**Medicare Fee-for-Service Recovery Audit Program**

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

The Centers for Medicare & Medicaid Services (CMS) has modified the additional documentation request (ADR) limits for the Recovery Auditor program for providers. The revised limits will be effective January 1, 2016.

Each provider's annual limit will be based on the number of Medicare claims paid in the previous year that are associated with their 6-digit **CMS Certification Number (CNN)** and the provider's **National Provider Identifier (NPI)** number.

1. The annual ADR Limit will be **one-half of one percent** (0.5%) of the provider's total number of paid Medicare claims from the previous year.

2. ADR letters are sent on a 45-day cycle. The annual ADR Limit will be divided by eight to establish the ADR cycle limit, which is the maximum number of claims that can be included in a single 45-day period. Although the Recovery Auditors may go more than 45 days between record requests, in no case shall they make requests more frequently than every 45 days.

   For example:

   - Provider A billed and was paid for 22,530 Medicare claims in 2014. The provider's ADR limit would be 22,530 x 0.005, which is 112.65. The ADR cycle limit would be 112.65/ 8 = 14.08 and would be rounded to **14** additional documentation requests per 45 days.

   - Provider B billed and was paid for 255,000 Medicare claims in 2014. The provider's ADR limit would be 255,000 * 0.005, which is 1,276. The ADR cycle limit would be 1,276/ 8, which is 159.375 and would be rounded to **159** additional documentation requests per 45 days.

3. ADR limits will be diversified across all claim types of a facility, based on the Types of Bill (TOB) that the provider was paid for in the previous year.

4. CMS will adjust a provider's ADR limit based on the provider's compliance with Medicare rules. Providers with low denial rates will have ADR limits decreased, while providers with high denial rates will have their ADR limits increase.

5. CMS reserves the right to establish a different record limit when directing the Recovery Auditors to conduct reviews of specific topics or providers.

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

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Beginning **March 15, 2012**, 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 400.

- Providers with over $100,000,000 in MS-DRG payments who were notified by CMS of an increased cap of 500 requests will now have a cap of 600.

E. Recovery Auditors may request up to 35 records per 45 days from providers whose calculated limit is 34 additional documentation requests or less.

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

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

- Provider C billed 156,253 claims last year. 2% of the claims volume is 3,125. The limit is calculated by dividing 3,125 by 8. The provider's limit is no more than 390 requests every 45 days.

- Provider D billed 426,000 claims last year. 2% of the claims volume is 8,520. The limit is calculated by dividing 8,520 by 8. This is equal to 1,065 requests. Since CMS has a maximum cap in place of 400 requests per 45 days, the provider's limit is 400.

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

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

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