRs is able to respond to the request timely, with current staffing levels.

The CMS reserves the right to change the timeframe for which providers have to submit additional documentation.

All medical record 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.

B. Storing and sharing medical records

The RAC shall make available to CMS, the MACs, QICs, OIG, and others as indicated by the CMS RAC COR any requested medical record. Records and case files can be transmitted via a secure line, secure CD, MPLS, or another method prescribed by CMS.

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

- provide a document management system,
- have the capability to receive and transmit esMD transmissions to providers, CMS and other Medicare contractors,
- 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.

Upon the end of the contract, the RAC shall send copies of the imaged records to the entity specified by the CMS RAC COR.

C. Paying for Medical Records

The RAC shall pay the provider for medical records in accordance with the current guidelines prescribed in the PIM (currently located in section 3.2.3.6), unless otherwise directed by the CMS RAC COR

The RAC is not required to reimburse providers for the additional documentation submitted during the Discussion Period.

D. Maintaining a Case File

The RAC shall maintain a complete case file for every complex reviewed claim, and every claim containing an improper payment identified through automated review. At a minimum, the case file shall include:

- A copy of all ADR and reminder letters
- Contacts with MACs, CMS or OIG
- Dates of any calls made, and
- Notes indicating what transpired during the call
- A copy of the no finding letter or review results letter
- Any discussion requests (including documentation received) and discussion decisions
- The date the claim was sent to the MAC for adjustment
- Accounts receivable information
- The demand letter date and amount
- Any appeal requests and decisions

When requested, the entire case file shall be available to be sent to CMS within seven (7) days of the request. Any costs (e.g., materials, shipping) associated with the file transfer to CMS shall be incurred by the RAC.

Annual Submission of Case Files to CMS

The RAC shall submit case files to the CMS RAC COR on an annual basis, following each contract year/period, including the base year and each option year/period. The RAC shall download all case file documents listed above, in the appropriate formats (e.g. Portable Document Format (PDF), Microsoft Word, etc.) onto accessible hard drives, for reviews that occurred during the immediately preceding contract year/period. For example, if the base year of the RAC contract was November 1, 2017 – October 31, 2018, the submitted hard drive(s) would contain case file documents for all activities that occurred during that timeframe.

Case files shall be submitted for all:

- Complex Reviews with "No Findings" letters sent
- Complex Reviews with Demand Letters sent
- Automated Reviews with Informational Letters issued

Additional details regarding the annual submission of case files shall be provided by the CMS RAC COR via Technical Direction Letter (TDL).

v. Task 5: Claim Review Process

Unless otherwise directed in this SOW, or through TDL from the CMS RAC COR, or through CMS-approved review guidelines, the RAC shall follow all policies in the PIM (100-08) regarding claim reviews.

A. Types of Reviews

1. Automated Review

Automated review occurs when a RAC makes a claim determination at the system level without a human review of the medical record.

Coverage/Coding Determinations Made Through Automated Review:
The RAC 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 RAC 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 RAC shall not use automated review. Examples of Medicare-sanctioned coding guidelines include CPT statements and Coding Clinic statements.

EXCEPTION: If the RAC identifies a "clinically unbelievable" issue (i.e., a situation where certainty of noncoverage or incorrect coding exists but no Medicare policy, Medicare articles or Medicare-sanctioned coding guidelines exist), the RAC may seek CMS approval to proceed with automated review.

Other Determinations Made Through Automated Review:
The RAC 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 may not exist for these situations.

2. Complex Review

Complex review occurs when a RAC makes a claim determination utilizing human review of the medical record or other required documentation. The RAC may use complex review in situations where the requirements for automated review are not met or the RAC 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. Copies of medical records will be needed to provide support for the improper payment.

Staff Performing Complex Coverage/Coding Reviews
Whenever performing complex coverage or coding reviews (i.e., reviews involving the medical record), the RAC shall ensure that coverage/medical necessity determinations are only made by licensed RNs or licensed therapists, who have previous medical review experience and have an understanding of Medicare policies

(including LCDs and NCDs), and that coding determinations are only made by certified coders.

Per standard coding guidelines, coders are trained to always select, and assign, the code with the highest level of specificity, based on the available documentation. Therefore, the RAC shall code the revised principal, secondary diagnosis, or procedures affecting or potentially affecting the MS-DRG assignment to the *highest level* of specificity per coding guidelines whether it impacts the MS-DRG or not.

In provider notification letters, the RACs shall provide a detailed level of feedback to the providers regarding errors in their claims. This detail includes a description of each identified coding error, including which code should have been applied by the provider/supplier, whether that code changes the provider/supplier's payment, or not.

If the RAC uses software to assist in coding reviews, the RAC shall only use this resource as a guide in determining the appropriate code. Coding software and "crosswalks" shall not be used to make a determination without additional verification and review of the medical record by a certified coder.

If CMS has questions/concerns regarding any coding determinations made by a RAC coder, the RAC shall provide the name(s) and credentials of the coder(s) responsible for those coding determinations, upon request from CMS.

Clinical validation is prohibited in all RAC reviews. Additionally, CMS reserves the right to limit the number of reviews or the time period available for review by RAC, state, claim type, provider type, or any other reason where CMS believes it is in the best interest of the Medicare program.

The RAC shall ensure that no nurse, therapist or coder reviews claims from a provider who was their employer within the previous 12 months. The RAC shall maintain and provide documentation upon the provider's request listing the credentials of the individuals making the medical review determinations. This only includes a reviewer's credentials. The RAC is not required to share names and personal information

<u>Timeframes for Completing Complex Coverage/Coding Reviews</u>
The RAC shall complete their complex reviews and notify the provider of the results within 30 days from receipt of the medical record documentation. The RAC may request an extension from CMS, if needed due to extenuating circumstances. If an extended timeframe for review is granted by the CMS RAC COR, the RAC shall notify the provider in writing, or via a web-based application (portal), of the delay.

Unless granted an extension by the CMS RAC COR, the RAC shall not receive a contingency fee in cases where more than 30 days have elapsed between receipt of the medical record documentation and issuance of the review results letter. The CMS RAC COR will closely monitor the RAC's monthly reports and review invoices to

determine occurrences of when the RAC has allowed more than 30 days to elapse between receipt of the medical record documentation and issuance of the review results letter. If CMS discovers these occurrences after the RAC has already been paid the contingency fee for the claim, CMS will subtract that amount from a future invoice.

B. Types of Claim Review Determinations

All RAC Claim Review Determinations will be based solely on the CMS-approved edit parameters and review guidelines associated with the approved review topic. RACs shall provide their review staff with training on the CMS-approved edit parameters and review guidelines, associated with each approved review topic, prior to beginning reviews on an approved topic.

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

1. Coverage Determinations

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

Full Denials

A full denial occurs when the RAC determines that the overpayment amount is the total paid amount for the service/item in question, such as when:

i. The submitted service/item was billed, and paid, but was not reasonable and necessary
ii. The submitted service/item was billed, and paid, but no service/item was provided

Partial Denials

A partial denial occurs when the RAC determines that only part of the claim/claim line paid amount was an overpayment, such as when:

i. The submitted service/item was billed, and paid, using an incorrect code, and/or incorrect number of units, that resulted in a higher payment than should have been received. But, a lower payment, using the correct code, and/or correct number of units, can still be made.

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

- Be included in one of the benefit categories described in Title XVIII of the Act;
- Not be excluded from coverage on grounds other than 1862(a)(1); and
- Be reasonable and necessary under Section 1862(a) (1) of the Act. The RAC shall consider a service to be reasonable and necessary if the RAC determines that the service is:
  - Safe and effective;
  - 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

- 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;
- One pair of conventional eyeglasses or contact lenses furnished subsequent to each cataract surgery with insertion of an interlobular lens.

The RAC shall be 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. RACs should use HCFA Ruling 95-1 and the guidelines listed below in selecting the appropriate denial reason.

2. Limitation of Liability Determinations

If a RAC identifies a full, or partial, overpayment because an item or service is not reasonable and necessary, the RAC 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 - 14.1 for further details.

3. Coding Determinations

The RAC 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).

4. Other Determinations

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

C. Basis of Determinations

1. Medicare Policies and Articles

The RAC shall comply with all NCDs, national coverage/coding articles, LCDs, local coverage/coding articles, and provisions in Internet Only Manuals, such as the Claims Processing Manual and the PIM. NCDs, LCDs, and coverage/coding articles can be found in the Medicare Coverage Database at http://www.cms.gov/medicare-coverage-database/.

Internet Only Manuals can be found at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS019033 . In addition, the RAC shall comply with all applicable change requests and Technical Direction Letters forwarded to the RAC by the CMS RAC COR.

The RAC should not apply any policy retroactively to claims processed prior to the effective date of the policy. The RAC shall ensure that policies utilized in making a review determination are applicable at the time the service was rendered.

The RAC 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 CMS Rulings.

If CMS instructs the RAC on the interpretation of any policy and/or regulation, the RAC shall abide by CMS' decision.

2. Internal Guidelines

As part of its process of reviewing claims for coverage and coding purposes, the RAC shall develop detailed written review guidelines. For the purposes of this SOW, these guidelines will be called "Review Guidelines." Review Guidelines allow the RAC to operationalize CMS policies to ensure consistent and accurate review determinations. Review Guidelines shall be a detailed step-by-step approach used to ensure coverage requirements are met and to assist the reviewers in making logical decisions based on the information in the supporting documentation.

All Review Guidelines must be approved by CMS prior to the RAC beginning any reviews on the topic, for which the Review Guidelines were developed. Review Guidelines do not create or change CMS policy. Approved Review Guidelines shall be shared with the appropriate MAC(s), or other contractors, at CMS' discretion.

3. Rationale for Determination

The RAC shall clearly document the rationale for the review determination. This rationale shall include 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.

The RAC shall ensure they are identifying pertinent facts contained in the medical record/documentation to support the review determination. Each rationale shall be specific to the individual claim under review and shall be included in the review results letter sent to the provider.

The RAC shall make a rationale available upon request to CMS, a MAC, the OIG, and others as indicated by the CMS RAC COR.

4. Other Considerations

The RAC shall comply with relevant instructions in the PIM (IOM 100-08), as related to the following:

- No medical records/documentation received in response to ADR letter
- Administrative relief from review in the presence of a disaster

vi. Task 6: New Issue Review Submission and Approval

The RAC shall participate in the CMS review approval process, through which review topics must be approved before the RAC can begin to review those topics. The RAC shall neither issue medical record requests without prior CMS RAC COR authorization, nor issue requests beyond any conditionally approved number of claims. The CMS review approval process includes the preparation and submission of documents by the RAC, detailing:

- the review topic;
- the type of review to be used for the review topic;
- the methodology for selecting claims for review;
- the methodology and rationale for identifying a claim as an improper payment;
- reviewing and submitting sample test claims, if required by CMS; and,
- participating in discussions with CMS, and the MACs, as necessary.

New Issue Package Submission and Approval Processes

To receive CMS approval for a proposed review topic, the RAC shall submit to CMS a new issue proposal package via email to the designated New Issue email box with a CC to their CMS RAC COR.

For an automated review, the proposal package shall contain, at a minimum, a completed new issue review form (Appendix A), detailed references, detailed edit parameters (Appendix B) and if applicable, a coding list with long descriptors (Appendix D).

Complex reviews will include all of the above, with the addition of detailed review guidelines (Appendix C). CMS may request additional documentation which could include: potential dollar amount of improper payment, good cause language for claim reopening, improper payment rationale, and/or a claim sample.

Each document submitted within the package shall be dated appropriately. Although CMS strongly encourages the RAC to discuss potential proposal topics with their respective MAC(s), the RAC is not required to receive validation from the MAC on the new issue prior to submission to CMS. CMS also encourages the RAC to focus on the development and submission of issue packages that can be applied nationally.

Additional details regarding requirements for New Issue Package documents and how they are to be submitted shall be provided by the CMS RAC COR, via Technical Direction Letter. Requirements may be changed by CMS, at CMS' discretion.

CMS reserves the right to share new issue packages with other parties such as the RAC Validation Contractor (RVC) as appropriate.

The CMS RAC COR will notify the RAC if/when the new issue is approved. Upon approval, the RAC shall post applicable information on its webpage. CMS reserves the right to share any information related to approved review issues with all CMS review

entities which may include, but is not limited to, other RACs in Medicare and Medicaid, MACs, the CERT contractor, or UPICs.

vii. Task 7: Website and Provider Portal

Regardless of format, all Web content or communications materials produced, including text, audio or video - must conform to applicable Section 508 standards to allow federal employees and members of the public with disabilities to access information that is comparable to information provided to persons without disabilities. All contractors (including subcontractors) or consultants responsible for preparing or posting content must comply with applicable Section 508 accessibility standards, and where applicable, those set forth in the referenced policy or standards documents below. Remediation of any materials that do not comply with the applicable provisions of 36 CFR Part 1194 shall be the responsibility of the RAC (or subcontractor or consultant).

For web-based applications, the RAC shall comply with the standards, policies, and procedures below:

Rehabilitation Act, Section 508, Accessibility Standards

- 29 U.S.C. 794d (Rehabilitation Act as amended)
- 36 CFR 1194 (508 Standards)
  - 36 CFR Part 1194.22 (a – p)
  - 36 CFR Part 1194.41 (a – c)
- http://www.access-board.gov/sec508/508standards.htm (508 Standards)
- FAR 39.2 (Section 508)
- CMS/HHS Standards, policies and procedures (Section 508)
  - Information Technology – General Information (https://www.cms.gov/Research-Statistics-Data-and-Systems/CMS-Information-Technology/Section508)

A. General Website

The RAC is required to maintain a Medicare FFS RAC website 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 RAC shall use the same format, language, and features, as determined by CMS.

The Medicare FFS Recovery Audit Program information shall appear on pages that are separate and distinct from any other non-Medicare work the RAC may have. The RAC shall obtain prior CMS RAC COR approval for all webpage updates.

B. Approved Review Website

Upon approval of a review topic, the RAC shall post all relevant information as required by CMS. This includes, at a minimum, the review issue name, description, date of CMS approval, the posting date, state(s)/MAC regions applicable, review type, provider type, affected code(s), and applicable references. CMS may require RACs to provide other review-specific information on the Approved Review Website, and may require implementation of standardized navigation functions, and/or a standardized format for display. At a minimum, the approved review listing shall be sortable by provider type,

review type, posting date, and state/MAC region. The RAC shall wait two weeks (14 calendar days), after posting a conditionally approved new issue to its website, before starting any reviews of the issue. This applies to all review types.

C. Provider Portal

The RAC shall develop and use a secure web-based application that will allow all provider types to view up-to-date information regarding the status of their claim reviews, view their ADR limits, and customize their contact information. The RAC shall use a CMS-approved secure process to give providers access to the portal.

The Provider Portal shall, at a minimum, include the following information:

- the provider's overall ADR limit
- dates of all ADR letters
- the date that the medical documentation was received for each claim being reviewed
- the date that medical review of the documentation began
- the date that medical review of the documentation was completed
- the outcome of the review (overpayment, underpayment, no finding)
- discussion period information
- appeals outcomes
- case closure date

The RAC shall update all dates and status information within 5 calendar days.

The RAC may make additional review information, such as review findings and rationales available on the portal. CMS may require RACs to provide other provider-specific or claim-specific information on the portal, and may require implementation of standardized functions, and/or a standardized format for display. CMS will work with RACs to enhance their provider portals, including more uniformity and consistency in the claim status section, as well as display reason statement identifiers where available.

All web-based applications shall be approved by the CMS RAC COR prior to allowing access to providers. The RAC shall provide the following information, regarding RAC Provider Portal users, to the CMS RAC COR, upon request:

- First and Last Name
- Telephone number (including area code)
- Email address
- NPI number(s)
- Associated Provider (Facility/Practice/Supplier) Name
- User's Title/Position at the associated provider

D. Provider (provider/practitioner/supplier) Address Customization

Within the provider portal, the RAC shall implement a secure method for providers to customize their address and point of contacts (e.g. Washington County Hospital, Medical Records Dept., attention: Mary Smith, 123 Antietam Street, Gaithersburg, MD 20879). The RAC may visit the CERT Contractor's address customization website at

https://certprovider.admedcorp.com/Home/SubmitRecordsToCert for an example of a simple but successful system. Each ADR letter must inform the provider about the existence of the address customization system.

viii. Task 8: Communication and Collaboration with Other Medicare Contractors

RACs shall share with CMS, and the appropriate MAC, review guidelines and edit parameters used to identify improper payments; and participate in conference calls with CMS and other contractors, as necessary for the purposes of assisting in the development of corrective actions to reduce the instance of improper payments.

The Recovery Audit Program often requires the assistance and collaboration of other contractors employed by CMS. The RAC shall work with other contractors as required, to maintain open and professional lines of communication with their peers.

The RAC shall collaborate with other CMS contractors and partners as directed by CMS for the purposes of adjusting improperly paid claims, supporting the appeals process, avoiding duplicative reviews, and referring potential fraud.

The RAC shall complete a Joint Operating Agreement (JOA) with all applicable Medicare contractors (MACs, UPICs, QICs, AdQIC) and any other CMS partners as instructed by CMS. The JOA shall encompass all communication between the Medicare contractor and the RAC. The JOA shall be mutually agreed to, reviewed (at least) annually[4], and updated as needed. The JOA shall prescribe 1) agreed upon service levels, 2) mechanism for file transfers and other communications, and 3) notification and escalation mechanisms with CMS involvement. The RAC shall initiate all JOAs within 90 days of award.

A. Communications relating to the claim adjustment:

The MAC serves as the conduit to allow the RAC to adjust claims and recoup overpayments. The relationship between the MAC and the RAC is crucial to the success of the Recovery Audit Program. The CMS will occasionally transition the claim processing workload from one MAC to another. Therefore, the JOA between the MAC and RAC shall include procedures related to MAC transitions including blackout periods[5].

<u>MAC Contract Closeout (Impact on the Recovery Audit Program)</u>

CMS has the following expectations with the MAC/RAC relationship:

- The MAC is an operational contractor of CMS and does not take direction from the RAC.
- Any communication issues with the MAC that cannot be addressed through provisions of the JOA, shall be escalated to the CMS RAC COR for additional discussions with the appropriate parties.

[4] The RAC shall comply with the required timeframes for each Medicare contractor. For example, MAC JOAs must be reviewed quarterly in the first year and annually in subsequent years.

[5] The impact of blackout periods on RAC activities in an effected jurisdiction may vary.

- The MAC is responsible for issuing timely demand letters, adjusting claims, applying recoupments, uploading data to the RACDW when required, and routine customer service and requests from CMS.
- The RAC is responsible for identifying improper payments, providing review rationale relating to MAC demand letters, completing in depth customer service, performing all research required to determine the status of a claim, responding to CMS and answering all correspondence unless otherwise instructed by CMS. The RAC shall work closely with the MAC to ensure all adjustments are made in a timely and accurate manner.
- Sharing identified areas of vulnerability within the program for peer review or action is encouraged.

B. Communications relating to appeals:

The RAC is expected to work with other CMS contractors, at subsequent levels of re-evaluation, to ensure an accurate and fair adjudication.

- **MAC:** The RAC shall foster a relationship with the claims processing contractors to ensure consistent application of the laws and policies surrounding Medicare payment. The RAC shall ensure that the MAC has received the completed appeal case file. The RAC shall work with the MACs to share appeals data, including reasons for RAC finding reversals. The RAC and MACs may also share areas identified as vulnerabilities.

- **Qualified Independent Contractor (QIC):** The RAC will forward new or requested evidence for appeal case files as necessary.

- **Administrative Qualified Independent Contractor (AdQIC):** The RAC shall work with the AdQIC so that they may determine whether QIC level appeals were promoted to the ALJ, and if so, which cases the contractors will mutually participate.

- **Office of Medicare Hearings and Appeals (OMHA):** The RAC may communicate with OMHA on matters regarding the intent to participate or elect party status, scheduling of hearings, and other similar administrative tasks. All other direct communication is prohibited, unless directed by the CMS RAC COR.

The RAC shall regularly review data provided by appeals contractors to identify ongoing trends or issues of vulnerability that may be applied to current reviews or potential appeals.

The AdQIC website assists with the coordination of CMS contractors' participation in Administrative Law Judge (ALJ) hearings.

C. Communication Regarding Potential Fraud

In addition to the JOA with all applicable UPICs, the RAC shall schedule regular meetings with all applicable UPICs to discuss potential referrals and trends each contractor is seeing in the applicable jurisdictions, in addition to any issues the UPIC wants to discuss. These

meetings shall occur at a minimum of quarterly. Meetings shall include all applicable operational staff as well as the RAC CMD. Informal referrals received from the UPIC or given to the UPIC during these meetings shall be included in the next monthly report to CMS.

The CMS has a Memorandum of Understanding (MOU) with the OIG regarding the referral of potential fraud. If a RAC discovers credible indications of potential fraud, the RAC shall concurrently refer the provider to their CMS RAC COR, and the OIG. The RAC shall include all details relevant to the referral.

If the RAC is contacted by investigative agencies pursuing provider review information (e.g., medical records, review work product, improper payment identification or collection data), the RAC shall refer the investigative agency to the CMS RAC COR for guidance. The CMS RAC COR may then request the information as defined above from the RAC. The RAC shall not discuss law enforcement investigations or information requests from investigative agencies with providers and shall refer any such provider questions to their CMS RAC COR.

D. Communications to avoid duplicative review:

CMS must ensure that RAC activities do not interfere with other reviews/investigations being conducted by alternate Medicare contractors or law enforcement personnel. Therefore, the RAC shall input all claims into the RACDW before attempting to identify or correct improper payments, so the RAC may identify claims that are temporarily suppressed or permanently excluded by another entity. Claims that are temporarily suppressed may eventually be released for review by the RAC.

E. Referrals

The CMS often receives referrals of potential improper payments from the MACs, UPICS, and Federal investigative agencies (e.g., OIG, DOJ). The CMS may require the RAC to review these claims, or other claims at risk, based on CERT reports, or other CMS data analysis.

Referrals received for topics that have not yet been approved by the new issue approval process for the RAC within that region must still comply with new issue approval process prior to audit initiation.

The RAC will be paid in a manner consistent with the contracted contingency fee for referrals. The review of such referrals is not optional. The CMS will send each notification of referral via a TDL which will detail the provider(s), the CPT/HCPCS(s), applicable approved New Issue concept(s), and number of reviews to be performed.

The RAC shall include a detailed “Referrals” section to their monthly administrative report.

NOTE: *Referrals are tracked via the RACDW. This system will be available to all Medicare contractors, to the CMS and to the RAC to make and track referrals. The RAC*

will be required to review and update the referral tracking system. The expected timeframe for review and decision is 30-45 days from the referral being entered into the system.

ix. Task 9: Activities Following Review

A. Communication with Providers about Improper Payment Cases

1. Automated review

The RAC shall communicate the results of each automated review that results in an overpayment determination by hard copy letter or fax and through a secure provider portal. The RAC shall inform the provider of which coverage/coding/payment policy or article was violated. The RAC need not communicate to providers the results of automated reviews that do not result in an overpayment determination.

2. Complex review

The CMS expects that the RAC shall perform a full review of the entire claim/claim line (as approved by CMS RAC COR) for all complex reviews, including coding validation and a reasonable and necessary determinations. Further guidance and instruction for individual claim types will be handled through the review approval process.

The RAC shall identify the particular reason each claim is denied. In situations in which the RAC identifies two different reasons for a denial, the RAC shall identify both reasons.

The RAC shall communicate to the provider the results of every complex review, including cases where no improper payment was identified, by hard copy letter or fax and through a secure provider portal notification. In cases where an improper payment was identified, the RAC shall inform the provider of which coverage/coding/payment policy or article was violated.

3. Contents of the Review Results Letter

The RAC shall send a letter or notification via secure provider portal indicating the results of the review within **30** days of receipt of medical records for complex medical record reviews, or after the improper payment identification for automated reviews. If the RAC needs more than 30 days, they are to contact the CMS RAC COR to request an extension.

The RAC shall ensure that the date a claim was reopened (regardless of the demand letter issue date) is documented, as well as the rationale for good cause when claims are reopened more than 12 months from date of the initial determination. The RAC shall clearly document the date the claim was reopened and the rationale for good

cause in the Review Results letters for all complex reviews, all automated reviews that resulted in an improper payment, as well as all case files. Each letter/notification must include:

- Identification of the provider(s) or supplier(s)--name, address, and provider number;
- The reason for conducting the review;
- A narrative description of the improper payment: state the specific issues involved that created the improper payment, including specific policy citations;

B. Allowance of a Discussion Period

All providers who receive a review results via hard copy letter or fax and portal notification (for automated and complex reviews) from the RAC are availed an opportunity to discuss the improper payment with the RAC before the claim is sent to the MAC for adjustment. Providers should use the Discussion Period to determine if there is other information, relevant to supporting the payment of the claim that could be sent to the RAC. The RAC shall wait 30 days, after sending the review results hard copy letter or fax and portal notification, to allow for the receipt of a discussion request, before forwarding the claim to the MAC for adjustment.

When the RAC receives a Discussion Period request from a provider/supplier, for an automated review that is accompanied by documentation including medical records the RAC is required to honor the request and ensure the medical record is reviewed by the appropriate, qualified personnel.

The RAC shall have an escalation process in place for the Discussion Period; however, if the physician (or a physician employed by the provider) requests to speak to the CMD, the CMD shall be available for that conversation. A physician employed by the provider does not include those physicians employed as consultants, nor can it be someone acting in a billing administrator or non-physician related capacity. Many physicians are not directly employed by a hospital, therefore the intent of this statement is for there to be a relevant conversation between a physician that directly cared for the beneficiary or a physician that is employed by the provider in the same facility that cared for the beneficiary. This facilitates a physician to physician dialog that adds relevant information to the discussion which may support the payment of the claim.

It is expected that the RAC include additional relevant parties during the discussion, including but not limited to clinicians and certified coders depending upon the type of review. For example, in the case of a DRG Coding Validation review discussion, it would be most appropriate for a certified coder to lead the discussion on behalf of the RAC with the support of the CMD.

During the discussion period, it is the RACs responsibility to identify **all** medical records sent by the provider as a result of a review results letter or informational letter. If records are received after these informational letters are sent during the 30-day period before the

adjustment is sent to the MAC, the RAC should assume they are in support of the payment of the provider/supplier's claim and should be reviewed as additional documentation.

All discussion requests should be in writing. The RAC shall provide written confirmation (by fax or email or any other applicable communication method) of all discussion requests within one business day of receipt. The RAC shall provide (by sending a hard copy letter or fax, and through their provider portal) a detailed, written rationale to the provider with their determination within 30 days of receipt of the request. The written rationale shall also be provided to CMS upon request, within one business day of receipt.

The RAC is not required to reimburse providers for the additional documentation submitted during the Discussion Period.

The RAC is not required to accept discussion requests after the 30-day request timeframe has passed. If the claim has already been forwarded to the MAC for adjustment, and the RAC receives a discussion request, the RAC shall immediately notify the provider in writing that the discussion request is invalid.

C. Determining the Overpayment Amount

In order to determine the actual overpayment amount, the claim adjustment will have to be completed by the MAC. Once the claim adjustment is completed, via the file-based mass adjustment process, the MAC will notify the RAC through the RACDW (or another method as instructed by CMS) of the overpayment amount. Only the difference between the paid amount and the amount that should have been paid will be collected.

D. Extrapolation

The RAC may use extrapolation for some claim types when all requirements are met. Extrapolation can be cost effective for low-dollar claims that require complex review and that have a history of having a high error rate. The RAC shall follow the procedures found in the PIM (currently Chapter 8, section 8.4), as well as MMA Section 935(a), regarding the use of extrapolation. The CMS RAC COR must approve the use of extrapolation.

E. The Claim Adjustment Process

The MAC will pursue the recoupment of Medicare overpayments, identified by the RAC, in accordance with Pub 100-06 Medicare Financial Management Manual, Section 10, Subsection 2 (Recoupment).

The RAC should not attempt recoupment, or forward, any claim to the MAC, or applicable CMS Data Center, for adjustment, if the anticipated amount of the overpayment is less than $25.00, excluding claims reviewed by extrapolation. Claims less than $25.00 cannot be aggregated to allow for demand unless extrapolation is used. If the RAC pursues

adjustment on a claim less than $25.00, the RAC shall not receive a contingency fee on any amounts recouped.

The RAC shall not forward any claim to the MAC or the CMS Data Center for adjustment, if the anticipated amount of the underpayment is less than $5.00.

The RAC shall not forward claims to the 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; payment without the modifier 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 identified overpayment, other lines are also adjusted because of system edits. CMS calls these additional lines "associated findings." While the RAC did not identify these lines for adjustment, they were initiated because of the RAC adjustment. The RAC receives credit for the entire claim adjustment and the MAC will include these additional lines on the demand letter to the provider.

A RAC identified adjustment may trigger the denial of the entire claim because of a known Medicare Secondary Payer (MSP) 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 RAC will not receive credit for the adjustment.

When partial adjustments to claims are necessary, the MAC shall downcode the claim whenever possible. The RAC will only be paid a contingency payment on the difference between the original claim paid amount and the revised claim paid amount. Examples would include DRG validations where a lower-weighted DRG is assigned or claim adjustments resulting in a lower payment amount after removing excessive units billed. If the system cannot currently accommodate this type of downcoding/adjustments, CMS will work with the system maintainers to create the necessary changes.

The way a claim is adjusted in the shared system may not necessarily correlate with the RAC contingency fee. For example, a RAC contingency fee could equate to the difference between the full denial and any services determined by CMS to be payable.

F. Demand Letters

Demand letters will be issued by the MACs.

G. Compromise and/or Settlement of Overpayment

CMS has the authority to enter into administrative agreements including individual or group compromises or settlements with providers without requiring the RAC's approval or input. If CMS determines that a compromise and/or settlement of a RAC identified

overpayment is in the best interest of Medicare at any time, the payment to the RAC will be adjusted so that the contingency payment is based only on the portion of the overpayment that remains collected or recouped after the administrative agreement, settlement or compromise.

CMS will adjust the RAC's invoicable amounts accordingly, which may result in the take-back of any overpaid contingency fees.

H. Potential Quality of Care Problems

Upon medical review, the RAC shall report potential quality of care issues immediately to the CMS RAC COR.

x. Task 10: Utilizations of the RACDW

The RACDW is a web-based application that houses data related to all RAC improper payment identifications and corrections (overpayment collections and returned underpayments). The RAC shall utilize the RACDW as the central repository for all claims information in the Recovery Audit Program. This includes consistently updating the RACDW timely with complete and accurate claim information and statuses on all reviews to prevent interference with law enforcement/fraud investigations and duplicating work on claims that have already been reviewed. The appropriate RAC staff shall attend all RACDW conference calls, and participate in all RACDW trainings, as required by CMS.

CMS will provide access to the RACDW. The RACDW is also used to prevent duplicative reviews by identifying claims as suppressions and exclusions. Suppressions are claims that have been targeted by another review entity, while exclusions are claims that have already been reviewed by another review entity. Suppressions and exclusions are not available to the RAC for review. The RAC shall provide the appropriate equipment (e.g. computers, laptops, with secure internet accessibility) to access the RACDW.

The RACDW stores claim and provider information, such as provider number, location, dates of service, claim paid amounts, and applicable codes. The RAC shall enter this data by using the most current version of the Claims Upload File Format, which shall be provided by the CMS RAC COR.

The RACDW is an integral part of the success of the Recovery Audit program and other medical review initiatives. However, the RACDW can only be successful if the data input into it by the RAC is reliable, timely, and valid.

A. Preventing Overlap

In order to minimize the impact on the provider community, it is critical that the RAC avoid situations where the RAC and another entity (MAC, UPIC, OIG, or other investigative agencies) are working on the same claim.

The RAC shall use the RACDW to determine if another entity already has the provider and/or claim under review. The RACDW will include a master table of suppressed providers and excluded claims that will be updated on a regular basis to prevent interference with law enforcement/fraud investigations and duplicating work on claims that have already been reviewed, the RAC shall upload each claim that it intends to review into the RACDW prior to beginning any review of that claim. After the RAC has uploaded the claim, the RACDW will notify the RAC whether the claim was suppressed, excluded, or available for review. Only claims that are not suppressed or excluded can be reviewed by the RAC.

1. 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 RAC to review. Exclusions entered after a RAC began its review will be handled individually based on the timing of the other review.

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

- A/B MACs and DME MACs
- Quality Improvement Organizations (QIO)
- UPICs
- Investigative Agencies (OIG, FBI, Department of Justice (DOJ))
- CERT Contractor
- CMS

2. Suppressions

CMS must ensure that RAC activities do not interfere with potential fraud reviews/investigations being conducted by other Medicare contractors or investigative agencies.

A provider's claims can be temporarily removed from RAC review using a suppression. Suppressions are used to minimize provider burden by preventing overlapping reviews when another Medicare contractor or an investigative agency intends to review a claim or provider.

Once a suppression record is entered into the RACDW, CMS will approve or reject that record. Approved suppressions are active for one year from the date of CMS approval. At the end of the year, the suppression will expire and may be extended by the originating entity. The suppression record may also be released at any time during the year by the originating entity or CMS. Claims reviewed by the originating entity during the period of suppression should be excluded.

The RAC will be notified to cease all activity if a suppression is entered after the

RAC begins its review.

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

- UPICs
- Investigative agencies (OIG, FBI, DOJ)
- CMS

B. RACDW Reporting of Possible/Identified Improper Payments

The RAC shall enter the necessary claim information and/or status updates within two business days of the event. The CMS will provide the specific format after contract award. All updates to the file format shall be shared with the RAC prior to implementation. The RAC shall use the most current version of the RACDW claims upload file format.

The RAC receives the improper payment amount and receivable/payable information from the MAC, or data center. The RAC receives such information for the purpose of conducting their audit operations, and shall not be held responsible for updating the RACDW with payment information, but shall be responsible for uploading the finalized adjustment date from the MAC.

Unless otherwise directed by CMS, the RAC updates the RACDW with the date of MAC demand letter or no findings letter, as well as the demanded amount (negative values for underpayments).

Note: If a valid appeal is filed at the MAC, the RAC shall immediately cease medical review of the any documentation related to the appeal.

C. RACDW Reporting and RAC Invoicing

The CMS requires certain criteria for claims to be eligible for invoicing. The RACDW will generate pre-filled invoices based on required claims information from the RAC and collection/payment and reversal transactions from the MAC. The existence of a transaction alone does not oblige CMS to pay the contingency fee associated with the claim. A RAC may only invoice and be paid for a claim correction, when all required data elements, as determined by CMS, has been entered correctly into the RACDW. All additional required criteria must be met for a claim to be eligible for invoicing. Contingency rates will be applied based on the demand letter date of the collection or refund to the provider.

If a RAC has concerns regarding the RACDW generated invoice, the RAC shall contact its CMS RAC COR before submitting the invoice for payment. The RAC may not add to the automatically generated invoices, although they may remove records with appropriate notice to the CMS RAC COR.

RAC Invoicing

The RACDW will generate, monthly, pre-filled invoices based on required claims information from the RAC and collection/payment and reversal transactions from the MAC. The existence of a transaction alone does not oblige CMS to pay the contingency fee associated with the claim. A RAC may only invoice and be paid for a claim correction, when all required data elements, as determined by CMS, have been entered correctly into the RACDW.

Also, all additional required criteria must be met for a claim to be eligible for invoicing. Additional required criteria includes the following:

- Initial Claim Upload date predates all other dates associated with the RAC's review
- Claim was not excluded from RAC review
- Claim was not suppressed before date of Date 10 (Findings sent to AC)
- RAC correctly applied approved edit parameters
- RAC correctly applied approved review guidelines
- RAC review was completed with approved timeframe(s)
- A collection/payment transaction occurred and was matched to the RAC's review
- The provider received an unfavorable, or partially favorable, decision at the second (QIC) level of the appeal process;
    - Or, the provider failed to file a valid timely appeal, at either the first (MAC) level or the second (QIC) level of the appeals process
- RAC determination was not overturned at any level of appeal

The CMS regularly reviews invoiced claims to ensure the claims meet all applicable criteria for invoicing. If CMS determines that a claim was included on an invoice and paid in error, CMS will collect the debt by subtracting the payment from the RAC's next invoice, or sending a demand letter, if necessary.

Contingency Fee Rates

Contingency fee rates will be applied based on the demand letter date of the amount collected from, or refunded to, the provider.

Accuracy Incentive

The CMS expects that the RAC shall have an accuracy rate of at least 95%, as calculated from the results of monthly accuracy audits performed by an independent validation contractor, or by the CMS.

The RACDW will calculate a rolling tally of all accuracy determinations for claims included in the monthly accuracy audits. For each percentage point above 95%, the RAC shall earn an additional 0.2% contingency fee increase. For example, a RAC with a contingency fee of 15% and a 96% accuracy rate would receive an additional 0.2% contingency fee increase, for a total of 15.2%.

The adjusted contingency fee will apply to all claims with collections, or paid underpayments for the applicable timeframe. Accuracy rates and contingency fees will be recalculated every three months.

Appeal Affirmation Incentive

The CMS expects that the RAC shall have an appeal affirmation rate of at least 90%, at the first level of appeals.

The appeal affirmation rate will be calculated by the RACDW, using a rolling tally of all affirmed, first-level, appeals (those with dispositions that are unfavorable to appellant), for each New Issue. For each percentage point above 90%, the RAC shall earn an additional 0.1% contingency fee increase. For example, a RAC with a contingency fee of 15% and a 91% appeal affirmation rate would receive an additional 0.1% contingency fee increase, for a total of 15.1%.

The adjusted contingency fee will apply to all claims with collections or paid underpayments for the applicable timeframe. Appeal overturn rates and contingency fees will be recalculated every three months.

In rare and unusual circumstances, CMS may consider a supplemental invoice involving transactions that are not in the RACDW or that failed automated matching; however, such consideration is solely at CMS' discretion. Acceptance of one or more supplemental invoices does not bind CMS to accepting future supplemental invoices.

D. Initial Claim Upload

Because the initial upload of the claim must occur prior to any review of the claim, dates associated with the review process (such as the date a medical record request was sent, for complex reviews; or, the date the claim was sent to the MAC for adjustment, for automated reviews) should never pre-date the initial upload date. Any claim that has a date associated with the review process that pre-dates the initial upload date will be flagged as permanently non-invoicable in the RACDW and the RAC shall not receive any contingency fee for that claim.

RACs shall delay sending ADRs until, at least, **60 days** after the claim paid date. This delay is necessary to minimize the likelihood of RACs reviewing a claim that had a prepayment review done by a MAC. Currently, MACs complex reviews are uploaded to the RACDW using a system-generated file. This file is used to exclude the MAC-reviewed claims from potential re-review by a RAC. Therefore, CMS has designated this 60-day wait time for RACs to allow ample time for MACs to upload their reviews into the RACDW.

The RAC will be notified by the RACDW to cease all activity, if a suppression is entered after the RAC begins its review.

Review Status Updates

Review Status dates that require timely updates in the RACDW include (at a minimum):

- 02 (Request for medical records)
- 05 (Received medical records from provider)
- 06 (RAC asks CMS for extension to complete review)
- 07 (New deadline for RAC to complete review)
- 08 (Improper payment results notification sent to provider)
- 09 (Request for discussion received from provider)
- 10 (Findings sent to AC)
- 11 (Readjudicated claim received from AC)
- 12 (Demand letter sent)
- 13 (Claim closed, without review)
- 14 (No findings letter sent)
- 16 (Additional Documentation Received as part of Discussion)
- 17 (Discussion results sent to provider)

The RAC shall enter the dates and any other information related to the review of each claim within two business days of the event.

Example 1:
When a RAC sends an Additional Documentation Request (ADR) letter to a provider, the RAC shall upload, into the RACDW, a Claims Upload File that includes a *Date Code* field with "Type of Date" indicator 02 (Request for medical records) and a *Date* field indicating the date the letter was sent. This upload must occur within two business days from the date the ADR letter was sent.

Example 2:
When a RAC sends an Improper payment results notification to a provider, the RAC shall upload, into the RACDW, a Claims Upload File that includes a *Date Code* field with "Type of Date" indicator 08 (Improper payment results notification sent to provider) and a *Date* field indicating the date the notification was sent. This upload must occur within two business days from the date the Improper Payment Results notification was sent. This upload should also include information associated with the improper payment, such as the Denial Reason code, final DRG/ICD/HOPPS/HIPPS/HCPCS code(s), and final Units of Service.

Demand Letter Date and Demand Amounts

The RAC shall be responsible for uploading the finalized adjustment date. The RAC updates the RACDW with the date of MAC demand letter, as well as the demanded amount (negative values for underpayments). Because this information is provided to the RAC from the MAC, this information does not have to be uploaded into the RACDW within two business days of the Demand Letter date, but should be entered by the RAC within 10 days of receiving the information from the MAC.

xi. Task 11: Review Quality Assurance and Accuracy

A. RAC Review Quality Assurance

Every six months (at a minimum), the RAC shall perform a Quality Assurance (QA) review of their approved New Issue packages and submit recommended revisions to ensure compliance with the most recent policy changes. Recommended revisions shall be submitted to the CMS RAC COR, in writing. Claims affected by any recommended revision shall not be reviewed by the RAC, until the revision(s) is(are) approved by the CMS RAC COR.

If upon review, the RAC finds that there were no policy changes relevant to a particular New Issue, the RAC shall provide notification to the CMS New Issue mailbox, as well as their CMS RAC COR

B. Accuracy Reviews

The CMS contracts with an independent validation contractor to perform monthly accuracy audits on RAC claim determinations. The RAC shall provide the Validation Contractor with the entire case files and all information[6] necessary to complete the audit. The RAC shall provide the case files through electronic submission, hard copy, or any other method CMS prescribes, within seven business days of notification by CMS. Additionally, the RAC shall comply with all Validation Contractor requests (as instructed through the CMS) and not impede any review processes. The CMS, MAC, or the validation contractor may also evaluate the clarity, accuracy, and completeness of the RAC letters to providers.

Accuracy determinations are open to dispute by the RAC. If the RAC disagrees with the decision, they can submit a dispute. To submit a dispute, the RAC shall follow all guidelines provided by the CMS RAC COR. Accuracy rates and contingency fees will be recalculated every three months

xii. Task 12: Supporting Identification of Overpayment in the Medicare Appeals Process and/or in the Debt Collection Improvement Act Process

The RAC shall provide support throughout the appeals process for any improper payment that is appealed by the provider. This includes taking party status at the Administrative Law Judge (ALJ) level of appeal in a minimum of 50% of cases and participating in a minimum of 50% of the remaining cases that reach this level. The RAC shall adhere to all instructions outlined in Pub. 100-08, Chapter 3 to elect their status at the ALJ level.

Providers are given appeal rights for Medicare overpayments and underpayments determined during the review process. If a provider chooses to appeal an overpayment/underpayment determined by the RAC, the RAC shall assist CMS with support of the overpayment/underpayment determination throughout all levels of the appeal. This includes

[6] The RVC also reviews information that is uploaded into the RACDW by the RAC. Any data that is entered into the RACDW incorrectly shall result in a lower accuracy score.

providing supporting documentation (including the medical record) with appropriate reference to Medicare statutes, regulations, manuals, and instructions when requested, participating in hearings associated with the improper payment, and providing assistance to CMS or other contractors at any hearings associated with the improper payment. Additionally, CMS may require RACs to upload all appeal case file documents into the Medicare Appeals System (MAS). RACs are required to use the AdQIC Participation Portal to review and elect participation status for Notices of Hearing (NOHs).

If the RAC receives a written appeal request, the RAC shall forward it to the appropriate adjudicator within one business day of receipt. If the RAC receives a verbal request for appeal from a provider, the RAC shall direct the provider to the applicable appeal instructions in their demand letter.

Additionally, the RAC 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.

Defending Improper Payment Determinations at ALJ Hearings

The RAC shall participate or take party status at Administrative Law Judge (ALJ) hearings. Further rules and procedures related to the ALJ hearing process begin at 42 CFR 405.1000 through 1054.

The RAC shall establish a process for assessing the notices of case promotion to the ALJ from the AdQIC to determine which cases should be selected for participation or party status. Factors to be examined should include, but not be limited to: policy implications, amount(s) in controversy, and the extent to which a particular review is, or has been, a recurring issue at the ALJ level of appeal. The RAC shall be proactive in evaluating potential redetermination cases that they expect to continue through to an ALJ hearing and, in some cases, should prepare a letter to include in the case file to indicate that they intend on participating if the case goes to a hearing.

RACs shall note that because the AdQIC is tasked with coordinating contractor interest in participation in ALJ hearings, all NOHs will be sent directly to the AdQIC from the OMHA. The AdQIC, within two (2) calendar days of receipt of the formal NOH from OMHA, will create a record in the AdQIC portal that will generate an email notification to the applicable RAC, notifying them that a hearing has been scheduled. RACs shall, upon receipt of the formal NOH e-mail alert, log onto the AdQIC website, https://participation.q2a.com, to access the NOH information. RACs shall make their elections, via the AdQIC website, within five (5) calendar days of the formal NOH e-mail sent date. The RAC shall adhere to all instructions outlined in Pub. 100-08, Chapter 3 to elect their status at the ALJ level.
In either participation situation (party or participant), the RAC shall be prepared to discuss details related to the facts of each claim under appeal, the relevant coverage policies and payment requirements, including any clarification required on decisions made earlier in the

appeals process. The RAC shall also be prepared to discuss the background on how the claim or provider was selected for review as well as matters related to the extrapolation process, if applicable.

Electing Party Status in ALJ Hearings

The RAC shall take party status in a minimum of 50% of all appeal cases that reach the ALJ level of appeal.

The election for party status shall be made consistent with the rules at 42 CFR 405.1012, and provided to the ALJ, appellant and all parties identified within five (5) calendar days of the formal NOH e-mail sent date. As a party, the RAC may file position papers, call witnesses and/or cross-examine witnesses of other parties, and/or request discovery, subject to the limitations of 42 CFR 405.1037(b). The RAC shall submit any position paper or additional evidence requested by the ALJ within timeframes established by the ALJ. A copy of any written statements must be provided to the other parties to the hearing at the same time they are submitted to the ALJ. The RAC shall be adequately prepared to respond to questioning by the ALJ or other parties regarding all issues related to the claims under appeal.

Participating in ALJ Hearings

The RAC shall participate in a minimum of 50% of the remaining cases that reach the ALJ level of appeal.

The election to participate shall be made consistent with the rules at 42 CFR 405.1010, and be provided in writing to the ALJ, appellant, and all parties identified, within five (5) calendar days of the formal NOH e-mail sent date. Participation may include filing position papers and providing testimony to clarify factual and policy issues involved in a case. The RAC shall be adequately prepared to respond to questioning by the ALJ (and by the appellant should the ALJ allow cross-examination) regarding all issues related to the claims under appeal.

Because participation status does not include the same rights as full party status, the RAC may not call witnesses, or cross-examine witnesses, of another party. The RAC must coordinate with other contractors in advance to solicit their participation should testimony from the other contractors be necessary.

RACs shall use form OMHA-105 to elect participation prior to the issuance and/or receipt of a formal NOH. CMS will provide form updates. As this process is prior to the issuance and/or receipt of a formal NOH, an OMHA adjudicator will not have yet been assigned. Therefore, form OMHA-105 shall be mailed to:

OMHA Central Operations
200 Public Square, Suite 1260,
Cleveland, OH, 44114-2316
Attn: CMS and CMS Contractor Elections Mail Stop

Note: If submitting an election to participate in an ALJ Hearing prior to the issuance and/or receipt of formal NOH, all RACs shall also send a copy of form OMHA-105 to the parties who were sent a copy of the notice of reconsideration.

For additional information, please refer to 42 Code of Federal Regulation (CFR) §405.1010(b)(1) and https://www.hhs.gov/about/agencies/omha/index.html .

xiii. Task 13: Conference Calls, Meetings and Travel

Conference Calls

The CMS expects the appropriate RAC staff to attend conference calls. Appropriate RAC staff are those that are directly responsible for performing or overseeing the daily RAC operations that are related to the topic(s) on each conference call's agenda.

Weekly Operational Calls

The RAC shall have a weekly operational call with their respective CMS RAC COR to discuss the progress of work, evaluate any problems, and discuss plans for immediate next steps of the project.

The RAC 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.

The RAC shall send agendas for meetings to their respective CMS RAC COR no later than 2 business days in advance, for any meeting with CMS. Meeting agendas shall include the name and title of each RAC staff member, and the respective agenda item(s) that they have been designated to discuss with CMS. All agenda items shall be as specific as possible.

Topics that were not included in the submitted agenda or if the appropriate RAC staff is not available to discuss a particular agenda item, it will be at CMS discretion to discuss during the meeting for which the agenda was prepared, and may be added to a future agenda, as long as that agenda meets the CMS requirements.

Draft meeting minutes shall be produced by the RAC and submitted to their respective CMS RAC COR, for review and approval, within 2 business days of the meeting. If revisions are necessary, the CMS RAC COR will provide instructions to the RAC on what changes are to be made. Revised meeting minutes shall be submitted to the CMS RAC COR within 1 business day.

Other Conference Calls

The following are examples[7] of RAC staff deemed appropriate by CMS for various CMS conference calls:

[7] CMS may also require specific RAC staff to attend other meetings. The CMS RAC COR will notify the RAC in such cases.

New Issues Calls

The RAC Project Manager, CMD, and Medical Review (MR) Manager shall attend and participate in all new issue related calls. In addition, if a meeting involves discussion of a specific review issue, the RAC shall include (at a minimum) the following information:

- Issue name
- Issue number
- Detailed question/comment/recommendation including any related reference/data so that the topic can be researched prior to the call

IT-related calls

For IT-related issues (including RACDW, CMS Information Systems Security and Privacy Requirements, National Claims History (NCH) data and mainframe discussions, etc.), the RAC CIO, SSO, and/or other RAC IT specialists, who have the ability to provide the background and detailed information to CMS, shall attend all IT-related calls.

RAC Validation Contractor (RVC) calls

The RAC shall make available the Project Manager, CMD, and MR Manager for all RVC calls. If a specific claim is scheduled to be discussed, the RAC shall make the actual Medical Reviewer available for discussion.

At CMS' discretion, conference calls may be scheduled more frequently. Additional conference calls may be held to discuss individual items and/or issues.

Meetings/Travel

The CMS expects the appropriate RAC staff to attend meetings. Appropriate RAC staff are those that are directly responsible for performing or overseeing the daily RAC operations that are related to the topic(s) on each meeting's agenda.

Annual RAC Operational Meeting

The following RAC personnel are required to attend the Annual RAC Operational Meeting:

- Project Manager
- Contract Medical Director
- Medical Review Manager
- Chief Information Officer/System Security Officer

Program Integrity Annual Meeting (PIAM)

PIAM attendance/participation is mandatory for the RAC CMD. While the RAC PM participation is recommended, it is not mandatory. Aside from mandatory participation by the CMD, RACs are permitted to invite other staff at their discretion. Contractors are limited to a maximum of five (5) staff members per RAC contract. All participants must register if planning to attend all or part of the meeting.

Travel

The RAC is required to travel to CMS Central Office in Baltimore, Maryland for the initial

meeting with CMS after contract award. In addition, the RAC is required to attend both the Program Integrity Annual Meeting (5 days) and the RAC Operational Meeting (1 day).

xiv. Task 14: Monthly Progress Reports

A. Monthly Administrative Progress Report

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

- Complications completing any internal RAC task
- Complications with any contractor, examples are MAC/QIC/AdQIC
- All provider outreach efforts upcoming and completed for each section including: Provider type, MAC jurisdiction, or state(s), Date, Method of outreach (webinar, teleconference, etc.) used and Date provider-related, state, association(s) were informed of the outreach session
- Recommended corrective actions to prevent or reduce improper payments for each review topic. For example: the RAC shall report on LCDs, or other policies, that may be outdated, technically flawed, or have other issues that do not provide optimal support for medical review decisions.
- Update on all JOAs
- Action items
- Number of fraud referrals submitted to the CMS RAC COR, for the reporting period
- Upcoming staff trainings, including webinar/conference call information for CMS RAC COR access
- Referral Reviews
  - All review concepts referred to the RAC and the associated New Issue number(s),
  - Provider(s) reviewed as the result of a referral,
  - Number of reviews to be conducted as part of the referral,
  - Number of reviews completed as part of the referral,
  - Outcome(s) of the referred reviews, and a
  - Status update on any outstanding reviews.

B. Monthly Appeals Report

The RAC shall submit monthly appeals reports. These reports shall be broken down by MAC jurisdiction into the following categories:

- A listing of appeal record requests from the MAC by review issue number for the month
- A listing of appeal record requests from the MAC to which the RAC has responded, by review issue number for the month
- A listing of all appeals dispositions by review issue number and level of appeal for the month
- Total number of appeals dispositions by review issue number from inception to date

- A listing of all ALJ hearings (by claim number and review issue number) in which the RAC took party status
- A listing of all ALJ hearings (by claim number and review issue number) in which the RAC participated

C. Monthly New Issues Report

The RAC shall include in the monthly progress report (spreadsheet) a New Issues tab. The New Issues tab shall include the following, as column headings:

- New Issue Name
- New Issue Number
- Review Type
- New Issue Approval Status (Approved, HOLD, Rescinded)
- Total Number of Reviews Conditionally Approved (total to date)
- Total Number of Reviews Completed (total to date)
- Number of Reviews Completed (in Prior Month)
- Date of Last Quality Assurance (QA) Review for this New Issue
- Date of Last Revision for this New Issue
- Reason for Revision (What changed?)
- Date Revision went into Effect (Effective Date)
- Due Date for Next QA Review
- Number of Discussion Periods Initiated in Prior Month
- Number of Discussion Periods Completed in Prior Month
- Number of Discussion Periods resulting in Overturned Decisions in Prior Month
- Primary Reason for Overturned Decisions during Discussions in Prior Month
- Number of Discussion Periods involving Physician to Physician Dialog

Under each column heading, the RAC shall include the most recent data related to the column heading. The RAC shall also note the date that the reported data was pulled, and the data source (e.g. RACDW, or internal RAC system, etc.).

Each approved New Issue shall have its own row on the report.

This report shall be supplied in addition to any appeals data or discussion period data that is separately reported. If no reviews have begun for a particular New Issue, the RAC shall indicate this with a zero ("0") and include an explanation in the appropriate field.

A standardized monthly report format may be required. If a standardized monthly report format is required, the CMS RAC COR will provide the format. Changes in the report format will be communicated by the CMS RAC COR no less than 30 days, prior to date on which the RAC shall submit the monthly report using the revised format.

Unless the CMS RAC COR approves alternative arrangements, each monthly report shall be submitted by the close of business on the fifth business day following the end of the calendar month. The monthly report shall be sent via secure e-mail to the CMS RAC COR.

xv. Task 15: Customer Service and Provider Outreach

The RAC shall maintain a quality customer service center to provide accurate and timely responses to CMS and provider inquiries. This includes responding to written, telephonic, and electronic inquiries within the appropriate timeframes. The RAC shall also perform any necessary provider outreach, as instructed by CMS.

A. Customer Service

1. The RAC 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 each applicable time zone. For example, if the RAC is conducting the work in California, the customer service number shall be staffed from 8:00 a.m. to 4:30 p.m. 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 RAC COR 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 necessary, the staff person that identified the improper payment shall return the call within one business day. The RAC shall provide a translator for Spanish speaking providers or other non-English speaking providers or debtors. This translator shall be available within one business day of the provider's original call.

2. The RAC shall provide remote call monitoring capability to CMS personnel in Baltimore or CMS regional offices, if directed by the CMS RAC COR. CMS may monitor RAC calls at any time without prior notification to the RAC. The RAC phone system must notify all callers that the call may be monitored for quality assurance purposes.

3. The RAC shall retain a written report of contact for all telephone inquiries and supply it to the CMS RAC COR within 48 hours of the request. At a minimum, the written report shall include the caller's name, provider name, provider identifier, phone number, date, reason for the call to the RAC, the response to the inquiry, and the outcome of the call, including any follow up contact by the RAC.

4. The RAC 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.

5. The RAC shall respond to written correspondence, including mailed and faxed documents, within thirty (30) days of receipt. The RAC shall confirm receipt of such

correspondence (by fax, email, or telephone) within one business day. The RAC shall provide the CMS RAC COR with copies of all correspondence (including email) indicating displeasure with the RAC, in the overpayment identification, or in the recovery methods utilized, within ten (10) calendar days of receipt of such correspondence.

6. The RAC shall respond to all email inquiries within two business days of receipt. (Friday after 5:00 p.m. - Monday 6:00 a.m. per time zone in the region and all federal holidays are excluded.) This includes requests from CMS as well as inquiries from providers and other external entities. In some instances, CMS will identify an inquiry as being a priority. Priority inquiries require an immediate response to the CMS RAC COR, and/or other designee, to confirm receipt of the inquiry. The deadline for any requested data will be included in the inquiry from CMS.

7. The Project Plan shall include a component on customer service and shall be updated 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.

B. Provider Outreach

The initial Project Plan shall include a section covering provider outreach. CMS will announce the use of the RAC in each region. All other debtor education and outreach concerning the use of the RAC will be the responsibility of the RAC. The RAC shall only educate providers on the business, purpose, and processes of the RAC. The RAC shall **not** educate providers on Medicare policy. The CMS RAC COR shall approve all debtor education and outreach presentations and written information shared with the provider, beneficiary, and/or other debtor communities before use. If requested by CMS, the RAC Project Manager for the CMS contract, at a minimum, shall attend any provider or debtor group meetings or congressional staff information sessions where the service provided by the RAC is the focus.

Provider outreach efforts shall include outreach to stakeholders under the RAC region, covering all provider types. Examples of outreach include, but are not limited to webinars, teleconferences, letters, in-person seminars, or partner events. The RAC may use any combination of outreach methods to reach its regional providers.

The RAC shall provide information, in its monthly administrative progress report, on all of its upcoming outreach efforts/sessions. The reported information, for each outreach session, shall include:

- Provider type targeted by the outreach session
- MAC jurisdiction, or state(s), targeted by the outreach session
- Date of the scheduled outreach session
- Method of outreach (webinar, teleconference, etc.) used for the outreach session
- Date provider-related, state, association(s) were informed of the outreach session

Provider outreach is an ongoing process that will continue throughout the timeframe of the RAC contract. CMS will closely monitor the RAC's outreach efforts, and may revise its provider outreach efforts, as necessary, to meet the goals of the Recovery Audit Program. Any revisions will be provided via future TDL.

C. Public Communications

The RAC must receive prior approval from CMS for all contractor press releases. The RAC shall **not** respond to requests from industry publications, newspapers, and journals for information involving the CMS Recovery Audit Program. These requests shall be forwarded to the CMS RAC COR.

The RAC shall include the CMS RAC COR in all public and congressional communications regarding the Recovery Audit Program. This includes issues regarding claims, appeals and system processes. The one exception is a discussion between the RAC and a provider and/or provider's representative.

xvi. Task 16: Administrative Period (Contract Closeout and Reconciliation)

Because the RAC must return its contingency fee for any collection that was later overturned on appeal, and due to the time it takes for claims to work through the appeals process, RAC contracts shall have an 18-month Administrative Period, during which only contract closeout and reconciliation activities, and no active reviews by the incumbent RAC, shall occur.

During the Administrative Period, CMS will continue to:

- recoup funds from providers on improper payments identified, and sent for adjustment, during the active recovery auditing (claim review) period,
- allow the RAC to invoice for contingency payments on eligible claims,
- allow the RAC to support the appeal process, and
- allow CMS to recoup contingency fees from overturned appeals

To prevent an interruption in claim reviews, the base year and first option year of the incoming RAC contract will, in most cases, occur concurrently with the outgoing RAC's Administrative Period. However, outstanding claims and appeals will not transition to the incoming RAC.

The outgoing RAC shall provide CMS with a bi-weekly closeout project status report organized by major closeout tasks. The report shall include a detailed discussion of outstanding issues, deliverables, problem resolution, and risk mitigation/contingency plans as appropriate.

VI. Administrative and Miscellaneous Issues

A. Payment Methodology

The RAC shall not receive any payments for the identification of the improper payments. The RAC shall be eligible for contingency fee payment for an accepted determination which will occur when all required claim elements are input into the RACDW and collection has occurred as a result of:

1. The provider failing to file a valid timely appeal, at either the first (MAC) level or the second (QIC) level of the appeals process.
2. Or, the provider received an unfavorable decision at the first (MAC) and second (QIC) level of the appeal process.

Contingency fee payments will be based on the demand letter date of the amount collected or refunded to the provider.

The contingency fee payment will be determined by the overpayments collected without netting out the underpayments. Underpayments are considered separately.

If a provider files an appeal disputing the overpayment determination and the appeal is adjudicated in the provider's favor at **ANY** level, the RAC shall repay Medicare any contingency fee payment that it received for that recovery. Repayment to Medicare will be subtracted from the next applicable invoice.

B. Point of Contact for the RAC

The primary point of contact for the RAC for all operational tasks in this SOW or any aspect thereof shall be the CMS RAC COR or his/her delegate. RACs shall not contact anyone in CMS with regard to work being performed under this contract without the written approval of the CMS RAC COR. The CMS Contracting Officer (CO) shall be the primary point of contact for all contract issues/questions.

The RAC's Project Manager shall be available to the CMS RAC COR during normal business hours. If the Project Manager is not going to be in the office, due to vacation, etc., the CMS COR will be notified at least one day in advance. In such cases, the Project Manager will designate a back-up person to serve as the central point of contact with CMS. Anyone serving as a back-up for the Project Manager will be required to have the ability to answer questions and/or provide data to the same degree that the Project Manager would be able to provide to CMS.

C. Recalled Cases

The 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 RAC shall immediately stop all activities included in the recall.

Recalls could occur for several reasons including additional activity that is occurring by another contractor/entity or lack of adherence by the RAC to any provision of the SOW. Recalls may be indefinite and may require a corrective action plan to resume activity. Recalls can be code specific, claim or provider specific, claim type or provider type

specific, jurisdiction specific, or region specific. The recall instructions issued by CMS will determine whether contingency fee payments will be made for prior work.

D. Reworked Claims

If CMS or the RAC determines that claims were improperly adjusted due to misinterpretation of CMS coverage or payment policy, or were outside of CMS' approved parameters, and the MAC must readjust the claims, CMS may limit or cease new RAC adjustments pending further review. Any contingency fee payments for these claims will be repaid to CMS through subtraction from the next applicable invoice. Additionally, CMS may elect to effect corrective actions for the RAC.

E. Case Record Maintenance

The RAC shall maintain a case file for every automated and complex review. This file shall include documentation of all processes followed by the RAC, including, but not limited to: a copy of all correspondence, additional documentation request letters, no findings letters, informational letters (automated reviews), review results letters, discussion requests, discussion results letters, 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 contract termination, the RAC shall return to CMS all case files stored in accordance with CMS instructions. Once an improper payment is determined all documentation related to that improper payment shall be kept in the case file. The RAC 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 https://www.whitehouse.gov/sites/whitehouse.gov/files/omb/circulars/A130/a130revised.pdf.

F. Recovery Deposits

The demand letters issued by the MAC will instruct providers to forward their refund checks to the appropriate address at the applicable MAC. If the RAC receives a refund check, the RAC shall forward the check to the appropriate address. Before forwarding the check, the RAC shall make copies of and otherwise document these payments. A copy shall be included in the appropriate overpayment case file.

G. Support OIG or Other Audits

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

H. Other Support Contractors

CMS is required to report on the RAC Program annually. To assist with the report, CMS may utilize an independent evaluation contractor to assist CMS with the analysis of data, provider survey, monitoring the RAC, and/or maintaining databases. Each RAC will have

a point of contact for the Evaluation Contractor and each RAC shall assign a point of contact in their organization. All requests will be filtered through the CMS RAC COR and shall be addressed within 15 days of receipt, unless otherwise noted in the request. Additionally, the RAC shall allow free access to papers, documents, office space, systems/software used specifically for tasks performed for this SOW, and personnel without impediment. CMS may request access to any of the aforementioned without RAC staff present; however, the RAC may alert CMS in cases where contractor staff must be present.

I. Quality Assurance

The RAC shall have the ability to implement and maintain Quality Assurance (QA) activities related to all major aspects of the Recovery Audit program.

1. Statement on Standards for Attestation Engagements

Each RAC shall be required to complete a Statement on Standards for Attestation Engagements Number 18 (SSAE 18 Type II Audit). Each RAC 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 SSAE 18 Type II audits.

The CMS control objectives can be found in IOM Pub. 100-6, Chapter 7, along with additional general information concerning a SSAE 18 Type II audit. The 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 contract 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.

2. Government Performance and Results (GPR) Goals

The RAC shall meet CMS' annual Government Performance and Results (GPR) goals related to contractor performance. The CMS will share the specific goals as they are released each year. If a RAC fails to meet a goal, a corrective action plan shall be submitted to CMS.

3. Contractor Performance Evaluations (CPE)

On a regular basis, CMS will 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.

4. Inter-Rater Reliability (IRR)

The RAC shall perform Quality Assurance (QA) reviews on their medical record reviews as part of an Inter-Rater Reliability (IRR) process on a monthly basis. The claims shall be randomly selected from all complex reviews with improper payment determinations. The RAC shall implement corrective actions for those reviewers whose IRR is below 90%. New employees shall maintain an IRR of 95% for at least

3 months following their initial training. Both the IRR and corrective action processes shall be detailed in the proposal. Additional QA reviews may be selected by CMS.

The RAC shall have the capability to produce a report of the claims subjected to QA, their outcomes, and any necessary corrective action upon request by CMS.

J. Remedies for Unsatisfactory Performance or Non-compliance

The CMS will take all actions it deems necessary to remedy unsatisfactory performance or non-compliance with any requirements within this SOW.

Examples of failures for which the CMS will take action, include, but are not limited to, the following:

- Failure to maintain an accuracy rate of at least 95%
- Failure to maintain an appeal affirmation rate of at least 90% (a/k/a overturn rate of less than 10%) at the first level of appeal
- Failure to timely enter the required claim/status information, including the data necessary for RAC invoicing purposes, into the RACDW
- Failure to perform Quality Assurance Reviews, every 6 months, for each New Issue package, in its entirety
- Failure to maintain an Inter-Rater Reliability (IRR) of at least 95% for all medical review personnel
- Failure to meet performance standards
    - For example:
        - not performing the amount of required claim reviews
        - not reviewing all claim/provider types
- Failure to meet, and maintain, personnel requirements
- Failure to meet, and maintain, system requirements
- Failure to meet, and maintain, system security requirements

Actions that CMS may take, at its discretion, include, but are not limited to, the following:

- rescinding approval (temporarily or permanently) of one, or more, New issues
- reduction in the number of conditionally approved reviews
- reduction in the number of ADRs that may be sent
- requiring the RAC to complete a Corrective Action Plan,
- limiting the scope of work under the RAC contract,
- limiting the period of performance of the RAC contract,
- not exercising the next option period of the contract,
- terminating the RAC contract

K. 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 contract period. It shall include a brief listing of all identification methods or other innovative, new processes utilized and their success or failure.

The RAC shall 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.

The RAC shall deliver the report to the CMS RAC COR. Drafts of all documentation shall be provided to CMS approximately six weeks prior to final deliverable due dates unless otherwise agreed to by CMS. The CMS staff will review materials and provide comments back to the contractor within two weeks, thereby allowing two additional weeks for the contractor to make any necessary revisions prior to submitting the final versions. 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, as specified by CMS. 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.

VII. Appendices

Appendix A: Schedule of Deliverables
Appendix B: Map of RAC Program Regions
Appendix C: Accuracy Review Dispute Form
Appendix D: 508 Standards per the Revised Section 508 of the Rehabilitation Act

APPENDIX A: SCHEDULE OF DELIVERABLES

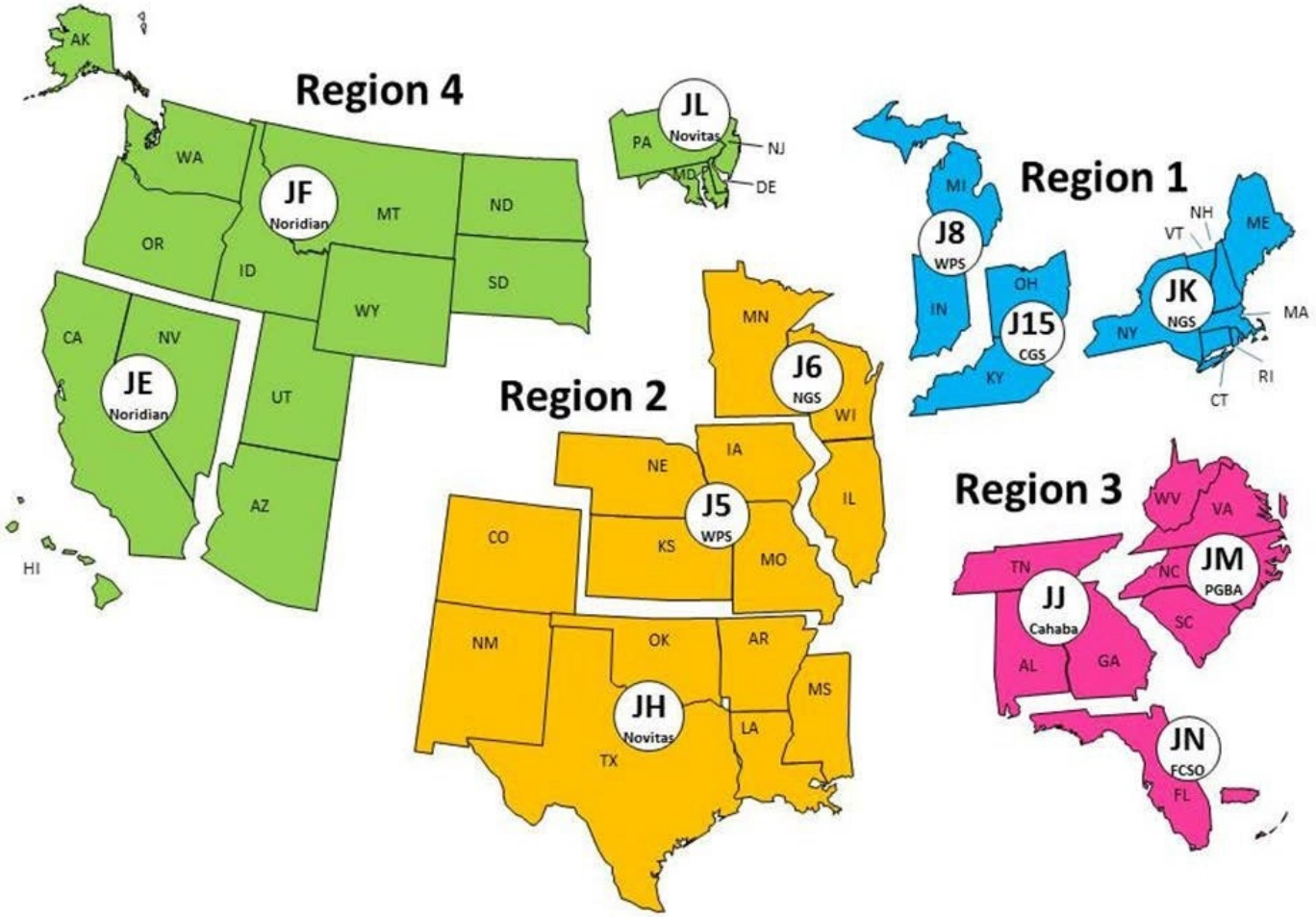
The RAC shall provide the necessary personnel, materials, equipment, support, and supplies to accomplish the tasks shown below in the specified timeframe. All work done under this contract shall be performed under the general guidance of the CMS RAC COR and subject to the COR's approval.

All documents shall be delivered to the CMS RAC COR in an electronic version via email, unless otherwise specified by the CMS RAC COR. At present, the CMS standard for word processing and spreadsheet documents are Microsoft Word 2016 and Microsoft Excel 2016, respectively. This is subject to change, and the RAC shall be prepared to submit deliverables in any new CMS standard.

Task Number	Deliverable Number	Deliverable	Due Date
Task 1	1	Initial Meeting	2 weeks from date of award
Task 2	2	Project Plan	Draft within 2 weeks after the initial meeting with CMS. Subsequent Project Plans due by COB on the fifth business day following the end of each quarter.
Task 13	3	Conference Calls	Weekly, and as needed
Task 14	4	Monthly Reports (Administrative, Appeals, New Issue)	Monthly – by COB on the fifth business day following the end of the month
Task 4. D.	5	Annual Case File Submissions	Annually, and within 15 days prior to the end of the Administrative Period of the contract.
Administrative and Miscellaneous Issues - K	6	Final Report- Draft	Within 6 weeks prior to the end of the Administrative Period of the contract.
Administrative and Miscellaneous Issues - K	7	Final Report- Final	Within 2 weeks prior to the end of the Administrative Period of the contract.

APPENDIX B: MAP OF RECOVERY AUDIT PROGRAM REGIONS

Map of RAC Region's 1-4 and Corresponding MAC Jurisdictions



APPENDIX C: ACCURACY REVIEW DISPUTE FORM

Accuracy Review Dispute Form

Date of Dispute:	Click here to enter a date.	**New Issue #:**	To be completed by the RAC.
RAC:	Choose an item.	**Accuracy Month:**	To be completed by the RAC.
Review Type:	Choose an item.	**Claim Number:**	To be completed by the RAC.

Section 1. Recovery Auditor

Clearly identify the area(s) that are being disputed:
To be completed by the RAC.
Provide original RVC Accuracy Review rationale:
To be completed by the RAC.
Provide detailed reasoning and rationale for each disputed area:
To be completed by the RAC.
List all questions for the RVC and/or CMS regarding the disputed area(s) identified above:
To be completed by the RAC.
References
To be completed by the RAC.
To be completed by the RAC.
Submitted by: To be completed by the RAC.

Section 2. RVC Response

RVC Response and Rationale:
To be completed by the RVC.
References
To be completed by the RVC.
To be completed by the RVC.
Submitted by: To be completed by the RAC.

Section 3. CMS Final Determination

DRAO Clinician Review:
To be completed by CMS.
Submitted by: To be completed by CMS.

RVC Final Decision:	Choose an item.
DRAO Clinician # 1 Final Decision:	Choose an item.
DRAO Clinician # 2 Final Decision:	Choose an item.
CMS Decision:	Choose an item.

APPENDIX D: 508 Standards per the Revised Section 508 of the Rehabilitation Act

Electronic Documents

General Exceptions

Technical Criteria:

E207.1 General - Where components of ICT are software and transmit information or have a user interface, such components shall conform to E207 and the requirements in Chapter 5

E207.2 WCAG Conformance - User interface components, as well as the content of platforms and applications, shall conform to Level A and Level AA Success Criteria and Conformance Requirements in WCAG 2.0 (incorporated by reference, see 702.10.1).

E207.2.1 Word Substitution - When Applying WCAG to Non-Web Software For non-Web software, wherever the term “Web page” or “page” appears in WCAG 2.0 Level A and AA Success Criteria and Conformance Requirements, the term “software” shall be substituted for the terms “Web page” and “page”. In addition, in Success Criterion in 1.4.2, the phrase “in software” shall be substituted for the phrase “on a Web page.”

E207.3 Complete Process for Non-Web Software - Where non-Web software requires multiple steps to accomplish an activity, all software related to the activity to be accomplished shall conform to WCAG 2.0 as specified in E207.2.

Electronic Content

Technical Criteria:

E205.1 General - Electronic content shall comply with E205.

E205.3 Agency Official Communication - Electronic content that is not public facing shall conform to the accessibility requirements specified in E205.4 when such content constitutes official business and is communicated by an agency through one or more of the following:

A. An emergency notification;
B. An initial or final decision adjudicating an administrative claim or proceeding;
C. An internal or external program or policy announcement;
D. A notice of benefits, program eligibility, employment opportunity, or personnel action;
E. A formal acknowledgement of receipt;
F. A survey questionnaire;
G. A template or form;
H. Educational or training materials; or

I. Intranet content designed as a Web page.

E205.4 Accessibility Standard (WCAG 2.0) - Electronic content that is not public facing shall conform to the accessibility requirements specified in E205.4 when such content constitutes official business and is communicated by an agency through one or more of the following:

A. An emergency notification;
B. An initial or final decision adjudicating an administrative claim or proceeding;
C. An internal or external program or policy announcement;
D. A notice of benefits, program eligibility, employment opportunity, or personnel action;
E. A formal acknowledgement of receipt;
F. A survey questionnaire;
G. A template or form;
H. Educational or training materials; or
I. Intranet content designed as a Web page.

E205.4.1 Word Substitution when Applying WCAG to non-Web Documents - For non-Web documents, wherever the term "Web page" or "page" appears in WCAG 2.0 Level A and AA Success Criteria and Conformance Requirements, the term "document" shall be substituted for the terms "Web page" and "page". In addition, in Success Criterion in 1.4.2, the phrase "in a document" shall be substituted for the phrase "on a Web page".

The following standards are applicable:

All WCAG A & AA Success Criteria apply.
602 Support Documentation
603 Support Services
302 Functional Performance Criteria

The following standards are applicable:

All WCAG A & AA Success Criteria - except
2.4.1 Bypass Blocks
2.4.5 Multiple Ways
3.2.3 Consistent Navigation
3.2.4 Consistent Identification
602 Support Documentation
603 Support Services
302 Functional Performance Criteria
602 Support Documentation
603 Support Services
302 Functional Performance Criteria

Software

Technical Criteria:

E501.1 Scope - The requirements of Chapter 5 shall apply to software where required by 508 Chapter 2 (Scoping Requirements), 255 Chapter 2 (Scoping Requirements), and where otherwise referenced in any other chapter of the Revised 508 Standards or Revised 255 Guidelines.

E502.1 General - Software shall interoperate with assistive technology and shall conform to 502.

E504.1 General - Where an application is an authoring tool, the application shall conform to 504 to the extent that information required for accessibility is supported by the destination format.

E504.2 Content Creation or Editing - Authoring tools shall provide a mode of operation to create or edit content that conforms to Level A and Level AA Success Criteria and Conformance Requirements in WCAG 2.0 (incorporated by reference, see 702.10.1) for all supported features and, as applicable, to file formats supported by the authoring tool. Authoring tools shall permit authors the option of overriding information required for accessibility.

E504.2.1 Preservation of Information Provided for Accessibility in Format Conv - E504.2.2 PDF Export - Authoring tools capable of exporting PDF files that conform to ISO 32000-1:2008 (PDF 1.7) shall also be capable of exporting PDF files that conform to ANSI/AIIM/ISO 14289-1:2016 (PDF/UA-1) (incorporated by reference, see 702.3.1).

E504.3 Prompts - Authoring tools shall provide a mode of operation that prompts authors to create content that conforms to Level A and Level AA Success Criteria and Conformance Requirements in WCAG 2.0 (incorporated by reference, see 702.10.1) for supported features and, as applicable, to file formats supported by the authoring tool.

E504.4 Templates - Where templates are provided, templates allowing content creation that conforms to Level A and Level AA Success Criteria and Conformance Requirements in WCAG 2.0 (incorporated by reference, see 702.10.1) shall be provided for a range of template uses for supported features and, as applicable, to file formats supported by the authoring tool.

502.2 Documented Accessibility Features - Software with platform features defined in platform documentation as accessibility features shall conform to 502.2.

502.2.2 No Disruption of Accessibility Features - Software shall not disrupt platform features that are defined in the platform documentation as accessibility features.

502.3.1 Object Information - The object role, state(s), properties, boundary, name, and description shall be programmatically determinable.

502.3.2 Modification of Object Information - States and properties that can be set by the user shall be capable of being set programmatically, including through assistive technology.

502.3.3 Row, Column, and Headers - If an object is in a data table, the occupied rows and columns, and any headers associated with those rows or columns, shall be programmatically determinable.

502.3.4 - Any current value(s), and any set or range of allowable values associated with an object, shall be programmatically determinable.

502.3.5 Modification of Values - Values that can be set by the user shall be capable of being set programmatically, including through assistive technology.

502.3.6 Label Relationships - Any relationship that a component has as a label for another component, or of being labeled by another component, shall be programmatically determinable.

502.3.7 Hierarchical Relationships - Any hierarchical (parent-child) relationship that a component has as a container for, or being contained by, another component shall be programmatically determinable.

502.3.8 Text - The content of text objects, text attributes, and the boundary of text rendered to the screen, shall be programmatically determinable.

502.3.9 Modification of Text - Text that can be set by the user shall be capable of being set programmatically, including through assistive technology.

502.3.10 List of Action

502.3.11 Actions on Objects - Applications shall allow assistive technology to programmatically execute available actions on objects.

502.3.12 Focus Cursor - Applications shall expose information and mechanisms necessary to track focus, text insertion point, and selection attributes of user interface components.

502.3.13 Modification of Focus Cursor - Focus, text insertion point, and selection attributes that can be set by the user shall be capable of being set programmatically, including through the use of assistive technology.

502.3.14 Event Notification - Notification of events relevant to user interactions, including but not limited to, changes in the component's state(s), value, name, description, or boundary, shall be available to assistive technology.

503.1 General - Applications shall conform to 503.

503.2 User Preferences - Applications shall permit user preferences from platform settings for color, contrast, font type, font size, and focus cursor.