UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

AMERICAN HOSPITAL ASSOCIATION, *et al.*, Plaintiffs, v. ALEX M. AZAR II, in his official capacity as ACTING SECRETARY OF HEALTH AND HUMAN SERVICES, Defendant.	Civil Action No. 14-cv-00851 (JEB)

DECLARATION OF GEORGE G. MILLS

I, George G. Mills, declare as follows:

1. I am the Deputy Director of the Center for Program Integrity (CPI) at the Centers for Medicare & Medicaid Services (CMS) within the Department of Health and Human Services (HHS or Department). I have held this position since June 2015. Prior to this position, from August 2013 to June 2015, I was the Deputy Director of the Office of Financial Management (OFM) within CMS, and from January 2009 to August 2013, I was the Director of the Provider Compliance Group within OFM. Among my duties in my current position, I oversee the Recovery Audit Contractor (RAC) program.

2. The statements made in this declaration are based on my personal knowledge, information contained in agency files, and information furnished to me in the course of my official duties.

3. Attached as Exhibit A is the final, currently operative RAC Statement of Work (SOW) dated October 31, 2017. The purpose of the redlining in this final SOW is to show the RACs any changes from the draft SOW that went out to bid. This operative SOW does not

contain any provision stating that the "[f]ailure to enter the necessary information timely will result in a 25% reduction in the applicable contingency fee for the affected claims."

4. On page 3 of Plaintiffs' Response Regarding Non-Deadline Remedies, plaintiffs point the court to https://tinyurl.com/jztek8r, Statement of Work for Part A/B Medicare Fee-for-Service Recovery Audit Program – Regions 1-4. This citation is to the draft SOW that went out to bid, which was subsequently modified and therefore is not the final, operative RAC SOW currently in effect.

5. CMS did not tie incentives to the existing SOW to ALJ overturn rates because ALJs are only required to give program guidance and local coverage decisions substantial deference and are permitted to decline to follow such guidance as long as they explain the reasons why the policy was not followed. *See* 42 C.F.R. 405.1062.

6. From Fiscal Years 2011 through 2013, RACs reviewed approximately 3.1 million inpatient-status claims submitted by hospitals before such reviews were moved to other contractors in order to give providers time to comply with the newly clarified Medicare coverage policy for these particular types of claims. RACs recovered $6,205,110,088 for the Medicare Trust Funds as a result of these reviews.

7. CMS transitioned hospital inpatient status reviews away from the RACs to the Medicare Administrative Contractors (MACs) in 2013 to allow providers time to comply with the newly clarified inpatient stay (or "two-midnight") rule. Later, in October 2015, those reviews were shifted from the MACs to the Quality Improvement Organizations (QIOs).

8. RACs have continued to do other, non-patient status claim reviews of hospital claims under the old and new contracts. From October 31, 2016 through July 11, 2018, the RACs have conducted 48,610 non-patient status reviews of hospital claims.

9. Starting with the new SOW (October 2016), CMS requires the RACs to review different claim types, which ensures the RACs are focusing on areas susceptible to high error rates and ensures that the RACs are not targeting only one provider or claim type. Most (>95 %) of paid Medicare Fee-for-service claims which have errors are for less than $500. The average RAC contingency fee for complex reviews, i.e., reviews that require the review of medical records, ranges from 13% to 36.34%, which means a RAC could receive less than $65 per claim for these reviews, which is less than the cost to the RAC to do the review, pay overhead, and participate in discussion periods and any appeal-related activities for each claim. In fact, most reviews of lower dollar claims are not complex reviews, which means the contingency percentage is lower resulting an even lower payment to the RAC for these reviews. In addition, as noted above, not every claim reviewed will have an improper payment (overpayment or underpayment). Therefore, the review of higher-dollar claims, most of which are hospital claims, allows the RACs to cover their costs of performing the lower-dollar claim reviews.

10. Transferring all post-pay hospital claim review to QIOs could very well deter contractors from signing on to become RACs in the first place and would threaten the continued existence of the RAC program. In fact, in the last round of contracting, one existing RAC declined to re-bid under the terms of the SOW that was issued.

I declare under penalty of perjury that the foregoing is true and correct to the best of my knowledge and belief.

Executed on August 3, 2018 in Baltimore, Maryland

George G. Mills

EXHIBIT A

Mills Declaration

Statement of Work for the Part A/B Medicare Fee-for-Service Recovery Audit Program – Region 1

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 the A/B Medicare Administrative Contractors (MACs) in Recovery Audit 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 Recovery Auditor 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 Recovery Audit Data Warehouse (the "Data Warehouse") and providing monthly reports in a timely, accurate, and efficient manner.

This SOW includes the following tasks, which are defined in detail in subsequent sections:

1. The Recovery Auditor shall perform postpayment review to identify Medicare claims that contain improper payments (overpayments or underpayments), which were made under Part A or Part B of Title XVIII of the Social Security Act. This includes review of all Medicare claim and provider types (excluding DMEPOS and HH/H) and a review of claims/providers that have a high propensity for error based on the Comprehensive Error Rate Testing (CERT) program and other CMS analysis. This also includes: requesting, obtaining, storing, sharing, and paying for medical documentation (for complex reviews); communicating review statuses and results (via letters and a web-based portal) to providers; maintaining case files; participating in discussion periods with providers; and, sending claims for adjustment.
2. The Recovery Auditor shall utilize the Data Warehouse as the central repository for all claims information in the Recovery Audit Program. This includes consistently updating the Data Warehouse 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.

3. The Recovery Auditor shall participate in a CMS review approval process, through which review topics must be approved before the Recovery Auditor can begin to review those topics. This process includes the preparation and submission of documents by the Recovery Auditor, 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; and, participating in discussions with CMS, the MACs, and CMS Review Plan Team, as necessary.
4. The Recovery Auditor 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.
5. Recovery Auditors 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.
6. The Recovery Auditor 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.
7. The Recovery Auditor 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 Recovery Auditor shall also perform any necessary provider outreach, as instructed by CMS.
8. The Recovery Auditor shall ensure compliance with all SOW and CMS system requirements, including Information Technology (IT) systems security policies, procedures and practices. This includes participating in the necessary security testing to obtain an Authority to Operate (ATO).
9. Optional Task – Prepayment Review
10. Optional Task – Contract Closeout and Reconciliation

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 Recovery Auditors 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 Financial Management Manual (specifically, Chapter 4, section 100) and the Program Integrity Manual (PIM) (specifically, Chapter 3) at www.cms.hhs.gov/manuals

- 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

- Comprehensive Error Rate Testing Reports (see www.cms.hhs.gov/cert)

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

- 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.

General Requirements

The SOW is subject to Section 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 Section 508 Compliance for Communications as applicable. 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 Recovery Auditor 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 Recovery Auditor 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.

A. Initial Meeting with CMS

The Recovery Auditor's project staff (including key personnel, the Project Manager and Medical Director) shall meet at CMS in Baltimore, Maryland with the CMS Contracting Officer Representative (COR) and appropriate CMS staff within two weeks of the date of award to discuss the project plan. The specific focus will be to discuss the timeframes for the tasks outlined below. Within two weeks of this meeting, the Recovery Auditor shall submit a formal project plan outlining the resources and timeframe for completing the work outlined. The initial project plan will be for the base year of the contract. The project plan is an evolving document and will serve as a snapshot of all proposed, and approved, review topics that the Recovery Auditor is identifying at the time. It is the Recovery Auditor's responsibility to update the project plan as new review topics are approved. The initial project plan and any subsequent updates must be approved by CMS prior to implementation.

1. Project Plan

The project plan shall include the following:

a. Proposed quarterly projection by review topics (e.g., excisional debridement); b) type of review (automated, complex, extrapolation); c) type of error (medical necessity, incorrect coding)
b. Provider Outreach Plan – At a minimum, the base provider outreach plan shall include potential outreach efforts to associations, providers, Medicare contractors, and other applicable Medicare stakeholders.
c. Recovery Auditor Organizational Chart – At a minimum the organizational chart shall identify the names and titles of key personnel and the organizational structure of the Recovery Auditor. Within two weeks of the initial meeting, the Recovery Auditor shall submit a detailed organizational chart extending past the key personnel to at least first-line management, as well as a contingency plan for dealing with unexpected changes in any key personnel for COR approval.

B. Transitions

1. Recovery Auditor Transition

From time to time in the Recovery Audit Program, CMS will need to transition work from the outgoing Recovery Auditor to a different incoming Recovery Auditor. This happens when the incumbent Recovery Auditor ceases work under the contract and the new Recovery Auditor begins work. The term "transition" will be applied to describe the coordination of work duties during the overlapping period when one Recovery Auditor's contract is ending and another Recovery Auditor's contract begins. It is in the best interest of all parties to ensure that transitions occur smoothly.

In order to ensure a successful transition, the outgoing contractor shall cooperate fully with the incoming contractor during the transition period. A transition is successful when the transfer of Medicare data, records, and operational activities from the outgoing contractor to the incoming contractor and/or CMS is accomplished so that:

- There is minimal disruption to providers;
- There is minimal disruption to the Recovery Audit program;
- The transition is completed within the required time period as stated in the transition plan;
- All parties with an interest in the transition (whether direct or indirect) are kept informed of the transition's status and progress.

The base year and option year one of this contract may overlap with the transition years of the preceding Recovery Audit program contract; however, outstanding claims and appeals will not transition to the incoming Recovery Auditor (See Task 11).

a. Transition Plan and Stakeholder Communications

The incoming Recovery Auditor shall submit a Transition Plan within fourteen (14) days of the Initial Meeting referenced above (General Requirements, Section A). The Transition Plan will include recommendations of specific dates regarding the initial of Joint Operating Agreements (JOAs) with the MACs and related contractors, provider outreach, provider communication, and submission of review topics for approval.

During the transition period, the Recovery Auditor shall hold weekly transition status teleconferences or meetings with the outgoing Recovery Auditor and CMS. The outgoing contractor will assist the incoming contractor in organizing, hosting, and providing toll-free telecommunication lines and facilities for transition meetings. The meetings will follow a prepared agenda to discuss the status of the major tasks, issues, deliverables, schedule, delays, problem resolution and risk mitigation and/or contingencies. The outgoing contractor shall assist in providing meeting agenda items for all meetings at least two business days before the meeting. The incoming contractor shall issue meeting minutes to all stakeholders within two business days after the meeting.

The outgoing and incoming contractor 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.

2. MAC Transition (Impact on the Recovery Audit Program)

The CMS will occasionally transition the claim processing workload from one MAC to another. The CMS will review each transition, independently taking into account the outgoing and incoming contractor, the impact on the provider community, historical experience and the Recovery Auditor's relationship with the involved contractors to determine the impact on the Recovery Audit Program. The impact on the Recovery Auditor may vary from relatively minor or no impact to a work stoppage in a specific area for a 3-6 month period of time. CMS will determine the impact to the Recovery Audit Program within 60 days of the announcement of the upcoming MAC transition and share that information with the Recovery Auditor. The affected Recovery Auditor shall submit a transition plan to CMS for approval, based on CMS' determination. The lack of an approved transition plan may result in a minimum transition time of six months.

C. Conference Calls

On a weekly basis, unless otherwise instructed by CMS, the Recovery Auditor's key project staff will participate in a conference call with the CMS COR to discuss the progress of work, evaluate any problems, and discuss plans for immediate next steps of the project. The Recovery Auditor 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.

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

D. Monthly Progress Reports

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

    a. Complications completing any task
    b. Communication with MAC/Qualified Independent Contractor (QIC)/Administrative QIC (ADQIC)
    c. Upcoming provider outreach efforts
    d. Update of project plan

e. Detailed report on discussion periods, including: the number of requests received (per new issue number), discussion period outcomes, information submitted by provider during discussion, and detailed rationale for any overturned decisions.
f. Update of audit topics being reviewed in the upcoming month
g. Recommended corrective actions to prevent or reduce improper payments for each review topic (e.g., Local Coverage Determination (LCD) change, system edit, provider education)
h. Possible issues not reviewed due to potentially ineffective policies*
i. Update on Joint Operating Agreements (JOAs)
j. Action items
k. Number of fraud referrals submitted to the CMS COR

*The Recovery Auditor shall also report on LCDs or other policies that may benefit from CMS evaluation and identify their characteristics (outdated, technically flawed, etc.). If a LCD is outdated, technically flawed or provides limited clinical details it will not provide optimal support for medical review decisions. Identification of these LCDs will improve the integrity of the Medicare Program and the performance of the Recovery Audit Program.

2. The Recovery Auditor shall submit monthly **appeals reports**. These reports shall be broken down by MAC jurisdiction into the following categories:

a. A listing of appeal record requests from the MAC by review issue number for the month
b. A listing of appeal record requests from the MAC to which the Recovery Auditor has responded, by review issue number for the month
c. A listing of all appeals dispositions by review issue number and level of appeal for the month
d. Total number of appeals dispositions by review issue number from inception to date
e. A listing of all ALJ hearings (by claim number and review issue number) in which the Recovery Auditor took party status
f. A listing of all ALJ hearings (by claim number and review issue number) in which the Recovery Auditor participated

At CMS discretion, a standardized monthly report(s) may be required. If a standardized monthly report is required, CMS will provide the format. Changes in the report format will be communicated no less than 30 days in advance.

Unless the CMS 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 month. The monthly report shall be sent via e-mail to the CMS COR.

E. Recovery Audit Data Warehouse

CMS will provide access to the Data Warehouse. The Data Warehouse is a web-based application that houses data related to all Recovery Auditor improper payment identifications and corrections (overpayment collections and returned underpayments). The Data Warehouse 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 Recovery Auditor for review. The Recovery Auditor shall provide the appropriate equipment to access the Data Warehouse. (More information on the Data Warehouse is located in Task 2.)

F. Data Accessibility

The Recovery Auditor shall be responsible for obtaining the necessary hardware and software associated with the transfer of CMS data.

To access CMS data, the Recovery Auditor shall acquire a secure line between the Recovery Auditor and the CMS Data Center. The Recovery Auditor 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 Recovery Auditor shall incur all costs associated with the establishment and maintenance of the secure line, as well as license costs. The Recovery Auditor 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 Recovery Auditor 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 Recovery Auditor with all necessary data files under the terms of this contract for the applicable geographic area. The Recovery Auditor 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 Recovery Auditor shall undertake all necessary steps in troubleshooting the cause of the problem. The Recovery Auditor 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.

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

The Recovery Auditor 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 Recovery Auditor shall pay for all charges associated with the storage and processing of any data necessary to accomplish SOW directives. The Recovery Auditor 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 Recovery Auditor shall comply with all CMS privacy and security requirements. The Recovery Auditor shall provide all personal computers, printers, and equipment to accomplish the work described herein throughout the contract term.

G. Geographic Region

Unless otherwise directed by CMS through technical direction, the claims being analyzed for this award will be all fee-for-service Part A and B claims (excluding DMEPOS and Home Health/Hospice) processed by the A/B MACs in Region 1 regardless of the provider's physical location. The A/B MAC jurisdictions and Recovery Audit regions can be found in Appendix 1.

H. Recovery Auditor Staff

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

1. Key Personnel

At a minimum, the Recovery Auditor shall designate a Project Manager and a Medical Director as key personnel. The Recovery Auditor may designate additional key personnel at its discretion.

The Recovery Auditor shall submit a CMS -approved contingency plan and designate backups for each key personnel role, as directed in SOW General Requirements, Section A(1)(c). The backup shall have similar skills and knowledge as the primary key personnel to ensure, to the greatest extent possible, continuity of operations and minimal interruptions in the event of an unexpected departure of key personnel. The Recovery Auditor shall notify the COR immediately regarding any unplanned changes in key personnel, and shall notify their COR at least fourteen (14) calendar days prior to any planned changes in key personnel.

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

For this SOW, "fully dedicated" means that the individual identified for the position shall be a Full Time Equivalent (FTE) employee and shall only work on one Recovery Auditor contract. This individual may not perform duties on any Medicare/non-Medicare contract or commercial line of business without approval by the Contracting Officer.

a) 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 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.

Work Experience
The Project Manager shall have 10 or more years 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.

b) Contractor Medical Director (CMD) **–** The CMD shall be fully dedicated to this contract. The Recovery Auditor 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 Recovery Auditor identified vulnerabilities;
- Overseeing the medical review process and providing the clinical expertise and judgment to understand LCDs, National Coverage Determinations (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 Recovery Auditors to share information on potential problem areas;
- Participating in CMD clinical workgroups as appropriate;
- Upon request, providing input to CMS Central Office on national coverage and payment policy, including recommendations for relative value unit (RVU) assignments;
- Participating in CMS/Recovery Auditor presentations 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 Recovery Auditor shall periodically verify that the CMD's license is current. When recruiting CMDs, the Recovery Auditor should give preference to physicians who have patient care experience and are actively involved in the practice of medicine.

2. Essential Personnel

The Recovery Auditor shall appoint a Chief Information Officer and a Systems Security Officer, as described below.

The Recovery Auditor shall have a CMS -approved contingency plan and designate backups for each essential personnel. The backup shall have similar skills and knowledge as the essential personnel to ensure, to the greatest extent possible, continuity of operations and minimal interruptions in the event of an unexpected departure of essential personnel. The Recovery Auditor shall notify the COR immediately regarding any unplanned changes in essential personnel, and shall notify their COR at least fourteen (14) calendar days prior to any planned changes in essential personnel.

a) Chief Information Officer (CIO) – The Recovery Auditor 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.

b) Systems Security Officer (SSO) – The Recovery Auditor 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, the CMS Business Partner System Security Manual (BPSSM).

Work Experience

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

3. Additional Personnel

a) Coders **–** Each Recovery Auditor 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 Recovery Auditor.

The CMS reserves the right to review the credentials of certified coders, RHIA and RHIT at any time under this SOW.

b) Registered Nurses **–** Each Recovery Auditor 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 Recovery Auditor must ensure that the license is current.

c) Therapists – Each Recovery Auditor is required to employ Therapists and other clinicians with previous experience in medical record review. Therapists are required to have current therapy licenses in the United States. The Recovery Auditor must ensure that the license is current.

d) All clinicians will be required to review medical records for medical necessity. The clinician must have an understanding of Medicare policies as well as LCDs and NCDs. Clinicians should be a resource for coders and non-clinical personnel.

e) In additional to the Medical Director, the Recovery Auditor is encouraged to utilize the expertise of a panel of clinical specialists, for consultation when performing medical review.

f) Customer Service Program Manager – The Customer Service Program Manager should have 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.

Any changes to the Recovery Auditor's organizational chart (down to the first line management) shall be submitted to the CMS COR within seven (7) business days of the actual change being made. First line management is Recovery Auditor 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 COR. This direction excludes changes to key personnel, which shall be communicated immediately to and approved by CMS before the transition occurs.

Specific Tasks

Task 1- Identification of Improper Payments on Postpayment Review

The Recovery Auditor shall pursue the identification of all Medicare claim types that contain improper payments, for which payment was made under either Part A or Part B of Title XVIII of the Social Security Act (excluding DMEPOS and Home Health/Hospice claims).

The Recovery Auditor shall comply with Reopening Regulations located at 42 CFR 405.980. Before a Recovery Auditor makes a decision to reopen a claim, the Recovery Auditor must have good cause and shall clearly document the good cause in review proposals and correspondence (review results letters, additional documentation requests (ADRs), etc.) to providers. Additionally, the Recovery Auditor 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 Recovery Auditor 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 Recovery Auditor is reviewing all claim types as directed. The CMS may allow for exceptions in the event of MAC transitions and other similar circumstances.

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. The Recovery Auditor shall assume a maximum of 14,000 claim adjustments per month, per MAC jurisdiction. Current workload limits apply only to postpayment reviews. Should the Recovery Auditor demonstrate a backlog of claims for a claims processing 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 Recovery Auditor 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 Recovery Auditor shall review all provider types listed above. The CMS conducts periodic evaluations of the Recovery Auditor's performance. If the CMS COR determines the contractor is not effectively reviewing all claim/provider types during these evaluations, CMS will consider official contract action (see Section K of Administrative and Miscellaneous Issues).

B. Improper payments excluded in this SOW

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

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

2. **Cost report settlement process and Medical Education payments –** The Recovery Auditor shall **not** attempt to identify underpayments and overpayments that result from Indirect Medical Education (IME) and Graduate Medical Education (GME) payments. The Recovery Auditor shall not review cost report settlements for overpayment/underpayment identification. Hospitals receiving Periodic Interim Payments (PIP) are not excluded from review.

3. **Claims more than three (3) years past the date of the initial determination –** The Recovery Auditor 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 Recovery Auditor after this timeframe shall be set aside. The Recovery Auditor shall take no further action on these claims except to indicate the appropriate status code in the Data Warehouse. The look back period is conducted starting from the date of the initial determination and ending with the date the Recovery Auditor issues the medical record request letter (for complex reviews) or the date of the overpayment notification letter (for automated reviews). Adjustments that occur after the 3 year timeframe can be demanded and collected, however, the Recovery Auditor shall not receive a contingency fee payment.

4. **Random selection of claims** – The Recovery Auditor 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. Therefore, the Recovery Auditor shall not use random review in order to identify cases for which it will order medical records from the provider. Instead, the Recovery Auditor shall utilize data analysis techniques in order to identify those claims most likely to contain overpayments. This process is called “targeted review”. The Recovery Auditor 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 Recovery Auditor to believe it is likely to contain an overpayment.

   A Recovery Auditor may receive provider referrals from CMS or other CMS contracting entities, and may perform provider specific reviews on approved issues. Referrals received for issues that have not yet been approved by the new issue approval process for the Recovery Auditor within that region must still comply with

new issue approval process prior to audit initiation.

The above paragraph does not preclude the Recovery Auditor from utilizing extrapolation techniques for targeted providers or services.

5. **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 Recovery Auditor. CMS attempts to remove these claims from the data prior to transmission to the Recovery Auditor.

The CMS reserves the right to limit the number of reviews or the time period available for review by Recovery Auditor, 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.

C. Underpayments

The Recovery Auditor shall review claims using automated, or complex, review to identify potential Medicare underpayments. Upon identification, the Recovery Auditor will communicate the underpayment finding to the appropriate MAC. The Recovery Auditor shall not ask the provider to correct and resubmit the claim. The Recovery Auditor shall obtain approval of the underpayment notification letter language from the CMS 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, RUG) on a claim that was billed at a low level of payment but should have been billed at a higher level of payment. The Recovery Auditor 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 Recovery Auditor 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 Recovery Auditor)
The Recovery Auditor does not have responsibility to randomly accept case files from providers for an underpayment case review. If the Recovery Auditor receives case files from providers that they did not request, the Recovery Auditor is under no obligation to respond to the provider, and may shred those records. Medical Record Requests

The Recovery Auditor may request medical records for the sole purpose of identifying an underpayment. If required, the Recovery Auditor shall pay for all medical record requests, regardless of whether an underpayment or overpayment is determined.

4. Appeal of the Underpayment Determination
The normal appeal process is available to providers for all underpayment determinations.

D. Obtaining, Storing, Sharing, and Paying for Medical Records

1. Obtaining medical records

Whenever needed for complex reviews, the Recovery Auditor may also obtain medical records by going onsite to the provider's location to view/copy the records or by requesting that the provider mail/fax or securely transmit the records to the Recovery Auditor. (Securely transmit means sent in accordance with the CMS business systems security manual – e.g., mailed CD, MDCN line, through a clearinghouse, esMD transmittal.)

Before ADRs may be sent, the Recovery Auditor shall have the capability to receive medical records via esMD. In addition, the Recovery Auditor shall utilize the Internal esMD, also known as IesMD, if and when CMS makes it available to request and receive medical documentation from other Medicare review contractors.

The Recovery Auditor shall accept imaged medical records sent on CD, DVD, or electronically. Although providers are not mandated to electronically store or transmit medical records, The Recovery Auditor shall possess the technology to accept document via electronic transmission. The Recovery Auditor shall remain capable of accepting faxed or paper medical record indefinitely.

If the Recovery Auditor attempts an onsite visit and the provider refuses to allow access to their facility, the Recovery Auditor shall not make an overpayment determination based upon the lack of access. Instead, the Recovery Auditor shall request the needed records in writing. When onsite review results in an improper payment finding, the Recovery Auditor shall copy the relevant portions of the medical record and retain them for future use. When onsite review results in no finding of improper payment, the Recovery Auditor need not retain a copy of the medical record.

CMS will institute an Additional Documentation Request (ADR) limit. The ADR limit will be provider-, or provider type- specific. An example of an ADR limit would be *no more than 0.5% of a hospital's paid Medicare claims in a 45-day period*. The CMS will establish ADR limits that are diversified across all claim types of a facility (e.g. outpatient hospital, physicians, etc.). The ADR limit may take into account a provider's annual Medicare payments.

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.

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/Provider-Resource.html.
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 Recovery Auditor does not request medical records in January and February, the Recovery Auditor cannot request 150 records in March.

The Recovery Auditor may deny claims where documentation is not submitted within 45 days (on day 46); however, the Recovery Auditor 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 Recovery Auditor 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.

2. Storing and sharing medical records

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

a. Storing and sharing IMAGED medical records

The Recovery Auditor shall, on the effective date of this contract, be prepared to store and share imaged medical records. The Recovery Auditor 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 Recovery Auditor shall send copies of the imaged records to the entity specified by the CMS COR.

3. Paying for Medical Records

The Recovery Auditor 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 COR. (The current per page rate is: medical records photocopying costs at a rate of $.12 per page for reproduction of PPS provider records and $.15 per page for reproduction of non-PPS institutions and practitioner records, plus first class postage.) The amount per page will not exceed

these rates. Providers (such as critical access hospitals) under a Medicare reimbursement system receive no photocopy reimbursement.

CMS guidelines will include the amount per page, the maximum amount per medical records and the amount per transmission, and the maximum payment amount per medical record. It is possible there will be different amounts per page depending on if the submission is paper, CD, fax, or esMD. ~~The maximum payment amount to a provider per medical record will not exceed $25.00.~~ The maximum payment amount to a provider per medical record will not exceed $27.00 (including a $2.00 transaction fee) for medical records sent via esMD; and, $25.00 (including first class postage) for medical records not sent via esMD.

The Recovery Auditor shall ensure that provider/clearinghouses first successfully complete a connectivity and readability test with the Recovery Auditor system before being invited to submit imaged or electronic records. The Recovery Auditor shall comply with all CMS business system security requirements when entering into arrangements regarding the transmission of medical records and other documentation.

4. Maintaining a Case File

The Recovery Auditor shall maintain a complete case file for every record requested. (See Section E of Administrative and Miscellaneous Issues for additional case record maintenance instructions.) At a minimum, the case file shall include:

- A copy of all ADR and reminder letters
- Contacts with Administrative Contractors, 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 adjustment was sent to the MAC
- 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 Recovery Auditor.

E. The Claim Review Process

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

1. Types of Reviews

a. Automated Review**.** Automated review occurs when a Recovery Auditor makes a claim determination at the system level without a human review of the medical record.

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

EXCEPTION: If the Recovery Auditor 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 Recovery Auditor may seek CMS approval to proceed with automated review.

ii. Other Determinations Made Through Automated Review
The Recovery Auditor 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.

b. Complex Review. Complex review occurs when a Recovery Auditor makes a claim determination utilizing human review of the medical record or other required documentation. The Recovery Auditor may use complex review in situations where the requirements for automated review are not met or the Recovery Auditor 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 overpayment.

i. Staff Performing Complex Coverage/Coding Reviews
Whenever performing complex coverage or coding reviews (i.e., reviews involving the medical record), the Recovery Auditor shall ensure that coverage/medical necessity determinations are made by RNs or therapists and that coding determinations are made by certified coders.

The Recovery Auditor shall ensure that no nurse, therapist or coder reviews claims from a provider who was their employer within the previous 12 months. The Recovery Auditor 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 Recovery Auditor is not required to share names and personal information Timeframes for Completing Complex Coverage/Coding Reviews

The Recovery Auditor shall complete their complex reviews and notify the provider of the results within 30 days from receipt of the medical record documentation. The Recovery Auditor may request a waiver from CMS if an extended timeframe is needed due to extenuating circumstances. If an extended timeframe for review is granted, The Recovery Auditor shall notify the provider in writing or via a web-based application of the delay. Unless granted an extension by CMS, The Recovery Auditor 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 COR will closely monitor the Recovery Auditor's monthly reports and review invoices to determine occurrences of when the Recovery Auditor 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 Recovery Auditor has already been paid the contingency fee for the claim, CMS will subtract that amount from a future invoice.

2. Types of Claim Review Determinations
When a Recovery Auditor reviews a claim, they may make any or all of the determinations listed below.

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

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 Recovery Auditor shall consider a service to be reasonable and necessary if the Recovery Auditor 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 Recovery Auditor 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. Recovery Auditors should use HCFA Ruling 95-1 and the guidelines listed below in selecting the appropriate denial reason.

b. Limitation of Liability Determinations
If a Recovery Auditor identifies a full, or partial, overpayment because an item or service is not reasonable and necessary, the Recovery Auditor 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.

c. Coding Determinations
The Recovery Auditor 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).

d. Other Determinations
The Recovery Auditor 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).

e. Individual Claim Determinations
The term “individual claim determination” refers to a complex review performed by a Recovery Auditor in the absence of a written Medicare policy, article, or coding statement. When making individual claim determinations, the Recovery Auditor shall utilize appropriate medical literature and apply appropriate clinical judgment. The Recovery Auditor shall consider the broad range of available evidence and evaluate its quality before making individual claim determinations. The extent and quality of supporting evidence is key to defending challenges to individual claim determinations. Individual claim determinations that challenge the standard of practice in a community shall be based on sufficient evidence to convincingly refute evidence presented in support of coverage. The Recovery Auditor shall ensure that their CMD is actively involved in examining all

evidence used in making individual claim determinations and acting as a resource to all reviewers making individual claim determinations.

3. Basis of Determinations

a. Medicare Policies and Articles

The Recovery Auditor 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 http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs.html . In addition, the Recovery Auditor shall comply with all applicable change requests and Technical Direction Letters forwarded to the Recovery Auditor by the CMS COR.

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

The Recovery Auditor 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 Recovery Auditor on the interpretation of any policy and/or regulation, the Recovery Auditor shall abide by CMS' decision.

b. Internal Guidelines

As part of its process of reviewing claims for coverage and coding purposes, the Recovery Auditor shall develop detailed written review guidelines. For the purposes of this SOW, these guidelines will be called "Review Guidelines." Review Guidelines, in essence, will allow the Recovery Auditor to operationalize CMS policies to ensure consistent and accurate review determinations. Review Guidelines shall be a detailed step-by-step approach to ensuring coverage requirements are met and to assist the reviewers in making logical decisions based on the information in the supporting documentation. The Recovery Auditor need not hold public meetings or seek public comments on their proposed review guidelines. However, they shall make their Review Guidelines available to CMS upon request. Review Guidelines do not create or change policy. In the absence of CMS policy, the Recovery Auditor shall develop Review Guidelines using evidence-based medical literature to assist reviewers in making an individual claim determination.

c. Rationale for Determination
The Recovery Auditor 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 Recovery Auditor 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 Recovery Auditor shall make a rationale available upon request to CMS, a MAC, the OIG, and others as indicated by the CMS COR.

d. Other Considerations

i. Administrative Relief from Review in the Presence of a Disaster
The Recovery Auditor shall comply with PIM 3.2.2 regarding administrative relief from review in the presence of a disaster.

F. 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 Recovery Auditor (or subcontractor or consultant).

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

Rehabilitation Act, Section 508, Accessibility Standards

(1) 29 U.S.C. 794d (Rehabilitation Act as amended)
(2) 36 CFR 1194 (508 Standards)
36 CFR Part 1194.22 (a – p)
36 CFR Part 1194.41 (a – c)
(3) http://www.access-board.gov/sec508/508standards.htm (508 Standards)
(4) FAR 39.2 (Section 508)
(5) CMS/HHS Standards, policies and procedures (Section 508)

a. Information Technology – General Information (http://www.cms.hhs.gov/InfoTechGenInfo/)

1. General Website

The Recovery Auditor is required to maintain a Medicare FFS Recovery Auditor 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 Recovery Auditor 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 Recovery Auditor may have. The Recovery Auditor shall obtain prior CMS COR approval for all webpage updates.

2. Approved Review Website

Upon approval of a review topic in Task 3.A, the Recovery Auditor 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 Recovery Auditors 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.

3. Provider Portal

The Recovery Auditor 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 Recovery Auditor shall use a CMS-approved secure process to give providers access to the portal. The Recovery shall, at a minimum, include the following information:

a. the provider's overall ADR limit
b. dates of all ADR letters
c. the date that the medical documentation was received for each claim being reviewed
d. the date that medical review of the documentation began
e. the date that medical review of the documentation was completed
f. the outcome of the review (overpayment, underpayment, no finding)
g. discussion period information
h. appeals outcomes
i. Case closure date

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

The Recovery Auditor may make additional review information, such as review findings and rationales available on the portal. CMS may require Recovery Auditors 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 Recovery Auditors 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 COR prior to allowing access to providers.

4. Address Customization System
Within the provider portal, the Recovery Auditor 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 Recovery Auditor may visit the CERT Contractor's address customization website at http://www.certcdc.com/certproviderportal/verifyaddress.aspx for an example of a simple but successful system. Each ADR letter must inform the provider about the existence of the address customization system.

G. Activities Following Review

1. Communication with Providers about Improper Payment Cases

a. Automated review

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

b. Complex review

The CMS expects that the Recovery Auditor shall perform a full review of the entire claim for all complex medical necessity reviews. This includes coding

validation and a reasonable and necessary determination. Further guidance and instruction for individual claim types will be handled through the review approval process (See Task 4.A).

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

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

c. Contents of the Review Results Letter

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

The Recovery Auditor 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. Including this information will lend credibility to the Recovery Auditor's documentation if the determination is appealed. The Recovery Auditor 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;

2. Allowance of a Discussion Period

All providers who receive a review results letter or portal notification (for automated and complex reviews) from the Recovery Auditor are availed an opportunity to discuss the improper payment with the Recovery Auditor 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 Recovery Auditor. The Recovery Auditor shall wait 30 days, after sending the review results letter or portal notification, to allow for the receipt of a discussion request, before forwarding the claim to the MAC for adjustment.

The Recovery Auditor can 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 providers employed as consultants.

All discussion requests should be in writing. The Recovery Auditor 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 Recovery Auditor shall provide (by sending a letter, or though their provider portal) a detailed, written rationale to the provider with their determination within 30 days of receipt of the request, and This written rationale shall also be provided to CMS upon request, within one business day of receipt.

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

The Recovery Auditor 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 Recovery Auditor receives a discussion request, the Recovery Auditor shall immediately notify the provider in writing that the discussion request is invalid.

3. Determining the Overpayment Amount

a. Full denials

A full denial occurs when the Recovery Auditor determines that:

i. Review of the medical record indicated that inpatient hospital care was not medically necessary, reasonable, and appropriate for the diagnosis and condition of the beneficiary at any time during the stay.
ii. The beneficiary did not require an inpatient level of care at any time during the admission.
iii. The submitted services/items were not reasonable and necessary as billed.
iv. No service was provided.

The overpayment amount is the total paid amount for the service in question.

b. Partial denials

A partial denial occurs when the Recovery Auditor determines that:

i. The submitted service was billed at a level higher than what was reasonable and necessary and a lower level service would have been reasonable and necessary, or
ii. The submitted service was upcoded (and a lower level service was actually performed) or an incorrect code (such as a discharge status code) was submitted that caused a higher payment to be made.
iii. The MAC failed to apply a payment rule that caused an improper payment (e.g. failure to reduce payment on multiple surgery cases).

In these cases, the Recovery Auditor must determine the level of service that was reasonable and necessary, or determine the correct code that represents the service described in the medical record. 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, preferably via the file-based mass adjustment process, the MAC will notify the Recovery Auditor through the Data Warehouse (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.

H. Extrapolation

The Recovery Auditor is encouraged to use extrapolation for some claim types when all requirements are met. Extrapolation may be cost effective for low-dollar claims that require complex review and that have a history of having a high error rate. The Recovery Auditor 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 Recovery Auditor shall request CMS approval for the use of extrapolation on a per issue basis.

I. The Claim Adjustment Process

The MAC will pursue the recoupment of Medicare overpayments that are identified through Task 1, in accordance with Pub 100-06 Medicare Financial Management Manual, Section 10, Subsection 2 (Recoupment).

The Recovery Auditor 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 Recovery Auditor pursues adjustment on a claim less than $25.00, the Recovery Auditor shall not receive a contingency fee on any amounts recouped.

The Recovery Auditor 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 Recovery Auditor 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 Recovery Auditor did not identify these lines for adjustment, they were initiated because of the Recovery Auditor adjustment. The Recovery Auditor receives credit for the entire claim adjustment and the MAC will include these additional lines on the demand letter to the provider.

A Recovery Auditor identified adjustment may trigger the denial of the entire claim because of a known Medicare Secondary Payer 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 Recovery Auditor will not receive credit for the adjustment.

When partial adjustments to claims are necessary, the MAC shall downcode the claim whenever possible. The Recovery Auditor 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; claim adjustments resulting in a lower payment amount after removing excessive units billed; and inpatient stays that were denied because they should have been billed as outpatient claims, and were later submitted and paid as such. 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 Recovery Auditor contingency fee. For example, a Recovery Auditor contingency fee could equate to the difference between the full denial and any services determined by CMS to be payable.

J. Periodic Interim Payment (PIP) Providers

Recovery Auditors may review claims (subject to CMS approval) from PIP providers; however, the Recovery Auditor shall ensure that the adjustments do not negatively impact the provider's ability to provide care. The Recovery Auditor shall work with the MAC to determine the financial impact of these reviews. This process should be documented in the Recovery Auditor's

JOA with the MAC. Recovery Auditors may only send ADRs to facilities receiving Periodic Interim Payments (PIP) within 6 months of the date of service.

K. Demand Letters

Demand letters will be issued by the MACs. Underpayment letters will continue to be sent by the Recovery Auditor and shall include all provider appeal rights.

L. 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 Recovery Auditor's approval or input. If CMS determines that a compromise and/or settlement of a Recovery Auditor identified overpayment is in the best interest of Medicare at any time, the payment to the Recovery Auditor 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 Recovery Auditor's invoicable amounts accordingly, which may result in the take-back of any overpaid contingency fees.

M. Voluntary Refunds from Providers

i. If a provider voluntarily refunds an overpayment for improperly paid claims after the Recovery Auditor issues an ADR or review results letter for the exact claims involved in the refund, the Recovery Auditor will receive their contingency fee for those corrections.

   - If the provider submits payment to the Recovery Auditor, the Recovery Auditor shall document the case in its files, and forward the check to the appropriate MAC.
   - If the provider submits payment to the MAC, the MAC may notify the Recovery Auditor and the Recovery Auditor shall document the case in its files. The Recovery Auditor should include processes for identifying and reporting provider voluntary refunds in its Joint Operating Agreements (JOAs) with the MACs. The Recovery Auditor shall provide all evidence and support to CMS linking the specific claims involved in the voluntary refund to the Recovery Auditor reviews, in order to receive a contingency for those claims.

ii. If a provider voluntarily refunds an overpayment that does NOT involve the same claims for which the Recovery Auditor has issued an ADR or review results letter, the Recovery Auditor is not entitled to a contingency fee.

   - If the provider submits payment to the Recovery Auditor, the Recovery Auditor shall forward the check to the appropriate MAC.
   - If the provider submits payment to the MAC, the Recovery Auditor does not need

to take action.

N. Potential Quality Problems

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

Task 2 - Utilization of the Data Warehouse

CMS utilizes the Data Warehouse to house information on all claims under review by the Recovery Auditor and other CMS review contractors. The Warehouse stores claim and provider information, such as provider number, location, dates of service, claim paid amounts, and applicable codes. The Recovery Auditor shall participate in all Data Warehouse trainings required by CMS. The Data Warehouse is an integral part of the success of the Recovery Audit program and other medical review initiatives. However, the Data Warehouse can only be successful if the data input into it by the Recovery Auditor is reliable, timely, and valid.

A. **Preventing Overlap**

In order to minimize the impact on the provider community, it is critical that the Recovery Auditor avoid situations where the Recovery Auditor and another entity (MAC, Zone Program Integrity Contractor (ZPIC), Office of Inspector General (OIG), or other investigative agencies) are working on the same claim.

The Recovery Auditor shall use the Data Warehouse to determine if another entity already has the provider and/or claim under review. The Data Warehouse will include a master table of suppressed providers and excluded claims that will be updated on a regular basis. Before beginning a claim review, the Recovery Auditor shall utilize the Data Warehouse to determine if a suppression or exclusion exists for that claim. The Recovery Auditor is not permitted to review suppressed or excluded claims.

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 Recovery Auditor to review. Exclusions entered after a Recovery Auditor 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)
- ZPICs
- Investigative Agencies (OIG, FBI, Department of Justice (DOJ))
- CERT Contractor
- CMS

2. Suppressions

CMS must ensure that Recovery Auditor 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 Recovery Auditor 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 Data Warehouse, 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 Recovery Auditor will be notified to cease all activity if a suppression is entered after the Recovery Auditor begins its review.

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

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

The CMS COR may also issue a TDL that suppresses claims. Immediately upon receipt of this TDL, the Recovery Auditor shall stop all work that could possibly affect the claims identified in the TDL, and make system and process changes to implement the suppression before resuming work.

B. Data Warehouse Reporting of Possible/Identified Improper Payments

The Recovery Auditor 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; however, Appendix 2 includes the current Data Warehouse claims upload file format. Failure to enter the necessary information timely will result in CMS taking necessary action, including, but not limited to, progressive reduction in ADR limits, modification/termination of the contract, requiring the Recovery Auditor to prepare a Corrective Action Plan, CMS' decision to not exercise the next option period of the contract, etc. ~~a 25% reduction in the applicable contingency fee for the affected claims.~~

The Recovery Auditor receives the improper payment amount and receivable/payable information from the MAC/EDC. The Recovery Auditor receives such information for the purpose of conducting their audit operations, and shall not be held responsible for updating the Recovery Auditor Data Warehouse with payment information, but shall be responsible for uploading the finalized adjustment date from the MAC.

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

C. Recovery Auditor Data Warehouse Reporting and Recovery Auditor Invoices

The CMS requires certain criteria for claims to be eligible for invoicing. The Data Warehouse will generate pre-filled invoices based on required claims information from the Recovery Auditor 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 Recovery Auditor 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 Data Warehouse. 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 Recovery Auditor has concerns regarding the Data Warehouse generated invoice, the Recovery Auditor shall contact its CMS COR before submitting the invoice for payment. The Recovery Auditor may not add to the automatically generated invoices, although they may remove records with appropriate notice to the CMS COR.

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

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 Recovery Auditor's next invoice, or sending a demand letter, if necessary.

Task 3 - Validation

A. Review Approval Process

To ensure that the Recovery Auditor is making accurate claim determinations and not inappropriately denying claims, all review issues must receive CMS approval before the Recovery Auditor may proceed with widespread reviews. This approval process will ensure that a Recovery Auditor's claim review does not conflict with Medicare policy and that the language used in communicating the improper payment to providers is clear and accurate. The Recovery Auditor must request approval by submitting a proposal package that includes all the necessary information, as requested by CMS, needed to approve a review. CMS may choose to review the

proposal package internally, use MACs, and/or use an independent validation contractor prior to making a final decision on the review proposal.

Review proposal packages must identify the type of review (automated, complex, or extrapolation) which will be used by the Recovery Auditor. The CMS will prescribe the format by which review proposals are to be submitted. The CMS may request that information be submitted by email, secure mailed CD, or through an electronic system. The CMS may allow the Recovery Auditor to request a sample of medical records when developing a test case for CMS to validate. The Recovery Auditor shall neither issue medical record requests without prior CMS COR authorization, nor issue requests beyond any conditionally approved number of claims.

The Recovery Auditor shall forward any requested information to the appropriate contact (CMS COR, MAC, e-mail address, etc.) The information requested may include, but is not limited to the following:

- Issue description
- Provider type
- Error type
- CMS policy references
- Codes for review
- Edit parameters
- Dates and states requested for review
- Potential dollar amount of improper payment
- Good cause for claim reopening
- Improper payment rationale
- Claim sample

The CMS COR will notify the Recovery Auditor if/when they may begin issuing medical record request letters and/or any subsequent documentation on the review. The CMS, MAC, or the validation contractor may also evaluate the clarity, accuracy, and completeness of the Recovery Auditor letter to providers.

Upon approval, the Recovery Auditor shall post applicable information on its webpage, as described in Task 1.F.2. Upon approval of the review by CMS, 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 Recovery Auditors in Medicare and Medicaid, MACs, the CERT contractor, or ZPICs.

Prior to submission of a proposed review, CMS encourages the Recovery Auditor to meet with the MACs (if not already required) in their jurisdiction to discuss potential findings the Recovery Auditor may have identified, the edit parameters used and any potential issues that may exist.

Every six months (at a minimum), the Recovery Auditor shall review their approved review packages to ensure compliance with the most recent CMS policy changes. Any changes to the criteria used to select claims for review, or the policy used to make the review determinations shall be submitted to the CMS COR for approval before continuing reviews. The CMS COR and associated staff shall then review such changes and issue guidance to the Recovery Auditor within a 30-day approval period.

B. Accuracy Reviews

The CMS contracts with an independent validation contractor to perform monthly accuracy audits on Recovery Auditor claim determinations. The Recovery Auditor shall provide the Validation Contractor with the entire case files and all information necessary to complete the audit. The Recovery Auditor 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 Recovery Auditor shall comply with all Validation Contractor requests (as instructed through the CMS) and not impede any review processes.

The data warehouse will calculate a rolling tally of all accuracy determinations for claims included in the monthly accuracy samples. Recovery Auditors shall maintain an accuracy rate of at least 95%. For each percentage point above 95%, Recovery Auditors shall earn a .2% contingency fee increase. For example, a Recovery Auditor with a base contingency fee rate of 15% and a 96% accuracy score would receive a .2% contingency fee increase, or 15.2%.

Additionally, failure to maintain an accuracy rate of 95% will result in CMS taking necessary action, including, but not limited to, progressive reduction in ADR limits, modification/termination of the contract, requiring the Recovery Auditor to prepare a Corrective Action Plan, CMS' decision to not exercise the next option period of the contract, etc. Accuracy determinations are open to dispute by the Recovery Auditor. Accuracy rates and contingency fees will be recalculated every three months.

Task 4 - Supporting Identification of Overpayments in the Medicare Appeal Process and/or in the Debt Collection Improvement Act Process

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 Recovery Auditor, the Recovery Auditor shall assist CMS with support of the overpayment/underpayment determination throughout all levels of the appeal. This includes 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 Recovery Auditors to upload all appeal case file documents into the Medicare Appeals System (MAS).

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

Additionally the Recovery Auditor 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.

The CMS expects that each Recovery Auditor shall have an appeal overturn rate of less than 10% at the first level of appeals for each fiscal year. This rate only includes decisions where a Recovery Auditor made an incorrect claim determination. Instances where a provider presents new information or corrects the claim will not be included. The data warehouse will calculate a rolling tally of all unfavorable appeal determinations (due to misapplication of CMS policy). For each percentage point below 10%, Recovery Auditors shall earn a .1% contingency fee increase. For example, a Recovery Auditor with a base rate of 15% and a 9% appeal overturn rate would receive a .1% contingency fee increase, or 15.1%.

Additionally, failure to maintain an overturn rate of less than 10% at the first level of appeal will result in CMS taking necessary action, including, but not limited to, progressive reduction in ADR limits, requiring the Recovery Auditor to prepare a Corrective Action Plan, CMS' decision to not exercise the next option period of the contract, modification/termination of the contract, etc.

Appeal overturn rates will be calculated by CMS for specific review issues. The adjusted contingency fee will apply to all claims with collections or paid underpayments under the identified review. Appeal overturn rates and contingency fees will be recalculated every three months by CMS.

A. Defending Improper Payment Determinations at ALJ Hearings

The Recovery Auditor 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 Recovery Auditor 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 Recovery Auditor 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.

A notice of an ALJ hearing issued by Office of Medicare Hearings and Appeals (OMHA) will be sent to the appropriate QIC. Advance coordination with the QIC will be necessary to ensure the contractor receives timely notification, as the election to participate must be made no later than 10 calendar days after receipt of the notice of hearing.

In either participation situation (party or participant), the Recovery Auditor 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 Recovery Auditor 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.

1. Electing Party Status in ALJ Hearings

The Recovery Auditor 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 10 calendar days of receipt of the notice of hearing (by the QIC). As a party, the Recovery Auditor 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 Recovery Auditor 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 Recovery Auditor shall be adequately prepared to respond to questioning by the ALJ or other parties regarding all issues related to the claims under appeal.

2. Participating in ALJ Hearings

The Recovery Auditor 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 10 days of receipt of the notice of hearing (by the QIC). Participation may include filing position papers and providing testimony to clarify factual and policy issues involved in a case. The Recovery Auditor 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 Recovery Auditor may not call witnesses, or cross-examine witnesses, of another party. The Recovery Auditor must coordinate with other contractors in advance to solicit their participation should testimony from the other contractors be necessary.

Task 5 - Assisting CMS in Prevention of Improper Payments

Through conference calls, reports and databases, the Recovery Auditor shall assist CMS in the prevention of improper payments.

This includes the sharing of review guidelines and edit parameters, used to identify improper payments with CMS and the appropriate MAC, and participating in conference calls with CMS and other contractors. Sharing this information will assist CMS and its contractors in conducting provider education, and implementing system edits to prevent current and future improper payments.

Task 6 - Communication and Collaboration with Other Medicare Contractors

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

The Recovery Auditor shall complete a JOA with all applicable Medicare contractors (MACs, ZPICs, QICs, AdQIC) and any other CMS partners as instructed by CMS. The JOA shall encompass all communication between the Medicare contractor and the Recovery Auditor. The JOA shall be mutually agreed to, reviewed quarterly, 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 Recovery Auditor 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 Recovery Auditor to adjust claims and recoup overpayments. The relationship between the MAC and the Recovery Auditor is crucial to the

success of the program. CMS has the following expectations with the MAC/Recovery Auditor relationship:

- The MAC is an operational contractor of CMS and does not take direction from the Recovery Auditor.
- Any communication issues with the MAC that cannot be addressed through provisions of the JOA, shall be escalated to the CMS Recovery Auditor COR for additional discussions with the appropriate parties.
- The MAC is responsible for issuing timely demand letters, adjusting claims, applying recoupments, uploading data to the Data Warehouse when required, and routine customer service and requests from CMS.
- The Recovery Auditor 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 Recovery Auditor 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 Recovery Auditor is expected to work with other CMS contractors, at subsequent levels of re-evaluation, to ensure an accurate and fair adjudication.

- **MAC:** The Recovery Auditor shall foster a relationship with the claims processing contractors to ensure consistent application of the laws and policies surrounding Medicare payment. The Recovery Auditor shall ensure that the MAC has received the completed appeal case file. The Recovery Auditor shall work with the MACs to share appeals data, including reasons for Recovery Audit finding reversals. The Recovery Auditor and MACs may also share areas identified as vulnerabilities.
- **QIC:** The Recovery Auditor will forward new or requested evidence for appeal case files as necessary.

- **AdQIC:** The Recovery Auditor 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.

- **OMHA:** The Recovery Auditor 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 COR.

The Recovery Auditor 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.

C. Communication Regarding Potential Fraud

In addition to the JOA with all applicable ZPICs, the Recovery Auditor shall schedule regular meetings with all applicable ZPICs to discuss potential referrals and trends each contractor is seeing in the applicable jurisdictions, in addition to any issues the ZPIC wants to discuss. These meetings shall occur at a minimum of quarterly with monthly being the ideal, depending on the ZPIC's availability. Meetings shall include all applicable operational staff as well as the Recovery Auditor CMD. Informal referrals received from the ZPIC or given to the ZPIC 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 Recovery Auditor discovers credible indicia of fraud the Recovery Auditor shall concurrently refer the provider to their CMS COR, the Recovery Audit Program's Law Enforcement Liaison (LEL), and the OIG. The Recovery Auditor shall include all details relevant to the referral.

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

D. Communications to avoid duplicative review:

CMS must ensure that Recovery Auditor activities do not interfere with other reviews/investigations being conducted by alternate Medicare contractors or law enforcement personnel. Therefore, the Recovery Auditor shall input all claims into the Data Warehouse before attempting to identify or correct improper payments, so the Recovery Auditor 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 Recovery Auditor.

E. Referrals

CMS often receives referrals of potential improper payments from the MACs, ZPICS/PSCs, and Federal investigative agencies (e.g., OIG, DOJ). At CMS discretion, CMS may require the Recovery Auditor to review these or other claims at risk claims based on CERT reports or other CMS data analysis.

CMS will communicate all information deemed necessary for the reviews, including pre-approval of the review language for the Recovery Auditor's approved review section of the website, edit parameters and/or review methodologies. If necessary, CMS may require the Recovery Auditor's CMD and staff presence on a conference call with the referral entity for explanation purposes.

The Recovery Auditor will be paid in a manner consistent with the contracted contingency fee for referrals. The review of such referrals is not optional.

NOTE: *CMS is developing a web-based referral tracking system. This system will be available to all Medicare contractors, to CMS and to the Recovery Auditor to make and track referrals. The Recovery Auditor will be required to review the referral tracking system and to determine if the referral will be reviewed or not. The Recovery Auditor is not required to act upon any non-mandatory referrals. However, the Recovery Auditor is required to update CMS with the decision and status. The expected timeframe for review and decision is 30-45 days from the referral being entered into the system.*

Task 7 - Customer Service and Provider Outreach

The Recovery Auditor 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.

A. Customer Service

1. The Recovery Auditor 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 Recovery Auditor is conducting the work in California, the customer service number shall be staffed from 8:00am to 4:30pm 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 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 Recovery Auditor 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 Recovery Auditor shall provide remote call monitoring capability to CMS personnel in Baltimore or CMS regional offices, if directed by the CMS COR. CMS may monitor Recovery Auditor calls at any time without prior notification to the Recovery Auditor. The Recovery Auditor phone system must notify all callers that the call may be monitored for quality assurance purposes.

3. The Recovery Auditor shall retain a written report of contact for all telephone inquiries and supply it to the CMS 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 Recovery Auditor, the response to the inquiry, and the outcome of the call, including any follow up contact by the Recovery Auditor.

4. The Recovery Auditor 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 Recovery Auditor shall respond to written correspondence, including mailed and faxed documents, within thirty (30) days of receipt. The Recovery Auditor shall confirm receipt of such correspondence (by fax, email, or telephone) within one business day. The Recovery Auditor shall provide the CMS COR with copies of all correspondence (including email) indicating displeasure with the Recovery Auditor, in the overpayment identification, or in the recovery methods utilized, within ten (10) calendar days of receipt of such correspondence. (If the Recovery Auditor is not sure how the correspondence will be interpreted, it should forward the correspondence to the CMS COR.)

6. The Recovery Auditor shall respond to all email inquiries within two business days of receipt. (Friday after 5:00 pm- Monday 6:00 am 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 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 Recovery Auditor in each region. All other debtor education and outreach concerning the use of the Recovery Auditor will be the responsibility of the Recovery Auditor. The Recovery Auditor shall only educate providers on the business, purpose, and processes of the Recovery Auditor. The Recovery Auditor shall **not** educate providers on Medicare policy. The CMS 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 Recovery Auditor 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 Recovery Auditor is the focus.

C. Public Communications

The Recovery Auditor must receive prior approval from CMS for all contractor press releases. The Recovery Auditor 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 COR.

The Recovery Auditor shall include the CMS Contracting Officer and/or 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 Recovery Auditor and a provider and/or provider's representative.

Task 8 - Ensuring Compliance with CMS Security Requirements

When using or disclosing protected health Information (PHI), the Recovery Auditor must be in compliance with the Health Insurance Portability and Accountability Act (HIPAA).

The Recovery Auditor shall comply with the CMS Security Assessment and Authorization (SA&A) methodology, policies, standards, procedures, and guidelines for Contractor facilities and systems.

The Recovery Auditor 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 Recovery Auditor 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 Recovery Auditor shall support CMS validation and accreditation of Contractor systems and facilities in accordance with CMS' SA&A methodology.

The Recovery Auditor 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 Recovery Auditor function and considers these controls adequate to meet CMS security standards and requirements.

The Recovery Auditor shall ensure security documents are uploaded and security controls are documented timely in the CMS FISMA Control Tracking System (CFACTS). The Recovery Auditor 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 Recovery Auditor shall begin the process to obtain an ATO within 60 days of contract award.

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

(OPTIONAL) Task 9 – Identification of Improper Payments on Prepayment Review

This task will only be active when CMS has authority to use Recovery Auditors to conduct prepayment review. This task includes Medicare claims that contain improper payments for which payment was requested under Part A or B of title XVIII of the Social Security Act. This includes the review of claims/providers that have a high propensity for error based on the CERT program and other CMS analysis.

CMS will determine the method by which claims will be flagged for prepayment review. Claim information will be shared with the Recovery Auditor using existing connectivity through the MDCN/MPLS lines. All claims selected for prepayment review by CMS shall be reviewed by the Recovery Auditor and are not optional.

Medical records will be requested upon a submitted claim hitting a prepayment edit, and may be requested from the MACs. Request limits do not apply to prepayment reviews.

The Recovery Auditor will issue a review results letter and communicate the decision to the MACs for payment or denial. The Recovery Auditor shall complete their reviews within 30 days of the documentation receipt date to comply with the Medicare Claims Processing Manual Pub

100-04 Chapter 1, Section 80.3.3. MACs will deny or pay claims based on the Recovery Auditor's review determination. Extensions will not be granted for prepayment reviews. The discussion period does not apply to prepayment reviews.

CMS may also require the review of associated claims, as applicable.

Existing provider administrative appeal rights would be applicable. Both the Recovery Auditor and MACs are responsible for inputting claim information in the Data Warehouse as appropriate. Prepayment-reviewed claims would not be available for post-payment review.

The Recovery Auditor shall submit a separate voucher for prepayment reviews. Unless explicitly instructed otherwise in this section, all requirements of Task 1are applicable to this section as well.

(OPTIONAL) Task 10 – Contract Closeout and Reconciliation

At any time during the Recovery Audit Program, CMS may authorize the optional task of contract closeout and reconciliation. If/when CMS authorizes this optional task, Recovery Auditors will cease active recovery auditing. This task may continue for up to two years.

The contract closeout and reconciliation period will only involve administrative activities. During this period CMS will continue to recoup funds from providers on improper payments identified during the active recovery auditing period, allow the Recovery Auditor to invoice for contingency payments on eligible claims, allow the Recovery Auditor to support the appeal process, and allow CMS to recoup contingency fees from overturned appeals.

Administrative and Miscellaneous Issues

A. Payment Methodology

The Recovery Auditor shall not receive any payments for the identification of the improper payments. The Recovery Auditor shall be eligible for contingency fee payment for an accepted determination which will occur when all required claim elements are input into the Data Warehouse 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 Recovery Auditor shall repay Medicare any contingency fee payment that it received for that recovery. Repayment to Medicare will be subtracted from the next applicable invoice. As stated in Task 2.B, failure by the Recovery Auditor to enter the necessary claim/status information into the Data Warehouse timely will result in CMS taking necessary action, including, but not limited to, progressive reduction in ADR limits, modification/termination of the contract, requiring the Recovery Auditor to prepare a Corrective Action Plan, CMS' decision to not exercise the next option period of the contract, etc. ~~a 25% reduction in the applicable contingency fee for the affected claims.~~

B. Point of Contact for the Recovery Auditor

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

The Recovery Auditor's Project Manager shall be available to the CMS 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 Recovery Auditor 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 Recovery Auditor to any provision of the Statement of Work (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 Recovery Auditor 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 Recovery Auditor 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 Recovery Auditor.

E. Case Record Maintenance

The Recovery Auditor shall maintain a case file for every improper payment that is identified, including documentation of subsequent recovery efforts. This file shall include documentation of all processes followed by the Recovery Auditor including a copy of all correspondence, 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 Recovery Auditor 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 Recovery Auditor 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 http://www.whitehouse.gov/omb/circulars/a130/a130trans4.html.

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 Recovery Auditor receives a refund check, the Recovery Auditor shall forward the check to the appropriate address. Before forwarding the check, the Recovery Auditor 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 Recovery Auditor, the Recovery Auditor 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 Recovery Auditor 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 Recovery Auditor, and/or maintaining databases. Each

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

I. Conference Attendance

The Recovery Auditor shall attend the annual Medical Review Conference held at CMS Central Office each year. Attendees shall include at least the Medical Director and Medical Review Manager from each contractor.

J. Quality Assurance

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

1. Each Recovery Auditor shall be required to complete a Statement on Standards for Attestation Engagements Number 16 (SSAE 16 Type II Audit). Each Recovery Auditor 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 16 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 16 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. The Recovery Auditor 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 Recovery Auditor fails to meet a goal, a corrective action plan shall be submitted to CMS.

3. 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. The Recovery Auditor 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 Recovery Auditor 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 Recovery Auditor 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.

K. Remedies for Unsatisfactory Performance

Failure by the Recovery Auditor to meet performance standards or otherwise comply with this SOW will result in the Recovery Auditor being placed on a Performance Improvement Plan. Failure to comply with, or meet the objectives of, the Performance Improvement Plan will result in corrective actions by CMS, including limiting the scope of work under the contract and possible contract termination.

If CMS determines that a Recovery Auditor is not performing the required amount of claim reviews or reviewing all claim/provider types as required (without a waiver from CMS), CMS will issue an official warning to the Recovery Auditor and issue a corrective action plan.

L. 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 Recovery Auditor 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 Recovery Auditor shall deliver the report to the CMS COR. Drafts of all documentation shall be provided to CMS approximately four 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.

SCHEDULE OF DELIVERABLES

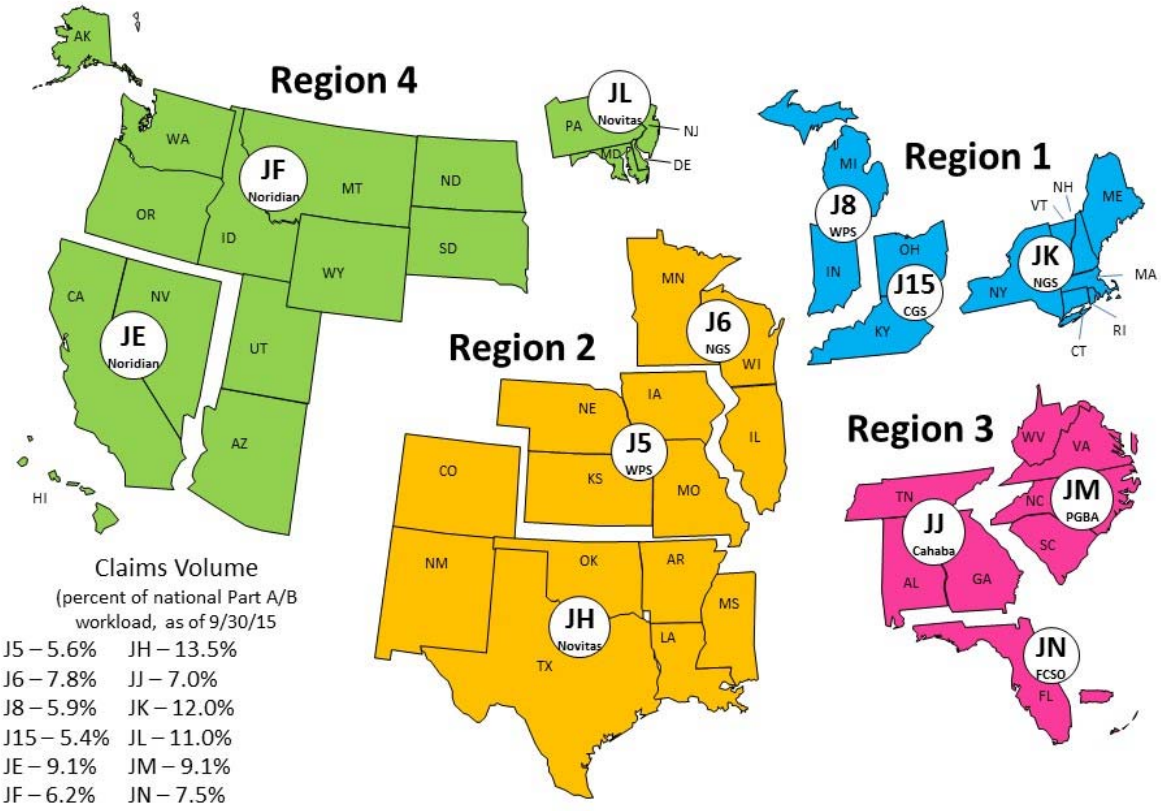
The Recovery Auditor shall provide the necessary personnel, materials, equipment, support, and supplies to accomplish the tasks shown below in the specified time. The contract Recovery Auditor shall complete the evaluation and report to CMS its findings. All work done under this contract shall be performed under the general guidance of the CMS COR and subject to the COR's approval.

Written documents for this project shall be delivered in hard copy to the CMS COR (2 copies), unless otherwise specified. These documents shall also be delivered to the CMS COR in an electronic version via email. At present, the CMS standard is Microsoft Word 2010 and Microsoft Excel 2010. This is subject to change, and the contractor shall be prepared to submit deliverables in any new CMS standard.

Task Number	Deliverable Number	Deliverable	Due Date (from contract award date)
General Requirements - A.	1	Initial Meeting	2 weeks from date of award
General Requirements – A.1	2	Project Plan	Within 2 weeks of the initial meeting
General Requirements - C	3	Conference Calls	Weekly or as needed
General Requirements – D.1	4	Monthly Progress Reports	Monthly – by COB on the fifth business day following the end of the month
General Requirements – D.2	5	Appeals Report	Monthly – by COB on the fifth business day following the end of the month

Administrative and Miscellaneous Issues - E	6	Case File Transfers	Within 15 days prior to the end of the contract period/Option Period
Administrative and Miscellaneous Issues - L	7	Final Report- Draft	Within 4 weeks prior to the end of the contract period
Administrative and Miscellaneous Issues - L	8	Final Report- Final	Within 4 weeks prior to the end of the contract period

APPENDIX 1 – Map of Recovery Audit Program Regions[2]



Claims Volume
(percent of national Part A/B workload, as of 9/30/15

J5 – 5.6%	JH – 13.5%
J6 – 7.8%	JJ – 7.0%
J8 – 5.9%	JK – 12.0%
J15 – 5.4%	JL – 11.0%
JE – 9.1%	JM – 9.1%
JF – 6.2%	JN – 7.5%

[2]Claim volume subject to change.

APPENDIX 2 – Data Warehouse Claims Upload File Format

Last Modified Date: 6/19/2015

***Please note that all layouts detailed here pertain to the same claim file. The header is the first record in the file, followed by the claim records.**

Header Layout

Field Name	Location	Length	Attributes	Sample	Valid Values and Notes
File Type	1	10	AN-10	CLAIM	Value: "Claim" Left justified, space fill
Filler	11	1	AN-1		Space fill
File Format Version	12	3	AN-3	005	Value: 005
Filler	15	1	AN -1		Space fill
Record Count	16	6	Num-6	000102	Number of records contained in file. Right justified, zero fill
Filler	22	1	AN-1		Space fill

Record Length	23	3	Num-3	211	211
Filler	26	1	AN -1		Space fill
Create Date	27	8	Num-8	20090617	File Creation Date Format = YYYYMMDD
Filler	35	7	AN -7		Space fill
Source ID	42	5	AN-5		Values = Contractor ID of the user who created the file. Left Justified
Filler	47	1	AN-1		Space fill
RAC Region	48	1	AN-1	A	A,B,C,D

Claim Record Layout

Field Name	Start	End	Length / Attributes	Required / Situational	Description - Valid Values and Notes
Record Type	1	1	1-AN	R	Claim Record-C
Claim Type	2	2	1-A	R	NCH MQA Record Identification Code 1 = Inpatient 2 = SNF 3 = Hospice 4 = Outpatient 5 = Home Health Agency

					6 = Carrier 7 = Durable Medical Equipment
Out-of-Jurisdiction Flag	3	3	1-A	S	Use "Z" for claims from out-of-jurisdiction providers. All other cases, use space.
State Code	4	5	2-A	R	State Codes: ME, CA
Place of Service ZIP Code	6	10	5-AN	R	US Postal Code where service rendered.
Contractor ID (Workload Number)	11	15	5-AN	R	Claims processing contractor ID number
Original Claim ID	16	38	23-AN	R	Unique identifier number assigned by Carrier, Fiscal Intermediary, A/B MAC or DME MAC to claim • For Claim Type 1 through 5 - length must be equal to or greater than 14. • For Claim Type 6 - length must be 15.

					• For Claim Type 7 - length must be 14.
Type of Bill	39	42	4-AN	R/S	* Required for Claim Type 1 - 5.
Provider Legacy Number	43	55	13-AN	S	Unique Provider Legacy Number of the provider that performed the service and filed the claim.
Provider NPI	56	65	10-AN	R	Unique Provider NPI of the provider that performed the service and filed the claim
DME Ordering Provider NPI	66	75	10-AN	S	NPI of Provider that prescribed the supplies.
Original Claim Paid Amount	76	84	9.2-N	R*	Amount of original payment made from Medicare fund ex: 999999.99 * Optional field for PR Reviews.
Original Claim Paid Date	85	92	8-N	R*	Date claim was paid YYYYMMDD * Optional field for PR Reviews.
Date of Service Start	93	100	8-N	R	Date service started/performed YYYYMMDD

Date of Service End	101	108	8-N	R	Date service ended YYYYMMDD
Provider Type	109	110	2-AN	R	Type of Provider or Supplier Valid Values: 1 = Lab/Ambulance 2 = Outpatient Hospital 3 = Home Health (HHA) 4 = Hospice 5 = Professional Services (physician/non-physician practitioner) 6 = DME by Supplier 7 = Skilled Nursing (SNF) 8 = Inpatient Hospital 9 = Inpatient Rehabilitation (IRF) 10 = Critical Access Hospital (CAH) 11 = Long Term Care Hospital (LTCH) 12 = DME by Physician 13 = Ambulatory Surgery Center (ASC) 14 = Other
CMS Provider Specialty Code	111	112	2-AN	S	CMS Provider Specialty Code in Carrier/DME files; no equivalent in institutional files

Review Type	113	114	2-AN	R	Automated Review-AR Complex Review-CR Semi-Automated Review-SA Pre-Payment Review-PR
Review Status	115	116	2-AN	S	Valid Values: UP = Underpayment Reimbursed in Full; OP = Overpayment Paid in Full; AP = Appealed Claim; RC = Review Concluded without identification of improper payment; CR = Debt Resolved by Contractor. Example: MAC notifies RAC that provider has declared bankruptcy or has disappeared. PR = Debt Resolved by Provider. Example: Provider supplies new evidence in discussion period; RAC agrees and reverses improper payment finding. TR = Terminated by CMS. Example: Claim was excluded while under review. ER = Closed due to

					error in record (can be reloaded as new corrected record) RE = Reopen claim(to activate a closed claim)
RAC Adjustment ID	117	139	23-AN	R*	* Required when Date Code "11" comes in. Otherwise, it is an optional field. **Once Date Code "11" has been uploaded, RAC Adjustment Claim Number is a required field on all subsequent uploads for this claim.**
Date Code A	140	141	2-AN	R*	Type of date: 01-Initial selection of record for audit 02-Request for medical records 03-Received provider's request for extension to submit records 04-New RAC-assigned deadline for provider to submit records request for extension 05-Received medical records from provider 06-RAC asks CMS for extension to complete review

					07-New deadline for RAC to complete review 08-Results letter sent to provider (complex review) 09-Request for discussion received from provider 10-Finding sent to AC 11-Readjudicated claim received from AC 12-Demand letter sent. **(Once Date Code "12" has been uploaded, Demand Letter Amount is a required field on all subsequent uploads for this claim.)** 13-Claim closed 14-No findings letter sent 15-Technical Denial Determination Date 16-Additional Documentation Received as part of Discussion * Date Code 01 is always required.
Date A	142	149	8-N	R	Date format YYYYMMDD

Date Code B	150	151	2-AN	S	Type of date:
Date B	152	159	8-N	S	Date format YYYYMMDD
Date Code C	160	161	2-AN	S	Type of date:
Date C	162	169	8-N	S	Date format YYYYMMDD
Date Code D	170	171	2-AN	S	Type of date:
Date D	172	179	8-N	S	Date format YYYYMMDD
Demand Letter Amount	180	188	9.2-N	R*	ex: 999999.99 * Required when Date Code "12" comes in. Otherwise, it is an optional field. * Submit negative amounts for underpayments **Once Date Code "12" has been uploaded, Demand Letter Amount is a required field on all subsequent uploads for this claim.**
Overpayment/ Underpayment Indicator	189	190	2-AN	S	Overpayment/ Underpayment Indicator Values: • OP: Overpayment (Demand

					Letter Amount > 0) • UP: Underpayment (Demand Letter Amount < 0) • NA: No Finding (Demand Letter Amount = 0) • blank: Review in progress (Demand Letter Amount is missing) **Required when:** *** Demand Letter Date (Date 12) or No Findings Letter Sent Date (Date 14) is not missing (OP or UP)**
Discussion Period Start Date	191	198	8-N	S	Date format YYYYMMDD
Discussion Period End Date	199	206	8-N	S	Date format YYYYMMDD
CMD Participated in Discussion	207	207	1-A	S	Values: • Y: yes • N: no

Additional Documentation Submitted as part of Discussion	208	208	1-A	S	Values: • Y: yes • N: no
Overturn Decision made based on Additional Documentation Submitted for Discussion	209	209	1-A	S	Values: • Y: yes • N: no
Initial Documentation Delivery Route (for documentation submitted in response to RA Request for Medical Record)	210	210	1-N	S	Values: • 1: esMD • 2: fax • 3: mail paper record • 4: mail electronic records on a disk • 5: other
Additional Documentation Delivery Route (for documentation submitted as part of discussion)	211	211	1-N	S	Values: • 1: esMD • 2: fax • 3: mail paper record • 4: mail electronic records on a disk

					• 5: other

Claim Line Item Record Layout

Field Name	Start	End	Length / Attributes	Required / Situational	Description - Valid Values and Notes
Record Type	1	1	1-AN	R	Line-L
Line item number	2	4	3-AN	R	Claim line item number; 000 for institutional claims. If line number = 000, then no other lines are acceptable for that claim
Original Diagnosis Code Version Indicator	5	5	1-N	R	9 for ICD-9 or 0 for ICD-10;
Original Principal Diagnosis Code (institutional) or line-specific Diagnosis Code (non-institutional)	6	12	7-AN	R	Original ICD-9 or ICD-10. Decimal point(.) is not allowed.
Final Diagnosis Code	13	13	1-N	S	9 for ICD-9 or 0 for ICD-10;

Version Indicator					
Final Principal Diagnosis Code (institutional) or line-specific Diagnosis Code (non-institutional)	14	20	7-AN	S	Final diagnosis code after audit. Decimal point(.) is not allowed.
Original DRG	21	23	3-AN	S	Original DRG on claim. It must be three digit numbers. Line 000 only
Final DRG	24	26	3-AN	S	Final DRG after audit. It must be three digit numbers. Line 000 only
Original ICD Procedure Code	27	33	7-AN	S	Original ICD9/ICD10 Procedure Code on RAC identified claim. Decimal point(.) is not allowed.
Final ICD Procedure Code	34	40	7-AN	S	Final ICD9/ICD10 Procedure Code after audit. Decimal

					point(.) is not allowed.
Original Non-DRG PPS/Hospice LOC Code	41	45	5-AN	S	Original HOPPS code for outpatient hospitals (APCs), HIPPS code for SNFs (RUG/AIs), HHAs (HHRGs) or IRFs (CMG/RICs), or Level of Care code for hospice claims.
Final Non-DRG PPS/Hospice LOC Code	46	50	5-AN	S	Final APC/HIPPS/LOC after audit
Original HCPCS	51	55	5-AN	S	Original HCPCS on claim. Not generally used for inpatient claims (exceptions do exist)
Final HCPCS	56	60	5-AN	S	Final HCPCS after audit. Not generally used for inpatient claims
Original Units of Service	61	63	3-N	S	Original units of service on claim
Final Units of Service	64	66	3-N	S	Final units of service on claims

Original BETOS Code	67	69	3-AN	S	Original Berenson-Eggers type of service (BETOS) code for the given HCPCS
Final BETOS Code	70	72	3-AN	S	Final BETOS code for the given HCPCS
CMS Issue Code	73	82	10-AN	R	Issue code assigned by eRAC Examples: C000012009 D000972010 Temporary issue codes are no longer allowed. RACs must obtain a permanent code from eRAC prior to submitting claims to the Data Warehouse.
Sub Vulnerability Code	83	86	4-AN	S	RAC-assigned reason claim/line considered overpaid/underpaid.
Filler	87	211	125-AN	R	Spaces