Medicare Program Integrity Manual
Chapter 9 – The Medicare Fee-for-Service (FFS) Recovery Audit Program

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(Rev. 12772; Issued: 08-09-24)

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9.1 – Medicare FFS Recovery Audit Program
(Rev. 921, Issued: 11-06-19 Effective: 11-04- 19, Implementation: 11-04-19)

Section 1893(h) of the Social Security Act (the Act) requires the Secretary of the Department of Health and Human Services (the Secretary) to utilize Recovery Audit Contractors (RACs) under the Medicare Integrity Program to identify underpayments and overpayments and recoup overpayments under the Medicare program associated with services for which payment is made under part A or B of title XVIII of the Act. The term RAC, as used in this section, refers to the Fee-For-Service (FFS) RACs.

In 2009, CMS expanded the use of RACs nationwide. Information on the program can be found at: https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Recovery-Audit-Program/

The RACs are responsible for identifying improper payments. The Medicare Administrative Contractors (MACs) are responsible for the adjustments of these claims.

9.2 – Communication with Recovery Audit Contractors (RACs)
(Rev. 921, Issued: 11-06-19 Effective: 11-04- 19, Implementation: 11-04-19)

When Contractors have questions regarding the Recovery Audit Program or their interaction with a RAC, they should contact the CMS RAC COR and applicable RAC contact.

9.2.1 – RAC Points of Contact
(Rev. 921, Issued: 11-06-19 Effective: 11-04- 19, Implementation: 11-04-19)

All MACs shall provide the CMS RAC COR the name, phone number, address, fax number, and email address of a primary point of contact (POC) and an alternate POC. The point of contact or alternate will be responsible for all communications with the CMS Contracting Officer Representative (COR) and the RAC. The POC will be contacted to handle improper payment issues such as offsets, claim processing issues, provider address information, status of claim adjustments and status of appeals. In addition, the contractor shall provide the CMS RAC COR with the name, phone numbers, addresses, fax number and email address of a medical review POC to handle such issues as local edits, provider education, and Local Coverage Determinations (LCDs), and other corrective action.

9.2.2 – Applications to Assist Communication
(Rev. 921, Issued: 11-06-19 Effective: 11-04- 19, Implementation: 11-04-19)

The Recovery Audit Contractor Data Warehouse (RACDW) is an online tool that has been developed to track all RAC activity, as well as, other review contractor activity. For access to the RACDW, email the CMS contact at **RAC@CMS.HHS.gov**.

9.2.3 – RAC/MAC Communication

(Rev. 921, Issued: 11-06-19 Effective: 11-04- 19, Implementation: 11-04-19)

The MACs shall work with the RAC to develop a communication process. This process shall be flexible and shall be reached by a mutual agreement. CMS has several items to assist in the communication efforts:

- RACDW
- Indicator Code of RAC Identified Overpayments
- System Generated Flat File of all A/R transactions on a daily basis
- Mass Adjustment Process
- CMS Secure Email

NOTE: Unless prior approval has been given by CMS, Personal Health Information (PHI) shall not be transferred over the internet, or via email. PHI may be transmitted via fax, telephone, mail pager, or CMS secure email.

9.2.4 – Referral to the UPIC

(Rev. 921, Issued: 11-06-19 Effective: 11-04- 19, Implementation: 11-04-19)

RACs that refer a complaint to the UPIC shall notify the UPIC via e-mail that a complaint is being referred as potentially fraudulent. The RAC shall develop a referral package (see below for what should be included in the referral package) for all complaints being referred to the UPIC and shall send the complaint via a secure method such as e-mail or mail directly to the UPIC. Complaints shall be forwarded to the UPIC for further review under the circumstances listed below (this is not an exhaustive list):

• Claims may have been altered

• Claims have been up-coded to obtain a higher reimbursement amount and appear to be fraudulent or abusive;

• Potential misrepresentation with respect to the nature of the services rendered, charges for the services rendered, identity of the person receiving the services, identity of persons or doctor providing the services, dates of the services, etc.;

• Alleged submissions of claims for non-covered services are misrepresented as covered services, excluding demand bills and those with Advanced Beneficiary Notices (ABNs);

• Claims involving potential collusion between a provider/supplier and a beneficiary resulting in higher costs or charges to the Medicare program;

• Alleged use of another person's Medicare number to obtain medical care;

• Alleged alteration of claim history records to generate inappropriate payments;

• Alleged use of the adjustment payment process to generate inappropriate payments; or

• Any other instance that is likely to indicate a potential fraud, waste, and abuse situation.

NOTE: Since this is not an all-inclusive list, the UPIC has the right to request additional information in the resolution of the complaint referral or the subsequent development of a related case (e.g., provider/supplier enrollment information).

When the above situations occur requiring that the complaint be referred to the UPIC for review, the RAC shall prepare a referral package that includes, at a minimum, the following:

- Provider/supplier name, NPI, provider/supplier number, and address.
- Type of provider/supplier involved in the allegation and the perpetrator, if an employee of the provider/supplier.
- Type of service involved in the allegation.
- Place of service.
- Nature of the allegation(s).
- Timeframe of the allegation(s).
- Date of service, procedure code(s).
- Beneficiary name, beneficiary HICN, telephone number.

NOTE: Since this is not an all-inclusive list, the UPIC has the right to request additional information in the resolution of the complaint referral or the subsequent development of a related case (e.g., provider/supplier enrollment information). The RAC shall maintain a copy of all referral packages.

9.2.5 – Joint Operating Agreement

(Rev. 921, Issued: 11-06-19 Effective: 11-04- 19, Implementation: 11-04-19)

All MACs and UPICs shall develop a Joint Operating Agreement (JOA) with each RAC in their jurisdiction. The JOA shall be mutually approved by all contractors and by CMS prior to its effective date. The JOA shall cover all requirements in this Internet Only Manual (IOM), but may expand upon those requirements and may provide alternative timeframes. The JOA shall include communication processes and timeframes for adjustments, recoupments, appeals, inquiries, and receipt of provider names and addresses.

9.2.6 – Provider Information

(Rev. 921, Issued: 11-06-19 Effective: 11-04- 19, Implementation: 11-04-19)

All MACs shall provide the RAC with a list of all provider numbers, names, addresses, and tax identification number from their jurisdiction. At a minimum, the contractor shall update the list every six months. The method and frequency of transfer shall be included in the JOA.

9.3 – Overview of the RAC Process

(Rev. 921, Issued: 11-06-19 Effective: 11-04- 19, Implementation: 11-04-19)

Upon contract award, the RACs will receive a data file from CMS containing National Claims History (NCH) data about claims that have been processed by the MACs in the appropriate jurisdictions based on the RAC contract. The RACs will receive monthly updated NCH data files. RACs will enter individual claim information into the RACDW for each claim under review. Assuming a provider or claim(s) has not been excluded or suppressed due to a previous medical review, fraud investigation or inclusion in the Comprehensive Error Rate Testing (CERT) sample, the RAC will continue with their review process.

The CMS may grant the RAC "read only" access to the Common Working File (CWF) (and any other systems at CMS' sole discretion) to obtain additional information pertaining to potential improper payments.

9.4 – Inputting Suppression and Exclusion Cases to the RACDW

(Rev. 12772; Issued: 08-09-24; Effective: 09-20-24; Implementation: 09-20-24)

The MAC, Supplemental Medical Review Contractor (SMRC), CERT*, and Unified Program Integrity Contractor (UPIC)* shall input all claims requiring suppression and exclusion into the RACDW. An exclusion is the permanent removal of a claim due to a previous review. A suppression is a temporary removal of a claim to an ongoing case development. *The UPIC shall refer to their specific suppression and/or exclusion requirements in IOM-100-8 Chapter 4.* The MAC can permanently exclude an individual claim or a series of claims, or suppress a provider's claim submission for a particular claim type for a period of time not to exceed one calendar year.

The following cases require **exclusion**:

- A medical review is in progress; or claims subjected to post payment review;
- Claims subjected to prepayment medical review;
- Claims originally denied and later paid by an appeal entity

The following cases require **suppression**:

- A fraud/*program* integrity review is in progress;
- The MAC or UPIC has been notified by an outside agency (law enforcement, Office of Inspector General (OIG), Department of Justice (DOJ)) that an investigation is ongoing.

The MACs shall not suppress or exclude claims that do not meet the above criteria. Claims on which the MAC is conducting education should not be suppressed.

The MACs shall enter suppression and/or exclusion records immediately after the need for these actions are identified. After the initial data input, contractors shall consistently monitor the RACDW and update on an as needed basis.

The MACs shall keep documentation on file that supports the information they added to the RACDW.

NOTE: The suppression or exclusion of an entire provider will require CMS approval. Additional direction can be found in the Medicare Program Integrity Manual (MPIM), Publication 100-08, Chapter 3, Section 3.5.2, and Chapter 4, Section 4.7.4.

9.5 - Adjusting the Claim

(Rev. 921, Issued: 11-06-19 Effective: 11-04- 19, Implementation: 11-04-19)

The MAC shall process RAC-initiated overpayments the same as any overpayment determined by the MAC.

The RAC shall submit claim adjustments directly to the Virtual Data Centers (VDCs) via the file-based mass adjustment process. Manual adjustments shall be limited to those that cannot be accommodated through more automated means. The MAC shall identify the origin of any manual adjustments by assigning RAC adjustment reasons and/or discovery codes as appropriate.

The MAC shall create an accounts receivable in accordance with the guidelines in the Medicare Financial Management Manual (MFMM), Publication 100-06, Chapter 4, Sections 20 and 80. The MAC shall issue all demand letters for any RAC identified overpayment, following the same process as for any other payment recoupment. The MAC shall include the initiating RAC's name and contact information in all demand letters. The MAC shall be responsible for fielding any administrative concerns related to the claim adjustment, such as, the issuance of demand letters, timeframes for recoupment and the appeals process. The RAC shall be responsible for any audit specific communications, such as reviewer rationale inquiries and discussion requests.

9.5.1 - Tracking Overpayments and Appeals

(Rev. 921, Issued: 11-06-19 Effective: 11-04- 19, Implementation: 11-04-19)

The RAC shall enter the required information into the RACDW and provide updates throughout the claims review process. The MAC shall upload all applicable adjustment outcome files into the RACDW on a daily (business day) basis. The MAC shall forward Health Integrated General Ledger Accounting System (HIGLAS) outcome/transaction files, if files are not sent in an automated fashion and shall ensure that the VDC return the appropriate Fiscal Intermediary Shared System/ Mandatory Claim Submission System/Viable Information Processing Systems Medicare System (FISS/MCS/VMS) files directly. Any MAC unable to meet such requirements in the required timeframe shall communicate with the CMS COR regarding the surrounding circumstance and the potential for alternate instruction.

The RAC shall notify the MAC of any files that the RAC did not receive from the VDC so the MAC can try to assist with the transfer of these files.

The MAC shall not make adjustments on RAC-initiated zero dollar claims unless the MACs are contacting the provider to notify them of a new denial reason.

9.5.1.1 - Tracking Appeals and Reopenings

(Rev. 921, Issued: 11-06-19 Effective: 11-04- 19, Implementation: 11-04-19)

Appeals and reopenings requests received in response to a RAC initiated improper payment shall be tracked. The status of any appeals shall be tracked through all available levels of the appeal process.

MCS and VMS contractors shall upload the weekly appeals report created in the standard systems to the RAC Data Warehouse no later than 2 business days after the end of the business week (typically Friday).

FISS contractors shall complete the supplied Excel spreadsheet, see CR 7458, when reporting monthly appeals and reopenings information. The MAC/Contractor shall upload the Monthly Recovery Auditor Appeals and Reopenings Report to the RAC Data Warehouse by the 15th business day of each month. Questions concerning upload of the file can be sent to the RAC Data Warehouse Help Desk. The report shall include the prior month's information and a copy shall be provided by email to the appropriate Recovery Auditor and the MAC COR.

NOTE: CMS is in the process of modifying the Medicare Appeals System (MAS) to track first level Part A appeals. The implementation of MAS will occur individually. However, MACs shall continue to run and upload the MAS report to the RAC Data Warehouse.

The MAC/Contractor shall include the additional tracking information supplied on the Excel monthly appeals and reopenings report. The MAC/Contactor shall record on the tracking report the rationale for the reversal. Reasons for Reversal Codes have been created and if one of the given codes is not appropriate, a narrative explanation shall be input.
The MAC/Contractor shall research, fix and upload within 15 calendar days of notification all errors, including claims that do not get uploaded to the RAC Data Warehouse.

9.5.2 – Underpayments

(Rev. 921, Issued: 11-06-19 Effective: 11-04- 19, Implementation: 11-04-19)

The MAC shall process all underpayments using the mass adjustment process whenever possible. The MAC shall upload a transaction file into the RACDW that includes the required information on the underpayment reimbursement to the provider.

9.5.3 – Error Files

(Rev. 921, Issued: 11-06-19 Effective: 11-04- 19, Implementation: 11-04-19)

The CMS established RAC workload limits for maximum number of claim adjustments the RAC shall send to the MAC in a calendar month. It is assumed that the majority of adjustments will be processed through the mass adjustment system. In some cases, claims submitted through the mass adjustment system cannot be processed due to a submission error and are identified on an error report. The RAC shall review the report, make the necessary changes, and resubmit the claim. In these situations, the MAC shall not count claims identified on error files, corrected and resubmitted by the RAC in the same month against the monthly workload twice.

9.5.4 – Closure/Retraction Files

(Rev. 921, Issued: 11-06-19 Effective: 11-04- 19, Implementation: 11-04-19)

The MAC shall cease adjustment activities upon written request from the RAC, including evidence of any the CMS required approval, as applicable. This activity could occur prior to the creation of the accounts receivable (AR). Activity could occur after creation of AR but before offset. The RAC acknowledges that if the notification is not received prior to the 36th day, offset will occur and RAC shall follow up with an adjustment file (same file format).

The MAC shall change the offset flag to "N" on the RAC account receivable upon written request from the RAC, including evidence of any CMS required approval, as applicable. The MAC shall follow CMS requirements for repayment. The MAC shall notify the RAC when the stop recovery actions are complete.

9.6 – Extended Repayment Schedule Requests Received on a RAC Initiated Overpayment

(Rev. 921, Issued: 11-06-19 Effective: 11-04- 19, Implementation: 11-04-19)

The MAC shall offer the provider the ability to repay the overpayment through an Extended Repayment Schedule (ERS). If the RAC receives an ERS request from a provider, it shall forward the request to the appropriate MAC for processing.

If the MAC receives an ERS from a provider for a RAC initiated overpayment, it shall inform the appropriate contact at the RAC and upload a transaction file into the RACDW for each ERS collection received. This process shall be included in the JOA's. The MAC shall refer to the MFMM, Publication 100-6, Chapter 4, Section 50.

9.7 – Appeals Resulting from RAC Initiated Denials

(Rev. 921, Issued: 11-06-19 Effective: 11-04- 19, Implementation: 11-04-19)

The MACs shall process any appeals stemming from a RAC improper payment (e.g. RAC decisions appealed by the providers or beneficiaries) as any other appeal request.

Upon receiving an appeal request for a RAC improper payment, the MAC shall request the medical records and any other supporting documentation from the RAC. The timeframes regarding requesting and receiving medical records from the RAC shall be

agreed upon in the JOA. Even if the MAC believes they have enough documentation to make a determination on the appeal, the MAC shall still request the medical records and any other supporting documentation, as providers may submit different documentation to the RAC than to the MAC upon appeal.

The MAC shall utilize the same approach in denying an appeal request (i.e. reopening or redetermination) as used with any other appeal request. For more information on to determine whether an appeal request should be processed as a reopening or redetermination, MACs shall refer to the Medicare Claims Processing Manual (MCPM), Publication 100-04, Chapter 34, Section 10.

9.8 - Referrals to the Department of the Treasury

(Rev. 921, Issued: 11-06-19 Effective: 11-04- 19, Implementation: 11-04-19)

All overpayments identified by the RAC shall follow the normal referral to Treasury process. The MAC shall issue the Intent to Refer letter following the normal process. The MAC shall update the RACDW with the referral to Treasury status code once referral is complete. If the MAC receives a question or dispute after referral that cannot be answered through the case file, the MAC shall contact the RAC for assistance. The communication process for the transfer of debt shall be agreed upon in the JOA.

9.9 - Reporting Administrative Costs Directly Associated with the RAC Program

(Rev. 921, Issued: 11-06-19 Effective: 11-04- 19, Implementation: 11-04-19)

Section 302 of the Tax Relief and Health Care Act of 2006 allows CMS to pay for all costs associated with conducting the RAC Program out of RAC collections. These costs are not attributed to a contractor's annual budget. These costs are only attributed to the RAC Program and are paid from RAC collections. The CMS has created two activity codes for the RAC program. The MAC shall use these codes for all activities related to the RAC Program. Detailed descriptions of the activity codes and what may be included are below.

Activity Code 11031 – RAC Implementation and Maintenance Activities

These duties include:

- Completion and maintenance of a JOA with the applicable RAC(s)
- Adjusting all claims identified by the RAC as containing an underpayment or an overpayment
- Performing validation of overpayment identifications if requested by CMS
- Creating and maintaining accounts receivables for RAC identified overpayments
- Collecting and processing monies received for RAC identified overpayments
- Processing offset for RAC identified overpayments
- Performing necessary provider education relevant to the operation of the RAC program if requested by CMS
- Creating exclusion files for upload to the RACDW
- Creating monthly/daily reports for upload to the RACDW

- Creating monthly/daily reports for feedback to the RAC
- Communicating with RACs and CMS
- Handling RAC related inquires
- Handling activities associated with withdrawing an overpayment not resulting from an appeal

Activity Code 12031 – RAC Initiated Appeal Activities

These duties include:
- Performing and adjudicating the redetermination
- Reporting appeals statistics to the CMS RAC COR or delegate
- Handling inquiries from CMS regarding RAC-identified overpayments
- Attending meetings with the RAC and/or the CMS COR
- Handling records, notes and documents regarding RAC and Provider appeals
- Processing and tracking all appeals for RAC identified overpayments and creating appeal reports for upload to the RACDW if requested by CMS
- Communicating with RACs and CMS
- Communicating with other appeal entities on RAC identified overpayment cases Qualified Independent Contractor (QIC), Administrative Law Judge (ALJ), Departmental Appeals Board (DAB)

9.10 - Potential Fraud

(Rev. 921, Issued: 11-06-19 Effective: 11-04- 19, Implementation: 11-04-19)

The RAC shall refer any claims it determines to be a potentially fraudulent to their CMS COR who will then forward this claim information to the appropriate area within CMS. The RAC shall concurrently refer the claims to the OIG in accordance with the memorandum of understanding (MOU).

9.11 - MAC Requirements Involving RAC Information Dissemination

(Rev. 921, Issued: 11-06-19 Effective: 11-04- 19, Implementation: 11-04-19)

When instructed by CMS, the MACs shall disseminate information concerning the RAC program to the provider community. The MAC shall notify the RAC when any community outreach and/or public education is taking place in their jurisdiction. If attending, the RAC shall only address their function as RACs. They may NOT address policy changes and/or provider education on other Medicare issues. It is also up to the discretion of the MAC to invite the RAC to speak at the event. It is also up to the RAC if it wants to attend the event. All information disseminated to the provider community concerning the RAC Program shall be approved by the CMS COR. Information shall be sent by email to the CMS COR 30 calendar days before the event.

9.12 - Voluntary Refund

(Rev. 11032; Issued: 09-30-21; Effective: 10-12-21; Implementation: 11-10-21)

If the MAC receives a voluntary refund from a provider on a claim in the RACDW, the MAC shall process the refund as they do all other voluntary refunds (i.e., in accordance

with the Medicare Program Integrity Manual (MPIM), Publication 100-08, Chapter 4, Section 4.2.2.8.1.3).

9.13 – Working with RAC Support Contractors

(Rev. 921, Issued: 11-06-19 Effective: 11-04- 19, Implementation: 11-04-19)

The MAC shall work cooperatively with all RAC Support Contractors by providing all requested data. This includes the Data Warehouse Contractor, the Validation Contractor, and any other contractor supporting the RAC process.

9.14 - Receivables Initiated by the RAC as Independent Audit Accessible Information

(Rev. 921, Issued: 11-06-19 Effective: 11-04- 19, Implementation: 11-04-19)

As stated in the MFMM, Chapter 7, Section 20.1, CMS requires its contractors to perform risk assessments on an annual basis. If an independent auditor requests the MAC to provide information on a RAC-initiated improper payment, the MAC shall request the documentation from the RAC and submit it to the auditor as requested. This process shall be documented in the JOAs. Situations where the RAC does not provide documentation as requested should be sent to the CMS COR, as soon as possible.

9.15 – MAC Participation in the Review Approval Process

(Rev. 921, Issued: 11-06-19 Effective: 11-04- 19, Implementation: 11-04-19)

The RACs are expected to share CMS-approved new issue packages with their respective MACs. However, MACs are no longer required to provide a validation report to CMS for each new issue package. MACs shall participate in conference calls with CMS on ad hoc basis when needed to discuss review topic questions if they arise during or after the approval process.

Transmittals Issued for this Chapter

Rev #	Issue Date	Subject	Impl Date	CR#
R12772PI	08/09/2024	Updates of Chapter 1, Chapter 2, Chapter 3, Chapter 4, and Chapter 9 in Publication (Pub.) 100-08, Including Complaint Referral Coordination Between Contractors	09/20/2024	13719
R11032PI	09/30/2021	Updates to Chapters 1, 3, 4, 5, 8 and 9 of Publication (Pub.) 100-08	11/10/2021	12375
R10984PI	09/09/2021	Updates to Chapters 1, 3, 4, 5, 8 and 9 of Publication (Pub.) 100-08 - Rescinded and replaced by transmittal 11032	11/10/2021	12375
R921PI	11/06/2019	The Medicare Fee-for-Service Recovery Audit Program	11/04/2019	11464
R908PI	10/04/2019	The Medicare Fee-for-Service Recovery Audit Program- **Rescinded and Replaced by Transmittal 921**	11/04/2019	11464
R71PI	04/09/2004	Rewrite of Program Integrity Manual (except Chapter 10) to Apply to PSCs	05/10/2004	3030
R43PI	06/20/2003	Plan of Care Documentation	07/01/2003	2727
R03PIM	11/22/2000	Complete Replacement of PIM Revision 1.	NA	1292
R01PIM	06/2000	Initial Release of Manual	NA	931

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