Attachment J-2

Statement of Work for the Recovery Audit Contractors
Participating in the Demonstration
(Non-Medicare Secondary Payer)
NO. 40700NMSPB

I. Purpose

The purpose of this contract will be to support the Centers for Medicare & Medicaid Services (CMS) in conducting a demonstration project in the states of California, Florida and New York using recovery audit contractors (RACs) to provide recovery audit services to identify underpayments and overpayments and/or recoup overpayments under the Medicare program for services for which payment is made under part A or B of title XVIII of the Social Security Act. CMS is utilizing this demonstration project to evaluate the use of recovery audit services in identifying and recouping overpayments determined during the post payment claim review process and in identifying and recovering Non-Medicare Secondary Payer (MSP) non beneficiary Group Health Plan (GHP) based overpayments. This demonstration project has been finalized in two Statement of Work packages. This package includes the requirements for RACs in identifying and recouping Non-Medicare Secondary Payer (MSP) non beneficiary Group Health Plan (GHP) based overpayments. Attachment J-1 includes the requirements for RACs in identifying and recovering MSP non-beneficiary GHP overpayments.

CMS envisions the following task:

1. Identifying **Medicare claims** through the post payment claims review process that contain non-MSP underpayments and overpayments for which payment was made under part A or B of title XVIII of the Social Security Act. This may NOT include identifying overpayments associated with non-MSP voluntary refunds.

    a. For each of these overpayments identified, the RAC SHALL attempt recoupment.

For any RAC-initiated overpayment that is appealed by the provider, the RAC shall provide support to CMS throughout the administrative appeals process and, where applicable, a subsequent appeal to the appropriate Federal court.

Note: Duplicate primary payments to providers (where both Medicare and another payer have made payment) are MSP recovery claims against the provider and are not within the scope of this SOW.

II. Background

Statutory Requirements

Section 306 of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA) requires the Secretary of Health and Human Services (the Secretary) to conduct a demonstration project for the Medicare population to demonstrate the use of RACs under the Medicare Integrity Program in identifying underpayments and overpayments and recouping overpayments under the Medicare program associated with services for which payment is made under part A or B of title XVIII of the Social Security Act.

CMS is required to actively review Medicare payments for services to determine accuracy and if errors are noted to pursue the collection of any payment that it determines was in error. To gain additional knowledge potential bidders may research the following documents:

- The Financial Management Manual, the Program Integrity Manual (PIM), and the Medicare Secondary Payer Manual (see www.cms.hhs.gov/manuals) published by CMS for use by CMS contractors,
- The Debt Collection Improvement Act of 1996
- The Federal Claims Collection Act, as amended and
- Related regulations found in 42 CFR.

III. 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 Statement of Work.

Task 1- Project Administration

A. Initial Meeting with PO and CMS Staff

The RAC's key project staff shall meet in Baltimore, Maryland with the PO and relevant CMS staff within two weeks of the date of award (DOA) 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 RAC will submit a formal project plan outlining the resources and time frame for completing the work outlined. It will

be the responsibility of the RAC to update this project plan as necessary during the course of the demonstration. In particular, the RAC will be responsible for notifying CMS when any changes in the project plan will affect the ability to complete tasks according to the agreed upon time frame. No changes shall be made to the project plan without prior approval from the PO.

B. Monthly Conference Calls

On a monthly basis the RAC'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 RAC 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.

C. Monthly Progress Reports

The RAC shall submit monthly administrative progress reports outlining all work accomplished during the previous month.

At a minimum, such reports shall cover the following items:

- Activities during the previous month:
    - For the identification of overpayment/underpayments and the collection of overpayments: underpayments and overpayments identified, overpayments demanded, overpayments disputed with status, "intent to refer" letters issued, overpayments collected in full, overpayments partially collected, overpayments resolved without collection (and the basis for resolution).
    - For the recovery of uncollectible non-MSP debts: debts collected in full, debts partially collected, debts resolved without collection (and the basis for resolution), reports on all other standard activities as described in the accepted proposal or as agreed upon by CMS and the RAC.
- Problems encountered and potential future problems including actual and possible delays in deliverables.
- Activities planned for the forthcoming month
- A brief discussion of substantive findings to date, if any

Each monthly report shall be submitted by the close of business on the fifth business day following the end of the month by email to the CMS PO and one copy accompanying the contractor's voucher that is sent to the CMS contracting officer.

D. RAC Database

CMS will provide a RAC Database to facilitate communication between the RACs, CMS, certain other contractors, and any other CMS-identified entity. CMS anticipates that the RAC Database will be a web-based application and that the RAC will connect to the RAC Database through a T1 line. CMS will provide user ID's/passwords to access the RAC Database. The RAC will be responsible for providing the appropriate equipment so that they can access the database.

Task 2- Identification of Non-MSP Overpayments

Identification of Non-MSP Medicare Overpayments and Underpayments

The RAC(s) shall pursue the identification of Medicare claims which contain non-MSP overpayments and underpayments for which payment was made or should have been made under part A or B of title XVIII of the Social Security Act.

A. Non-MSP Overpayments/Underpayments INCLUDED in this Statement of Work

Unless prohibited by Section 2B, the RAC may attempt to identify overpayments/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

The RAC may attempt to identify non-MSP overpayments/underpayments on claims (including inpatient hospital claims)—

- Appropriately submitted to carriers and intermediaries in California, Florida, and New York, or
- Appropriately submitted to DMERCs for services provided to beneficiaries with a primary residence in California, Florida, or New York.

B. Non-MSP Overpayments/Underpayments EXCLUDED from this Statement of Work

The RAC may NOT attempt to identify overpayments/underpayments arising from any of the following:

1. ***Services provided under a program other than Medicare Fee-For-Service***
   For example, RACs may NOT attempt to identify overpayments/underpayments in the Medicare Managed Care program, Medicare drug card program or drug benefit program.

2. ***Cost report settlement process***
   RACs may NOT attempt to identify underpayments and overpayments that result from Indirect Medical Education (IME) and Graduate Medical Education (GME) payments

3. ***Evaluation and Management (E&M) services that are incorrectly coded (CPT codes 99201-99499)***
   The RAC shall NOT attempt to identify overpayments/underpayments that result form a provider mis-coding the E&M service (e.g., billing for a level 4 visit when the medical record only supports a level 3 visit.). However, the RAC MAY attempt to identify overpayments/underpayments arising from:
   - E&M services that are not reasonable and necessary
   - violations of Medicare's global surgery payment rules even in cases involving E&M services

4. ***Claims paid or denied in the current fiscal year.***

   The RAC shall not attempt to identify any overpayment or underpayment in the current fiscal year. The RAC shall limit its work to claims paid in prior fiscal years.

5. ***Claims where the Medicare regulations indicate that the Medicare program does not have the authority to reopen claims***

   The RAC shall not attempt to identify any overpayment or underpayment more than 4 years past the date of the initial determination made on the claim. Any overpayment or underpayment inadvertently identified by the RAC after this timeframe shall be set aside. The RAC shall take no further action on these claims except to indicate the appropriate status code on the RAC Database.

6. ***Claims where the beneficiary is liable for the overpayment because the provider is without fault with respect to the overpayment***

   The RAC shall not attempt to identify any overpayment where the provider is without fault with respect to the overpayment. If the provider is without fault with respect to the overpayment, liability switches to the beneficiary. The beneficiary would be responsible for the overpayment and would receive the demand letter. The RAC may not attempt recoupment from a beneficiary. One example of this situation may be a service that was not covered because it was not reasonable and necessary but the beneficiary signed an Advance Beneficiary Notice.

Chapter 3 of the PIM and HCFA/CMS Ruling #95-1 explain Medicare liability rules. Without fault regulations can be found at 42 CFR 405.350 and further instructions can be found in Chapter 3 of the Financial Management Manual.

7. Random selection of claims

The RAC 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 RAC shall not use random review in order to identify cases for which it will order medical records from the provider. Instead, the RAC shall utilize data analysis techniques in order to identify those claims most likely to contain overpayments. This process is called "targeted review". The RAC 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 RAC to believe it is likely to contain an overpayment.

8. *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 RAC.

9. Prepayment Review.

The RAC shall identify Medicare overpayments and underpayments using the post payment claims review process. Any other source of identification of a Medicare overpayment or underpayment (such as prepayment review) is not included in the scope of this contract.

C. 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, CMS would like to avoid situations where the RAC and another Medicare contractor are working on the same claims. Therefore, the RAC Database will be used to by the RAC to determine if another entity already has the provider and/or claim under review. The RAC Database will include a master table of excluded providers and claims. This table will be updated on an as needed basis. Before beginning a claim review the RAC shall input the claim(s) into the RAC Database. If another entity has the provider and/or claim under review the RAC Database will notify the RAC. If the RAC Database does not inform the RAC that the provider and/or claim is under review the RAC may proceed with the review. As updates to the master table are received, the RAC Database will scan all current entries in the

database. If any exist that are now excluded the RAC will be notified through a report. will also The following contractors may input providers and/or claims into the master table for exclusion:

- o Part B physician or supplier claims: the carrier medical review unit for the state.
- o Part A claims (other than inpatient PPS hospital claims and long term care hospital claims): the intermediary medical review unit for the state.
- o Part A inpatient PPS hospital claims and long term hospital claims: the Quality Improvement Organization (QIO) for the state.
- o Durable Medical Equipment, Prosthetics, Orthotics and Supplies: the appropriate DMERC medical review unit or full PSC medical review unit for that state.

For the purposes of this SOW, these contractors will be called "affiliated contractors" or ACs.

The AC will only identify the claim as not available for review for the following reasons: 1) the AC has an ongoing postpay review on the claim, 2) the AC previously made a prior authorization determination on the claim, 3) the AC previously requested the medical record associated with the claim, or 4) the AC previously issued a full or partial denial for the claim. CMS will instruct ACs that once a claim is identified as available, the AC may not begin a postpayment medical review case on similar claims (i.e., same provider, same services). CMS policy is that the first organization to identify the overpayment gets to develop the case.

2. ***Preventing RAC overlap with contractors, CMS, OGC, DOJ, OIG and/or other law enforcement entities performing potential fraud reviews.***

CMS must ensure that RAC activities do not interfere with potential fraud reviews being conducted by Benefit Integrity (BI) Program Safeguard Contractors (PSCs) or DMERC BI units or with potential fraud investigations being conducted by law enforcement. Therefore, RACs shall input all claims into the RAC Database before attempting to identify or recover overpayments. (The master table described above will be utilized.) The following contractors may input providers and/or claims into the master table for exclusion:

- o The BI PSC for the state and/or
- o The DMERC BI unit with claims jurisdiction for beneficiaries residing in the state

For the purposes of this SOW, these contractors will be called "BI contractors."

(See Task 7, section F regarding how BI contractors or CMS can recall cases at any time.) CMS policy is that the BI contractor's (and law enforcement's) needs take precedence over the RAC's desire to pursue a case.

D. Obtaining and Storing Medical Records for non-MSP reviews

Whenever needed for non-MSP reviews, the RAC may obtain medical records by going onsite to the provider's location to view/copy the records or by requesting that the provider mail/fax the records to the RAC. If the RAC attempts an onsite visit and the provider refuses to allow access to their facility, the RAC may not make an overpayment determination based upon the lack of access. Instead, the RAC shall request the needed records in writing.

1. ***Paying for medical records***

   a. *RACs* <u>*shall*</u> *pay for medical records.*

      Should the RAC request medical records associated with:
      - an acute care inpatient prospective payment system (PPS) hospital (DRG) claim,
      - a Long Term Care hospital claim,

      the RAC shall pay the provider for producing the records in accordance with the current formula or any applicable payment formula created by state law. (The current per page rate is: medical records photocopying costs at a rate of $.12 per page for reproduction of PPS provider records and $.15 per page for reproduction of non-PPS institutions and practitioner records, plus first class postage. Specifically, hospitals and other providers (such as critical access hospitals) under a Medicare cost reimbursement system, receive no photocopying reimbursement. Capitation providers such as HMOs and dialysis facilities receive $.12 per page. The formula calculation can be found at 42 CFR §476.78(c). All changes to the formula calculation or rate will be published in the Federal Register.)

   b. *RACs* <u>*may*</u> *pay for medical records.*

      Should the RAC 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 RAC may (but is not required to) pay the provider for producing the record using any formula the RAC desires.

2. ***Updating the Case File***

The RAC shall indicate in the case file (See Task 7, section H for additional case record maintenance instructions.)

- o A copy of all request letters,
- o Dates of any calls made, and
- o Notes indicating what transpired during the call.

3. ***Assessing an overpayment for failing to provide requested medical record.***

Pursuant to the instructions found in PIM 3.10 and Exhibits 9-12, the RAC may find the claim to be an overpayment if medical records are requested and not received within 45 days. Additional letters/calls are at the discretion of the RAC.

4. ***Storing and sharing medical records***

The RAC must make available to all ACs, CMS, OIG, (and others as indicated by the PO) any requested medical record.

a. *Storing and sharing PAPER medical records*

Should the RAC choose to store and share paper medical records upon request, they shall:

- o Store medical record NOT associated with an overpayment for 1 year,
- o Store medical records associated with an overpayment for duration of the contract,
- o Send the copy via mail or fax within 10 calendar days of the request
- o 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 RAC Database will not be available for this purpose.

b. *Storing and sharing IMAGED medical records*

Should the RAC choose to store and share imaged medical records, they shall:

- o Provide a document management system that meets the requirements outlined in Appendix 1
- o 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 RAC Database will not be available for this purpose.

Upon the end of the demonstration or contract, the RAC shall send copies of the imaged records to the contractor specified by the PO.

E. Coverage and/or Correct Coding Review Process

1. Coverage Criteria.

The RAC shall consider a service to be covered under the Medicare program if it meets all of the following conditions:

a. It is included in one of the benefit categories described in Title XVIII of the Act;

b. It is not excluded from coverage on grounds other than 1862(a)(1); and

c. It is reasonable and necessary under Section 1862(a)(1) of the Act.

2. Minor Omissions.

The RAC shall not make denials on minor omissions such as missing dates or signatures.

3. Medicare Policies and Articles.

The RAC shall comply with all National Coverage Determinations (NCDs), Coverage Provisions in Interpretive Manuals, national coverage and coding articles, local coverage determinations (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 Database (www.cms.hhs.gov/mcd). Coverage Provisions in Interpretive Manuals can be found in various parts of the Medicare Manuals. In addition, the RAC shall comply with all relevant joint signature memos forwarded to the RAC by the project officer.

4. ***Internal Guidelines.***

   As part of its process of reviewing claims for coverage and coding purposes, the RAC may (but is not required to) develop detailed written review guidelines. For the purposes of this SOW, these guidelines will be called "Internal Guidelines." Internal Guidelines, in essence, will allow the RAC to operationalize carrier and intermediary LCDs and NCDs. Internal Guidelines shall specify what information should be reviewed by reviewers and the appropriate resulting determination. The RAC need not hold public meetings or seek public comments on their proposed internal guidelines. However, they must make their Internal Guidelines available to CMS, ACs, BI contractor and the public upon request. Internal Guidelines shall not create or change policy.

5. ***Administrative Relief from Review in the Presence of a Disaster.***

   The RAC shall comply with PIM 3.2.2 regarding administrative relief from review in the presence of a disaster.

6. ***Evidence.***

   The RAC shall only identify a claims overpayment where there is supportable evidence of the overpayment. There are two primary ways of identification:
   a) Through “automated review” of claims data without human review of medical or other records; and
   b) Through “complex review” which entails human review of a medical record or other documentation.

7. ***Automated Coverage/Coding Reviews.***

   The RAC shall use automated review only in situations where there is certainty that the services is not covered or incorrectly coded, was a duplicate payment or other claims related overpayment. An automated review may only be performed if the requirements of PIM 3.5.1 are met. For example, if the National Coverage Determination (NCD) or Local Coverage Determination (LCD) states that the service is never considered reasonable and necessary for people with condition X, the RAC may identify this overpayment via an automated review. On the other hand, if the NCD states that the service is rarely considered reasonable and necessary for people with condition X, the RAC shall conduct a complex review in order to determine if an overpayment exists.

8. ***Complex Coverage/Coding Reviews.***

   The RAC shall use complex medical review in situations where the requirements of PIM 3.5.1 are not met. Complex medical review is used in situations where there is a high probability (but not certainty) that the service is not covered and copies of medical records will be needed to provide support for the overpayment.

F. Activities Following Review

1. Rationale for Determination.

The RAC shall document the rationale for the determination. This rationale shall list the review findings including a description of the Medicare policy or rule that was violated and a statement as to whether the violation a) resulted in an overpayment or b) did not affect payment.

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

a. Storing and sharing PAPER rationale documents

Should the RAC choose to store and share review rationale documents in paper format, they shall:

- Store rationale documents NOT associated with an overpayment for 1 year,
- Store rationale documents associated with an overpayment for the duration of the contract,
- Send the copy via mail or fax within 10 calendar days of the request
- Maintain a log of all requests for rationale documents indicating at least the requester, a description of the rationale being requested, the date the request was received, and the date the request was fulfilled. The RAC Database will not be available for this purpose.

c. *Storing and making available IMAGED rationale documents*

Should the RAC choose to store and make available imaged rationale documents, they shall:

- Provide a document management system that meets the requirements outlined in Appendix 1,
- Store rationale documents NOT associated with an overpayment for 1 year,
- Store rationale documents associated with an overpayment for the duration of the contract,

- Maintain a log of all requests for rationale documents 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 RAC Database will not be available for this purpose.

Upon the end of the demonstration or contract, the RAC shall send copies of the imaged rationale documents to the contractor specified by the PO.

2. *Communication with Providers about Non-MSP Cases*

a. *Automated review.*

The RAC shall communicate to the provider the results of each automated review that results in an overpayment determination. The RAC shall inform the provider of which coverage/coding/payment policy or article was violated. The RAC need not communicate to providers the results of automated reviews that do not result in an overpayment determination. The RAC shall record the date and format of this communication in the RAC Database.

b. *Complex review.*

The RAC shall communicate to the provider the results of every complex review (i.e., every review where a medical record was obtained), including cases where no overpayment was identified. In cases where an overpayment was identified, the RAC shall inform the provider of which coverage/coding/payment policy or article was violated. The RAC shall record the date and format of this communication in the RAC Database.

3. *Determine the Overpayment Amount on Non-MSP Cases*

a. *Full denials*

A full denial occurs when the RAC determines that:

i. The submitted service was not reasonable and necessary and no other service would have been reasonable and necessary, or
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 RAC 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).

In these cases, the RAC must determine the level of service that was reasonable and necessary or represents the correct code for 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 AC. Once the AC completes the claim adjustment, the AC will notify the RAC through the RAC Database (Or another method instructed by CMS) of the overpayment amount. The RAC shall then proceed with recovery. The RAC can only collect the difference between the paid amount and the amount that should have been paid.

c. Extrapolation.

Follow the procedures found in PIM 3.10 and Exhibits 9-12, as well as MMA Section 935(a), regarding the use of extrapolation.

d. Recording the Overpayment Amount in the RAC Database

The RAC shall update the RAC Database with:

- The overpayment amount for each claim in question
- Line level claim detail with overpayment/underpayment amounts;
- The date of the original demand, any subsequent demand and the DCIA intent to refer letter;
- The applicable interest rate;
- Collection detail and/or document adjustments due to valid documented defenses to the overpayment.

Once an overpayment is identified, the RAC shall proceed with the Recovery of Medicare Overpayments.

G. Potential Fraud

The RAC shall report instances of potential fraud immediately to the BI contractor via the RAC Database. The RAC must review all entries made by the BI contractor

into the RAC Database on a daily basis to see if the BI contractor has recalled any cases. (If possible, the RAC Database will create a report to assist the RAC in determining if any new recalled cases exist and if any of them are being worked by the RAC.) (See Task 7 section F on recalled cases)

Task 3- Non-MSP Underpayments

Upon identifying an underpayment, normally through an automated review, the RAC will update the RAC Database (Or another method instructed by CMS) with the claim and the underpayment status code. On a monthly basis the RAC shall submit a report to the PO listing all underpayments the RAC identified during the month. All documentation supporting the underpayment determinations shall be attached to the report. The report and supporting documentation shall be characterized so that a reviewer could easily determine what documentation goes with what underpayment determination. The PO will maintain a file and then forward relevant Medicare underpayment information to the appropriate AC or instruct the appropriate AC to proceed with the underpayment determination.

Task 4- Recoupment of Non-MSP Overpayments

The RAC(s) will pursue the recoupment of non-MSP Medicare overpayments that are identified through Task 2. The recovery techniques utilized by the RAC shall be legally supportable. The recovery techniques shall follow the guidelines of all applicable CMS regulations and manuals as well as all federal debt collection standards. Some guidelines specific to CMS include, but are not limited to, 42 CFR, the Debt Collection Improvement Act of 1996, and the Federal Claims Collection Act, as amended. The RAC is required to follow the manual guidelines in the Medicare Financial Management Manual, Chapter 3 & 4, as well as instructions in CMS One Time Notifications and Joint Signature Memorandum unless otherwise instructed in this statement of work or specifically agreed to by the PO.

CMS utilizes a threshold for the recovery of overpayments to physicians and suppliers for **non-MSP** Part B or DME claims. This threshold is $10.00. The RAC shall not demand or attempt recoupment on a **non-MSP** overpayment for a Part B service to a physician or supplier if the amount is less than $10.00. Overpayments may be aggregated to meet the $10.00 threshold. CMS does not utilize a threshold for the recovery of overpayments for non-MSP Part A claims.

A. Demand Letter

After identification, the first recovery step taken by the RAC shall be the issuance of a written demand letter. Non-MSP demand letter(s) shall include all necessary information specified in the Medicare Financial Management Manual, Chapter 4, section 20 and section 90 (unless specifically excluded in this statement of work). The CMS Project Officer shall approve a sample demand letter before any demand letters can be sent.

B. Recoupment through Current and/or Future Medicare Payments

Medicare utilizes recoupment, as defined in 42 CFR 405.370 to recover a large percentage of all Medicare provider overpayments. "Recoupment" as defined in 42 CFR 405.370 is the recovery by Medicare of any outstanding Medicare debt by reducing present or future Medicare provider payments and applying the amount withheld to the indebtedness. Non-MSP overpayments identified and demanded by the RAC will also be subject to the existing withhold procedures. The existing withhold procedures can be found in the Medicare Financial Management Manual, Chapter 4, section 40.1. The withhold of present and/or future payments will occur by the appropriate Medicare FI or Carrier. These withhold procedures will be used for all non-MSP provider overpayments.

Once payments are withheld, the withhold remains in place until the debt is satisfied in full or alternative payment arrangements are made. As payments are withheld they are applied against the oldest outstanding overpayment. The debt receiving the payments may or may not have been determined by the RAC. All payments are first applied to interest and then to principal. Interest accrues from the date of the demand letter and in accordance with 42 CFR 405.378.

The RAC will receive a contingency payment, as stated in the Payment Methodology attachment, for all amounts recovered from the withhold of present and/or future payments that are applied to the principal amount identified and demanded by the RAC.

The RAC should not stop recovery attempts strictly because recoupment of the overpayment through current and/or future Medicare payments is being attempted. Outside of the first demand letter and the Intent to Refer demand letter and the offset process, the RAC can determine the recovery methods they choose to utilize. See the Medicare Financial Management Manual, Chapter 4 §20 and §90 for minimum requirements of the Medicare Fiscal Intermediaries and Carriers. All recoupment methods shall be explained in the bidder's proposal.

C. Repayment Through Installment Agreements

The RAC shall offer the provider the ability to repay the overpayment through an installment plan. The RAC shall have the ability to approve installment plans up to 12 months in length. If a provider requests an installment plan over 12 months in length the RAC shall forward a recommendation to the appropriate regional office. The regional office will review the case and if the recommended installment plan is over 36 months in length, the regional office will forward the recommendation to Central Office for approval. The RAC shall not deny an installment plan request. However, the RAC may recommend denial. All recommended denials shall be forwarded to the appropriate regional office for review. If necessary the regional office will request Central Office

assistance. If an installment plan requires assistance from the Regional or Central Office, the package shall include all documents listed in the Medicare Financial Management Manual, Chapter 4, Section 50.3. When reviewing all installment agreements the RAC shall follow the guidelines in section 1893(f)(1) of the Social Security Act as amended by section 935(a) of the Medicare Prescription Drug, Improvement and Modernization Act of 2003.

The RAC will receive a contingency payment based on the principal amount of each installment payment. As the provider submits monthly payments, the RAC shall receive the applicable contingency payment for the principal amount received.

D. Referral to the Department of Treasury

The Debt Collection Improvement Act of 1996 (DCIA) requires federal agencies to refer eligible delinquent debt to a Treasury designated Debt Collection Center for cross servicing and further collection activities, including the Treasury Offset Program. CMS is mandated to refer all eligible debt, over 180 days **delinquent**, for cross servicing.

Per DCIA referral criteria, “delinquent” is defined as debt: (1) that has not been paid (in full) or otherwise resolved by the date specified in the agency’s initial written notification (i.e., the agency’s first demand letter), unless other payment arrangements have been made, or (2) that at any time thereafter the debtor defaults on a repayment agreement.

Debts ineligible for referral include:

- Debts in appeal status (pending at any level);
- Debts where the debtor is in bankruptcy;
- Debts under a fraud and abuse investigation if the contractor has received specific instructions from the investigating unit (i.e., Office of Inspector General or Office of General Counsel, etc.) not to attempt collection;
- Debts in litigation (“litigation” means litigation which involves the federal government as a party; it does not include litigation between the debtor and some party other than the federal government);
- Debts where the only entity which received the last demand letter is the employer and the employer is a Federal agency (MSP debts only);
- Debts where the debtor is deceased;
- Debts where CMS has identified a specific debt or group of debtors as excluded from DCIA referral (MSP debts only);
- Debts where there is a pending request for a waiver or compromise;
- Debts less than $25.00 (for non-MSP this amount is principal only; for MSP this amount is principal and interest);
- Debts of $100 or less where no TIN is available.

The RAC shall issue a written notification to the debtor with the appropriate intent to refer language within a time frame that allows for the RAC to issue an appropriate reply to all timely responses to the "intent to refer" letter before the debt is 130 days **delinquent**. All outstanding debts remaining unresolved and not under a non-delinquent installment agreement must be sent to the affiliated contractor for referral to Treasury on or before they are 130 days delinquent. The intent to refer language can be found in the Medicare Financial Management Manual, Chapter 4, Section 70 for non-MSP. The RAC is required to cease all recovery efforts once the debt is referred to the Department of Treasury. The AC will prepare the case for referral and will notify the RAC, through the RAC Database when the debt is referred. Once the overpayment referred is it is no longer the responsibility of the RAC. However, the RAC shall receive a lesser contingency payment as identified in the Payment Methodology Scale if Treasury is able to fully or partially collect the overpayment. This fee will be a percentage of the principal amount recovered after deduction for fees that must be paid to Treasury.

E. Compromise and/or Settlement of Overpayment

The RAC shall not have any authority to compromise and/or settle an identified or possible non-MSP overpayment. If a debtor presents the RAC with a compromise request, the RAC shall forward the overpayment/MSP recovery claim case and all applicable supporting documentation to the CMS PO for direction. The RAC must include its recommendation on the request and justification for such recommendation. If the debt is greater than $100,000, the package must include a completed Claims Collection Litigation Report (CCLR). If the provider presents the RAC with a settlement offer or a consent settlement request, the RAC shall forward the overpayment case and all applicable supporting documentation to the CMS PO for direction. If CMS determines that a compromise and/or settlement is in the best interests of Medicare, the RAC shall receive a contingency payment for the portion of principal that was recouped, providing that the RAC initiated recoupment by sending a demand letter prior to the compromise and/or settlement offer being received.

F. Voluntary/Self-Disclosure of Non-MSP Overpayments by the Provider

If a provider voluntarily self-discloses a non-MSP overpayment after the RAC issues a demand letter or a request for medical record, the RAC 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-disclosed overpayment must be in the RAC's most recently approved project plan.

- If the provider self-discloses this kind of case to the RAC, the RAC shall document the case in its files and databases, and forward the check to the appropriate Medicare contractor.
- If the provider self-discloses this kind of case to the Medicare contractor, the Medicare contractor will notify the RAC within 5 calendar days and will forward the case file (minus the check) to the RAC within 10 calendar days. The RAC will document the case in its files and databases.

The RAC shall cease recovery efforts for the claims involved in the self-disclosure immediately upon becoming aware (i.e., when the RAC is notified by the Medicare contractor, the provider, etc.)

If a provider voluntarily self-discloses a non-MSP overpayment, and the self-disclosed overpayment does NOT involve the same types of services for which the RAC had issued a demand letter or a request for medical records, then the RAC is not entitled to a contingency fee amount.

- If the provider self-discloses this kind of case to the RAC and forward the check to the appropriate Medicare contractor.
- If the provider self-discloses this kind of case to the Medicare contractor, the RAC need take no action.

The RAC may continue recovery efforts since the provider self- disclosure involved a different provider/service combination.

<u>Unsolicited/Voluntary Refunds (by check or claims adjustment, including those due to credit balances</u>) -- Occasionally the AC may receive an unsolicited/voluntary refund from a provider An unsolicited/voluntary refund is a refund that is submitted to the AC 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 AC. By definition, an unsolicited/voluntary refund (by check or by claims adjustment) must occur before a demand letter is issued. The RAC shall not receive any contingency payment on an unsolicited/voluntary refund.

G. Recoupment During the Appeals Process

This section is applicable only to non-MSP provider overpayments and MSP non-beneficiary GHP uncollectible debt. There is no formal administrative appeals process for employer, insurer/third party administrator, or workers' compensation carrier debt although the RAC must respond timely and appropriately to all debtor communications, including payment by check. Additionally the RAC 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.

The RAC shall ensure that all demand letters initiated as a result of an identified overpayment in Task 2 contain provider appeal rights, where applicable.

If a provider files an appeal with the appropriate entity within the appropriate timeframes, the RAC shall follow Section 1893(f)(2) of the Social Security Act as amended by section 935(a) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 regarding the limitation on recoupment.

Once the RAC is notified of the appeal request, the RAC shall cease all recovery efforts. If a provider instructs the RAC that it has filed an appeal, the RAC shall cease recovery efforts and confirm the appeal request with the CMS Project Officer or its delegate. After the reconsideration level of the appeal process (completed by the Qualified Independent Contractor (QIC)) is adjudicated (or the first level of appeal if the QIC reconsideration process has not been implemented yet), the RAC shall resume recovery efforts if the decision was against the provider.

The aging of the provider overpayment for debt referral purposes will cease while recovery efforts are stopped during the appeal process. Interest shall continue to accrue, from the date of the demand letter, throughout the appeals process.

G. Interest

For non-MSP debt -- Regulations regarding interest assessment on determined non-MSP Medicare overpayments and underpayments can be found at 42 CFR 405.378. Interest will accrue from the date of the final determination and will either be charged on the overpayment balance or paid on the underpayment balance for each full 30-day period that payment is delayed. The interest rate in effect on the date of final determination is the rate that will be assessed for the entire life of the overpayment. When payments are received, payments are first applied to any accrued interest and then to the remaining principal balance. Contingency fees are based upon the principal amounts recovered. All payments are applied to interest first, principal second.

H. Customer Service

The RAC 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 RAC is conducting the demonstration in California the customer service number shall be staffed from 8:00am to 4:30pm Pacific standard time. 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 Project Officer before use.

The staff answering the customer service lines shall be knowledgeable of the demonstration. The staff shall have access to all identified non- overpayments and shall be knowledgeable of all possible recovery methods and the appeal rights of the provider (for provider debts). If need be, the staff person responsible for that overpayment shall return the call within 1 business day. The RAC 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.

The RAC shall respond to written correspondence within 30 days of receipt. The RAC shall provide the CMS Project Officer with copies by fax and mailed hard copy, of all correspondence indicating displeasure in the demonstration, in the overpayment identification, or in the recovery methods utilized, within ten (10) calendar days of receipt of such correspondence. (If the RAC is not sure how the correspondence will be interpreted, it should forward the correspondence to the CMS Project Officer.)
The RAC shall provide remote call monitoring capability to CMS personnel in Baltimore. The RAC's phone system must notify all callers that the call may be monitored for quality assurance purposes.

The RAC shall retain a written report of contact for all telephone inquiries.

Task 5- Supporting Identification of Non-MSP Overpayment 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 RAC, the RAC shall assist CMS with support of the overpayment determination throughout all levels of the appeal. This includes providing supporting documentation 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 RAC. This third party may be the current Medicare contractor, a third party contractor identified by CMS, a Qualified Independent Contractor, 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 RAC 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 RAC shall contact the CMS PO within one business day of receipt for assistance. If the RAC receives a verbal request for appeal from a provider, the RAC 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 RAC and the CMS PO of the appeal request and the outcome of each applicable appeal level through the RAC Database. The update to the RAC Database shall occur within 5 business days of learning of the appeal request and/or decision.

Additionally the RAC 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.

<u>Task 6a- Reporting of Identified, Demanded and Collected Medicare Non-MSP Overpayments and Identified Medicare Non-MSP Underpayments</u>

The RAC will be required on a monthly basis to provide the CMS PO or its delegate with detailed information concerning non-MSP overpayments and underpayments that have been identified, overpayments that have been demanded and overpayments that have been fully or partially collected. At CMS discretion, these figures supplied by the RAC shall be incorporated into the financial statements prepared by CMS. The RAC 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. CMS will supply the RAC with the correct format for the reporting no later than 15 calendar days after the first recovery efforts have begun.

<u>Database Reporting of Possible/Identified Non-MSP</u>

CMS plans to utilize a database to house information on potential and outstanding non-MSP overpayments under the RAC realm of responsibility. This database will store outstanding overpayment data, determination dates, principal and interest amounts, the status of the overpayment and will allow CMS to prepare detailed and/or summary reports from various data included in the database.

At least 15 days prior to the beginning of the identification process begins, each RAC will receive a training manual for the database that will be utilized by CMS for this demonstration project. In addition to the training manual, CMS will conduct training on the applicable system. This training will be completed by teleconference, video-conference or onsite at CMS or the RAC site at least 15 days prior to the beginning of the first identification and recovery efforts.

Contractors will be required to either manually or electronically enter the following types of information into the database:

*Universe of potential overpayments (electronic file update if possible)

*Manual update of status code when approval to request medical records is needed, when various demand letters are sent, when claim adjustments are needed…

<u>Task 6b Other Systems Created by RAC</u>

The RAC is free to utilize a subsequent system in addition to RAC Database provided by CMS. Any subsequent system shall not take the place of the RAC Database.

All reports generated from an alternative system shall be converted to Microsoft Excel 2000 prior to submission to the CMS Project Officer.

Task 7 – Administrative and Miscellaneous Issues

A. Administrative Functions

Once the RAC has identified a non-MSP overpayment, the RAC shall send the debtor a demand letter as indicated in Task 4A. This demand letter shall request that the debtor submit payment in full. Payments shall be sent to the appropriate third party contractor or lockbox. CMS will instruct the RACs of the applicable payment address. (CMS plans, if possible, to have a separate address/lockbox for all overpayments demanded by the RAC.) At CMS discretion, CMS may utilize a third party contractor to process the administrative functions for the non-MSP overpayments and underpayments determined by the RAC. This may include the financial reporting of the receivable, any claims adjustments necessary to ensure an accurate claims history, the appeal process, depositing the refund check and initiating offset. The RAC shall have no rights in the selection of a third party contractor to process the administrative functions if CMS elects to utilize such a third party contractor. The RAC shall interact cooperatively with the third party contractor on an as-needed basis.

B. Separate reporting

If a single entity is awarded a single contract that includes more than one of the four major tasks identified in section I of this SOW, the reporting and data for each of those for major tasks must be kept separate.

C. Payment Methodology

All payments shall be paid only on a contingency fee basis and shall be based on the principal amount of the collection.

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 RAC shall not receive any payments for the identification of the non-MSP overpayments or underpayments.

- 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.)

- For a RAC for the identification of non-MSP overpayment and underpayments and the recovery of non-MSP overpayments:

  - ❖ The RAC shall be paid a percentage of the amount that is collected through its recovery efforts. A RAC's recovery efforts are defined as a recoupment received through a demand letter or telephone call or some other form of contact through a check from the provider. Recoupment by offset shall not be considered a RAC recovery effort for the purposes of establishing the contingency percentage to be paid.

- The RAC shall receive 50% of the agreed upon contingency percentage for any of the following recovery efforts:

  - ❖ Recovery efforts accomplished through the offset process of a fiscal intermediary or carrier.

  - ❖ Recovery efforts accomplished through Treasury offset or another collection vehicle after the debt is referred to the Department of Treasury.

  - ❖ Recoveries made through a self-disclosure made by a provider in result of a prior RAC identified request for medical records or demand letter. Self-disclosed service and time period must be included in the RAC's project plan.

- If a provider files an appeal disputing the non-MSP overpayment determination and the appeal is adjudicated in the provider's favor at the first level, the RAC shall repay Medicare the contingency payment for that recovery. If the appeal is adjudicated in the agency's favor at the first level, the RAC shall retain the contingency payment for that recovery. Subsequent appeals, after the first level of appeal, will not affect the RAC's ability to retain the contingency payment. (The first level of appeal is currently a reconsideration for Part A providers and either a carrier review or a carrier hearing for Part B and DMERC providers. At some point during the demonstration, final regulations will be released, which will change the appeal process for all Medicare providers. The first level of appeal may change to a redetermination for all Medicare providers or to a reconsideration for all Medicare overpayments. This change will not negatively impact the payment methodology for the RACs.)

D. Geographic Location of Demonstration

The claims being analyzed for this award will be claims from providers with originating addresses in New York, California and Florida (or debts associated with claims, as

applicable) appropriately submitted to carriers and intermediaries in New York, California and Florida and claims (or debts associated with claims, as applicable) submitted to a DMERC for a beneficiary with a primary residence in New York, California or Florida.

E. Point of Contact for RACs

The primary point of contact for the RACs shall be the CMS PO or his/her delegate.

For non-MSP, the RACs and current Medicare Contractors shall communicate via the RAC Database discussed in Task 6. This includes all communication related to requests for medical records, fraud investigation, appeal, offset and claim adjustments. Any necessary communications other than through the RAC Database, shall be forwarded to the CMS PO who will facilitate any possible discussions with the appropriate Medicare contractor. The CMS PO shall be copied on all correspondence, email or written, between the RAC and the current Medicare contractor.

F. Data Accessibility

CMS shall provide the RAC with one data file of all claims in the appropriate geographic area. The RAC will be able to update this file on a monthly basis. The data file format, data fields available and user agreements can be found at http://www.cms.hhs.gov/data/order/identifiable.asp#safs**.**

Any additional data requests will be subject to the normal fees charged by CMS. The RAC shall follow the normal CMS procedures for requesting additional data. The RAC shall pay for 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 RAC shall pay for all charges associated with the storage and processing of any data necessary to accomplish the demonstration. The RAC shall establish and maintain back-up and recovery procedures to meet industry standards. The RAC shall comply with all CMS privacy and security requirements. The RAC shall provide all personal computers, printers and equipment to accomplish the demonstration throughout the contract term.

G. Recalled Cases

CMS may determine that a non-MSP case or a particular uncollectible debt should be handled by CMS staff and may recall the case/debt for that reason. Should CMS recall a case/debt, the RAC shall immediately stop all activities on the case/debt identified by CMS for recall and return the case/debt and all related information to CMS within one (1) business day of the recall request.

The RAC shall receive no payment, except for monies already recouped, for recalled cases.

A BI PSC or BI Unit of a DMERC may determine that overpayment identification or recoupment action on a case should cease and may recall the case for that reason. Should the BI PSC/unit recall a case, the RAC shall immediately stop all activities on the case identified by the BI PSC/unit for recall. The RAC shall receive no payment, except for monies already recouped for recalled cases.

All requests for recall shall be forwarded to the CMS PO for concurrence. CMS and the BI PSC or BI Unit of a DMERC shall have a valid reason for the recall of the case. If there is a dispute, the CMS PO shall make the final decision concerning the recall of the case.

H. Case Record Maintenance

The RAC shall maintain a case file for every Non-MSP overpayment 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, including demand letters, a telephone log for all conversations with the provider/insurer/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). For non-MSP, 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 contract termination, the RAC shall return to CMS all case files stored in accordance with CMS instructions. Once a non-MSP overpayment or underpayment is determined, all documentation shall be kept in the case file. The RAC 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.

I. Recovery Deposits

The demand letters issued by the RAC will instruct debtors to forward their refund checks to the appropriate address which will be specified by CMS at a later date. All refund checks shall be payable to the Medicare program. If the RAC receives a refund check, the RAC shall forward the check to the appropriate address. Before forwarding the check, the RAC shall make copies of and otherwise document these payments. A copy shall be included in the appropriate overpayment case file.

J. Submit a List of Claims Adjustments

In order to maintain an accurate claims history for the beneficiary, the appropriate claims adjustment, if necessary, must be made once an overpayment is determined. The RAC, however, will not have access to the claims processing system utilized by Medicare. To enable the claims history updates to occur, the RAC shall forward the claim to the appropriate Medicare contractor. (This may occur through the RAC Database or through

another method instructed by CMS.) The appropriate Medicare contractor will perform the claim adjustment and relay the overpayment amount, if necessary, back to the RAC. The Medicare contractor will be instructed to complete the claim adjustment within 5 calendar days of the RAC notifying the Medicare contractor. Once the claim adjustment is completed, the beneficiary will receive a Medicare Summary Notice notifying them of the adjustment. Any customer service inquiries to the current Medicare contractor shall be forwarded to the appropriate RAC, if necessary. CMS will provide the RAC with the format for reporting the claim adjustments prior to the beginning of the identification process.

K. Support OIG or Other Audits

Should the OIG, CMS or a CMS authorized contractor choose to conduct an audit of the RAC, the RAC shall provide workspace and produce all needed reports and case files within 1 business day of the request.

L. Public Relations & Outreach

The initial project plan shall include a section covering public relations and outreach. CMS, through the Medicare fiscal intermediaries and carriers, will announce the use of the RACs in the specified geographic area. CMS will also post a notice regarding this effort on its COBC website and on the CMS website for Medicare Secondary Payer Debt Collection and Referral FAQs. All other debtor education and outreach (or beneficiary education for efforts involving follow-ups to the MSP IEQ) concerning the use of RACs will be the responsibility of the RAC. The RAC shall only educate providers on their business, their purpose and their process. The RACs shall **not** educate providers on Medicare policy. The CMS PO shall approve all presentations and written information shared with the provider, beneficiary, and/or other debtor communities before use. If requested by CMS, the RACs project manager for the demonstration, at a minimum, shall attend any provider group or debtor group meetings or congressional staff information sessions where the services provided by the recovery audit contractors are the focus.

Task 8 Final Report

The final report shall include a synopsis of the entire demonstration 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 demonstrations, as well as any advantages or disadvantages encountered. From a contractor point of view, the final report should determine if the demonstration was a success or a failure and provide support for either opinion.

Attachment J-2

A final report shall be delivered to the CMS PO in the three formats (paper/electronic) as stated below and in the required "electronic" formats to the *fnlrpts@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 Markup Language (HTML), and in Microsoft Word 2000 [for text] or Microsoft Excel [for tables]. Data tables must be in HTML and PDF formats as well. Charts and graphs must be in Graphical Interchange Format. Data files (spreadsheets, databases) must be made available primarily as comma-delimited or flat files, with proprietary file formats (Excel, Access) available as alternative downloads. Documents submitted in PDF must be prepared using Adobe Acrobat 5.0 (or subsequent versions) to assure compliance with the requirements of Section 508 (Rehabilitation Act) when placed on CMS's Web site. More detailed guidelines for creation of internet-ready content are available on CMS's Web site at *http://www.cms.gov*. (The Final Report shall conform to CMS's Author's Guidelines: Grants and Contracts Final Reports—http://www.cms.gov/research/author4.pdf.) In addition, the contractor shall provide a 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.

Attachment J-2

SCHEDULE OF DELIVERABLES

The contract awardee shall provide the necessary personnel, materials, equipment, support, and supplies to accomplish the tasks shown below in the specified time. The contract awardee 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 project officer (PO) subject to the PO's approval.

Written documents for this project shall be delivered in hard copy to the project officer (2 copies), unless otherwise specified. These documents shall also be delivered to the Project Officer in an electronic version via email or a 3.5-inch diskette. At present, the CMS standard is Microsoft Word 2000 and Microsoft Excel 2000. This is subject to change, and the contractor shall be prepared to submit deliverables in any new CMS standard.

Task Number	Deliverable Number	Deliverable	Due Date (from contract award date)
1.a.	1	Initial Meeting	2 weeks
1.a.	2	Project Plan	4 weeks
1.b.	3	Monthly Conference Calls	Monthly
1.c.	4	Monthly Progress Reports	Monthly
2.	5	Requests for Medical Records	Bi-weekly or at least monthly (non-MSP identification of overpayments and underpayments and recovery only)
3.	6	Monthly Underpayment report	Monthly (non-MSP identification of overpayments and underpayments and recovery only)
6	7	Monthly Financial Report	Monthly
6	8	Claim Adjustment report	Weekly
6	9	Training on RAC Database	Within 15 days of the start of Task 2
6	10	Case File Transfers	Within 15 days after contract end
9	11	Final Report- Draft	Within 4 weeks of contract end date
9	12	Final Report- Final	Within 8 weeks of contract end date

Attachment J-2

PAYMENT METHODOLOGY SCALE

1	% When non-MSP recovery is made through RACs efforts (check sent in by provider in response to demand letters, phone calls…)	______
2	50% of the contingency fee specified in number 1 above when non-MSP recovery is made through the offset process by the Medicare fiscal intermediary or carrier	
3	50% of the contingency fee specified in number 1 above when non-MSP recovery is made after the debt is referred to the Department of Treasury	
4	50% of the contingency fee specified in number 1 when a self-disclosure is made by a provider in result of a prior RAC identified request for medical requests or demand letter/ Self disclosed service and time period must be included in the RAC's project plan	
5	% When no recovery is made for a non-MSP overpayment	0%

Appendix 1 - Requirements for Optional Imaging of Medical Records and Rationale Documents

The following are the minimum technical requirements for any RAC choosing to implement the electronic imaging of medical records and rationale documents. Costing information is provided as a general guideline for the RAC. Costs for specific system implementations could vary significantly depending upon the number of documents imaged/stored by the RAC, systems already in place, the configuration chosen by the RAC, and other factors beyond the scope of this document. Prices provided are estimates and do not reflect final costs expected by CMS.

1. The RAC contractor shall use a system compatible with the IBM Content Manger Technical Suite on a Sun Solaris 9 platform to index and store imaged documents. The RAC contractor shall follow all existing and future technical guidelines issued by CMS/OIS regarding the indexing and storage of imaged documents.

2. The imaging and indexing process used by the RAC contractor shall be compatible with the IBM Content Manager Technical Suite and related modules. The RAC contractor shall follow all existing and future technical guidelines issued by CMS/OIS regarding scanning hardware and software. Currently, CMS recommends using Kodak family scanners and Kofax imaging software; however, this not a requirement for RACs at this time. See the table at the end of this appendix for general pricing information.

3. The RAC contractor shall have the ability to receive documents via a fax server. The RAC contractor shall index each incoming document based on beneficiary name, provider name, contractor number, claim control number and any other field mandated by CMS. In addition, for providers/contractors who choose not to submit documents via fax, the RAC contractor shall receive hardcopy records and scan the records. All documents received by mail shall be scanned and indexed in order and shall be scanned and indexed within one business day of receipt.

4. Imaged documents shall be stored in a central medical record image repository that utilizes the IBM Content Manger Technical Suite. The image repository shall be located at the RAC contractor site. CMS plans to require the RACs who choose to maintain imaged medical records to send all images to a CMS IBM Content Manager System (located in Baltimore, Maryland) at some point during the time period of the demonstration.

5. The RAC contractor shall support versioning of received documents, since the system will need to handle multiple versions of a document from the same request.

6. The RAC contractor shall support partitioning of document images so that specific sections of the document images can be reviewed independent of other sections to support the current medical review process.

7. The RAC contractor shall support a less than 5 second image retrieval time over a reasonably loaded T1 connection for the online retrieval system. Typical medical record image size is 5-10 pages for Part B and DMERC; and 50-100 pages for Part A.

8. The RAC shall make the imaged documents available to any authorized Medicare contractor using the IBM Content Manager E-client over MDCN lines.

Attachment J-2

Appendix 2 – Demographics

Calendar Year 2003 Data

Durable Medical Equipment (DME) CY 2003

State	DME Line Items	Allowed Charges
Florida	9,569,766	$1,163,313,908
New York	4,951,506	$494,985,071
California	6,757,242	$783,752,727

Carrier CY 2003

State	# of Claims Paid	Allowed Charges
Florida	59,871,560	$8,131,261,017
New York	48,108,283	$6,135,012,996
California	54,121,018	$7,392,490,891

Intermediary CY 2003

State	# of Claims Approved	Total Payments (Including Outpatient, Inpatient plus Passthrough, SNF, HHA, and Hospice if applicable)
Florida	6,147,794	$6,494,749,049
New York	11,310,463	$13,327,283,725
California	8,694,767	$10,007,764,811

The above figures are approximations and are not necessarily complete year data.

Additional benefit payment data and comprehensive error rate testing data can be found by visiting the www.cms.gov website.

Payment Methodology

(Non-Medicare Secondary Payer)
NO. 40700NMSPB

This Payment Methodology is a DRAFT Document and subject to change. Any change will not affect the receipt of contingency payment by the RAC.