AHCA Q & A
Questions from Providers Sent to CMS on April 26, 2013
Responses form CMS Received on May 7, 2013

1. How long does the MAC have to get back to the provider with a payment decision?
    a. **The payment decision will be provided by the Recovery Auditors in the form of a Review Results letter. For prepayment Therapy claims this process is completed within 10 days. For postpayment Therapy claims this process is also completed immediately upon receiving the Providers medical records for review.**
2. When does the RAC 10 day deadline start?
    a. **The 10 day timeline starts once the Recovery Auditor receives the medical record from the Provider.**
3. What will happen if the RACs miss the 10 day deadline for review? Example: A provider is concerned about the MMR ADR responses that it has received (primarily from Palmetto at this time) that are denied because Palmetto didn't have time to log them into its system before the submission deadline they required of the provider, even though they were received by Palmetto timely. With the above in mind, the provider would like to know what will happen if the RACs miss the 10 day deadline for review? Automatic denial as in the example? Automatic approval as occurred when the MMR requests were for preauthorization, or nothing & the provider just waits for a response.
    a. **There are no "Automatic Denials" for outpatient therapy claims. All claims are being reviewed manually by the Recovery Auditors. CMS oversees a strict quality assurance plan for all Recovery Auditors as defined within the Statement of Work (SOW). Any provider who has questions regarding the 10 day time period is encouraged to call their applicable Recovery Auditor customer service phone line which may be found on the Provider Compliance Group Interactive Map.**
4. What is the timeline for the MAC to issue an additional documentation request?
    a. **The additional documentation request (ADR) is immediately issued once the claim has been identified as at or above the $3,700 threshold cap.**
5. What is the timeframe regarding the RAC obligation to send the provider a results letter?
    a. **Please see question #1.**
6. Is there any repercussion for the MAC, RAC, QIC and ALJ for not meeting timelines for review periods?
    a. **CMS holds the MACs and QICs responsible for meeting timeframes as part of their annual performance assessment. CMS does not oversee the ALJs so we cannot discuss ALJ requirements. If the RACs do not complete the review within the standard 60 days then they will not receive their contingency fee. The RACs meeting of the 10 day requirement will be used as part of their annual performance assessment.**
7. How often will the RACs post to the claim status portals?
    a. **There is no given time, but most RACs post almost immediately to the claim status portal. CMS would suggest contacting the specific RAC if there are issues.**
8. Is the RAC required to post the received date for the record in the esMD?
    a. **The RAC does not post into esMD but if a record was received through esMD the received date would be posted in the portal.**
9. Is the RAC results letter similar to the MAC's manual audit results letter? The MAC's manual audit stated they would give details but they only gave a very generic sentence or two at the most. Is there a more detailed explanation?
    a. **If the Recovery Auditors determine an improper claim has been submitted, a review results letter will be sent to the provider, which clearly documents the rationale for the determination. The letter provides vital information to the provider regarding the Recovery Auditors findings and detailed description of the coverage/coding or Medicare policy or rule that was violated.**
10. Why is the discussion period not allowed for pre-payment reviews?
    a. **A discussion period is not feasible for pre-payment reviews related to the immediate turn around that is necessary to stay within the 10 day time frame.**
11. Can the ADR requests and claim status identify which discipline is under review when PT/ST exceeds the threshold and OT has not as in the following example: "SNF claims are billed monthly and include all Part B

Billing. If PT/ST exceed the threshold and OT has not; currently there is no indication as to which charges/discipline are to be reviewed. So, we have to submit all discipline's documentation."

a. **The ADR request will specify the necessary documentation required to compare the medical record to the therapy claim.**

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