

RAC Program Improvements

The CMS is 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, including improved accuracy, less provider burden, and more program transparency. These changes will be effective with the next Recovery Audit Program contract awards.

Concern	Program Change
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 before sending the claim to the MAC for adjustment. Providers will not have to choose between initiating a discussion and an appeal.
Providers do not receive confirmation that their discussion request has been received.	Recovery Auditors must confirm receipt of a discussion request within three days.
Recovery Auditors are paid their contingency fee after recoupment of improper payments, even if the provider chooses to appeal.	Recovery Auditors must wait until the second level of appeal is exhausted before they receive their contingency fee.
Additional documentation request (ADR) limits are based on the entire facility, without regard to the differences in department within the facility.	The CMS is establishing revised ADR limits that will be diversified across different claim types (e.g., inpatient, outpatient).
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 require Recovery Auditors to adjust the ADR limits in accordance with a provider's denial rate. Providers with low denial rates will have lower ADR limits while provider with high denial rates will have higher ADR limits.