Medicare Fee-for-Service Recovery Audit Program

Additional Documentation Limits for Medicare providers (except suppliers and physicians)

Beginning August 22, 2011 the additional documentation requests limits will follow the guidelines below:

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

For example:

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

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

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

C. The limit is based on claims volume only. The type of claims do not factor into the limit.

D. The maximum number of requests per 45 days is 300. (Effective November 2, 2010)

E. Recovery Auditors may request up to 35 records per 45 days from providers whose calculated limit is 34 additional documentation requests or less. (Effective August 22, 2011)

F. The limit is equal to 1% of all claims submitted for the previous calendar year divided by 8. The Recovery Auditors may go more than 45 days between record requests but may not make requests more frequently than every 45 days. A provider's limit will be applied across all claim types, including professional services.

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

- Provider C billed 156,253 claims last year. 1% of the claims volume is 1,562. The limit is calculated by dividing this by 8. The provider's limit is no more than 195 requests every 45 days.

- Provider D billed 426,000 claims last year. The breakout of claims is below:

  50,000 inpatient claims,

75,000 outpatient claims,
20,000 SNF covered stays,
20,000 home health episodes of care,
250,000 physician claims,
10,000 inpatient rehab claims and
1,000 hospice claims.

1% of the claims volume is 4,260. The limit is calculated by dividing 4,260 by 8. The provider's limit is no more than 532 requests every 45 days. Since CMS has a maximum cap in place the provider's limit is equal to the cap.

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

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