

Region [Region #] Recovery Audit Contractor (RAC)

Date [Request Date]

[Point of Contact]

[Physician Practice Name]

[Street Address Line 1]

[Street Address Line 2]

[City, State ZIP]

Re: [Provider Name] - NPI [Provider NPI]

Subject: Additional Documentation Request

Letter Request ID: [Letter Request ID]

Batch ID: [Batch number – letter sequence number]

Dear Medicare Provider/Supplier,

The Centers for Medicare & Medicaid Services (CMS) has retained Performant Recovery, Inc. (Performant) to carry out the Recovery Audit Contractor (RAC) program in Region [Select for Region 1] [1 which includes MI, IN, CT, OH, NY, VT, NH, ME, MA, RI, and KY] [Select for Region 5] [5 which is Nationwide]. The RAC program, mandated by Congress, is aimed at identifying Medicare improper payments.

The results of our data analysis justified reopening your claim(s) under §1869(b) (1) (G) of the Social Security Act and 42 CFR 405.980(a) (1). These results also serve as good cause to reopen the claim(s), if required by 42 CFR 405.980(b) (2).

Performant is requesting additional documentation for the claims listed in the attachment as part of a post payment review. The claims were selected based on a CMS approved issue. After the review of the claim(s) is complete, you will receive a Review Results Letter with the final review determination. If an underpayment or overpayment is identified, there is a 30-day period in which you may submit a discussion request form to review the matter. Once the discussion request has been responded to or the 30 day period has passed, the claim(s) will be sent to your Medicare Administrative Contractor (MAC) for adjustment. Details regarding the issue(s) identified are listed in the attachment.

Should you choose to have Performant send all future correspondence to a different address than what was used for this letter, please go to Performant's website and update the address on file. To customize your address and/or contacts please go to <https://www.performantrac.com/>. Select the [Click Here](#) button on the right side of the home page and an address customization form is available to you 24/7. To check claim review status information, log into the Secure Provider Portal link on the website. Questions regarding any updates or login procedures should be directed to Customer Service at 1-866-201-0580.

Performant Recovery, Inc.

[Address 1]

[Address 2 (if necessary)]

[City, State, Zip]

866-201-0580 TOLL FREE

325-224-6710 FAX

www.performantrac.com

In accordance with 42 USC 1320(c) (5) (A) (3) and §1833 of the Social Security Act, you must provide documentation upon request to support claims for Medicare services. This request is in compliance with the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule, which allows release of information without explicit patient consent for treatment, payment and health care operations.

All documentation should be submitted to the address or fax number below within 45 days of the date of this notice. The due date is *[insert record due date 45 days from ADR date]*. Your response is required even if you are unable to locate the requested documentation.

CMS has established a new maximum number of medical records that can be requested from a provider per 45 day period. CMS reserves the right to establish a different record limit when directing the Recovery Auditors to conduct reviews of specific topics or providers.

Please consult the following CMS links regarding ADR limit determinations based on provider types:

Additional Documentation Limits for Institutional Providers

<https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Recovery-Audit-Program/Downloads/Institutional-Provider-Facilities-ADR-Limits.pdf>

Additional Documentation Limits for Durable Medical Equipment (DME) Suppliers

<https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Recovery-Audit-Program/Downloads/April-2013-Supplier-ADR-Limit-Update2.pdf>

Physician/Non-Physician Practitioner Additional Documentation Limits

<https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Recovery-Audit-Program/Downloads/PhyADR.pdf>

The maximum number of medical records that may be requested from you per 45 days is:

Bill Type	ADR Limit	Bill Type	ADR Limit	Bill Type	ADR Limit	Bill Type	ADR Limit	Bill Type	ADR Limit	Bill Type	ADR Limit
11X	2	12X	0	13X	1	14X	7	15X	0	16X	5
17X	16	18X	0	19X	18	20X	1	21X	9	22X	10
23X	0										

(or)

Bill Type	ADR Limit	Bill Type	ADR Limit	Bill Type	ADR Limit
11X	10	PHYS	8	DME	3

Note: these are two different samples of the table that will hold the data

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

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If you fail to send the requested documentation or contact us by the record due date listed above, the claim will be submitted to the Medicare contractor and a claim adjustment or overpayment recoupment will be initiated.

Performant is required to reimburse providers for the submission of medical records. PIM section 3.2.3.6 regarding medical record reimbursement does not apply to DMEPOS Suppliers. If you meet the definition of a PPS provider, payment will be in the amount of \$.12 cents per page plus shipping cost if mailed via USPS regular mail. If you are a non-PPS institution or practitioner, records will be reimbursed at \$.15 cents per page plus shipping. If sent via esMD an additional \$2 will be added in lieu of postage. The maximum payment to a provider per medical record shall not exceed \$27 if records are submitted via esMD or \$25 for all other submission types.

A copy of the attached barcode page should be affixed to the requested additional documentation. Please bundle documents for each claim separately, with the barcode page on top, to enable us to confirm receipt of documents.

- Please be sure all documentation submitted is **legible**
- **All Blank pages should be OMITTED** (Note: Provider will not be paid for blank pages)
- Free of staples, paperclips or holes of any kind
- Records must be copied on **only one side**
- The image file name **MUST** be “provider NPI-Claim number”. For example if the claim number **123456** is requested and the provider NPI was **654321**, the filename would be **654321-123456.pdf** or **654321-123456.tiff**
- Multiple charts can be sent on one CD/DVD but each chart request must be a separate PDF/TIFF file.

You may submit this documentation by postal mail (either on paper or as images on CD/DVD), via fax, or esMD.

If you choose to password protect the CD/DVD please use password: [*CD Password*]
Requirements for submitting imaged documentation on CD or DVD can be found on <https://www.performantrac.com/>

Documentation can be mailed to:

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

Documentation can be faxed to: 325-224-6710.

Please visit the following CMS web page for background on [esMD](https://www.cms.gov/ESMD/)
(<https://www.cms.gov/ESMD/>)

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

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www.performantrac.com

Questions regarding this request should be directed to Customer Service at 1-866-201-0580.

Sincerely,
Performant
Region [Region #]
Recovery Audit Contractor
Enclosure

Inserts:
Claim(s) and Issue(s) Selected for Review
Bar Code Sheet(s)

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

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Requested Claims

Issue: [CMS Issue Number] [Concept Name], [Code Type] [List of Codes]

Good Cause: [Required paragraph 1]

[Optional paragraph 2]

[Optional paragraph 3]

Beneficiary Information		Medical Record / Patient Control / Claim #		Dates of Service ase #	
Name:	[Name]	MR#	[MR#]	Fm:	[FM]
DOB:	[DOB]	Control#	[Control #]	To:	[TO]
HIC#	[HIC#]	Claim#	[Claim #]	Case #:	[Case#]
Amount:	[Amount]				
Name:	Doe, Jane	MR#	XYZ1234567	Fm:	4/7/2008
DOB:	11/11/1932	Control#	XZ1234567JW	To:	4/7/2008
HIC#	1234567891A	Claim#	401122334455	-Case #:	900045677777
Amount:	[Amount]				
Name:	Rodriquez, Jesus	MR#	NNN1234567	Fm:	6/6/2008
DOB:	11/11/1933	Control#	YZ1234567FF	To:	6/6/2008
HIC#	1234567892A	Claim#	309988776655	-Case #:	900054683245
Amount:	[Amount]				

Please submit the following components of the medical record corresponding to claim date(s):

[List of required MR Sections]

[Free for text for additional instructions]

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

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Please include the below barcode cover page with the requested additional documentation. If you send paper, please copy the barcode cover page as the first page for each document and check mark the barcode associated with the documents attached. Please include the barcode page with faxed documents. **Documentation submitted without proper identifying documentation will not be loaded.** Questions regarding this request should be directed to Customer Service at 1-866-201-0580.

Beneficiary Information		DOB & DOS		Case #
Name:	Smith, John	DOB:	11/11/1931	900054683245
Claim#:	5012345678901234ABC	HIC	1234567890A	
PT Cntrl:	501234567890.23456	DOS	01/06/08 - 01/08/08	
Amount	:			[Bar Code]
Name:	Doe, Jane	DOB:	11/11/1931	900054683245
Claim#:	501234567890	HIC	1234567890A	
PT Cntrl:	501234567890	DOS	01/06/08 - 01/08/08	
Amount				[Bar Code]
Name:	Rodriquez, Jesus	DOB:	11/11/1931	900054683245
Claim#:	501234567890	HIC	1234567890A	
PT Cntrl:	501234567890	DOS	01/06/08 - 01/08/08	
Amount				[Bar Code]
Name:	Smith, John	DOB:	11/11/1931	900054683245
Claim#:	5012345678901234ABC	HIC	1234567890A	
PT Cntrl:	501234567890.23456	DOS	01/06/08 - 01/08/08	
Amount				[Bar Code]
Name:	Doe, Jane	DOB:	11/11/1931	900054683245
Claim#:	501234567890	HIC	1234567890A	
PT Cntrl:	501234567890	DOS	01/06/08 - 01/08/08	
Amount				[Bar Code]