



Medicare

Claim Review Programs:

MR, NCCI Edits, MUEs, CERT, and RAC



Background

Since 1996, the Centers for Medicare & Medicaid Services (CMS) has implemented several initiatives to prevent improper payments before the claim is processed, and identify and recoup improper payments after the claim has been processed. The overall goal of CMS' claim review programs are to reduce payment error by identifying and addressing billing errors concerning coverage and coding made by providers. The *Improper Medicare FFS Payments Report – May 2008* shows that 3.7 percent of the Medicare dollars paid did not comply with one or more Medicare coverage, coding, billing, or payment rules. This equates to \$10.2 billion in Medicare overpayments and underpayments annually. This report can be reviewed at http://www.cms.hhs.gov/apps/er_report/edit_report_1.asp?from=public&reportID=9 on the CMS website.



CMS employs a network of contractors to process claims submitted by physicians, hospitals, and other health care providers/suppliers and make payment to those providers in accordance with the Medicare rules and regulations. These organizations, called Carriers, Fiscal Intermediaries (FIs), and Medicare Administrative Contractors (MACs)¹, are also referred to as Medicare claims processing contractors. CMS also employs Program Safeguard Contractors (PSCs)², which are responsible for identifying cases of suspected fraud and taking appropriate corrective actions.

This booklet describes the following five claim review programs and their role in the lifecycle of Medicare claims processing. The columns on the table below divide the programs based on performance of prepayment or postpayment reviews.

Table 1. Medicare Prepayment and Postpayment Claim Review Programs

Prepayment Claim Review Programs	Postpayment Claim Review Programs
National Correct Coding Initiatives (NCCI) Edits	Comprehensive Error Rate Testing (CERT) Program
Medically Unlikely Edits (MUE)	Recovery Audit Contractor (RAC)
Carrier/FI/MAC Medical Review (MR)	Carrier/FI/MAC Medical Review (MR)

The first two programs (NCCI Edits and MUE) review claims *before* they are paid (called prepayment review). The second two programs (CERT and RAC) review claims *after* they are paid (called postpayment review). The MR program can perform both prepayment and postpayment reviews. A table at the end of this booklet summarizes the five programs and how they proactively identify potential billing errors concerning coverage and coding.

¹*Medicare Contracting Reform (MCR) Update* – In Section 911 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) Congress mandated that the Secretary of the Department of Health and Human Services replace the current contracting authority under Title XVIII of the Social Security Act with the new Medicare Administrative Contractor (MAC) authority. This mandate is referred to as Medicare Contracting Reform. Medicare Contracting Reform is intended to improve Medicare's administrative services to beneficiaries and health care providers. All Medicare work performed by Fiscal Intermediaries and Carriers will be replaced by the new A/B MACs by 2011. Providers may access the most current MCR information to determine the impact of these changes and to view the list of current MACs for each jurisdiction at <http://www.cms.hhs.gov/MedicareContractingReform/> on the CMS website.

²Currently, Durable Medical Equipment (DME) PSCs perform medical review of DME claims. In the near future this function will be transferred to the DME MACs. The DME PSCs will be renamed Zone Program Integrity Contractors (ZPICs).

National Correct Coding Initiatives (NCCI) Edits

CMS developed the NCCI to promote national correct coding methodologies and to control improper coding that leads to inappropriate payment in Medicare Part B claims. The coding policies are based on coding conventions defined in the American Medical Association's (AMA's) Current Procedural Terminology (CPT) Manual, Healthcare Common Procedure Coding System (HCPCS) Manual, national and local Medicare policies and edits, coding guidelines developed by national societies, standard medical and surgical practice, and/or current coding practice. NCCI edits are updated quarterly.

NCCI Edits Process

The NCCI edits are automated pre-payment edits. This means that as the submitted claim is processed by the Medicare claims processing contractor's systems, the submitted procedures are analyzed to determine if they comply with the NCCI edit policy. Processing systems test every pair of codes reported for the same date of service for the same beneficiary by the same provider against the NCCI edit tables. If a pair of codes hits against an NCCI edit, the column two code of the edit pair is denied unless it is submitted with an NCCI associated modifier and the edit allows such modifiers.



HCPCS/CPT codes representing services denied based on NCCI edits may not be billed to Medicare beneficiaries. Since these denials are based on incorrect coding rather than medical necessity, the provider cannot utilize an "Advanced Beneficiary Notice" (ABN) form to seek payment from a Medicare beneficiary. Furthermore, since the denials are based on incorrect coding rather than a legislated Medicare benefit exclusion, the provider cannot seek payment from the beneficiary with or without a "Notice of Exclusions from Medicare Benefits" (NEMB) form.

Additional NCCI Resources

NCCI Edits Overview Web Page

<http://www.cms.hhs.gov/NationalCorrectCodInitEd/>

Claims Processing Manual Chapter 23 - Section 20.9

<http://www.cms.hhs.gov/manuals/downloads/clm104c23.pdf>

Providers/suppliers who have concerns regarding specific NCCI edits can submit comments in writing to:

National Correct Coding Initiative
Correct Coding Solutions LLC
P.O. Box 907
Carmel, IN 46082-0907
Attention: Niles R. Rosen, M.D., Medical Director and
Linda S. Dietz, RHIA, CCS, CCS-P, Coding Specialist
Fax #: 317-571-1745

The *CCI Edits Manual* may also be obtained by purchasing the manual, or sections of the manual, from the National Technical Information Service (NTIS) website at <http://www.ntis.gov/products/cci.aspx> on the Internet, or by contacting NTIS at 1-800-363-2068 or 703-605-6060.

Medically Unlikely Edits (MUEs)

Performed by: Medicare Claims Processing Contractors

To lower the Medicare Fee-for-Service (FFS) paid claims error rate, CMS established units of service edits for Medicare Part B benefit claims, referred to as MUEs. Just like the NCCI edit, the MUE edit is an automated prepayment edit that helps prevent inappropriate payments. As the submitted claim is processed by the Medicare claims processing contractor's systems, the submitted procedures are analyzed to determine if they comply with the MUE policy. An MUE for a HCPCS/CPT code is the maximum units of service under most circumstances that a provider would report for a code for a single beneficiary on a single date of service. MUEs are not meant to establish Medicare payment policy, but rather to improve the accuracy of Medicare payments. MUEs do not exist for all HCPCS/CPT codes.

CMS develops MUEs based on anatomic considerations, HCPCS/CPT code descriptors, CPT coding instructions, established CMS policies, nature of service/procedure, nature of an analyte, nature of equipment, and clinical judgment. Prior to implementation of MUEs, national healthcare organizations are offered an opportunity to review and comment about proposed edits. The MUEs do not require that Medicare contractors perform manual review or suspend claims. The MUEs only apply to the services specifically listed in the table of MUEs; thus all services will not have MUEs associated with them.

In January 2007, CMS implemented the first MUEs for approximately 2,800 HCPCS/CPT codes based on anatomic considerations in version 1.0. There are quarterly updates to MUEs on the same schedule as the quarterly updates to NCCI. On October 1, 2008, with implementation of MUE version 2.3, the majority of existing MUEs were made public and posted on the CMS website. The published MUEs consist of most of the codes with MUE values of 1 through 3. In the future, some codes with MUE values of 4 or more will be published. CMS will not publish all MUE values that are 4 or higher because of fraud and abuse concerns. In addition, some MUEs with lower values believed by CMS to be vulnerable to fraud and abuse may not be published. Quarterly updates to the MUE values are on the same schedule as quarterly updates to the MUE.

Providers should not interpret MUE values as utilization guidelines. MUE values do NOT represent units of service that may be reported without concern about medical review. Providers should continue to report only services that are medically reasonable and necessary.

MUEs Process

Claim lines that pass the MUE edits continue to be processed. Those claim lines that violate the MUE edits are not processed for payment, however the claims are handled differently depending on the type of Medicare claims processing contractor.

Table 2. Units of Service In Excess of MUE Criteria

Carriers	Fiscal Intermediaries (FIs)
Physicians/suppliers may appeal a claim line denial due to an MUE if medically reasonable and necessary units of service exceed the MUE value.	An appeal process is not available for providers that receive an RTP as a result of an MUE. If the provider performed medically reasonable and necessary units of service in excess of the MUE value, the provider may use CPT modifiers when resubmitting the claim. See the answer to Question #4 in Table 3 [MUEs Frequently Asked Questions (FAQs)].
Physicians/suppliers may request modification of an MUE value by contacting the NCCI contractor. See the answer to Question #8 in Table 3 (MUEs FAQs).	Physicians/suppliers may request modification of an MUE value by contacting the NCCI contractor. See the answer to Question #8 in Table 3 (MUEs FAQs).

Table 3. MUEs Frequently Asked Questions (FAQs)

Question	Answer
1. What is the CMS MUE program?	The CMS MUE program was developed to reduce the paid claims error rate for Medicare claims. MUEs are designed to reduce errors due to clerical entries and incorrect coding based on anatomic considerations, HCPCS/CPT code descriptors, CPT coding instructions, established CMS policies, nature of a service/procedure, nature of an analyte, nature of equipment, and unlikely clinical treatment.
2. What is an MUE?	An MUE is a unit of service (UOS) edit for a HCPCS/CPT code for services rendered by a single provider/supplier to a single beneficiary on the same date of service. The ideal MUE is the maximum UOS that would be reported for a HCPCS/CPT code on the vast majority of appropriately reported claims. The MUE program provides a method to report medically reasonable and necessary UOS in excess of an MUE. See answer to Question #4.
3. How are claims adjudicated with MUEs?	All CMS claims processing contractors adjudicate MUEs against each line of a claim rather than the entire claim. Thus, if a HCPCS/CPT code is reported on more than one line of a claim by using CPT modifiers, each line with that code is separately adjudicated against the MUE. FIs and A/B MACs processing claims with the FISS system, return to provider claim lines with units of service exceeding the MUE for the HCPCS/CPT code on the claim line. The claim line is not denied. Therefore, no appeal process exists for MUEs for claims processed by FISS. Carriers and A/B MACs processing claims with the MCS system deny the entire claim line if the units of service on the claim line exceed the MUE for the HCPCS/CPT code on the claim line. Since claim lines are denied, the denial may be appealed. <i>(See answer to Question #4 for guidance on reporting medically reasonable and necessary services in excess of an MUE.)</i> DMACs processing claims with the VMS system deny the entire claim line if the units of service on the claim line exceed the MUE for the HCPCS/CPT code on the claim line. Since claim lines are denied, the denial may be appealed.

Question	Answer
4. How do I report medically reasonable and necessary units of service in excess of an MUE?	Since each line of a claim is adjudicated separately against the MUE of the code on that line, the appropriate use of CPT modifiers to report the same code on separate lines of a claim will enable a provider/supplier to report medically reasonable and necessary units of service in excess of an MUE. CPT modifiers such as -76 (repeat procedure by same physician), -77 (repeat procedure by another physician), anatomic modifiers (e.g., RT, LT, F1, F2), -91 (repeat clinical diagnostic laboratory test), and -59 (distinct procedural service) will accomplish this purpose. Modifier -59 should be utilized only if no other modifier describes the service.
5. Is there an appeal process for claim lines denied based on MUEs?	Since claim lines are denied at Carriers and A/B MACs processing claims with the MCS system and at DMACs processing claims with the VMS system, MUE-based claim line denials at these contractors may be appealed. However, at FIs and A/B MACs processing claims with the FISS system, claim lines with units of service exceeding an MUE are returned to the provider. No claim denial occurs, and appeals are not available. Appeals should be submitted to local contractors not the MUE contractor, Correct Coding Solutions, LLC.
6. How are claim lines adjudicated against an MUE for a repetitive service reported on a single claim line?	Some contractors allow providers to report repetitive services performed over a range of dates on a single line of a claim with multiple units of service. If a provider reports services in this fashion, the provider should report the “from date” and “to date” on the claim line. Contractors are instructed to divide the units of service reported on the claim line by the number of days in the date span and round to the nearest whole number. This number is compared to the MUE for the code on the claim line.

Question	Answer
7. How were MUEs developed?	MUEs were developed based on HCPCS/CPT code descriptors, CPT coding instructions, anatomic considerations, established CMS policies, nature of service/procedure, nature of an analyte, nature of equipment, and clinical judgment. All edits based on clinical judgment as well as many others were reviewed by workgroups of contractor medical directors. Prior to implementation of MUEs, the proposed edits were released for a review and comment period to the AMA, national medical/surgical societies, and other national healthcare organizations, including non-physician professional societies, hospital organizations, laboratory organizations, and durable medical equipment organizations.
8. How do I request a change in the MUE value for a HCPCS/CPT code?	If a provider/supplier, healthcare organization, or other interested party believes that an MUE value should be modified, it may write Correct Coding Solutions, LLC at the address below. The party should include its rationale and any supporting documentation. However, it is commonly recommended that the party contact the national healthcare organization whose members perform the procedure prior to writing to Correct Coding Solutions, LLC. The national healthcare organization may be able to clarify the reporting of the code in question. If the national healthcare organization agrees that the MUE level should be modified, its support and assistance may be helpful in requesting the modification of an MUE level. Requests for modification of an MUE level should be sent to the following: National Correct Coding Initiative Correct Coding Solutions, LLC P.O. Box 907 Carmel, IN 46082-0907 FAX: 317-571-1745 Some MUEs were modified in 2008 based on data refinement. The data refinement resulted in some MUE values being increased and others being decreased.
9. How do I make an inquiry about the MUE program other than about MUE levels for specific HCPCS/CPT codes?	Inquiries about the MUE program other than those related to MUE values for specific HCPCS/CPT codes should be sent to the following: Valeria Allen (valeria.allen@cms.hhs.gov)

Question	Answer
10. Has CMS published the MUE levels for HCPCS/CPT codes?	On October 1, 2008, with implementation of MUE version 2.3, the majority of existing MUEs with values of 1-3 were made public and posted on the CMS website. Future postings will also include some codes with MUE values of 4 or more. National healthcare organizations and contractors with information about MUE values that are not published on the CMS website should continue to maintain confidentiality of those values.
11. Will CMS implement MUEs for additional HCPCS/CPT codes?	CMS began implementation of MUEs for HCPCS/CPT codes on January 1, 2007. There are quarterly updates to the MUE files which include MUEs for additional codes. Although most HCPCS/CPT codes will have MUEs, some groups of codes have been temporarily excluded for future consideration.

Additional MUE Resources

CR 5402 – Medically Unlikely Edits (MUEs)

<http://www.cms.hhs.gov/transmittals/downloads/R178PI.pdf>

NCCI Edits: Medically Unlikely Edits (MUEs)

http://www.cms.hhs.gov/NationalCorrectCodInitEd/08_MUE.asp#TopOfPage

Quarterly Update to Medically Unlikely Edits (MUEs), Version 1.2, Effective July 1, 2007 (CR 5603)

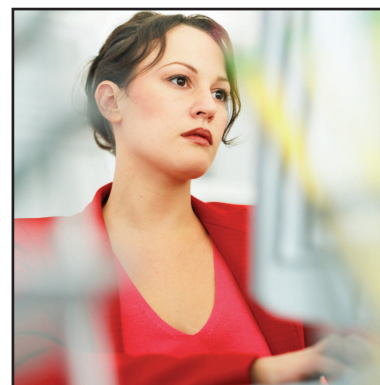
<http://www.cms.hhs.gov/transmittals/downloads/R1265CP.pdf>

Carrier/FI/MAC MR Program

Performed by: Medicare Claims Processing Contractors

Through analysis of claims data and evaluation of other information (e.g., complaints), suspected billing problems are identified by Medicare claims processing contractors. MR activities are targeted at identified problem areas appropriate for the severity of the problem.

If the Medicare claims processing contractor verifies that an error exists through a review of a small sample of claims, the contractor classifies the severity of the problem as minor, moderate, or significant and imposes corrective actions that are appropriate for the severity of the infraction.



The following types of corrective actions can result from MR:

- **Provider Notification/Feedback** — Problems detected at minor, moderate, or significant levels will require the contractor to inform the provider of appropriate billing procedures.

- **Prepayment review** — Prepayment review consists of MR of a claim prior to payment. Providers with identified problems submitting correct claims may be placed on “prepayment review”, in which a percentage of their claims are subjected to MR before payment can be authorized. Once providers have re-established the practice of billing correctly, they are removed from prepayment review.
- **Postpayment review** — Postpayment review involves MR of a claim after payment has been made. Postpayment review is commonly performed by using Statistically Valid Sampling. Sampling allows an underpayment or overpayment (if one exists) to be estimated without requesting all records on all claims from providers. This reduces the administrative burden for Medicare and costs for both Medicare and providers.

To help prevent improper payments, education for providers submitting claims is provided by Provider Outreach and Education (POE) department.

Both prepayment and postpayment reviews may require providers to submit medical records. When medical records are requested, the provider must submit them within the specified timeframe or the claim will be denied.

Note: Effective August 1, 2008, Quality Improvement Organizations (QIOs) are no longer performing the MR for payment of acute inpatient prospective payment system hospital and long-term care hospital claims submitted after December 31, 2007. These reviews are the responsibility of the A/B MACs or FIs. QIOs will continue to perform provider-requested higher-weighted Diagnosis Related Group reviews.

Additional Medical Review Resource

Medicare Program Integrity Manual

<http://www.cms.hhs.gov/Manuals/IOM/list.asp>



Comprehensive Error Rate Testing (CERT) Program

Performed by: CERT Review Contractor (CRC) and CERT Documentation Contractor (CDC)

CMS developed the CERT program to produce a national Medicare FFS error rate as required by the Improper Payments Information Act. CERT randomly selects a small sample of Medicare FFS claims. CERT then reviews the claims and medical records from providers/suppliers who submitted the claims, and reviews the claims for compliance with Medicare coverage, coding, and billing rules. In 2007, the CERT contractor randomly sampled 133,333 claims from Medicare claims processing contractors during a one-year period. This process was designed to pull a blind sample of claims each day from all of the claims providers submitted that day.

When performing these reviews, the CERT contractor follows Medicare regulations, billing instructions, National Coverage Determinations (NCDs), coverage provisions in interpretive manuals, and the respective Medicare claims processing contractor’s Local Coverage Determinations (LCDs). The CERT contractor does not develop or apply its own coverage, payment, or billing policies. To better measure the performance of the Medicare claims processing contractors and to gain insight into the causes of errors, CMS decided to calculate not only a national Medicare FFS paid claims error rate but also a provider compliance error rate. The results of the reviews are published in an annual report (and semi-annual updates).

Paid Claims Error Rate

This rate is based on dollars paid after the Medicare contractor made its payment decision on the claim. This rate includes fully denied claims for FFS claims. The paid claims error rate is the percentage of total dollars that all Medicare FFS contractors erroneously paid or denied and is a good indicator of how claim errors in the Medicare FFS Program impact the trust fund. CMS calculates the gross rate by adding underpayments to overpayments and dividing that sum by total dollars paid.

Provider Compliance Error Rate

This rate is based on how the claims looked when they first arrived at the Medicare claims processing contractor before the contractor applied any edits or conducted any reviews. The provider compliance error rate is a good indicator of how well the contractor is educating the provider community since it measures how well providers prepared claims for submission. CMS does not collect covered charge data from provider facilities that submit claims to FIs or A/B MACs; therefore, current facility data is insufficient for calculating a provider compliance error rate.

Other Error Rates

The CERT report may also describe other error rates to provide the most specific information available to target problem areas. Other error rates include error rates by specific contractor, by service type, and by provider type.

CERT Process

The CERT post-pay medical review process begins at the Medicare claims processing contractors. After the claims have been processed, samples of the claims are selected for CERT review. The CERT then uses information from the claims processing contractors to request documentation from the provider/supplier who submitted the sampled claim. The claim and the supporting documentation are reviewed by CERT program clinicians who determine if the claim was submitted and paid appropriately. The CERT program collects additional information from the contractor for each claim considered to be in error via a feedback process.

Due to the sampling methodology, very few providers would be subject to CERT review. However, provider claims that are selected for CERT review are subject to potential post-pay payment denials, payment adjustments, or other administrative or legal actions depending upon the result of the review. Claims can be adjusted or denied based on the CERT review and normal appeals rights and processes do apply.



Additional CERT Resources

Medical Review Process: CERT Web Page

http://www.cms.hhs.gov/MedicalReviewProcess/06_cert.asp#TopOfPage

CERT Overview Web Page

http://www.cms.hhs.gov/CERT/01_overview.asp#TopOfPage

CERT Reports Web Page

<http://www.cms.hhs.gov/CERT/CR/list.asp>

Recovery Audit Contractor (RAC)

Performed by: Medicare RAC Contractors

Section 306 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) required CMS to complete a three-year demonstration program to determine whether the use of RACs is a cost-effective means of identifying and correcting Medicare overpayments and underpayments in the Medicare Fee-For-Service Program. This demonstration program began in March 2005 with jurisdictions in California, Florida, and New York because they are the largest states in terms of Medicare utilization. In the summer of 2007, the demonstration program was expanded to three more states to include Massachusetts, South Carolina, and Arizona. The RAC demonstration program ended in March 2008. As of March 27, 2008, RACs succeeded in correcting more than \$1.03 billion in Medicare improper payments. Approximately 96 percent of the improper payments were overpayments collected from providers and the remaining four percent were underpayments paid to providers. The majority of the overpayments (85 percent) were collected from inpatient hospital providers; 6 percent were collected from Inpatient Rehabilitation Facilities (IRFs); and 4 percent were collected from outpatient hospital providers.

In December 2006, the Tax Relief and Health Care Act of 2006 made the RAC Program permanent and authorized the expansion of the program nationwide by January 10, 2010. CMS plans to implement the permanent RAC Program gradually beginning in the summer of 2008. The latest information about the permanent RAC Program can be found at http://www.cms.hhs.gov/RAC/10_ExpansionStrategy.asp#TopOfPage on the CMS website.

RAC Process

RACs are tasked with detecting and correcting improper payments on Medicare claims (i.e., collecting overpayments and paying back underpayments). During FY 2007, CMS gave each demonstration RAC all the claims for their jurisdiction that had been paid by Medicare claims processing contractors between October 1, 2002 and September 30, 2006.

RACs apply statutes, regulations, CMS national coverage, payment, and billing policies, as well as LCDs that have been approved by the Medicare claim processing contractors. RACs do not develop or apply their own coverage, payment, or billing policies.

In general, RACs will not review a claim that has previously been reviewed by another entity. RACs analyze the claims data using their proprietary software, and identify claims that clearly contain improper payments and those that likely contain improper payments. In the case of clear improper payments, the RAC contacts the provider and requests a refund of any overpayment amounts and pays the provider any underpayment amounts. In the case of claims that contain likely improper payments, the RAC requests the medical record from the provider, reviews the claim and medical record, and then makes a determination as to whether the claim contains an overpayment, an underpayment, or a correct payment.

If a denial or adjustment is indicated by the review, providers will receive overpayment/underpayment notification letters. Providers can appeal denials (including no documentation denials) following the normal appeal processes by submitting documentation supporting their claims.

Additional RAC Resources

RAC Overview Web Page

http://www.cms.hhs.gov/RAC/01_Overview.asp#TopOfPage

RAC Expansion Strategy Web Page

http://www.cms.hhs.gov/RAC/10_ExpansionStrategy.asp#TopOfPage

Proposed 2008 RAC Jurisdictions Map

<http://www.cms.hhs.gov/RAC/Downloads/Four%20RAC%20Jurisdictions.pdf>

CMS RAC Status Document FY 2007

<http://www.cms.hhs.gov/RAC/Downloads/2007%20RAC%20status%20Document%20vs1.pdf>

Table 4. Summary of MR, NCCI Edits, MUE, CERT, and RAC

	NCCI	MUE	Carrier/FI/ MAC Medical Review	CERT	RAC
Providers Impacted	<i>Providers who submit claims for Part B services using HCPCS/CPT codes</i>	<i>Providers who submit claims for Part B services using HCPCS/CPT codes</i>	<i>Providers who submit FFS claims</i>	<i>Providers who submit FFS claims</i>	<i>Providers who submit FFS claims</i>
Medicare Contractor	<i>CCI Contractor (develops the edits) Medicare claims processing contractor operates the edits</i>	<i>CCI Contractor (develops the edits) Medicare claims processing contractor operates the edits</i>	<i>Carriers Fiscal Intermediaries Medicare Administrative Contractors</i>	<i>CERT Review Contractor (CRC) CERT Documentation Contractor (CDC)</i>	<i>Medicare RAC Contractors</i>
Claims Impacted	<i>All Part B claims screened</i>	<i>All Part B claims screened</i>	<i>Targeted claim review – number varies by Contractor's Medical Review strategy</i>	<i>Limited random claim sample – historically < 150,000 nationally/year</i>	<i>Targeted claim review – number varies by RAC's audit strategy</i>
Prepayment Edit	<i>Yes – tables updated quarterly</i>	<i>Yes – tables updated quarterly</i>	<i>Yes</i>	<i>No</i>	<i>No</i>

	NCCI	MUE	Carrier/FI/ MAC Medical Review	CERT	RAC
Postpayment Medical Record Review	No	No	Yes	Yes	No – if clear payment error Yes – if likely payment error
Provider Response to Audit Request	N/A	N/A		Providers must submit medical records to the CDC within 30 days from the receipt date of the initial letter	Providers must submit medical records to the RAC (or request an extension) within 45 days from the date of the initial letter requesting medical records
Right to Appeal	No	Yes – if billed to Carriers or MACs No – if billed to FIs or A/B MACs (but may resubmit when RTP'd)	Yes – using traditional appeals processes	Yes – using traditional appeals processes	Yes – using traditional appeals processes

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