



Recovery Audit Contractor (RAC) Program Frequently Asked Questions

This information is intended to assist a healthcare provider understand the basic process and principles associated with the CMS Recovery Audit program. It does not represent a complex summary of the Recovery Auditor's Statement of Work with CMS, nor the complete detail of the Program. For additional information, you may refer to the CMS website at www.CMS.gov. Search 'Recovery Audit Program.'

Acronym	Definition
ADR	Additional Documentation Request
CMS	Centers for Medicare and Medicaid Services
MAC	Medicare Administrative Contractor (a.k.a. Payer, Fiscal Intermediary)
NPI	National Provider Identifier
RA	Recovery Auditor
RAC	Recovery Audit Contractor
RRL	Review Results Letter

What are the various review types and how do they differ?¹

There are two categories of reviews – Automated and Complex

Automated

No medical records are requested or reviewed. Discovery is done through data-mining. By definition, there is clear and unambiguous CMS policy that supports the results as an overpayment/underpayment. There is no RRL sent to the Provider. All Automated Reviews initiated after January 1, 2016 will be posted on the Provider Portal when they are identified. This will serve as the start of the Provider's 30-day window for a Discussion Request (optional-see information below on the Discussion Request).

Complex

Claims are selected for review, and the RA sends an ADR to the Provider. The Provider has 45 days to respond to the ADR. Starting with ADRs issued January 1, 2016 or later, the RA has 30 days to conduct the review from the date the documentation is received by Cotiviti. If the documentation is not received within 45 days, the RA makes one good faith effort to follow-up with the Provider. If no documentation is subsequently received, the full amount of the claim is sent to the MAC for adjustment. This is considered a *technical denial*. Subsequent to a Complex review, the Provider will generally receive one of three letter types from Cotiviti:

- ~ Review Results Letter (RRL): The review is complete, and there was an overpayment or underpayment finding. This letter gives the Provider a detailed rationale to support the finding, the amount of the impending adjustment, and what the Provider can anticipate in terms of next steps.
- ~ No Findings Letter: Confirms that the review has been completed, and there were no findings. No adjustments will be sent to the MAC pertaining to that review.
- ~ Non-receipt Letter: This is confirmation the claim has been technically denied due to non-receipt of the requested documentation. The claim will be sent to the MAC for full adjustment.

¹This information is taken from the Recovery Auditor Statement of Work found at www.CMS.gov. This information is subject to change/update at any time, and the above information is current as of the date on this document.



Does CMS approve all audit concepts?¹

Yes, CMS not only has to pre-approve what is being audited (the specific concept) they also have to approve whether that concept is appropriate for an Automated or Complex review type.

How does a Provider know what audit concept is responsible for a RAC adjustment?¹

For Complex reviews, the ADR contains the specific audit rationale and so does the subsequent RRL a Provider may receive. However, since there are no letters sent for Automated reviews, it is the Provider Portal that will display the 'Approved Issue Number' associated with each claim. There is a link within the Portal to the 'Approved Issues List' which fully describes the audit concept. Copy and paste that number into the search bar, and you will see the rationale for that particular Automated review. In addition to navigating to the Approved Issues List from within the Portal, you can go to it directly from www.Cotiviti.com/RAC under the heading of *Knowledge Base*, you will see a link to *Approved Issues*. A complete list of all issues and review types are available, sortable and searchable.

How are claims selected for review?

Recovery Auditors target audit concepts – not providers. A series of complex and proprietary algorithms are used to analyze claim data based on propensity for error. The selection process targets both over-payments and underpayments.

How many charts can be requested for a particular Provider?¹

Medical record request limits are based on two components that are mutually exclusive – frequency of request, and number of charts requested. The frequency may be no sooner than 45 days. CMS, not the Recovery Auditors, calculates the limits. The limits are separated by DME, Physician and Facility. For Facilities, the limits are calculated by individual NPI. Future limits are subject to change based on NPI-specific audit results. The Medical Record Request Limits are displayed both within the Provider Portal as well as on the ADR itself. For additional information, see www.CMS.gov and search *Additional Documentation Limits*.

When records are sent to Cotiviti, when will the status change to *Medical Record Received on Cotiviti's Provider Portal*?

Please allow 2-3 business days following the receipt of medical records for the Portal to reflect their receipt. It is not until your documentation is imaged, ingested, and matched to their corresponding claim(s) record that they can be tracked on the Portal by searching their corresponding ICN. Also, the information displayed on the Portal is only refreshed once every night. Regardless of the time it takes to process those records, their receipt date will always reflect the date we physically received them.

Since there is no ADR, at what point do claims for Automated and Semi-automated reviews show up on Cotiviti's Provider Portal?

All Automated Reviews initiated after January 1, 2016, will be posted on the Provider Portal when they are identified. This will serve as the start of the Provider's 30-day window for a Discussion Request (optional).

As it pertains to the RAC program, what role does the Recovery Auditor play vs the MAC (aka Medicare, payer, fiscal intermediary)? How do I know who to contact?

At the most basic level, the role of the RA is to select the claims and conduct the review, and the role of the MAC is to process any resulting adjustments and serve as the conduit for any subsequent appeal activity. Therefore, should you

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have a question that pertains to anything in the RAC process up to the point where the claim may be pending adjustment with the MAC, you should contact the RA. Cotiviti's contact information is as follows:

RACInfo@Cotiviti.com

866-360-2507

Representatives are available Monday through Friday 8:00am to 6:30pm EST

How do I know which Recovery Audit Contractor to contact?

RA activity across the country is handled by several contractors. To understand how that activity and/or other CMS contractor activity is allocated, please visit www.CMS.gov and search 'Smart Map'.

Who sends the ADR for a post-payment review – the RA or the MAC? ¹

The Recovery Auditor sends the ADR to the Provider.

Who sends the Demand Letter – the RA or the MAC? ¹

It is the MAC that sends the Demand Letter to the Provider.

What information is in the Demand Letter?

Even though the format and specifics of the Demand Letter can vary from one MAC to another, the basic content is consistent. The Demand Letter contains the amount of the adjustment, the source of the adjustment (e.g. RA review, etc.), when/how the adjustment will occur, and the procedure for filing an appeal. A Demand Letter may not solely contain adjustments as a result of an RA review-there are other contractors, including the MAC themselves, that may do reviews and initiate claim adjustments.

After the Provider is notified of a finding, how long is it until the claim is adjusted?

For an ADR dated January 1, 2016 or later, adjustments will be held for 30 days before being submitted to the MAC. For complex claim reviews, this is 30 days from the date from the Review Results Letter. If a Discussion Request is received during this period, the pending adjustment will continue to be held pending the outcome of the Discussion review. All Automated Reviews initiated after January 1, 2016 will be posted on the Provider Portal when they are identified, and the adjustment will be held for 30 days before being submitted to the MAC. If a Discussion Request is received during this period, the pending adjustment will continue to be held pending the outcome of the Discussion Review.

While a large percentage of adjustments process automatically through a bulk process, for many reasons there are many that need to be input manually by the MAC. For those that need to be input manually, they can take anywhere from 3-4 weeks to be processed. Cotiviti does not have visibility into the timing or prioritization of those adjustments at the MAC. Because those adjustments have not yet been processed, many times the front line representatives at the MAC are not aware those adjustments are even pending. Typically their system will only reflect what has already processed. They would need to reach out to their appropriate back-office processing group to inquire about a pending adjustment for a particular claim. Cotiviti's Provider Portal will reflect that the adjustment has been sent to the MAC, and its status will not change until the MAC has processed it and sent the Demand Letter to the Provider.

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What is the difference between a Discussion Request and an Appeal?

These processes are mutually exclusive and cannot be pursued simultaneously. A Discussion Request submitted to the RA-but an Appeal is submitted to the MAC. Here are the basic differences between the two:

After receiving the results from the RA's review, the Provider has the option to submit additional information and/or medical documentation that they believe would support a different outcome. This is referred to as a *Discussion Request*, and the form to initiate such a request is found on Cotiviti's website www.Cotiviti.com/RAC under the heading of HOW TO. Instructions are available on the form itself, and we encourage Providers to utilize this process when they believe it would be beneficial. The *Discussion Request Form* is sent to Cotiviti and can only be sent within 30 days from the date of the Review Results Letter; or 30 days from the Provider Portal notification for an Automated Review. During that time, no adjustments will be set to the MAC. Following receipt of a complete Discussion Request, the RA has 30 days to review and respond to the Provider. A Provider is afforded only 1 Discussion Request per claim.

A first-level Appeal (also referred to as a Redetermination) is filed with the Medicare Administrative Contractor, and the process for doing so is described on the MAC's Demand Letter. On a Provider files an Appeal, the RA is not permitted to complete a response to a Discussion-even if it was received prior to the Appeal being filed with the MAC.

What if a Provider needs more time to submit records?

A Provider has 45 calendar days from the date printed on the ADR to submit the requested documentation. If it is prior to the expiration of the 45-day time period, then call Cotiviti at 866-360-2507 and one of our Provider Service Specialists will be glad to provide an extension. Representatives are available Monday through Friday from 8am to 6:30pm Eastern Standard Time.

If I received a *Non-Receipt Letter* from Cotiviti, can I still submit records to be reviewed?

Even after the issuance of a Non-Receipt Letter, the RA holds the adjustment submission to the MAC for 30 days. If you do submit the documentation during this 30 day waiting period, Cotiviti will review it. Upon receipt, Cotiviti has an additional 30 days to conduct the review and issue a Review Results Letter.

In what format may I submit medical documentation?

Complete instructions may be found on the ADR itself, as well as at www.Cotiviti.com/RAC under HOW TO.

Electronic

- CMS's portal esMD (Electronic Submission of Medical Documentation) [recommended]
- CIOX Health (we have a direct connection with this Health Information Handler)

Digital

- CD or DVD or thumb drive (will not be returned)
- **NOTE:** There are very specific format and password requirements for the records to be accepted. Please refer to the instructions referred to above.

Paper

- See the instructions on the ADR itself as to how to prepare and submit paper documents.

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- Please be sure to use the bar-coded claim(s) listing we provided as coversheets/separators for the documentation submitted.

Are there other reasons why a RA review can be closed?

Yes. There are many different reasons a review initiated by an RA could be suspended after it has begun, and/or reasons why the findings are not submitted to the MCA for adjustment. As an example, the RA may be notified a claim has already been adjusted by the MAC. Also, CMS, at any time and at their discretion, may provide technical direction to close claims or audit concepts from review. In those instances, a *Closure* or *Withdrawal* letter will be sent to the Provider and the data column in the Portal 'Claim Closure' will reflect the date the claim was closed. Cotiviti's standard Closure Letter, however, does state that the claim(s) may become eligible for review at a later date. Not all circumstances will result in a Closure Letter being sent to the Provider. For example, Automated reviews-no ADR had been sent to the Provider, so there is no accompanying Closure Letter.

How do I access and use Cotiviti's Provider Portal?

Go to www.Cotiviti.com/RAC. On the left, you will see an icon for *Provider Portal Login*. Under **HOW TO** on that same page, you can view/download the *Provider Portal User Guide* for step-by-step instructions.

Is a Provider reimbursed for the cost of submitting documentation?

In accordance with the CMS Statement of Work, the provider will be reimbursed for the cost of providing copies of the medical records. The reimbursement is automatic and not in response to an invoice. For PPS providers, it will be in the amount of \$0.12 cents per page, plus shipping cost if mailed via USPS regular mail. For non-PPS institutions and practitioners, it will be in the amount of \$0.15 cents per page, plus shipping cost if mailed via USPS regular mail. The maximum for PPS providers and non-PPS institutions and practitioners is \$27 for records sent via esMD and \$25 for all other submission types. Reimbursement is only for records sent in response to an ADR-not subsequent documentation such as a Discussion Request or correspondence. If a Provider submits records to Cotiviti utilizing CIOX Health, reimbursement is made directly to them. Otherwise, reimbursement is always made directly to the Provider-even if the Provider utilizes another Health Information Handler to submit documentation.

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