PERFORMANT

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES

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

Date: [*Current Date*]

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

Re: [*Provider Name*] [*Provider NPI*]
Subject: Review Results Letter
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. 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payments may occur because of incorrect coding, lack of sufficient documentation or no documentation, use of an outdated fee schedule, billing for services that do not meet Medicare's coverage and/or medical necessity criteria, or failure to follow other program requirements.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 request for additional medical documentation, detailed in a letter dated [*ADR Letter Date*], constituted reopening under §1869(b)(1)(G) of the Social Security Act (the Act) and 42 CFR 405.980(a) (1). Our good cause to reopen the claim, if required by 42 CFR 405.980(b) (2), was described in the letter as well.

Based on the medical documentation reviewed for the selected claim(s), Performant determined whether the services were reasonable and necessary as required by §1861 of the Act, or met the Medicare coverage requirements as required in §1862 of the Act, or met the requirements outlined in §1866 (a)(1)(A)(i) of the Act.

Along with the claims payment determination, there were limitations of liability decisions for denials of those services subject to provisions of §1879 of the Act. Those claims for which it

was determined that you knew, or should have known, and the beneficiary did not know or could not have been reasonably expected to have known that the services were noncovered have been included in the results of this review. In addition, there were determinations as to whether or not you are without fault for the improper payment under the provisions of §1879 of the Act. Those claims for which you are not without fault have been included in the results of this review. Detailed information regarding these claims and the findings identified during the review are attached to this letter.

Disagree with the Findings? Your Right to a Discussion

If you disagree with the findings and wish to discuss this matter:

- Please complete the **Discussion Period Request Form** at https://performantrac.com/sample-documents/ and fax to 833-366-6118
- Please submit within **30 days** from the date of this letter. The Recovery Auditor will wait this mandatory period before forwarding the claim to the Medicare Administrator Contractor (MAC) for adjustment.
- For Denied Claims- Your request to discuss this matter must include:
    - Evidence to support why your services provided are covered by Medicare (coverage indications, limitations and medical necessity) were properly coded and correctly billed.
- You may also request a physician-to-physician discussion at the time the discussion form is submitted.
- 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 Recovery Auditor.
- Please include a detailed narrative of the ***physician-to-physician** request describing additional information relevant to the payment of the claim.
- A physician who is employed by the provider as a consultant cannot take part in the physician-to-physician discussion as per the RAC statement of work.

*Please note: 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 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))

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
Enclosure

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

DRG Review Results

HICN #: [*HICN #*]
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: [*Insert DRG description here*]

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

Principal Procedure Code: [*Principal Code*]
Secondary Procedure(s): [*Secondary Code(s) (*Could be *up to 5 total.)*]

Discharge Status/Disposition: [*Discharge Code (Always 2 numbers)*]

PERFORMANT REVISED DRG ASSIGNMENT: [*Insert DRG description here*]

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

Principal Procedure Code: [*Principal Code*]
Secondary Procedure(s): [*Secondary Code(s) (*Could be *up to 5 total.)*]

Discharge Status/Disposition: [*Discharge Code (Always 2 numbers)*]

Audit Determination Rationale:
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.

This claim has been selected and reviewed as part of a coding validation audit. Data analysis reveals a billing pattern that is potentially inconsistent with one or more of the following: CMS Internet-Only Manuals (IOMs), Publication 100-08; Medicare Program Integrity Manual (PIM), Chapter 6, Section 6.5.3 - DRG Validation Review; ICD-9 or ICD-10 Coding Manual (for dates of service on claim); ICD-9 or ICD-10 Addendums and Coding Clinics; Uniform Hospital Discharge Data Set (UHDDS) - Reporting of Inpatient Data Elements, July 31, 1985, Federal Register (Vol. 50, No. 147), Pages 31038-31040.

Coder DRG Validation/Sequencing:

[*RAC shall include additional information here such as specific details on which coverage/medical necessity/coding payment policy or article was violated. This would include a statement as to what is at the core of the major issue, i.e., which rules apply and which provisions were violated, as well as the patient specific information, including the results of the individual review and rationale for the decision as well as any coding changes that will occur - if any.*]

Discussion Period

- If you disagree with our decision, you can request a Discussion Period.
- To request a Discussion Period, complete form at https://performantrac.com/sample-documents/ and send by mail/fax to Performant.
- You may request a ***physician-to-physician** discussion and clearly indicate so on the Discussion Period Form.
- Providers can submit additional information or documentation during the 30 day Discussion Period to support why their claim was paid correctly.
- Please include a detailed narrative of the ***physician-to-physician** request describing additional information relevant to the payment of the claim.
- After waiting the mandatory 30 days, the Recovery Auditor will forward the claim to the MAC for adjustment.

***Please note,** a physician who is employed by the provider as a consultant cannot take part in the physician-to-physician discussion as per the RAC statement of work. 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 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)).

Clinical Review Supporting Documentation: (Optional)
[*Clinical Review Rationale*]