PERFORMANT

Region [*Region #*] Recovery Audit Contractor (RAC)

Date [*Request Date*]

[*Facility Point of Contact*]
[*Physician Practice Name*]
[*Street Address Line 1*]
[*Street Address Line 2*]
[*City, State ZIP*]

NPI:
PTAN:
Phone:
Fax:
Letter Request ID:
Batch ID:

RE: Review Results Letter

Dear Medicare Provider/Supplier,

Thank you for your cooperation with providing the additional documentation requested in our previous letter, dated [*ADR Letter Date*]. Based on our review of the documentation, it has been determined that the claim was paid in error, resulting in an improper payment. Therefore, good cause has been established for reopening the claim in accordance with reopening procedures addressed in 42 CFR, sections 405.980(a)(1) and (b)(2), and 405.986.
As described in our previous letter, in accordance §§ 1874A(h)(4) and 1893(f)(7), (h)(1) and (3) of the Social Security Act, the Centers for Medicare & Medicaid Services (CMS) has retained Performant Recovery, Inc. (Performant) as the Recovery Audit Contractor (RAC) to carry out the Recovery Audit Program Region (Select for Region 1) [1 which includes CT, IN, KY, MA, ME, MI, NH, NY, OH, RI, and VT] (Select for Region 2) [2 which includes AR, CO, IA, IL, KS, LA, MN, MO, MS, NE, NM, OK, TX, WI] (Select for Region 5) [5 which is Nationwide]. The RAC program, mandated by Congress, is aimed at identifying Medicare improper payments. Improper payments include overpayments and underpayments. Improper payments may occur because of incorrect coding, lack of sufficient documentation or no documentation, use of an outdated fee schedule, billing for services that do not meet Medicare's coverage and/or medical necessity criteria, or failure to follow other program requirements.

The RAC may reopen and revise the initial determination or redetermination made on a claim within 4 years from the date of the initial determination or redetermination upon establishing

good cause. Good cause may be established when there is new and material evidence that was not available or known at the time of the determination or decision; and may result in a different conclusion; or the evidence that was considered in making the determination or decision clearly shows on its face that an obvious error was made at the time of the determination or decision. Good cause for reopening a claim may include but is not limited to OIG report findings, data analysis findings, comparative billing analysis, etc. Reopenings of initial claim determinations by Medicare contractors are addressed in the following Medicare legal and regulatory documents: Social Security Act (SSA), § 1869(b)(1)(G), 42 CFR 405.926, 42 CFR 405.980(a)(1) and (b)(2), 42 CFR 405.982, 42 CFR 405.984, 42 CFR 405.986, the Medicare Claims Processing Manual, CMS Pub. 100-04, Chapter 34, Sections 10.6.1 and 10.11, Medicare Claims Processing Manual, Pub. 100-04, Chapter 34, Section 10.6.1 and Medicare Program Integrity Manual, CMS Pub 100-08, Chapter 3, Section 3.5.1.

YOUR RIGHT TO DISAGREE

*If you disagree with our findings, you have the option to complete our **Discussion Request Form** which must include evidence to support why you feel the services you provided are covered by Medicare and were properly coded and correctly billed.*

- If the additional documentation you provide substantiates a change to our original finding, no adjustment will be sent to your Medicare Administrative Contractor (MAC), and we will send you a revised letter.
- You have 30 days from the date of this review results letter, which is also the date of the provider portal notification, to submit the discussion request in writing. If you need an extension to submit your documentation during the 30-Day Discussion Period, please contact Customer Service at **[RAC call in #]**.
- During this period, or during our review of your discussion request, Performant will not submit any adjustments to your Medicare Administrative Contractor (MAC). After that period expires, the claim(s) identified as improper will be shared with your Medicare Administrative Contractor (MAC) and they will issue a demand letter which will also describe your formal appeal rights from that point forward.
- You can find the most updated discussion request form at https://performantrac.com/sample-documents/ and the submission instructions are on the discussion request form itself – including how the physician or a physician who is employed by the provider, not a consultant, may request to speak to Performant's Medical Director.

Reason for Review:

This review was conducted because our analysis of your billing data revealed that services may have been improperly billed to Medicare. Refer to Audit Detail section below for more details of the review.

How the Overpayment was Determined:

As part of a complex, post-pay targeted review initiative for the issue approved by CMS, claims processed were selected for review to determine if the services billed were reasonable and necessary and that all other requirements for Medicare coverage were met, under the provisions outlined in sections 1814, 1833(e), 1835, 1861, 1862, and 1866(a)(1)(A)(i) of the Social Security Act (SSA). The selected claim was reopened on [ADR Date] and the documentation you provided to us was reviewed by our medical review staff.

Based on the medical documentation reviewed for the selected claims, we found that the service/item you submitted for reimbursement were not reasonable and necessary, as required by the Medicare statute, or did not meet other Medicare coverage requirements. Along with our claims payment determination, we made limitation on liability decisions for denials of those services subject to the provisions of §1879 of the Social Security Act (the Act). Those claims for which we determined that you knew, or should have known, that the services were noncovered have been included in the results of this review. In addition, we made decisions as to whether or not you are without fault for the overpayment under the provisions of §1870 of the Act. Those claims for which you are not without fault have been included in the results of this review.

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- You can find the most updated discussion request form at https://performantrac.com/sample-documents/ and the submission instructions are on the discussion request form itself – including how the physician or a physician who is employed by the provider, not a consultant, may request to speak to Performant's Medical Director.

Audit Detail

All applicable reviews have been conducted on the claim(s) and the results are indicated below. No further RAC reviews will be performed.

HICN/MBI #: [*HICN/MBI #*]
Beneficiary: [*Beneficiary Name*]
Claim #: [*Claim #*]
Patient Ctrl #: [*Patient Ctrl #*]
Case ID: [*Case ID*]
Date(s) of Service: [*mm/dd/yyyy – mm/dd/yyyy*]

PROVIDER DRG ASSIGNMENT: xxx *(insert DRG description here)*

Principal Diagnosis Code & POA: xxx.xx Y
Secondary Diagnosis Code(s) & POA: xxx.xx Y, xxx.xx N *(could be up to 8 total- POA could be Y, N, U, W or 1)*

Principal Procedure Code: xx.xx
Secondary Procedure(s): xx.xx, xx.xx *(could be up to 5 total)*

Discharge Status/Disposition: xx *(always 2 numbers)*

PERFORMANT REVISED DRG ASSIGNMENT: xxx *(insert DRG description here)*

Principal Diagnosis Code & POA: xxx.xx Y
Secondary Diagnosis Code(s) & POA: xxx.xx Y, xxx.xx N (*could be up to 8 total- POA could be Y, N, U, W or 1)*

Principal Procedure Code: xx.xx
Secondary Procedure(s): xx.xx, xx.xx *(could be up to 5 total)*

Discharge Status/Disposition: xx *(always 2 numbers)*

Rationale for Audit Determination:

[Determination Rationale] [Auditor Notes. Narrative description examples:

- Based on criteria addressed in Social Security Act, §§ 1833(e) and 1861(a)(1)(A), and (insert any additional, applicable references, such as Medicare Manuals, LCD, LCA), the documentation in the medical record(s) you submitted for review did not include such information as necessary to determine that the billed service(s) was reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.
- The documentation submitted for review did not include sufficient information to support that Medicare's coverage criteria was met per [insert applicable LCD/NCD/LCA

- The documentation submitted for review did not include sufficient information to support the: level of service billed/service was rendered as billed/item was coded as billed.

Clinical Review Supporting Documentation: [Clinical Rationale (if exists)]

If you believe determination was made in error, you have an opportunity to enter into a Discussion Period with Performant. Providers should use the discussion period to determine if there is other information, relevant to supporting the payment of the claim that could be sent to the Recovery Auditor. Please complete the "Discussion Period Request Form" posted on Performant's RAC Forms and Samples page (https://performantrac.com/sample-documents/) and submit it within 30 days from the date of this letter. You also have an opportunity to submit a request for a Physician-to-Physician Discussion with Performant's Medical Director and provide additional information to support the original payment of the claim(s). Providers/Suppliers are encouraged to use the Discussion Period to determine if there is other information, relevant to supporting the payment of the claim reopened by the Recovery Auditor. For more information, please refer to the detailed explanation of the 30-Day Discussion Period provided in further sections of this letter.

Why You Are Responsible:

You are responsible for the overpayment if you knew or had reason to know that service(s) were not reasonable and necessary, and/or you did not follow correct procedures or use care in billing or receiving payment, and you are found to be not without fault under §1870 of the Act. A list of specific claims that have been determined to be fully or partially noncovered, the specific reasons for denial, identification of denials that fall under §1879 of the Act and those that do not, the determination of whether you are without fault under §1870 of the Act, an explanation of why you are responsible for the incorrect payment can be found in Audit Detail section above.

Disagree with Findings? Your Right to a Discussion

This letter serves as notification of our revised determination of the claim(s) listed in the Audit Detail section above. If you disagree with this determination and wish to discuss this matter, you may request to do so within 30 days from the date of this letter.

What is the 30-Day Discussion Period?

The 30-Day Discussion Period offers Providers/Suppliers the opportunity to review the improper payment findings and provide Performant with additional information and/or documentation to

support the original payment, prior to the claim being forwarded to the Medicare Administrative Contractor (MAC) for adjustment.

During the 30-Day Discussion Period, Providers/Suppliers may also request a Physician-to-Physician Discussion. This allows the Provider/Supplier an opportunity to request a conversation between the ***physician**** that directly cared for the beneficiary, or a physician employed in the same facility where that care was provided, and Performant's Medical Director to discuss details of the services that were billed, but may not have been clearly documented in the medical record, or that were potentially misinterpreted by the RAC reviewer.

Providers/Suppliers and Physicians should use the discussion period to determine if there is other information, relevant to supporting the payment of the claim that could be sent to the RAC.

**** Please Note:*** A physician employed by the provider does not include those providers employed as consultants. The term "physician", when used in connection with the performance of any function or action, means (1) a Doctor of Medicine or Osteopathy legally authorized to practice medicine and surgery by the State in which he/she performs such function or action or (2) a Doctor of Podiatric Medicine legally authorized to perform as such by the State (Social Security Act- Sec. 1861(r)). Therefore, Physician-Physician Discussion requests shall not be granted to a physician employed by the provider as a consultant, nor to anyone acting in a billing administrator or other non-physician-related capacity for the provider.

What happens after submitting the Discussion Form and additional documentation/information?

The RAC will provide confirmation of the Discussion request via the Provider Portal within one (1) business day of receiving your completed request form. Performant encourages providers/suppliers to check the Provider Portal to track the receipt status of the Discussion request documentation.

Documentation and information received during the Discussion Period will be reviewed by qualified Performant personnel, including but not limited to clinicians and certified coders, depending upon the type of review. Performant will send a notification via the provider portal and a letter with a detailed explanation of the discussion review determination to the provider within 30 days of receipt of the request.
If the claim determination is favorable to you, the claim will not be forwarded to the MAC for adjustment.

Important Information and Instructions for Requesting a Discussion with the RAC during the 30-Day Discussion Period

- Access the **Discussion Period Request Form** located on Performant's website at https://performantrac.com/sample-documents/ or in the Provider Information section of

Performant's secure provider portal at https://secure.performantrac.com/ and complete it electronically. This form must accompany all discussion requests.

- Complete the Discussion Period Request Form electronically (please do not hand write) and submit within **30 days** from the date of this letter.
- **If you need an extension of time to submit your documentation during the 30-Day Discussion Period, please call Customer Service at [RAC call in #].**
- Performant will wait 30 days, after sending the Review Results Letter to allow for the receipt of a discussion request, before forwarding the claim(s) to the Medicare Administrative Contractor (MAC) for adjustment.
- One Request Form must be submitted for each claim you wish to discuss
- You may request a Physician-to-Physician Discussion and clearly indicate so on the Request Form.
- If requesting a Physician-Physician Discussion, please include the name and credentials of the physician who will attend the call, as well as a detailed narrative, describing the reason for the request and any additional information relevant to the payment of the claim.
- Upon submitting the request, please use the completed Discussion Period Request Form as the first page of each submission.
- Along with the completed Request Form, include evidence, such as additional documentation and/or information, to support why you believe the claim(s) was properly coded, correctly billed, and should be covered by Medicare (coverage indications, limitations, and/or medical necessity).

- Please submit the **Discussion Period Request Form AND accompanying documentation by mail or fax.**
- If submitting by mail, please use a traceable method with delivery confirmation.

Mail to:
Performant Recovery, Inc.
Discussion Period Request
P.O. Box 3568
San Angelo, TX 76902

- If submitting by secure fax, please use fax cover form indicating the number of pages and fax to (833) 366-6118. Please verify successful transmission by printing a confirmation report.

Please call Performant's Customer Service at [RAC call in #] if you have any questions. Thank you for your prompt attention to this matter.
Sincerely,

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Notes, are not included in the letter but are used to assist with construction of the letter

03/15/23 ver 1.2.8 Add conditional text on page 1 for Region 2
09/29/23 ver 1.2.9 Remove med rec fax # from footer