Recovery Audit Program Improvements

As the current Recovery Auditor contracts come to a close and the new contracts are being prepared, CMS has evaluated a number of concerns raised about the program and is now pleased to announce a number of changes to the Recovery Audit Program in response to industry feedback. The CMS is confident that these changes will result in a more effective and efficient program, by enhanced oversight, reduced provider burden, and more program transparency. These changes will be effective with each new contract award beginning with the DME, Home Health and Hospice Recovery Audit contract awarded on December 30, 2014.

	Provider Concern	Benefit to Provider Community
Reducing Provider Burden		
A1.	ADR limits are the same for all providers of similar size and are not adjusted based on a provider's compliance with Medicare rules.	CMS will establish ADR limits based on a provider's compliance with Medicare rules. Providers with low denial rates will have lower ADR limits while provider with high denial rates will have higher ADR limits. The ADR limits will be adjusted as a provider's denial rate decreases, ensuring the provider that complies with Medicare rules has less Recovery Audit reviews.
A2.	To comply with timely filing rules, hospitals must submit a claim within 1 year from the date of service, but the Recovery Auditors have a 3-year look-back period, which results in acute inpatient hospitals being unable to rebill denials from patient status reviews.	CMS will limit the Recovery Auditor look-back period to 6 months from the date of service for patient status reviews, in cases where the hospital submits the claim within 3 months of the date of service.
A3.	Additional documentation request (ADR) limits are based on the entire facility, without regard to the differences in departments within the facility.	CMS established ADR limits will be diversified across all claim types of a facility (e.g., inpatient, outpatient). This ensures that a provider with multiple claim types is not disproportionately impacted by Recovery Audit review in one claim type (e.g. all of a provider's inpatient rehabilitation claims reviewed or all inpatient).
A4.	Providers who are not familiar with the Recovery Audit Program immediately receive requests for the maximum number of medical records allowed.	CMS established ADR limits will include instructions to incrementally apply the limits to new providers under review. This will ensure that a new provider is able to respond to the request timely and with current staffing levels.
A5.	ADR limits for physicians should not be increased with the new contracts.	At the beginning of the new contracts, CMS will not increase the ADR limits for physicians.
A6.	Providers must wait 60 days before being notified of the outcome of their complex reviews	Recovery Auditors will have 30 days to complete complex reviews and notify providers of their findings. This provides more immediate feedback to the provider on the outcome of their reviews.
A7.	Recovery Audits should be conducted by	Recovery Auditors are required to have a

	physicians of the same specialty or subspecialty.	Contractor Medical Director and are encouraged to have a panel of specialists available for consultation. In addition, physicians are afforded the opportunity to discuss the improper payment identification with the Contractor Medical Director, who is a physician.
A8.	Upon notification of an appeal by a provider, the Recovery Auditor is required to stop the discussion period.	Recovery Auditors must wait 30 days to allow for a discussion request before sending the claim to the MAC for adjustment. Providers will not have to choose between initiating a discussion and an appeal and can be assured that modifications to the improper payment determination will be made prior to the claim being sent for adjustment.
A9.	Providers do not receive confirmation that their discussion request or other written correspondence has been received.	Recovery Auditors must confirm receipt of a provider's discussion request or other written correspondence within three business days.
A10.	Each Recovery Auditor's provider portal is formatted differently and some show different information than others.	CMS will work with Recovery Auditors to enhance their provider portals, including more uniformity and consistency in the claim status section, as well as display reason statement identifiers where available.
A11.	Providers receiving Periodic Interim Payments (PIP) may have their entire payment offset due to improper payment adjustments.	The revised ADR limits will help ensure PIP providers are not negatively impacted with improper payment adjustments. However, if a backlog were to exist, CMS would require incremental adjustments to ensure there was not a full recovery of a PIP. This will ensure that PIP providers' cash flow is not negatively impacted by the Recovery Auditors.
A12.	Recovery Auditors are paid their contingency fee after recoupment of improper payments, even if the provider chooses to appeal.	Recovery Auditors will not receive a contingency fee until after the second level of appeal is exhausted. Previously, Recovery Auditors were paid immediately upon denial and recoupment of the claim. This delay in payment helps assure providers that the decision made by the Recovery Auditor was correct based on Medicare's statutes, coverage determinations, regulations and manuals. Note: if claims are overturned on appeal, providers are paid interest calculated from the date of recoupment. For more information please visit
Enhancing CMS' Oversight		

B1.	CMS did not provide enough public information about the Recovery Audit Program.	CMS will provide further information about the Recovery Audit Program through increased public reporting of data such as appeals, Quality Assurance activities, and timeliness standards. This will allow the provider community to have access to Recovery Audit Program data and to ensure all requirements are followed by providers and the Recovery Auditors.
B2.	Recovery Auditors focused much of their resources on inpatient hospital claims.	CMS will require the Recovery Auditors to broaden their review topics to include all claim/provider types, and will be required to review certain topics based on a referral, such as an OIG report.
B3.	Recovery Auditors are not penalized for high appeal overturn rates.	Recovery Auditors will be required to maintain an overturn rate of less than 10% at the first level of appeal, excluding claims that were denied due to no or insufficient documentation or claims that were corrected during the appeal process. Failure to do so will result in CMS placing the Recovery Auditor on a corrective action plan, that could include decreasing the ADR limits, or ceasing certain reviews until the problem is corrected. This will help to assure the providers that the Recovery Auditors are making valid determinations by holding the Recovery Auditors accountable for their decisions.
B4.	Providers are concerned with the accuracy of Recovery Auditor automated reviews and Recovery Auditors are not penalized for low accuracy rates.	Recovery Auditors will be required to maintain an accuracy rate of at least 95%. Failure to maintain an accuracy rate of 95% will result in a progressive reduction in ADR limits. CMS will continue to use a validation contractor to assess Recovery Auditor identifications and will improve the new issue review process to help ensure the accuracy of Recovery Auditor automated reviews. This will help to assure the providers that the Recovery Auditors are making valid determinations by holding the Recovery Auditors accountable for their decisions.
Increasing Program Transparency		
C1.	Providers are unsure of who to contact when they have complaints/concerns about the Recovery Audit program.	CMS established a Provider Relations Coordinator to offer more efficient resolutions to affected providers. This position gives providers a name and contact information when issues arise that cannot be solved by having discussions with the Recovery Auditor
C2.	Providers need more information on	CMS will continue to post Provider Compliance

	how to prevent improper payments and bill correctly.	Tips to the CMS website. These compliance tips, in addition to education and MLN Matters articles give information to help providers prevent errors before they occur.
C3.	Providers are unclear about the information in the Recovery Auditor new issue website postings.	CMS will require the Recovery Auditors to provide consistent and more detailed review information concerning new issues to their websites. This will allow providers to easily navigate all of the issues that may be under Recovery Audit review.
C4.	CMS does not have a valid method for providers to rate each Recovery Auditor's performance.	CMS will consider developing a Provider Satisfaction Survey. This survey would give providers an outlet to give feedback to CMS on the Recovery Auditors performance.