Medicare Fee-for-Service Recovery Audit Program
Additional Documentation Limits for Medicare providers (except suppliers and physicians)

Beginning April 15, 2013, the additional documentation requests (ADR) limits will follow the guidelines below:

A. The maximum request amount is per campus. The definition of campus is one or more facilities under the same Tax Identification Number (TIN) located in the same area (using the first three positions of the ZIP code). This is different than the definition used for provider-based status.

For example:

- Provider A has TIN 123456789 and two physical locations in ZIP codes 12345 and 12356; the two locations would count as one campus unit.

- Provider B has TIN 123456780 and is physically located in 12345 and 21345. Each location is counted separately. Each location has its own limit.

B. Each limit is based on the provider's Medicare claims volume from the previous calendar year.

C. In addition to a limit based on the Medicare claims volume, claim type will also factor into the limit. Recovery Auditors may select up to 75% of any claim type for review. A campus claim type could include acute hospital inpatient (IPPS), hospital outpatient (OPPS), skilled nursing facility (SNF), inpatient rehabilitation facility (IRF), inpatient psychiatric facility (IPF), ambulatory surgery center (ASC) or physician claims. The maximum from any single claim type would be 75% of the campus ADR limit and the remaining 25% can be requested from any or all other types. For example, if a provider has submitted IPPS, OPPS, IRF and physician claims, the Recovery Auditor may select up to a maximum of 75% of the calculated ADR from one of the claim types, and the balance of the calculated ADR may be selected from any single or combination of the remaining claim types.

D. The maximum number of requests per 45 days is 400.

- Providers with over $100,000,000 in MS-DRG payments will have a cap of 600.

E. Recovery Auditors may request up to 20 records per 45 days from providers whose calculated limit is 19 additional documentation requests or less.

F. The limit is equal to 2% of all claims submitted for the previous calendar year divided by 8. The Recovery Auditors may go more than 45 days between record requests but may not make requests more frequently than every 45 days. A provider's limit will be applied across all claim types, including professional services.

Note: Fiscal Year limits are based on all submitted claims (paid or denied). Interim/final bills and RAPs/final claims are considered one unit. For example:

- Provider C billed 156,253 claims last year, consisting of IPPS and OPPS claims. Two percent of the claims volume is 3,125. The limit is calculated by dividing 3,125 by 8. The provider's ADR is no more than 391 requests every 45 days. Because there is also a 75% limit on any particular claim type, only 294 IPPS claims may be selected for review. The difference of 97 requests may be selected from OPPS claims.

- Provider D billed 426,000 claims last year, consisting of IPPS, OPPS and IRF claims. Two percent of the claims volume is 8,520. The limit is calculated by dividing 8,520 by 8. This is equal to 1,065 requests per 45 days. Since their previous year MS-DRG payments exceed $100,000,000, the provider's ADR is limited to the maximum cap of 600 requests. Because there is also a 75% limit on any particular claim type, only 450 IPPS claims may be selected for review. The difference of 150 requests may be selected from OPPS and IRF claims.

G. For Skilled Nursing Facility (SNF) claims, one additional documentation request represents a beneficiary's entire episode of care. This includes medical records for all services rendered from the date of admission to the final date of discharge.

H. CMS may give the Recovery Auditors permission to exceed the limit. Permission to exceed the limit may occur by CMS's own initiative or from the Recovery Auditor requesting permission. CMS or the Recovery Auditor will notify affected providers in writing.

The table below summarizes changes to the additional documentation request limits; specific changes are noted in bold font:

Table 1 Additional Documentation Limits for Medicare providers

Old
Campus Concept
100% of any claim type
400 ADR cap /maximum every 45 days
• If >$100M annual MS-DRG payments, then 600 ADR cap
35 minimum record request
2% of Medicare claims volume
Exceptions allowed
New
Campus Concept
75% Limit on any particular claim type
400 ADR cap /maximum every 45 days
• If >$100M annual MS-DRG payments, then 600 ADR cap
20 minimum record request
2% of Medicare claims volume
Exceptions allowed

Questions concerning this update can be directed to RAC@cms.hhs.gov.