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: Technical Denial Letter

Dear Medicare Provider/Supplier,

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, and 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payments may occur because of incorrect coding, lack of sufficient documentation or no documentation, use of an outdated fee schedule, billing for services that do not meet Medicare's coverage and/or medical necessity criteria, or failure to follow other program requirements.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.

Reason for Selection:

This selection 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).

At this time, the RAC has not received the requested records; therefore, the claim has been denied due to lack of documentation to support the billed services.

You have the right to submit the medical records within 30-calendar days of the date of this letter. Medical records may be submitted via paper, fax, CD/DVD, and via esMD as instructed in the Additional Documentation Request. A Discussion Request Form should not be used for this type of denial.

If the medical records are received within 30-calendar days of the date of this letter, the RAC shall conduct a medical review of the submitted documentation using the CMS-approved review guidelines. A Review Results letter will be sent to you. At that time, you will have the right to disagree and may submit a discussion request.

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.

Disagree with Findings?

You have the right to submit the medical records within 30-calendar days of the date of this letter. Medical records may be submitted via paper, fax, CD/DVD, and via esMD as instructed in the Additional Documentation Request. A Discussion Request Form should not be used for this type of denial.

Audit Detail

At this time, the RAC has not received the requested records; therefore, the claim has been denied due to lack of documentation to support the billed services.

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*]

Rationale for Audit Determination:
[Determination Rationale]

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,

Performant Region [*Region #*]
Recovery Audit Contractor

Performant Recovery, Inc.
[Address 1]
[Address 2 (if necessary)]
[City, State, Zip]

[RAC call in #] TOLL FREE
[RAC fax number] FAX
www.performantrac.com