



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: Automated Review Initial Findings Letter

Dear Medicare Provider/Supplier,

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], in accordance §§ 1874A(h)(4) and 1893(f)(7), (h)(1) and (3) of the Social Security Act. 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payments may occur because of incorrect coding, lack of sufficient documentation or no documentation, use of an outdated fee schedule, billing for services that do not meet Medicare's coverage and/or medical necessity criteria, or failure to follow other program requirements.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.

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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-](#)

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.

[08, Chapter 3, Section 3.5.1.](#)

Performant conducted data analysis on claims that identified improper payment(s). The data analysis revealed an aberrant billing pattern or that national or local coverage criteria was not met for the services billed. Based on this information, good cause was established, and the claims were reopened in accordance with the reopening procedures addressed in 42 CFR, sections 405.980(a)(1) and (b)(2), and 405.986. As a result, it was determined that your claim was paid in error, resulting in an overpayment.

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.

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How the Overpayment was Determined:

As part of an automated, 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 and reviewed on [Insert Date of IFL].

Based on the review of the selected claim(s), we found that the service(s)/item(s) 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 claim(s) 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. Detailed information regarding these claims and the findings identified during the review are attached to

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- 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.

this letter.

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Rationale for Audit Determination:

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.

Detailed information regarding the claim(s) and finding(s) identified during the review are attached to 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, and the amount of the overpayment is attached.

Disagree with Findings? Your Right to a Discussion

This letter serves as notification of our revised determination of the claim(s) listed in the attachment. 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.

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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.

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.

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- **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 this Initial Finding 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,

Performant
 Region [Region #]
 Recovery Audit Contractor

Performant Recovery, Inc.
 [Address 1]
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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.

Issue: [CMS Issue Number] [Concept Name], [Code Type (blank if not applicable)] [List of Codes (blank if not applicable)]

Rationale:

[Required paragraph 1.] – Vulnrabilitycodes.demandtext
[Optional paragraph 2] - Vulnrabilitycodes.demandtext1
[Optional paragraph 3] - Vulnrabilitycodes.demandtext2

Beneficiary Information/ Date of Service		Medical Record / Patient Control /Claim #/ Original Claim Paid Amount		Case #
Name:	Smith, John	MR#	ABC1234567	 9 0 0 0 5 4 6 8 3 2 4 5
DOB:	11/11/1931	Control#	XY1234567NN	
HIC/MBI:	1234567890A	Claim#	501234567890	
DOS	01/06/2008 to 01/08/2008	Amount	\$122,345.00	
Admit	01/06/2008	Discharge	01/08/2008	
<p>Line # [] DOS MM/DD/YYYY-MM/DD/YYYY</p> <p>Provider Billed: HCPCS: xxxxxx Modifiers: xx xx xx xx Units: ### POS: ###</p> <p>RAC Suggested: HCPCS: xxxxxx Modifiers: xx xx xx xx Units: ### POS: ###</p> <p>Reference Claim: [Claim Number or N/A] Line Number: xx Paid On: mm/dd/yyyy HCPCS: [HCPCS] DOS: [mm-dd-yyyy – mm-dd-yyyy] Modifiers: [mm, mm] Units: [uuu] Admit: [mm-dd-yyyy] Discharge: [mm-dd-yyyy]</p>				
Name:	Smith, John	MR#	ABC1234567	 9 0 0 0 5 4 6 8 3 2 4 5
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Issue: [CMS Issue Number] [Concept Name], [Code Type (blank if not applicable)] [List of Codes (blank if not applicable)]

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.

[Required paragraph 1.]
[Optional paragraph 2]
[Optional paragraph 3]

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Name:	Smith, John	MR#	ABC1234567	
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HIC/MBI:	1234567890A	Claim#	501234567890	
DOS	01/06/08 to 01/08/08	Amount	\$122,345.00	
Admit Date	01/06/2008	Discharge Date	01/08/2008	
Line # [4] DOS MM/DD/YYYY-MM/DD/YYYY Provider Billed: HCPCS: xxxxxx Modifiers: xx xx xx xx Units: ### POS: ### RAC Suggested: HCPCS: xxxxxx Modifiers: xx xx xx xx Units: ### POS: ### Reference Claim: [Claim Number or N/A] Line Number: xx Paid On: mm/dd/yyyy HCPCS: [HCPCS] DOS: [mm-dd-yyyy – mm-dd-yyyy] Modifiers: [mm, mm] Units: [uuu] Admit: [mm-dd-yyyy] Discharge: [mm-dd-yyyy]				
Name:	Smith, John	MR#	ABC1234567	
DOB:	11/11/1931	Control#	XY1234567NN	
HIC/MBI:	1234567890A	Claim#	501234567890	
DOS	01/06/08 to 01/08/08	Amount	\$122,345.00	
Admit Date	01/06/2008	Discharge Date	01/08/2008	
Line # [4] DOS MM/DD/YYYY-MM/DD/YYYY Provider Billed: HCPCS: xxxxxx Modifiers: xx xx xx xx Units: ### POS: ### RAC Suggested: HCPCS: xxxxxx Modifiers: xx xx xx xx Units: ### POS: ### Reference Claim: [Claim Number or N/A] Line Number: xx Paid On: mm/dd/yyyy HCPCS: [HCPCS] DOS: [mm-dd-yyyy – mm-dd-yyyy] Modifiers: [mm, mm] Units: [uuu] Admit: [mm-dd-yyyy] Discharge: [mm-dd-yyyy]				

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Issue: [CMS Issue Number] [Concept Name], [Code Type (blank if not applicable)] [List of Codes (blank if not applicable)]

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.

[Required paragraph 1.]

[Optional paragraph 2]

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