

Recovery Audit Program Improvements - Completed (as of October 31, 2016)

- CMS regularly posts Provider Compliance 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. *(Effective 2014)*
- 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. *(Effective June 2, 2014)*
- Recovery Auditors are 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 helps to assure the providers that the Recovery Auditors are making valid determinations by holding the Recovery Auditors accountable for their decisions. *(Effective May 15, 2015)*
- Recovery Auditors are 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 helps to assure the providers that the Recovery Auditors are making valid determinations by holding the Recovery Auditors accountable for their decisions. *(Effective May 15, 2015)*
- CMS limited 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. *(Effective May 15, 2015)*
- CMS instructed the Recovery Auditors to incrementally apply the additional documentation request (ADR) limits to new providers under review. This ensures that a new provider is able to respond to the request timely and with current staffing levels. *(Effective May 15, 2015)*
- Recovery Auditors are required to have a 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. *(Effective May 15, 2015)*
- CMS required the Recovery Auditors to provide consistent and more detailed review information concerning new issues to their websites. This allows providers to easily navigate all of the issues that may be under Recovery Audit review. *(Effective May 15, 2015)*
- CMS has revised the ADR limits for facility claims. The limits are 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 a Recovery Auditor's review in one claim type

(e.g. all of a provider's inpatient rehabilitation claims reviewed or all inpatient hospital claims reviewed). *(Effective **January 1, 2016**)*

- At this time, CMS is not increasing the ADR limits for physicians. Physician ADR limits have not changed since **February 14, 2011**.
 - At this time, CMS is not increasing the ADR limits for DMEPOS providers and suppliers. DMEPOS provider and supplier ADR limits have not changed since **April 2013**.
 - The revised ADR limits 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.
- CMS is establishing ADR limits based on a provider's compliance with Medicare rules. Providers with low denial rates will have lower ADR limits while providers with high denial rates will have higher ADR limits. The ADR limits will be adjusted as a provider's denial rate decreases, resulting in the provider that complies with Medicare rules having less Recovery Audit reviews. *(Effective **January 1, 2016**)*
 - CMS is developing a Provider Satisfaction Survey. This survey would give providers an outlet to give feedback to CMS on the Recovery Auditors' performance. *(Completed **April 2016**)*
 - 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. *(Anticipated in the **FY 2015 Recovery Audit Program Report To Congress**)*
 - Recovery Auditors will have 30 days to complete complex reviews and notify providers of their findings, instead of the current 60 days. This provides more immediate feedback to the provider on the outcome of their reviews. Recovery Auditors will continue not to receive a contingency fee for those complex reviews that are not completed within the required timeframe. *(Effective **December 31, 2015**)*
 - 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. *(Effective **December 31, 2015**)*
 - Recovery Auditors must confirm receipt of a provider's discussion request or other written correspondence within three business days. *(Effective **December 31, 2015**)*
 - Changed to within one business day, under new contracts *(Effective **October 31, 2016**)*

- 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. *(Effective **December 31, 2015**)*
- 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. *(Effective **December 31, 2015**)*
- 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. *(Effective **October 31, 2016**)*