Statement of Work for the Recovery Audit Program  
Durable Medical Equipment (DME), Home Health/Hospice  
Recovery Auditor

I. Purpose

The Recovery Audit Program’s mission is to reduce Medicare improper payments through the efficient detection and correction of improper payments, and the implementation of actions that will prevent future improper payments.

The purpose of this contract will be to support the Centers for Medicare & Medicaid Services (CMS) in completing this mission through the identification and correction of improper payments for durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS), and home health/hospice (HH/H) claims submitted under Part B of Title XVIII of the Social Security Act (the Act). The CMS expects the Recovery Auditor to review DMEPOS items and HH/H claims to assist the Agency in lowering future error rates and in identifying improper payments that have the greatest impact on the Trust Fund.

This contract includes the following tasks, which are defined in detail in subsequent sections of this Statement of Work (SOW):

1. Identifying Medicare DMEPOS and HH/H claims that contain overpayments or underpayments for which payment was made under Part B of Title XVIII of the Act. This is commonly referred to as postpayment review. This includes the review of DMEPOS items that have a high propensity for error based on the Comprehensive Error Rate Testing (CERT) program and other CMS analysis.

2. Identifying Medicare DMEPOS and HH/H claims that contain overpayments or underpayments for which payment was requested under Part B of Title XVIII of the Act. This is commonly referred to as prepayment review. This includes the review of all DMEPOS and home health/hospice claims that have a high propensity for error based on the CERT program and other CMS analysis.

3. For any Recovery Auditor identified improper payment that is appealed by the provider, the Recovery Auditor shall provide support to CMS throughout the administrative appeals process and, where applicable, a subsequent appeal to the appropriate Federal court. This includes participating or taking party status at the Administrative Law Judge (ALJ) level of appeal in a minimum of 25% of the cases that reach this level.

4. For any Recovery Auditor identified vulnerability, support CMS in developing an Improper Payment Prevention Plan to help prevent similar improper payments from occurring in the future. This includes the sharing of recovery audit methodologies, algorithms, and edit parameters used to identify improper payments with CMS and the appropriate Medicare Administrative Contractor (MAC). Sharing this information may assist CMS and its contractors in conducting provider education, and implementing system edits to prevent current and future improper payments.

5. Performing the necessary provider outreach to notify provider communities of the Recovery Auditor’s purpose and direction.
6. Maintaining a quality customer service center to provide accurate and timely responses to provider inquiries.

7. The Recovery Auditor shall ensure compliance with all SOW and CMS system requirements, including Information Technology (IT) systems security policies, procedures and practices.

8. Collaboration with the four regional DME and HH/MACs that process DMEPOS and HH/H claims, and other CMS contractors and stakeholders.

9. Performing other administrative and miscellaneous tasks as directed by CMS in support of the Recovery Audit Program.

II. Background

Statutory Requirements

Section 302 of the Tax Relief and Health Care Act of 2006 requires the Secretary of the Department of Health and Human Services to utilize Recovery Auditors under the Medicare Integrity Program to identify and correct improper payments associated with services for which payment is made under Part A or B of Title XVIII of the Social Security Act.

Section 402(a)(1)(J) of the Social Security Amendments of 1967 as amended, 42 U.S.C. §1395b-1(a)(1)(J) allows CMS to implement a demonstration to utilize Recovery Auditors for prepayment review, and waive the provision to pay their contingency payments from already disbursed funds. This demonstration is scheduled to run until December 31, 2014.

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, potential bidders may research the following documents:

- The Debt Collection Improvement Act of 1996
- The Federal Claims Collection Act, as amended and related regulations found in 42 CFR
- Comprehensive Error Rate Testing Reports (see www.cms.hhs.gov/cert)
- Recovery Audit Program Status Document (see www.cms.hhs.gov/rac)
- Health Insurance Portability and Accountability Act of 1996 (Public Law 104-191)

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 incorrect code but the payment amount is not altered are not considered improper payments for the Medicare FFS Recovery Audit Program.
III. Transitions

Outgoing Recovery Auditor to Incoming Recovery Auditor

From time to time in the Recovery Audit Program, transitions from one Recovery Auditor (outgoing contractor) to another Recovery Auditor (incoming contractor) will need to occur (i.e., when the incumbent Recovery Auditor ceases work and the new Recovery Auditor begins work). The term transition will be applied to activities that are being performed by more than just the incoming Contractor (i.e., others involved in the transition such as the outgoing contractor). It is in the best interest of all parties to ensure transitions occur smoothly.

If an incumbent Recovery Auditor (contract with CMS from February 2009- February 2014 or other date designated by CMS to be the end date of the contract) is awarded a new contract in any region, all outstanding receivables, claim adjustments, discussion periods, and appeals will transition and continue to be the responsibility of the Recovery Auditor who identified the improper payment. If a new Recovery Auditor (no previous Medicare Fee-For-Service Recovery Auditing contract from February 2009- February 2014) is awarded a contract all outstanding receivables in the region without an incumbent Recovery Auditor will transition to the new Recovery Auditor. The new Recovery Auditor will then be responsible to complete any remaining appeal workload but will not lose the contingency fee for overturned appeals that they did not identify.

In order to ensure a successful transition, the outgoing contractor shall cooperate fully with the incoming contractor during its closeout 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 implementation (whether direct or indirect) are kept informed of the transition’s status and progress.

The transition plan that CMS will put into place during the last year of the current Recovery Audit contracts will help to decrease and mitigate the number of receivables and appeals requiring transition. However, CMS feels strongly that a transition of outstanding receivables and appeals is necessary to ensure continuity of the program. The transfer of work between an incoming and outgoing contractor is not unusual even though the Recovery Audit contracts are somewhat specialized. CMS feels it is in the best interest of the incumbent recovery auditors to continue to process any outstanding receivables and/or appeals identified by them in the previous contract. This is to their advantage as well as the agency’s advantage because a thorough hearing at the ALJ will be possible. It is to the incumbent’s advantage because they do not have to be concerned about any negative consequences that would come from the result of another entity arguing on their behalf or no argument at all. The overturn rate at that time is reflective on the incumbent contractor not necessarily the incoming contractor.

A. Transition Plan and Stakeholder Communications

The incoming contractor shall submit a Transition Plan within 14 days of the kick-off meeting. The contractor shall provide CMS a revised Transition Plan within 7 calendar days of the kick-off meeting to reflect any changes in the Plan due to modification of the schedule or tasks. The
Transition Plan will include recommendations of specific dates with regard to requests for medical records, written notification of an overpayment, any written correspondence and/or phone communication with providers.

During the transition period, a bi-weekly transition status teleconference or meeting with the outgoing contractor, incoming contractor, and CMS shall be held. The outgoing contractor shall assist the incoming contractor in organizing, hosting, and providing toll-free telecommunication lines and facilities for transition meetings. The meetings shall follow a prepared agenda and attendees shall 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 (every other week) 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.

**Outgoing DME or HH/H MAC to Incoming DME or HH/H MAC (Impact on the Recovery Audit Program)**

The DME and HH/H MACs perform all duties associated with processing DMEPOS and HH/H claims and payment services submitted under Part B of the Medicare program. CMS will occasionally transition the DME or HH/H MAC workload from one contractor to another. 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 relationship with the involved contractors to determine the impact on the Recovery Audit Program. The impact may vary from relatively minor or no impact to a work stoppage in a specific area for a 3-6 month period of time. The impact to the Recovery Audit Program will be determined within 60 days of the announcement of the upcoming transition. The Recovery Auditor will be required to submit a transition plan to CMS for approval. The lack of an approved transition plan will result in a minimum transition time of 6 months.

**IV. Specific Tasks**

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 the 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 Auditors to perform their tasks efficiently. 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 not extend from the tasks in this contract and will be applicable to the identification and recovery of improper payments.

**Task 1 – General Requirements**

**A. Initial Meeting with CMS Contracting Officer Representative (COR) and CMS Staff**
**Project Plan** – The Recovery Auditor’s key project staff (including overall Project Director and key sub Project Directors) shall meet in Baltimore, Maryland with the CMS 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 time frames for the tasks outlined below. Within 2 weeks of this meeting, the Recovery Auditor will submit a formal project plan in Microsoft Project, outlining the resources and time frame for completing the work outlined. The initial project plan shall be for the base year of the contract. The project plan shall serve as a snapshot of everything the Recovery Auditor is identifying at the time, and it is the Recovery Auditor’s responsibility to update the project plan as new issues arise. The initial project plan and any subsequent updates must be approved by CMS prior to implementation.

The project plan shall include the following:

1. **Detailed quarterly projection by vulnerability issue** (e.g., excisional debridement) including: a) incorrect procedure code and correct procedure code; b) type of review (automated, semi-automated, complex, extrapolation); c) type of vulnerability (medical necessity, incorrect coding)

2. **Provider Outreach Plan** – A base provider outreach plan shall be submitted as part of the proposal. CMS will use the base provider outreach plan as a starting point for discussions during the initial meeting. Within 2 weeks of the initial meeting, the Recovery Auditor shall submit to the CMS COR a detailed provider outreach plan for the respective region. At a minimum, the base provider outreach plan shall include potential outreach efforts to associations, providers, Medicare contractors, and other applicable Medicare stakeholders.

3. **Recovery Auditor Organizational Chart** – A draft contractor organizational chart shall be submitted as part of the proposal. The organizational chart shall identify the number of key personnel and the organizational structure of the Recovery Auditor. A detailed organizational chart extending past the key personnel shall be submitted within two weeks of the initial meeting. Any changes to the Recovery Auditor’s organizational chart (down to the first line management) shall be submitted within seven (7) business days of the actual change being made to the CMS COR. 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 excludes changes to key personnel which shall be communicated immediately to CMS and approved by CMS before the transition occurs.

**B. Monthly Conference Calls**

A minimum of two monthly conference calls to discuss the Recovery Auditor project will be necessary.

1. On a biweekly basis the Recovery Auditor’s key project staff will participate in a conference call with CMS to discuss the progress of the 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.

2. On a monthly basis the Recovery Auditor’s key project staff will participate in a conference call with CMS to discuss findings and process improvements that will facilitate CMS in paying claims accurately in the future. CMS 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 required to be completed more frequently. Also, other conference calls may be called to discuss individual items and/or issues.

C. 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 DME MAC/HH/H MAC/Qualified Independent Contractor (QIC)/Administrative QIC (ADQIC)
   c. Upcoming provider outreach efforts
   d. Update of project plan
   e. Detailed discussion period requests received (report shall identify number of discussion requests per new issue number, discussion period outcomes, and information submitted by provider during discussion).
   f. Update of vulnerability issues being reviewed in the upcoming month
   g. Recommended corrective actions for vulnerabilities (e.g., Local Coverage Determination (LCD) change, system edit, provider education)*
   h. Update on how vulnerability issues were identified and potential vulnerabilities not reviewed due to potentially ineffective policies
   i. Update on Joint Operating Agreements (JOAs)
   j. Action items
   k. Fraud referrals to the CMS COR
   l. Problems encountered
   m. Process improvements to be completed by Recovery Auditor

   At CMS discretion a standardized monthly report(s) may be required. If a standardized monthly report is required, CMS will provide the format.

   * The Recovery Auditors will identify and report LCDs 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 Auditors shall submit monthly appeals reports. These reports shall be broken down by MAC jurisdiction into the following categories:

   a. Number of appeal record requests from the DME and HH/H MAC by new issue number for the month
   b. Number of appeals record requests from the DME and HH/H MAC responded to by new issue for the month
   c. Number of appeals affirmed per new issue number for the month
   d. Number of appeals affirmed per new issue number inception to date
3. The Recovery Auditor shall submit monthly financial reports outlining all work accomplished during the previous month. The report shall be broken down into the following eleven categories:

   a. Overpayments collected – Amounts shall only be on this report if the amount has been collected by the DME MAC or HH/H MAC (in summary and detail)
   b. Underpayments returned – Amounts shall only be on this report if the amount has been paid back to the provider by the DME MAC or HH/H MAC (in summary and detail)
   c. Overpayments adjusted – Amounts shall be included on this report if an appeal has been decided in the provider’s favor or if the Recovery Auditor rescinded the overpayment after adjustment occurred (in summary and detail)
   d. Overpayments identified – This report includes claims where the Recovery Auditor believes an overpayment exists because of an automated or complex review, but the amount has not yet been demanded by the DME MAC or HH/H MAC
   e. Overpayments demanded – This report includes claims that have been adjusted by the DME MAC or HH/H MAC and demand letters have been sent out. Claims with collections should not be included in this report.
   f. Underpayments identified – This report includes claims where the Recovery Auditor believes an underpayment exists due to an automated or complex review but the amount has not been paid back to provider yet
   g. Number of claim reviews on a prepayment basis
   h. Improper payment prevents as a result of a prepay review
   i. Number of medical records requests from each provider (in detail) and the amount paid to each provider (in detail) for the medical record requests for the previous month
   j. Number of medical reviews completed within 30 days
   k. Number of reviews that failed to meet the 30 day review timeframe and the rationale for failure to complete the reviews within 30 days

Reports a, b, c and h in #2 above shall also be included with the monthly voucher to CMS.

All reports shall be in summary format with all applicable supporting documentation.

At CMS discretion, a standardized monthly report(s) may be required. If a standardized monthly report is required, CMS will provide the format.

Unless alternative arrangements are approved, 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, and one copy shall accompany any contractor voucher sent to the CMS accounting office.

D. Recovery Audit Data Warehouse

CMS will provide access to the Recovery Audit Data Warehouse (the Data Warehouse). The Data Warehouse is a web based application which houses all Recovery Auditor identifications and collections. The Data Warehouse includes all suppressions and exclusions. Suppressions and exclusions are claims that are not available to the Recovery Auditor for review. The Recovery Auditor will be responsible for providing the appropriate equipment so they can access the Data Warehouse. (More information on the Data Warehouse is located in Task 8 – Reporting of Identified, Demanded and Collected Medicare Overpayments and Identified Medicare Underpayments.)
E. Geographic Region

Unless otherwise directed by CMS through technical direction, the claims being analyzed for this award will be all fee-for-service DME claims processed by the DME MACs nationwide.

A map of the Recovery Audit regions and DME MAC regions can be found in Appendix 2.

F. Recovery Auditor Staff

1. Key Personnel – CMS does not have a required number of key personnel. At a minimum, the Project Director, the Medical Director, and the Chief Information and Systems Security Officer will be key personnel. CMS expects that key and additional personnel listed below will comprise an adequate structure to account for the different claim types, customer service and IT responsibilities.

a) Project Director – The Project Director shall be dedicated to Medicare line of business and act as a central point of contact with CMS and other stakeholders. The Project Director should have previous experience as a project manager, and demonstrate knowledge of the Medicare program. Knowledge of CMS FFS Recovery Audit Program requirements and activities is preferred.

b) Recovery Auditor Medical Director – Each Recovery Auditor must employ a minimum of one Full Time Equivalent (FTE) contractor medical director (CMD) and arrange for an alternate when the CMD is unavailable for extended periods. The CMD FTE must be composed of either a Doctor of Medicine or a Doctor of Osteopathy who has relevant work and educational experience. More than one individual’s time cannot be combined to meet the one FTE minimum. The CMD is a key personnel on this contract and must be approved by CMS.

Relevant Work Experience

- Prior work experience in the health insurance industry, utilization review firm or health care claims processing organization.
- Extensive knowledge of the Medicare program particularly the coverage and payment rules, and
- Public relations experience such as working with physician groups, beneficiary organizations or Congressional offices.

Relevant Educational Experience

- Experience practicing medicine as board certified doctor or medicine or doctor who is currently licensed.

All clinicians employed or retained as consultants must be currently licensed to practice medicine in the United States, and the contractor must periodically verify that the license is current. When recruiting CMDs, contractors must give preference to physicians who have patient care experience and are actively involved in the practice of medicine.

Primary duties include:

- Providing the clinical expertise and judgment to understand LCDs, National Coverage Determinations (NCDs) and other Medicare policy;
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 vulnerabilities;

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.

Other duties include:

- Interacting with the CMDs at 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.

c) Chief Information and Systems Security Officer (CISSO) – The CISSO will oversee information technology (IT) practices, and perform the duties of System Security Officer in accordance with IOM Pub. 100-17, the CMS Business Partner System Security Manual. The CISSO shall have knowledge of and extensive practical experience in the following areas:

i. IT systems security policies,
ii. procedures and practices to manage security administrative duties in large organizations,
iii. Coordinating with program stakeholders.

d) Recovery Auditor 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 credentialled 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.

e) Registered Nurses – Each Recovery Auditor is required to employ registered nurses. Registered nurses are required to have current licenses in nursing in the United States. The Recovery Auditor must ensure that the license of the clinician is current. Clinicians must have previous experience in medical record review. Clinicians will be required to review medical records for medical necessity and for clinical validation. The clinician must have an understanding of Medicare policy as well as LCDs and NCDs. Clinicians should be a resource for coders and non-clinical personnel.

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.

**Task 2 – Identification of Improper Payments on Post-payment Review**

Recovery Auditors are required to 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 must clearly articulate the good cause in new issue proposals and correspondence (review results letters, ADRs, etc.) to providers. Additionally, Recovery Auditors shall ensure that processes are developed 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 impact the provider’s ability to provide care.

To assist the Recovery Audit Program, CMS works closely with the DME and HH/H MACs to establish monthly workload figures. These figures are generated after consultation with the Recovery Auditor. The workload figures are typically modified annually, with the option for modification if necessary. Workload limits equate to the number of claims that a claims processing contractor is required to adjust on a monthly basis. Current workload limits apply only to post-payment reviews. A Recovery Auditor’s failure to meet established workload limits and maintain an acceptable volume of post-payment reviews repeatedly without notice to the CMS COR may result in a decrease to future workload limits.

Should the Recovery Auditor demonstrate a backlog of claims for a claims processing contractor, and have projections showing the necessity for a higher sustained minimum monthly workload, the CMS will consider increasing future workload limits.

**A. Improper payments included in this SOW**

Unless prohibited by Section 2C, 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:

• DME suppliers
• Home Health Agency
• Hospice

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, Recovery Auditors shall not attempt to identify improper payments in the Medicare Managed Care program, Medicare drug card program or drug benefit program.

2. **Cost report settlement process and Medical Education payments** – Recovery Auditors shall not attempt to identify underpayments and overpayments that result from Indirect Medical Education (IME) and Graduate Medical Education (GME) payments. Recovery Auditors 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 3 years past the date of the initial determination made on the claim. The initial determination date is defined as the claim paid date. 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 on 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), the date of the overpayment demand notification letter (for semi-automated and 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.

**Note:** CMS reserves the right to limit the time period available for Recovery Auditor review by Recovery Auditor, region/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.

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 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.

NOTE: 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
Auditors.

C. Underpayments

The Recovery Auditor will review claims, using automated or complex reviews, to identify potential
Medicare underpayments. Upon identification the Recovery Auditor will communicate the
underpayment finding to the DME or HH/H MAC. The mode of communication and the frequency
shall be agreed upon by both the Recovery Auditor and the DME or HH/H MAC. If necessary, the
Recovery Auditor shall share any documentation supporting the underpayment determination with the
DME or HH/H MAC.

Neither the Recovery Auditor nor the DME or HH/H MAC may ask the provider to correct and
resubmit the claim, although the Recovery Auditor shall issue an Underpayment Notification Letter
including the claim(s) and beneficiary detail.

A sample letter shall be approved by the CMS COR before issuing the first letter.

For purposes of the Recovery Auditor program, a Medicare underpayment is defined as
those 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 changes to the diagnosis, procedure or order in that line or payment group
would create an underpayment, the Recovery Auditor will 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 pricer. (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 will have no responsibility to randomly accept case files from providers for an underpayment case review. If case files are received from providers that were not requested by the Recovery Auditor, the Recovery Auditor may shred those records. The Recovery Auditor is under no obligation to respond to the provider.

4. Medical Record Requests

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

5. Appeal of the Underpayment Determination

The normal appeal process is available to providers for all underpayment determinations.

D. Validation Process

1. New Issue Review Approval

To ensure that Recovery Auditors are 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. The review 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. CMS may choose to review the issue internally, use MACs, or use an independent validation contractor.

Once the Recovery Auditor chooses to pursue a new issue that requires semi-automated, complex or automated review, the Recovery Auditor shall notify CMS of the issue in a format to be prescribed. CMS may request that information be submitted by email, mailed CD, or through an electronic system. The Recovery Auditor may request up to 10 medical records when developing
a test case for CMS to validate. The Recovery Auditor shall not issue medical record requests beyond the 10 test claims without prior CMS approval.

The Recovery Auditor shall forward any requested information to the appropriate contact (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 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 (beyond the 10 test claims) and/or any subsequent documentation on the new issue. CMS or the validation contractor may also evaluate the clarity, accuracy, and completeness of the Recovery Auditor letter to providers.

Upon new issue review approval, the Recovery Auditor shall post the issue name, description, posting date, state applicable, review type, provider type and any relevant code(s) to the Recovery Auditor website. At a minimum, the new issue listing shall be sortable by provider type and posting date. Additional sort methodologies may include state, issue number and claim type.

Upon approval of the new issue by CMS, CMS reserves the right to share new issues with all CMS review entities which may include, but is not limited to, other Recovery Auditors in Medicare and Medicaid, MACs, CERT contractor, and ZPICs.

Prior to submission to the new issue process, CMS encourages the DME Recovery Auditor to meet with the DME MAC(s) 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) Recovery Auditors shall review their approved issues to ensure compliance with the most recent CMS policy changes. Any changes to a new issue and the policy used to make the review determinations shall be submitted to the CMS COR for approval before beginning reviews. The CMS COR and associated staff shall then review such changes to issues and/or policy and issue guidance to the Recovery Auditors within a 30 day approval period.

E. Preventing Overlap

1. Preventing overlap with contractor performing claim review and/or responsible for recoveries

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 (DME MAC, HH/H
MAC/FI/Carrier/MAC, Zone Program Integrity Contractor (ZPIC)/Program Safeguard Contractor (PSC), Office of Inspector General (OIG), or other investigative agencies) are working on the same claim.

Therefore, the Data Warehouse will be used by the Recovery Auditor 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 exclusion exists for that claim. Recovery Auditors are not permitted to review suppressed or excluded claims. The Recovery Auditor will be notified to cease all activity if a suppression is entered after the Recovery Auditor begins its review; exclusions entered after Recovery Auditor reviews begin shall be handled individually based on the timing of the other review.

Definition of 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.

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

- FLs, Carriers, A/B MACs and DME and HH/H MACs
- Quality Improvement Organizations (QIO)
- ZPICs/PSCs
- Investigative Agencies (OIG, FBI, Department of Justice or DOJ)
- Comprehensive Error Rate Testing (CERT) Contractor
- CMS Recovery Auditor COR

2. Preventing Recovery Auditor overlap with contractors, CMS, OIG and other investigative agencies performing potential fraud reviews

CMS must ensure that Recovery Auditor activities do not interfere with potential fraud reviews/investigations being conducted by other Medicare contractors or investigative agencies. Therefore, Recovery Auditors shall input claims into the Data Warehouse before attempting to identify or recover overpayments. (The master table described above will be used.)

Definition of Suppression – A suppressed provider and/or claim is typically a provider and/or claim that are part of an ongoing investigation. Once a suppression record is entered into the Data Warehouse, CMS will approve or reject the suppression record. Approved suppressions are temporary and will eventually be released by the suppression entity.

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

- ZPICs/PSCs, OIG and other investigative agencies (e.g., DOJ, FBI)
- CMS Recovery Audit Data Warehouse COR

The CMS Recovery Auditor COR may also issue a Technical Direction Letter (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.

F. Obtaining, Storing and 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.)

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

Recovery Auditors must remain capable of accepting faxed or paper medical record indefinitely.

Recovery Auditors shall develop the necessary processes to accept imaged medical records sent on CD, DVD, or electronically. Although providers are not mandated to electronically store or transmit medical records, Recovery Auditors shall possess the technology to accept document via electronic transmission.

If the Recovery Auditor attempts an onsite visit and the provider refuses to allow access to their facility, the Recovery Auditor may 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.

When requesting medical records the Recovery Auditor shall use discretion to ensure the number of medical records in the request does not negatively impact the provider’s ability to provide care. CMS will institute a medical record request limit. Different limits may apply for different provider types and for hospitals the limit may be based on size of the hospital (number of beds). The limit would be per provider location and type per time period. An example of a medical record limit would be no more than 50 inpatient medical record requests for a hospital with 150-249 beds in a 45 day time period. CMS may enact a different limit for different claim types (outpatient hospital, physicians, supplier, etc). The medical record request limit may also take into account a hospital’s annual Medicare payments. Current limits can be found in the Downloads Section of the CMS RAC Website at the following URL: http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Recovery-Audit-Program/Program-Providers-Resources.html

The medical record request 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 time period and the Recovery Auditor does not request medical records in January and February, the Recovery Auditor cannot request 150 records in March.
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 must make available to all Part A/B and DME MACs, FFIs/Carriers, CMS, QICs, OIG, (and others as indicated by the CMS COR) any requested medical record. Records and case files can be transmitted via a MDCN line, CD, IesMD, MPLS or another method prescribed by CMS.

*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. The Data Warehouse will not be available for this purpose. The Recovery Auditor shall make information about the status of a medical record (outstanding, received, review underway, review complete, case closed) available to providers upon request. Recovery Auditors shall develop a web-based application for this purpose. All web-based applications shall be approved by the CMS COR.

For purposes of this section sharing imaged medical records means the transmission of the record on a disk, CD, DVD, FTP or MDCN line, MPLS, or esMD. PHI shall not be transmitted through any means except a MDCN line, MPLS, postal mail, overnight courier, a fax machine, or esMD.

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

a. Recovery Auditors shall pay for medical records associated with acute care inpatient prospective payment system (PPS) hospital (DRG) claims and Long Term Care hospital claims.

The Recovery Auditor shall pay the provider for producing the records in accordance with the current guidelines prescribed by CMS. (The current per page rate is: medical records photocopying costs at a rate of $.12 per page for reproduction or 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. Specifically, hospitals and other providers (such as critical access hospitals) under a Medicare cost reimbursement system, receive no photocopying reimbursement.

Recovery Auditors are required to pay for copying of the inpatient (PPS) and Long Term Care hospital medical records on at least a monthly basis. For example, a Recovery Auditor may choose to issue checks on the 10th of the month for all medical records received the previous month. All checks should be issued within 45 days of receiving the medical record.

CMS guidelines will include the amount per page, the maximum amount per medical record and the amount per transmission. It is possible there will be different amounts per page depending on if the submission was paper, CD, fax or esMD.

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

The maximum payment amount to a provider per medical record shall not exceed $25.00.

b. Recovery Auditors may pay for medical records should the Recovery Auditor request medical records associated with any other type of claim including, but not limited to, the facilities listed in PIM 1.1.2, paragraph 2. The Recovery Auditor may (but is not required to) pay the provider for producing the record using any formula the Recovery Auditor prefers.

4. Maintaining a Case File

The Recovery Auditor shall maintain a complete case file for every record requested. (See Task 9; Section G for additional case record maintenance instructions.) At a minimum, the case file shall include

- A copy of all request 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
- Information related to when the adjustment was sent to the DME MAC and the accounts receivable and demand letter date and amount
- Any discussion requests and decisions
- Any appeal requests and decisions

When requested, the entire case file shall be available to be sent to CMS and the Validation Contractor within seven (7) days of the request.

G. The Claim Review Process

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, CPT Assistant statements, and Coding Clinic statements.)

EXCEPTION: If the Recovery Auditor identifies a “clinically unbelievable” issue (i.e., a situation where certainty of noncoverage or incorrectly 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. Unless or until CMS approves the issue for automated review, the Recovery Auditor must make its determinations through complex 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 often don’t 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. 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. Complex 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. Recovery Auditors 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. Recovery Auditors are not required to share names and personal information. If the provider requests to speak to the CMD regarding a claim(s) denial the Recovery Auditor shall ensure the CMD participates in the discussion.

**ii. Timeframes for Completing Complex Coverage/Coding Reviews**
Recovery Auditors shall complete their complex reviews within 30 days from receipt of the medical record documentation. Recovery Auditors may request a waiver from CMS if an extended timeframe is needed due to extenuating circumstances. If an extended timeframe for review is granted, Recovery Auditors shall notify the provider in writing or via a web-based application of the situation that has resulted in the delay and will indicate that the Notification of Findings will be sent once CMS approves the Recovery Auditor moving forward with the review. Unless granted an extension by CMS, Recovery Auditors 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.

**iii. DRG Validation vs. Clinical Validation**
DRG Validation is the process of reviewing physician documentation and determining whether the correct codes, and sequencing were applied to the billing of the claim. This type of review shall be performed by a certified coder. For DRG Validations, certified coders shall ensure they are not looking beyond what is documented by the physician, and are not making determinations that are not consistent with the guidance in Coding Clinic.

Clinical validation is an additional process that may be performed along with DRG validation. Clinical validation involves a clinical review of the case to see whether or not the patient truly possesses the conditions that were documented in the medical record. Recovery Auditor clinicians shall review any information necessary to make a prepayment or post-payment claim determination. Clinical validation is performed by a clinician (RN, CMD or therapist). Clinical validation is beyond the scope of DRG (coding) validation, and the skills of a certified coder. This type of review can only be performed by a clinician or may be performed by a clinician with approved coding credentials.

For Medicare to consider coverage and payment for any item or service, the information submitted by the supplier or provider must corroborate the documentation in the beneficiary’s medical documentation and confirm that Medicare coverage criteria have been met.

c. **Semi-Automated Review**
Semi-Automated Review is a two-part review. The first part is the identification of a billing aberrancy through an automated review using claims data. This aberrancy has high indexes of suspicion to be an improper payment. The second part includes a
Notification Letter that is sent to the provider explaining the potential billing error that is identified. The letter also indicates that the provider has 45 days to submit documentation to support the original billing. If the provider decides not to submit documentation, or if the documentation provided does not support the way the claim was billed, the claim will be sent to the Medicare claims processing contractor for adjustment and a demand letter will be issued. However, if the submitted documentation does support the billing of the claim, the claim will not be sent for adjustment and the provider will be notified that the review has been closed. This type of review is to be used in which a clear CMS policy does not exist but in most instances the items and services as billed would be clinically unlikely or not consistent with evidence-based medical literature.

The Recovery Auditor is not required to reimburse providers for the additional documentation submitted for semi-automated reviews. Recovery Auditors must complete these reviews within 30 days of receiving the documentation.

2. **Types of Determinations a Recovery Auditor may make**

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:

i. Be included in one of the benefit categories described in Title XVIII of the Act;

ii. Not be excluded from coverage on grounds other than 1862(a)(1); and

iii. 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:

   A. Safe and effective;
   
   B. 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
   
   C. 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;
- and
- One pair of conventional eyeglasses or contact lenses furnished subsequent to each cataract surgery with insertion of an interlobular lens.

Recovery Auditors must be very 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. Contractors should use HCFA Ruling 95-1 and the guidelines listed below in selecting the appropriate denial reason.

**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 - 14.3 for further details.

**b. 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.)

**c. Other Determinations**

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

Consistent with Section 937 of the MMA, the Recovery Auditor shall not make denials on minor omissions such as missing dates or signatures if the medical documentation indicates that other coverage/medical necessity criteria are met. Any questions regarding whether a claim shall be denied for a minor omission shall be directed to the CMS COR.

d. **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 which 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, Coverage Provisions in Interpretive Manuals, national coverage and coding articles, LCDs (formerly called local medical review policies (LMRPs)) and local coverage/coding articles in their jurisdiction. NCDs, LMRPs/LCD and local coverage/coding articles can be found in the Medicare Coverage Data Warehouse [http://www.cms.hhs.gov/mcd/overview.asp](http://www.cms.hhs.gov/mcd/overview.asp). Coverage Provisions in Interpretive Manuals can be found in various parts of the Medicare Manuals. In addition, the Recovery Auditor shall comply with all relevant joint signature memos forwarded to the Recovery Auditor by the project officer.

Recovery Auditors should not apply a LCD retroactively to claims processed prior to the effective date of the policy. Recovery Auditor shall ensure that policies utilized in making a review determination are applicable at the time the service was rendered except in the case of a retroactively liberalized LCDs or CMS National policy.

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 Rulings.

If an issue is brought to the attention of CMS by any means and 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 must make their Review Guidelines available to CMS upon request. Review Guidelines shall not create or change policy. In the absence of CMS policy, Review Guidelines shall be developed using evidence-based medical literature to assist reviewers in making a determination.

c. Rationale for Determination.

The Recovery Auditor shall clearly document the rationale for the determination. This rationale shall list the review findings including 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. Recovery Auditors shall ensure they are identifying pertinent facts contained in the medical record to support the review determination. Each rationale shall be specific to the individual claim under review.

The Recovery Auditor shall make available upon request by any other ACs, CMS, OIG, (and others as indicated by the CMS COR) any requested rationale.

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.

ii. Re-openings of Claims Denied Due to Failure to Submit Necessary Medical Documentation (remittance advice code N102) -- In cases where the Recovery Auditor denies a claim with remittance advice code N102 (“This claim has been denied without reviewing the medical record because the requested records were not received or were not received timely.”) and the denial is appealed, the appeals department may, at CMS direction, send the claim to the Recovery Auditor for reopening under certain conditions, listed in CMS Pub. IOM 100-04, Chapter 34, §10.3. If this occurs, the Recovery Auditor shall conduct a reopening of claims sent by the appeals department within 30 days of receipt of the forwarded claim and requested documentation by the Recovery Auditor. In addition, the Recovery Auditor shall issue a new letter containing the outcome of the review and the information required by PIM Chapter 3, §3.6.5.

H. Activities Following Review

1. Communication with Providers about Improper Payment Cases

The Recovery Auditor shall send the provider only one (1) review results per claim. However, in cases when the Recovery Auditor could not perform a comprehensive review of the claim because aspects of the review had not yet been approved by CMS for widespread review, the Recovery Auditor may issue 1 review results letter for those aspects where approval had been granted and reserve the right to conduct another review in the future. This scenario could happen when the coding review has been approved, but medical necessity review has not been approved.
Prior to completing an additional, different review the Recovery Auditor shall notify the provider. The Recovery Auditor shall not request the additional documentation again but shall afford the provider the opportunity to submit additional documentation for the new review. The time period for submission shall be the same as an original additional documentation request.

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, each reason shall be identified. For example, if the Recovery Auditor identified a problem with the coding of respiratory failure and denied several claim(s) because the wrong procedure code and wrong diagnosis code(s) were billed, the Recovery Auditor shall list in its letter all claims in which an improper payment was identified that contained the wrong procedure code and separately list those denied because the wrong diagnosis code was billed. Recovery Auditors shall ensure that the date a claim was reopened (regardless of the demand letter issue date) is documented and 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 Recovery Auditor documentation if the Recovery Auditor determination is appealed. Recovery Auditors shall clearly document the date the claim was reopened and the rational for good cause in the Notification of Recovery Auditor Review Findings (for initial determinations made by a Part A claims processing contract), in the demand letter (for initial determinations made by a Part B claims processing contractor) and in all case files.

a. Automated review

The Recovery Auditor shall communicate by letter to the provider the results of each automated review that results in an overpayment determination. 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. The Recovery Auditor shall record the date and format of this communication in the Recovery Auditor Data Warehouse.

b. Complex review

The Recovery Auditor shall communicate to the provider the results of every semi-automated and complex review, including cases where no improper payment was identified. 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. The Recovery Auditor shall record the date and format of this communication in the Recovery Auditor Data Warehouse.

c. Contents of Notification of Recovery Auditor Complex Review Findings Letter

The Recovery Auditor shall send a letter to the provider indicating the results of the review within 30 days of the exit conference (for provider site reviews) or receipt of medical records (for Recovery Auditor site reviews). If the Recovery Auditor needs more than 30 days, they are to contact the CMS COR for an extension. Each letter must include:

- Identification of the provider(s) or supplier(s)—name, address, and provider number;
• The reason for conducting the review (See Section SOW 2F-3);
• A narrative description of the overpayment situation: state the specific issues involved which created the improper payment and any pertinent issues as well as any recommended corrective actions the provider should consider taking;
• The findings for each claim in the sample, including a specific explanation of why any services were determined to be non-covered, or incorrectly coded;
• A list of all individual claims including the specific reason for noncoverage,
• For statistical sampling for overpayment estimation reviews, any information required by PIM, Chapter 3, Section 3.10.4.4

2. Allowance of a Discussion Period

All providers receiving a demand letter from the DME or HH/H MAC, and/or review results letter from the Recovery Auditor are availed an opportunity to discuss the improper payment with the Recovery Auditor. The Recovery Auditor can have an escalation process in plan for the discussion period, however, if the physician (or a physician employed by the provider) requests to speak to a physician, that request must be acted upon. A physician employed by the provider does not include provider(s) employed as consultants. The request for a discussion period shall be utilized to determine if the provider has other information relevant to the payment of the claim. All discussion requests should be in writing and shall be responded to by the Recovery Auditor within 30 days of receipt, unless the Recovery Auditor is notified by the affiliated contractor of a provider initiated appeal. If during the discussion period the Recovery Auditor is notified by the contractor that the provider initiated the appeals process, the Recovery Auditor shall immediately discontinue the discussion period and send a letter to the provider that the Recovery Auditor cannot continue the discussion period once an appeal has been filed.

If the Recovery Auditor modifies the original improper payment identification, written notification shall be sent to the provider so that the provider can share it with the appropriate appeal entity if necessary. If the claim has already been forwarded to the DME or HH/H MAC for adjustment, the Recovery Auditor shall immediately notify the DME or HH/H MAC that the claim no longer requires adjustment or needs to be re-adjusted.

3. Determine the Overpayment Amount

a. Full denials

A full denial occurs when the Recovery Auditor determines that:

i. The submitted series was not reasonable and necessary as billed.
ii. 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 not reasonable and necessary but 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 DME MAC failed to apply a payment rule that caused an improper payment (e.g. failure to reduce payment on multiple surgery cases).

**Note:** Other situations that are not categorized above should be brought to the CMS COR’s attention before the Recovery Auditor sends notification to the provider.

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 DME or HH/H MAC. Once the DME or HH/H MAC completes the claim adjustment, preferably via the file-based mass adjustment process, the DME or HH/H MAC will notify the Recovery Auditor through the Data Warehouse (or another method 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.

*How the adjustment is completed in the shared system may not necessarily correlate with the Recovery Auditor contingency amount. For example, a Recovery Auditor contingency amount could equate to the difference between the full denial and any services determined by CMS to be payable.

**c. Extrapolation**

Recovery Auditors are 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. Recovery auditors shall follow the procedures found in PIM (currently Chapter 8, section 8.4), as well as MMA Section 935(a), regarding the use of extrapolation. The use of extrapolation shall be approved for each issue prior to beginning.

**4. The Claim Adjustment Process**

The MAC will pursue the recoupment of Medicare overpayments that are identified through Task 1.

The Recovery Auditor shall not attempt recoupment or forward any claim to the DME or HH/H MAC or the applicable CMS Data Center for adjustment if the anticipated amount of the overpayment is less than $25.00 unless the recovery auditor is choosing to review the claims using extrapolation. Claims less than $25.00 cannot be aggregated to allow for demand unless extrapolation is used and if inadvertently demanded the Recovery Auditor shall not receive a contingency fee on any amounts recouped.

The Recovery Auditor shall not forward any claim to the DME or HH/H MAC or the CMS Data Center for adjustment if the anticipated amount of the underpayment is less than $1.00.

The Recovery Auditor shall not forward claims to the DME or HH/H 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. Without the modifier payment 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 Recovery Auditor identified overpayment other lines are 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 MAC will include these additional lines and denial reason codes on the written notification to the provider.

Also, 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 denial and will not receive credit for the adjustment identified by the Recovery Auditor.

When partial adjustments to claims are necessary, the DME or HH/H 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, and inpatient stays that should have been billed as outpatient. If the system cannot currently accommodate this type of downcoding/adjustments, CMS will work with the system maintainers to create the necessary changes. This includes some medical necessity claims.

I. Demand Letters

Demand letters will be issued by the MACs. Demand letters should include:

- An explanation of the provider’s or supplier’s right to submit a rebuttal statement prior to recoupment of any overpayment (see PIM Chapter 3, Section 3.6.6)
- An explanation of the procedures for recovery of overpayments including Medicare’s right to recover overpayments and charge interest on debts not repaid within 30 days, and the provider’s right to request an extended repayment schedule.
- The provider appeal rights information.

Underpayment Letters – Underpayment letters will continue to be sent by the Recovery Auditors and shall include all provider appeal rights.

J. Compromise and/or Settlement of Overpayment

If CMS determines that a compromise and/or settlement is in the best interest of Medicare, the Recovery Auditor shall receive a contingency payment for the portion of principal that was recouped, provided that all regular attempts to initiate recoupment were utilized.

K. Voluntary/Self-Reported Overpayments by Providers

If a provider voluntarily self-reports an overpayment after the Recovery Auditor issues an improper payment notification letter or a request for medical records, the Recovery Auditor will
receive a discounted contingency fee based on the Payment Methodology Scale. In order to be eligible for the contingency fee, the type and dates of service for the self-reported overpayment must be in the Recovery Auditor’s most recently approved project plan.

- If the provider self-reports this kind of case to the Recovery Auditor, the Recovery Auditor shall document the case in its files, and forward the check to the appropriate Medicare contractor.
- If the provider self-reports this kind of case to the MAC, the MAC will notify the Recovery Auditor. The Recovery Auditor will document the case in its files. Timeframes associated with the reporting of the voluntary/self-reported overpayment shall be addressed in the Joint Operating Agreement (JOA) between the Recovery Auditor and the DME or HH/H MAC.

The Recovery Auditor shall cease recovery efforts for the claims involved in the self-report immediately upon becoming aware (e.g., when the Recovery Auditor is notified by the DME or HH/H MAC, the provider, etc.)

If a provider voluntarily self-reports an overpayment, and the self-reported overpayment does NOT involve the same types of services for which the Recovery Auditor has issued a demand letter or a request for medical records, then the Recovery Auditor is not entitled to a contingency fee amount.

- If the provider self-reports this kind of case to the Recovery Auditor, the Recovery Auditor shall forward the check to the appropriate Medicare contractor.
- If the provider self-reports this kind of case to the Medicare contractor, the Recovery Auditor does not need to take action.

The Recovery Auditor may continue recovery efforts since the overpayment the provider self-reported involved a different provider/service combination.

L. Unsolicited/Voluntary Refunds (by check or claims adjustment, including those due to credit balances)

Occasionally the DME or HH/H MAC may receive an unsolicited/voluntary refund from a provider. An unsolicited/voluntary refund is a refund that is submitted to the DME or HH/H MAC without a demand letter. It is a situation where the provider realizes that a refund is due the Medicare program and refunds the money to the DME or HH/H MAC. By definition, an unsolicited/voluntary refund (by check or by claims adjustment) must occur before a demand letter is issued. The Recovery Auditor shall not receive any contingency payment on an unsolicited/voluntary refund.

M. Interest

Regulations regarding interest assessment on determined Medicare overpayments and underpayments can be found at 42 CFR 405.378. Recovery Auditor contingency fees are based upon the principal amounts recovered. All payments are applied to interest first, principal second.

N. Communication Regarding Potential Fraud
In addition to the JOA with all applicable ZPICs, the Recovery Auditor shall establish regular meetings with all applicable ZPICs to discuss potential fraud referrals and trends each contractor is seeing in the applicable jurisdictions. These meetings shall occur at a minimum of quarterly with monthly being the ideal. Meetings shall include all applicable operational staff as well as the Contractor Medical Director. Informal referrals received from the ZPIC or given to the ZPIC during these meetings shall be included in the next monthly report to CMS. Formal referrals to the ZPIC or OIG shall be sent to the CMS COR who will share the referral with the appropriate division in CMS.

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 their respective CMS COR for guidance. The CMS COR may then request the information as defined above from the Recovery Auditor. Recovery Auditors are not permitted to discuss law enforcement investigations or information requests from investigative agencies with providers.

O. Potential Quality Problems and Rework of claims

The Recovery Auditor shall report potential quality issues immediately to their respective CMS COR.

Task 3 – Identification of Improper Payments on Prepayment Review

This task includes Medicare claims that contain improper payments for which payment was requested under Part 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.

Through Technical Direction and/or Change Request, CMS will instruct the DME and HH/H MACs 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 shall be reviewed by the Recovery Auditor.

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

The Recovery Auditor will issue a review results letter and communicate the decision to the DME or HH/H MAC for payment or denial. Recovery Auditors 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. The DME and HH/H 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 Recovery Auditors and DME and HH/H MACs are responsible for inputting claim information in the Data Warehouse as appropriate. Prepayment-reviewed claims would not be available for post-payment review.
Unless explicitly instructed otherwise in this section, all information in Task 1 is applicable to this section as well.

**Task 4 – Supporting Identification of Overpayments in the Medicare Appeal Process and/or in the DCIA Process**

Providers are given appeal rights for the majority of Medicare overpayments determined during the post payment review process. If a provider chooses to appeal an overpayment determined by the Recovery Auditor, the Recovery Auditor shall assist CMS with support of the overpayment 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, providing assistance, and representing CMS at any hearings associated with the overpayment when requested by CMS.

Providers shall request an appeal through the appropriate Medicare appeals process. A third party shall adjudicate all appeal requests related to provider overpayments identified by the Recovery Auditor. This third party may be the current DME or HH/H MAC, a third party contractor identified by CMS, a QIC, an Administrative Law Judge, or HHS’ Departmental Appeals Board’s Medicare Appeals Council. Some recovery claims may eventually be appealed to the appropriate Federal court. If the Recovery Auditor receives a written appeal request it shall forward it to the appropriate third party adjudicator within one business day of receipt. If the appropriate Medicare contractor is not known, the Recovery Auditor shall contact the CMS COR within one business day of receipt for assistance. If the Recovery Auditor receives a verbal request for appeal from a provider, the Recovery Auditor shall give the provider the telephone number of the appropriate Medicare contractor and inform them that their verbal request does not suspend the permissible time frame for requesting an appeal as set forth in the demand letter.

The appropriate Medicare contractor will notify the Recovery Auditor and the CMS COR of the appeal request and the outcome of each applicable appeal level. This notification will occur at least once a month.

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.

**Task 5 – Assisting CMS in the Development of the Medicare Improper Payment Prevention Plan**

Through weekly calls, reports and databases, the Recovery Auditor shall assist CMS in the development of the Medicare Improper Payment Prevention Plan. The Medicare Improper Payment Prevention Plan is a listing of all Recovery Auditor vulnerabilities identified that CMS may need to address through LCDs, NCDs, provider education or system edits.

**Task 6 – Collaboration with Other Medicare Contractors**
The Recovery Audit Program often requires the assistance and collaboration of other contractors employed by CMS. The Recovery Auditors are expected to work with other contractors as required, and to maintain open and professional lines of communication with their peers.

The Recovery Auditor shall complete a JOA with all applicable Medicare contractors (FIs, Carriers, DME and HH/H MACs, MACs, ZPICs/PSCs, 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 and 2) notification and escalation mechanisms with CMS involvement.

a) **Referrals from CMS** - CMS often receives referrals of potential improper payments from the FIs/Carriers/MACs, ZPICs/PSCs, and Federal investigative agencies (e.g., OIG, DOJ). At CMS discretion, CMS may choose to forward the referral to the Recovery Auditor for the Recovery Auditor’s consideration.

The largest source of referrals for which Payment Methodology Scale B will be enacted will be improper payments identified and recouped by the Recovery Auditor from an OIG report that was referred to the Recovery Auditor by CMS after June 30, 2010. Referrals will be given to the Recovery Auditors via a TDL. The TDL will include all information deemed necessary by CMS but may also include a pre-approval of the issue, language for the Recovery Auditor’s new issue section of the website and edit parameters and/or review methodologies. This is not an all inclusive listing of possible inclusions in the TDL. If necessary, CMS may require the Recovery Auditor’s CMD and staff presence on a conference call with the OIG for explanation purposes. Recovery Auditors shall ensure they report the issue as an OIG referral on the New Issue form and shall follow the rest of the requirements in the Recovery Auditor SOW regarding demand, collection, and reporting.

Each referral sent to the Recovery Auditors by CMS will require a decision by the Recovery Auditor within 30 calendar days. The decision point will be if the Recovery Auditor intends to pursue the issue in its jurisdiction and when. Upon acceptance of the issue the Recovery Auditor will have to track the progress and report back to CMS periodically. Once the web-based referral tracking system is in place the tracking will take place in it. Until then, all issue tracking shall occur in the Recovery Auditor’s monthly report to the CMS COR. Specific tracking guidance will be shared with the Recovery Auditors at the time of the first referral.

If the DME Recovery Auditor chooses to not review the issue, CMS reserves the right to give the issue to another contractor. This could be another Recovery Auditor not associated with a specific geographical jurisdiction that is responsible only for referrals from CMS.

**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 Auditors to make and track referrals. The Recovery Auditors 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 referral. 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.

b) **Communications to prevent illegal provider and participant actions:**

If the Recovery Auditor discovers that a provider is potentially conducting themselves fraudulently, the provider/participant must be reported to the CMS COR. The CMS COR will review the referral and determine proper routing.

c) **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.

d) **Communications relating to the claim adjustment:**

The DME and HH/H MACs serve as the conduit to allow the Recovery Auditor to adjust claims and recoup overpayments. The relationship between the DME and HH/H MAC and the Recovery Auditor is crucial to the success of the program. CMS has the following expectations with the DME and HH/H MAC and Recovery Auditor relationship:

- The DME and HH/H MAC is an operational contractor of CMS and does not take direction from the Recovery Auditor.
- Any communication issues with the DME and HH/H MAC that cannot be addressed through provisions of the JOA, shall be escalated to the Recovery Auditor COR at CMS for additional discussions with the appropriate parties.
- The DME and HH/H MAC is responsible for issuing timely demand letters, adjusting claims, applying recoupments, uploading 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 DME and HH/H 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 DME and HH/H 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.

e) **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.
FI/Carrier/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 claims processing contractors and Recovery Auditor shall work together to share appeals data, including reasons for recovery audit finding reversals. The Recovery Auditor and claims processing contractors may also share areas identified as vulnerabilities.

QIC: The Recovery Auditor shall ensure that the QIC has received the completed case file, so that they may properly review the earlier decision. The Recovery Auditor will forward new or requested evidence 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.

Auditors are expected to review data provided by appeals contractors to identify ongoing trends or issues of vulnerability that may be applied to current reviews or potential appeals.

f) Referrals from the CERT Program

CMS releases an annual CERT program error rate. CMS will share claim type specific information with the Recovery Auditors for their review. If CMS has evidence to believe the Recovery Auditor is not reviewing claim types with a high error rate as determined by CMS, CMS will issue an official warning to the Recovery Auditor via a notification of performance concern from the CMS Contracting Officer. This notification shall identify the specific claim type failing to be audited, shall include the documentation citations that support the conclusions, and a CMS allotted time frame for Recovery Auditor correction. If the lack of reviews continue, CMS will consider recalling the specific claim type(s) from the Recovery Auditor and giving the opportunity to review the claims to another CMS contractor. If this loss of access to specific claims/provider type(s) occurs, it will be a permanent change.

Task 7 – Customer Service and Provider Outreach

1. Customer Service

a) 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 the 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 that the improper payment shall return the call within one (1) business day. The Recovery Auditor shall provide a translator for Spanish speaking providers or other prospective debtors. This translator shall be available within 1 business day of the provider’s original call.

Recovery Auditors must receive prior approval from CMS for all contractor press releases. Recovery Auditors 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.

b) 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.

c) The Recovery Auditor shall respond to written correspondence within thirty (30) days of receipt. The Recovery Auditor shall provide the CMS Project Officer with copies by fax and mailed hard copy, 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.)

d) The Recovery Auditor shall respond to all discussion requests within 30 days of receipt. The incoming discussion request and the written reply as well as any supporting documentation shall be included in the case file.

e) 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.

f) 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 it being when requested. At a minimum, the written report shall include the provider name, phone number, date and reason for the call to the Recovery Auditor, the response to the inquiry, and the outcome of the call.

g) The Recovery Auditor shall respond to all email inquiries within 2 business days of receipt. (Friday after 5:00 pm- Monday 6:00 am per time zone in the region, all federal holidays are excluded) This includes requests from CMS as well as inquiries from providers and other external entities.

h) 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.
i) The Recovery Auditor shall develop a mechanism to allow providers to customize their address and point of contact (e.g. Washington County Hospital, Medical Records Dept., attention: Mary Smith, 123 Antietam Street, Gaithersburg, MD 20879). All Recovery Auditors shall develop a web-based application for this purpose. All web-based applications shall be approved by the CMS COR. Recovery Auditors 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 medical record request must inform the provider about the existence of the address customization system.

2. **Provider Outreach**

a) The initial Project Plan shall include a section covering provider outreach. CMS will announce the use of the Recovery Auditors in the specified geographic area. All other debtor education and outreach concerning the use of Recovery Auditors will be the responsibility of the Recovery Auditor. The Recovery Auditor shall only educate providers on their business, their purpose, and their processes. The Recovery Auditors shall **not** educate providers on Medicare policy. The CMS COR shall approve all presentations and written information shared with the provider, beneficiary, and/or other debtor communities before use. If requested by CMS, the Recovery Auditors 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 Auditors are the focus.

b) The Recovery Auditor is required to maintain a Medicare Recovery Auditor webpage 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 Medicare 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 Medicare webpage concerns.

**Task 8 – Reporting of Identified, Demanded and Collected Medicare Overpayments and Identified Medicare Underpayments**

The Recovery Auditor will be required on a monthly basis to provide the CMS COR or its delegate with detailed information concerning overpayments and underpayments that have been identified, overpayments that have been demanded and overpayments that have been fully or partially collected. The Recovery Auditor shall have supporting documentation for all line items on the report. This report will be due no later than the fifth (5th) business day of the following month. Section 4 – General Requirements, Subsection C – Monthly Progress Reports contains additional information required in the monthly financial reports.

**Data Warehouse Reporting of Possible/Identified Improper Payments**

CMS utilizes the Data Warehouse to house information on potential and outstanding improper payments under the Recovery Auditor purview. The Warehouse stores outstanding overpayment data, determination dates, principal and interest amounts, the status of the overpayment and allows CMS to prepare detailed and/or summary reports from various data included in the Warehouse.

a. **The following bullets in this Section (a) summarize when a Recovery Auditor shall enter data into the Warehouse.**
1. Recovery Auditor chooses claim for potential review (complex, automated, or semi-automated) and uploads required elements to the Warehouse. If the claim is suppressed or excluded (initially or at any point in the review) the Recovery Auditor stops work immediately.

2. Updating various review types:
   a) COMPLEX REVIEW: Recovery Auditor updates the Warehouse with the medical record request date, date of provider’s extension request and revised due date (if applicable), date of receipt, date of Recovery Auditor request for review period extension and revised date granted by CMS (if applicable), results letter sent date and date claim sent to the DME or HH/H MAC/EDC for adjustment (if applicable).
   b) AUTOMATED REVIEW: Recovery Auditor updates the Data Warehouse with date claim sent to the DME or HH/H MAC/EDC for adjustment.
   c) SEMI-AUTOMATED REVIEW: Recovery Auditor updates the Data Warehouse with the advisory letter date and (as applicable) the date of provider’s extension request and revised due date, date of records receipt, date of Recovery Auditor request for review period extension and revised date granted by CMS, results letter date and date claim sent to the DME or HH/H MAC/EDC for adjustment.

3) Recovery Auditor receives the improper payment amount and receivable/payable information from the DME or HH/H 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 date the finalized adjustment was received from the DME or HH/H MAC.

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

Recovery Auditor Data Warehouse Reporting and Recovery Auditor Invoices

1. The Data Warehouse is an integral participant in the success of the Recovery Auditor project. However, the Recovery Auditor Data Warehouse can only be successful if the data input into it by the Recovery Auditor is reliable, timely and valid. The Data Warehouse shall produce pre-filled invoices based on claims information from the Recovery Auditor linked to collection/payment and reversal transactions from the DME or HH/H MAC. Contingency rates will be automatically applied based on transaction type codes reported by the claim processing contractors.

2. Recovery Auditors may not add to the automatically generated invoices, although they may remove records with appropriate notice to the CMS COR.

3. CMS may consider supplemental invoices with transactions that are not in the Recovery Audit Data Warehouse or that failed automated matching, but such consideration is solely at the discretion of CMS. Acceptance of one or more supplemental invoices does not bind the Agency to accepting future supplemental invoices.

b. Inaccurate Information Input into the Recovery Audit Data Warehouse
CMS hires a contractor to maintain and enhance the Data Warehouse. Whenever erroneous files are input into the Data Warehouse, CMS has to pay the contractor by the hour to fix the file. All costs attributed to fixing errors input by the Recovery Auditor will be absorbed by the Recovery Auditor. CMS will accomplish this by notifying the Recovery Auditor and by subtracting that amount from the next invoice.

For example: A Recovery Auditor uploads a file of 30,000 claims and later realizes that the wrong provider type was input. In order to fix the error, CMS must notify the Data Warehouse maintainer to change the provider type or delete the entire file. If this takes 4 hours to complete and the Data Warehouse maintainer is paid $100 per hour, the next invoice for the Recovery Auditor will have $400 deducted from it for the cost of the error.

CMS has instituted this new process to ensure all Recovery Auditors understand the importance of the Data Warehouse and take due diligence when inputting information into it and to ensure that CMS can accurately budget for the maintenance of the Data Warehouse.

d. Other Systems Created by Recovery Auditor

The Recovery Auditor is free to utilize a subsequent system in addition to the Data Warehouse provided by CMS. Any subsequent system shall not take the place of the Data Warehouse.

All reports generated from an alternative system shall be converted to appropriate Microsoft Excel version requested by the CMS COR.

Task 9 – Administrative and Miscellaneous Issues

a) Separate reporting

The reporting and data collection/analysis or each of the major tasks must be kept separate and submitted in the appropriate format per Section 4 – General Requirements, Subsection C – Monthly Progress Reports.

b) Payment Methodology

All payments shall be paid only on a contingency fee basis and shall be based on the principal amount of the collection or the amount paid back to a provider (underpayment).

Contingency fees:

- Because interest collected is returned to General Revenue rather than to the Medicare Trust Funds, a contingency fee shall not be paid on any interest collected.

- The Recovery Auditor shall not receive any payments for the identification of the improper payments.

- The contingency fee will be determined by the overpayments collected without consideration given to the underpayments identified (i.e. without netting out the underpayments against the
overpayments.) Underpayments in a claim are counted separately.

**Note:** 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 the contingency payment for that recovery. Repayment to Medicare will occur on the next applicable invoice.

c) **Point of Contact for Recovery Auditor**

The primary point of contact for the Recovery Auditor shall be the CMS COR or his/her delegate.

d) **Data Accessibility**

CMS shall provide the Recovery Auditor with all applicable data files for all claims paid during the specific timeframes of the contract. The Recovery Auditor will receive new data updates as they become available (monthly or quarterly). The data file format, data fields available and user agreements are available upon request. To access data the Recovery Auditor shall acquire a Medicare Data Communications Network (MDCN) line. This is a secure line between the Recovery Auditor and the CMS Data Center. The cost of the MDCN line shall be incurred by the Recovery Auditor. Anticipated costs range from $1500-$2000 per month. This does not include setup costs. These costs may increase at any time. CMS will provide the applicable points of contact to set up the MDCN line. In addition, the Recovery Auditor must acquire the appropriate software to enter into the CMS Data Center. IBM/Sterling Commerce Connect:Direct software is currently being utilized by CMS for this purpose. There is no other alternative software. At this time, the price of the IBM/Sterling Commerce Connect:Direct software is approximately $185,000.00. The Recovery Auditors are responsible for all costs of the MDCN line and the software.

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 procedures to meet industry standards. 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.

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

Recovery Auditors shall ensure compliance with Federal Security Information Management Act (FISMA) of 2002 and the guidelines established by the National Institute of Standards and Technology (NIST) Special Publication (SP) 800-37, Guide for the Security Authorization of Federal Information Systems, dated August 2008, and CMS Technical Reference Architecture Standards. Recovery Auditor shall ensure compliance with systems security policies, procedures and practices designed to manage and transmit CMS claims information. Recovery Auditors shall ensure security documents are uploaded and security controls are documented in the CMS.
FISMA Control Tracking System (CFACTS). The Recovery Auditors shall correct any security deficiency, conditions, weaknesses, findings, or gaps identified by all CMS audits, reviews, evaluations, tests and assessments, in a timely manner (Time is of the essence in correcting the deficiencies or in remediating the findings of a systems security audit).

e) Recalled Cases and Reworked Claims

Recalled Cases - 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 because of 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. Recalls are indefinite and may require a corrective action plan to resume activity. Recalls can be claim or provider specific, claim type or provider type specific, jurisdiction specific, or region specific. Unless instructed by CMS through technical direction, demands previously issued will still continue to be recouped and the Recovery Auditor will receive a contingency fee, if appropriate.

Reworked Claims - If CMS or the Recovery Auditor determines that claims were improperly adjusted due to misinterpretation of CMS coverage or payment policy by the Recovery Auditor, CMS may limit or cease Recovery Auditor adjustments pending further review. Additionally, CMS may elect to effect corrective actions for the Recovery Auditor.

f) 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 contractor 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 contractor 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 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.

g) Recovery Deposits

The demand letters issued by the DME or HH/H MAC will instruct debtors to forward their refund checks to the appropriate address at the applicable Medicare contractor (DME or HH/H MAC). All refund checks shall be payable to the Medicare program. 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.

h) 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.

i) **Support Evaluation Contractor**

CMS is required to report on the Recovery Auditor Program annually. To assist with the report, CMS utilizes an independent evaluation contractor. This contractor assists CMS with the analysis of data, completes the provider survey, may assist CMS in monitoring the Recovery Auditors, and maintains the referral database. 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. At times, the evaluation contractor may request data from each Recovery Auditor. All requests will be filtered through the CMS COR and should be addressed within 15 days of receipt unless otherwise noted in the request.

j) **Quality Assurance**

1. Each Recovery Auditor shall be required to complete a Statement of Auditing Standards No. 70 (SAS 70) 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 SAS 70 Type II audits.

2. CMS control objectives can be found in IOM Pub. 100-6, Chapter 7. 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 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.

   Additional general information concerning a SAS 70 audit can be found in IOM Pub. 100-6, Chapter 7.

3. At CMS discretion, CMS may 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. At CMS discretion, CMS may contract with an independent contractor to perform an accuracy audit on a Recovery Auditor’s identifications. At a minimum, this audit would be performed annually.

5. Quality Assurance for Medical Record Reviews Inter-Rater Reliability (IRR) Process -- The Recovery Auditor shall perform QA reviews as part of an 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 employees 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 and their outcomes upon request by CMS.

k) Final Report

The final report shall include a synopsis of the entire contract project. This includes a final report identifying all amounts identified and demanded, all amounts collected and all amounts still outstanding at the end of the demonstration. It shall include a brief listing of all identification methods or other new processes utilized and their success or failure.

The contractor should 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.

A final report shall be delivered to the CMS COR in the three formats (paper/electronic) as stated below and in the required “electronic” formats to the fnlrrpts@cms.hhs.gov mailbox:

1) Paper, bound, in the number of copies specified;

2) Paper, unbound, suitable for use as camera-ready copy;

3) Electronic, as one file in Portable Document Format (PDF), as one file in Hypertext 200-word abstract/summary of the final report suitable for submission to the National Technical Information Service. Drafts of all documentation shall be provided to CMS Approximately four weeks prior to final deliverable due dates unless otherwise agreed to. CMS staff will review materials and provide comments back to the contractor within 2 weeks, thereby allowing 2 additional weeks for the contractor to make any necessary revisions. 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. 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 contract awarder shall provide the necessary personnel, materials, equipment, support, and supplies to accomplish the tasks shown below in the specified time. The contract awarder 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 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 2007 and Microsoft Excel 2007. This is subject to change, and the contractor shall be prepared to submit deliverables in any new CMS standard.

<table>
<thead>
<tr>
<th>Task Number</th>
<th>Deliverable Number</th>
<th>Deliverable</th>
<th>Due Date (from contract award date)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.a.</td>
<td>1</td>
<td>Initial Meeting</td>
<td>2 weeks</td>
</tr>
<tr>
<td>1.a.</td>
<td>2</td>
<td>Project Plan</td>
<td>4 weeks</td>
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<tr>
<td>1.b.</td>
<td>3</td>
<td>Monthly Conference Calls</td>
<td>Monthly</td>
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<tr>
<td>1.c.</td>
<td>4</td>
<td>Monthly Progress Reports</td>
<td>Monthly</td>
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<td>6</td>
<td>5</td>
<td>Financial Report</td>
<td>Monthly</td>
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<tr>
<td>1</td>
<td>6</td>
<td>Vulnerability Report</td>
<td>Monthly</td>
</tr>
<tr>
<td>6</td>
<td>7</td>
<td>Training on RAC Data Warehouse</td>
<td>Within 15 days of the start of Task 2</td>
</tr>
<tr>
<td>6</td>
<td>8</td>
<td>Case File Transfers</td>
<td>Within 15 days after contract end</td>
</tr>
<tr>
<td>9</td>
<td>9</td>
<td>Final Report- Draft</td>
<td>Within 8 weeks of contract end date</td>
</tr>
<tr>
<td>9</td>
<td>10</td>
<td>Final Report- Final</td>
<td>Within 4 weeks of contract end date</td>
</tr>
</tbody>
</table>
APPENDIX 2 – MAP OF RECOVERY AUDIT CONTRACTOR REGIONS

5 Recovery Auditors; 4 A/B (avg. 293,606,999) and 1 DME

Region A: 296,310,751
Region B: 291,614,015
Region C: 283,979,318
Region D: 302,523,912

Region E: 109,934,938
Region F: 68,532,302
Region G: 156,641,254
Region H: 134,972,761
Region I: 150,682,292
Region J: 80,932,595
Region K: 145,628,459
Region L: 124,056,672
Region M: 101,040,768
Region N: 102,005,955
Region DME: 73,913,260
Durable Medical Equipment MAC Jurisdictions