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Customer Service Program Manager

RECOVERY AUDIT CONTRACTOR (RAC) REGION 1

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

PERFORMANT

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All processes and guidelines are undergoing continuous improvement and modification by Performant and the Centers for Medicare and Medicaid Services (CMS). The most current edition of the information contained in this release can be found on the Performant RAC Website and the Medicare Fee for Service Recovery Audit Program | CMS.

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AGENDA

- Performant Introduction
- Scope of RAC Regions & Key Contract Characteristics
- Recovery Audit Goals
- Review Types
- Additional Documentation Requests (ADR letters)
- Record Submissions and Reimbursement
- RAC Website Resources Review
  - Resource links
  - Provider portal
  - ADR limits
  - Contact names, phone numbers, and addresses
- Questions & Answers

PERFORMANT AT-A-GLANCE

PERFORMANT AT-A-GLANCE

1976
founded

1,200
employees

Medicare RAC
Region 1 (NE & MW)—Parts A & B and Region 5 (National)—DMEPOS, home health, hospice

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

PERFORMANT

PERFORMANT LOCATIONS

LIVERMORE, CA

- Corporate Headquarters
- IT and Data Analytics

SUNRISE, FL

- Data Analytics & Reporting
- Medical Director Team
- Segment Specialists
- Issue Development

SAN ANGELO, TX

- RAC Management Team
- Audit Team
- Appeals and Discussion Team
- RAC Operations Unit
  - Customer Service Team
  - Medical Records Intake Team
  - Appeals and Discussion Team

REMOTE STAFF

- Performant Recovery and RAC Leadership Team
- Contractor Medical Directors (CMDs)
- New Issue Team
- Nurse Auditors
- Certified Coder Auditors

SCOPE OF RAC REGIONS

RECOVERY AUDIT CONTRACTORS (RACs)

Medicare Fee-for-Service (FFS) RACs

REGION 1: STATES & MAC JURISDICTIONS

- Michigan & Indiana
  - J8 WPS MAC jurisdiction
- Ohio & Kentucky
  - J15 CGS MAC jurisdiction
- New York, Vermont, New Hampshire, Maine, Massachusetts, Rhode Island & Connecticut
  - JK NGS MAC jurisdiction

RAC PROGRAM MISSION

> The Medicare Fee for Service (FFS) Recovery Audit Program's mission is to identify and correct Medicare improper payments through the efficient detection and collection of overpayments made on claims of health care services provided to Medicare beneficiaries, and the identification of underpayments to providers so that the CMS can implement actions that will prevent future improper payments in all 50 states.

HEALTHCARE AUDIT INTEGRITY

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

PERFORMANT

COMMITMENT TO INTEGRITY: OUR TEAMS

CUSTOMER SERVICE

- Average of 10 to 12 years of experience
- 100% of staff are located in the U.S. and are U.S. citizens
- We are here to **help**

CLINICAL AUDIT

- Mix of talent from Utilization Review, ER, CCU/ICU, Med-Surg, CM, SNF, Therapists, etc.
- All nurses are registered with active unrestricted licenses

CODING AUDIT

- Mix of talent skilled in inpatient coding and/or certified as RHIA/RHIT, CCS & CPC (some with multiple certifications), and registered nurses
- All coders have current certifications
- Average 15+ years of combined experience (range: 3 to 30 years)

PHYSICIAN TEAM

- Mix of specialties with access to multiple specialty panels
- Average 15+ years of combined experience (range: 10 to 20 years)

RECOVERY AUDIT GOALS

RECOVERY AUDIT GOALS

The goals of the Recovery Audit Program are to conduct reviews to ensure the right amount has been paid to a legitimate provider for correctly coded, medically necessary services, provided to an eligible beneficiary in an appropriate setting while ensuring:

TRANSPARENCY

CONSISTENCY

ACCOUNTABILITY

TRANSPARENCY: CONCEPT DEVELOPMENT

PROCESS

All audit concepts/ issues require CMS approval

REFERENCES

Concepts/issues developed must include specific supporting regulatory references (i.e., NCDs, LCDs, IOM, SSA, CFR, etc.)

WEBSITE

Detailed overview of issue information available for review

TRANSPARENCY: WEBSITE DETAIL

CMS requires the RACs to provide consistent and detailed review information concerning new issues on their website (https://performantrac.com/).

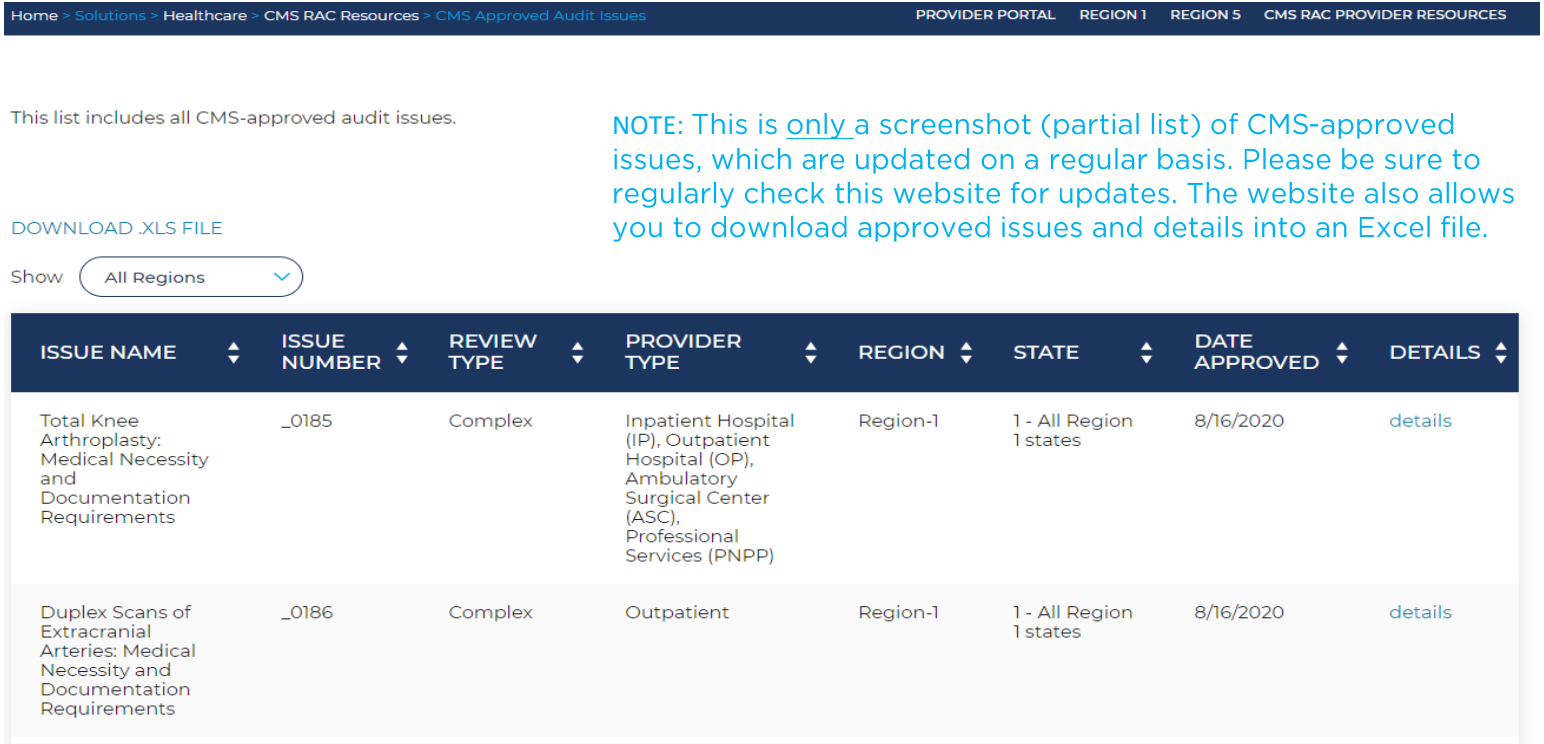
SUPPORTING RESOURCES

- Approved Issues
- FAQs
- Sample Documents
- Additional Document Submission Instructions
- Discussion Request Form

EXTERNAL RESOURCES

- Medicare FFS RAC website
- CMS Manuals
- Understanding Remittance Advice
- Institutional (i.e., facilities) Additional Documentation Limits
- Durable Medical Equipment (DME) Additional Documentation Limits
- Physician/Non-Physician Practitioner Additional Documentation Limits
- AHA

TRANSPARENCY: APPROVED ISSUES



NOTE: This is only a screenshot (partial list) of CMS-approved issues, which are updated on a regular basis. Please be sure to regularly check this website for updates. The website also allows you to download approved issues and details into an Excel file.

Please see Performant's website for a **current** list of approved issues (https://performantrac.com/audit-issues).

CONSISTENCY: IN AUDIT

- All RACs have established:
  - Same CMS-approved concepts
  - Guidelines set by Medicare rules and regulations, LCDs, NCDs, IOMs, SSA, CFR, etc.
  - ADR limitation rules
  - Look-back period rules
  - Timeframes for discussion and review

CONSISTENCY: DISCUSSION PERIOD

PURPOSE: To offer providers the opportunity to submit additional information, if they disagree with the review determination.

PROCESS:

RAC considers additional information, reaudits the account, and either upholds or overturns the original decision.

BENEFIT:

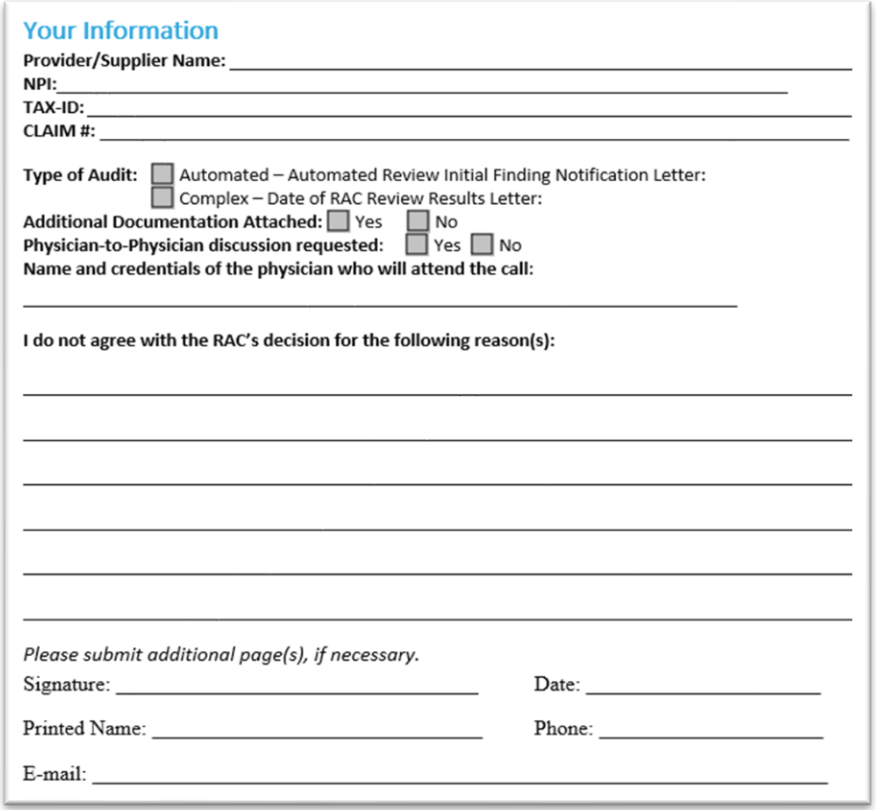
If a decision is overturned during the Discussion Period, the RAC will not send an adjustment to the MAC; **no further action** will be required of the provider.

CONSISTENCY: DISCUSSION PERIOD (CONT.)

SUPPORTING RESOURCES

- Approved Issues
- FAQs
- Sample Documents
- Additional Document Submission Instructions
- Discussion Request Form

[Performant Financial - Welcome to Performant's New Provider Resources Section (performantrac.com)]



Your Information

Provider/Supplier Name: _____

NPI: _____

TAX-ID: _____

CLAIM #: _____

Type of Audit: ☐ Automated – Automated Review Initial Finding Notification Letter:
☐ Complex – Date of RAC Review Results Letter:

Additional Documentation Attached: ☐ Yes ☐ No

Physician-to-Physician discussion requested: ☐ Yes ☐ No

Name and credentials of the physician who will attend the call:

_____

I do not agree with the RAC's decision for the following reason(s):

_____

_____

_____

_____

_____

_____

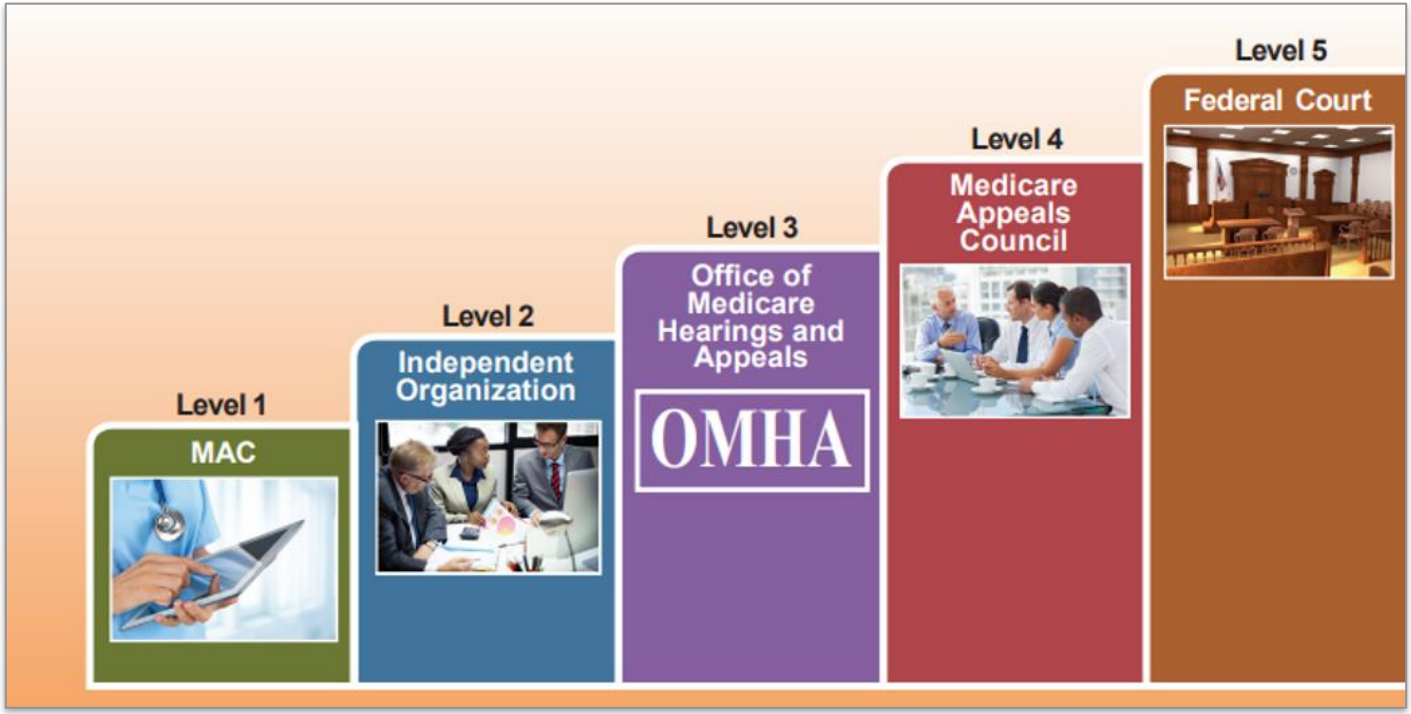
Please submit additional page(s), if necessary.

Signature: _____ Date: _____

Printed Name: _____ Phone: _____

E-mail: _____

CONSISTENCY: APPEAL PROCESS PARTS A & B



The following links to the document on the CMS website that details and guides you through each appeal process--Medicare Parts A & B Appeals Process.

ACCOUNTABILITY: IN AUDIT

Minimum overturn rate for RACs at the first level of appeal, excluding claims that were denied due to no documentation or insufficient documentation or claims corrected during the appeal process.

Minimum accuracy rate RACs must maintain; failure to do so results in a progressive reduction in ADR limits.

ACCOUNTABILITY: RVC

01 WHAT IS A REVIEW VALIDATION CONTRACTOR (RVC)?

An independent third party that performs audits on RAC reviews

02 WHAT DOES THE RVC AUDIT?

Every type of audit reviewed by the RAC is selected for sampling

03 WHEN DOES THE RVC AUDIT?

Audits can be pulled after the demand letter date is posted at the RACDW

04 WHAT HAPPENS WHEN THE RVC AUDIT IS UNSATISFACTORY?

1) RACs can dispute the RVC's decision by following the "Dispute Process"
2) RACs must maintain an accuracy rate of **95% or higher**; failure to meet this standard can result in **corrective action** and **reduction in the RAC ADR limits**

RAC REVIEW TYPES

REGION 1 REVIEW TYPES

AUTOMATED

- Does not require review of medical record documentation for claim determination
- Claims identified through systematic edit parameters based on Medicare regulations/policies and billing guidelines
- RAC issues Informational/Initial Findings Letter (IFL) to the provider as notification of improper payment
- Provider has 30-days from the IFL date to file a Discussion Request with the RAC
- Claim may be submitted to MAC for adjustment on day 31

COMPLEX

- Requires medical record documentation to be reviewed for claim determination
- ADR letters are sent in accordance with CMS Approved Provider ADR Limits
- RAC issues ADR to provider
- Provider to furnish documentation to RAC
- Clinical review completed within 30 days of receipt of provider's documentation
- Provider has 30 days from the Review Results Letter date to submit a Discussion Request with the RAC
- Claim may be submitted to MAC for adjustment on day 31

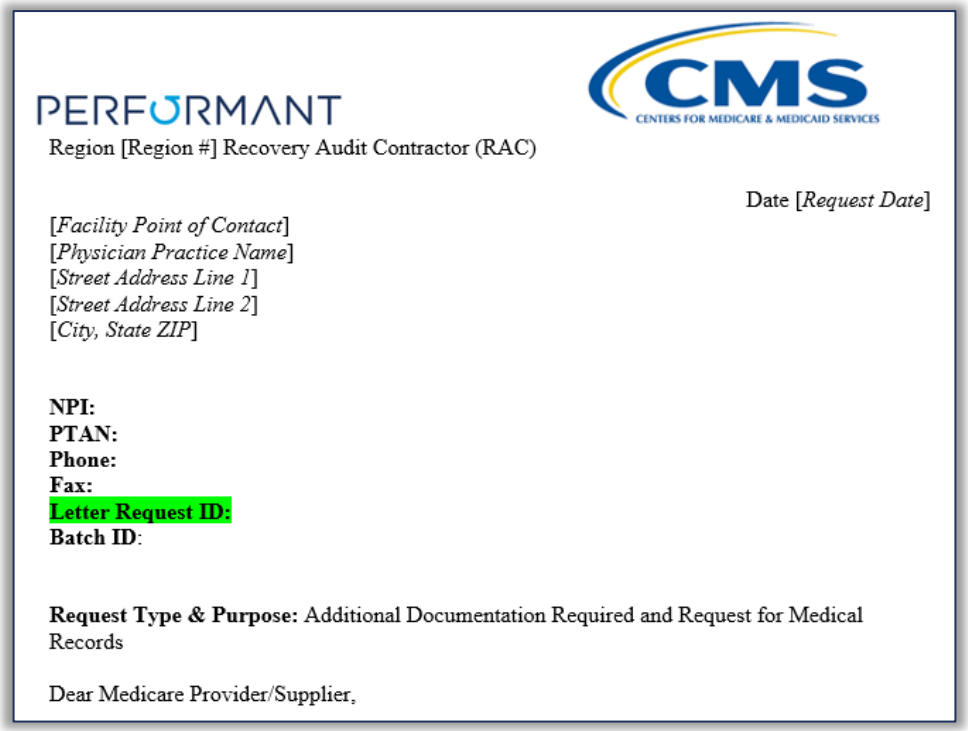
CMS-REQUIRED

- RAC is required to perform provider specific reviews on approved issues that CMS has referred to them
- Not subject to and/or counted towards CMS approved provider ADR Limits
- RAC issues ADR to provider
- Provider to furnish documentation to RAC
- Clinical review completed within 30 days of receipt of provider's documentation
- Provider has 30 days from the Review Results Letter date to submit a Discussion Request with the RAC
- Claim may be submitted to MAC for adjustment on day 31

ADDITIONAL DOCUMENTATION REQUESTS

ADDITIONAL DOCUMENTATION REQUESTS

- Facility/Provider/Supplier name and address
- NPI
- Letter Request ID
- Letter Request type and purpose



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:

Request Type & Purpose: Additional Documentation Required and Request for Medical Records

Dear Medicare Provider/Supplier,

ADDITIONAL DOCUMENTATION REQUESTS

- 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 for reopening a claim may include but is not limited to OIG report findings, data analysis findings, comparative billing analysis, etc.
- The RAC may request records every 45 days at a minimum and must not exceed the established ADR Limits.

Request Type & Purpose: Additional Documentation Required and Request for Medical Records

Dear Medicare Provider/Supplier,

In accordance with §§ 1874A(h)(4) and 1893(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 in your region. 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) and 1893(f)(7), 42 CFR 405.926, 42 CFR 405.980, 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, and Medicare Program Integrity Manual, CMS Pub 100-08, Chapter 3, Section 3.5.1.

ADDITIONAL DOCUMENTATION REQUESTS

- Supporting reference links and ADR limit links

CMS RAC website link: https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Recovery-Audit-Program

Performant RAC website link:https://performantrac.com/solutions/healthcare/cms-rac-resources/cms-rac-provider-resources/default.aspx

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/ADR-Limits-Institutional-Provider.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

ADDITIONAL DOCUMENTATION REQUESTS

- Individualized ADR Limits
- Reason for Selection

The maximum number of medical records that may be requested with the exception of CMS-Required Reviews, 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 above are two different samples of the table that will hold the data

Reason for Selection:

Your RAC, Performant, is requesting additional documentation for the selected list of claims as part of a post-payment, complex review approved by CMS. Details regarding the issue(s) identified are listed in the Requested Claims attachment. As a reminder, the RAC may reopen

ADDITIONAL DOCUMENTATION REQUESTS

- Specifies when the records are due by
- Consequences for not complying by due date or extension date

Action: Additional Documentation

Federal law requires that providers/suppliers submit medical record documentation to support claims for Medicare services upon request. Providers/Suppliers are required to send supporting medical records to Performant. **Please note that providing medical records of Medicare patients to Performant does not violate the Health Insurance Portability and Accountability Act (HIPAA).** Patient authorization is not required to respond to this request.

An extension for the submission of additional documentation may be requested by contacting Performant's Customer Service via email or phone.

When: mm/dd/yyyy

Please provide the requested documentation or contact Performant to request an extension by mm/dd/yyyy. A response is still required by mm/dd/yyyy even if you are unable to locate the

Consequences:

An improper payment (overpayment) will be determined in instances where the provider/supplier fails to send the requested documentation or contact Performant to request an extension by mm/dd/yyyy. After the claim determination has been made, providers/suppliers will receive a Review Results Letter. Providers/Suppliers who wish to discuss the determination may request to

ADDITIONAL DOCUMENTATION REQUESTS

- Instructions on how to properly submit records
- The next pages cover each method of submission in detail

Instructions:

Performant accepts documents via paper, fax, CD/DVD, and electronic submission of medical documentation (esMD).

1. The documentation submitted for this review must be a copy. Do not submit original documentation.
2. A copy of this Additional Documentation Request (ADR) letter and attached barcode page should be affixed to the documentation. Please bundle documents for each claim separately, with the barcode page on top. This method allows us to confirm receipt of all requested documents.
3. Please be sure all documentation is **legible.**
4. **All Blank pages should be OMITTED** (Note: Provider will not be reimbursed for blank pages)
5. Make sure records are free of staples, paperclips, or holes of any kind.
6. Records must be copied on **one side only.**
7. 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**
8. Multiple charts can be sent on one CD/DVD but each chart request must be a separate PDF/TIFF file.
9. Providers/suppliers are responsible for obtaining supporting documentation from third parties (hospitals, nursing homes, suppliers, etc.).
10. Refer to the 'Supporting Documentation' attachment for a list of required supporting documentation to be submitted.
11. Please do not include Powers of Attorney, Living Wills, Correspondence, or Prior Episodes of Care.
12. 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.

Submission Methods:

ADDITIONAL DOCUMENTATION REQUESTS

- The final pages list the beneficiary claims requested, what records should be included to support the review, and the barcode sheets for record separation when submitting records.

The patient's medical record must contain sufficient documentation of the patient's medical condition to substantiate the necessity for the type and quantity of items ordered and for the frequency of use or replacement (if applicable). This information must be available upon request.

Beneficiary Information		Medical Record / Patient Control /Claim #		Dates of Service Case #	
Name:	[Name]	MR#	[MR#]	Fm:	[FM]
DOB:	[DOB]	Control#	[Control #]	To:	[TO]
HIC/MBI:	[HIC or MBI]	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/MBI:	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/MBI:	1234567892A	Claim#	309988776655	Case #:	900054683245
Amount:	[Amount]				

Please submit all applicable documentation that supports justification of payment of claims corresponding to claim date(s) of service included in this request, including but not limited to the following components of the beneficiary's medical record:

Sample list:
- Ambulance records
- Discharge summary
- Nursing dcoumentation
- Physician notes
- Operative / procedure report
- This is not an inclusive list. All pertinent informaiton must be considered

RECORD SUBMISSIONS

MEDICAL RECORD SUBMISSIONS

- Requested documentation can be submitted via:
  - esMD
  - Postal mail as either
    - Images on CD/DVD or
    - Paper copies
  - Fax
- The records should be submitted by the date designated in the ADR letter
  - If for any reason, extra time is needed to gather and submit records, it is imperative to call Customer Service at 1-866-201-0580 and request a short extension

MEDICAL RECORD SUBMISSION PROCESS

1. In the example to the right there are 3 distinct record requests. Copy the Bar Code Sheet(s) as the first page for each corresponding set of documents.

2. Place a check mark in the box to associate which claim # the corresponding set of documents is for. Records for each claim should be a **separate and distinct bundle**.

3. Large record sets should be mailed or submitted via esMD. **If faxing, each record set per claim must be sent in a separate fax.** Faxes are received electronically and mixed claim records in one fax can lead to errors.

Beneficiary Information	DOB & DOS	RA Case #	
Name:	DOB:	Check Box	 90033321614
Claim#:	HIC:		
PT Cntrl:	DOS: 9/17/2014 - 9/23/2014		
Amount:			
Name:	DOB:	Check Box	 90033319824
Claim#:	HIC:		
PT Cntrl:	DOS: 11/17/2014 - 11/25/2014		
Amount:			
Name:	DOB:	Check Box	 90033322414
Claim#:	HIC:		
PT Cntrl:	DOS: 4/17/2013 - 4/19/2013		
Amount:			

ELECTRONIC SUBMISSION OF MEDICAL DOCUMENTATION

WHAT DOES esMD PROVIDE?

A secure electronic communication channel for the exchange of:

- ADR Letters (medical records request letters) from RACs to providers (only those registered to receive ADRs through esMD)
- Medical records and supporting documentation from providers to RACs
- Discussion Period requests from providers to RACs

WHAT ARE THE BENEFITS OF esMD?

- Secure way to transmit protected health Information (PHI)
- Reduced labor costs—helps to reduce the amount of labor required to fulfill medical record requests by eliminating the need to print and mail paper, feed a fax machine, or burn CDs
- Reduced hard costs—reduces hard costs like shipping and handling expenses (Note: medical record reimbursement still applies for records sent via esMD)

esMDBusinessOwners@cms.hhs.gov
www.cms.gov/esMD

MEDICAL RECORD PAYMENT

The Medicare Program Integrity Manual (PIM) Section 3.2.3.6. provides guidance to RACs on reimbursement for medical records. Performant tracks record submissions and issues a check within 45 days of record submission. There is no requirement to invoice.

Type of Record	Cost[1]
PPS Provider Record Reproduction	$0.12 cents per page, plus first-class postage[2]
Non-PPS Institution and Practitioner Record Reproduction	$0.15 cents per page, plus first-class postage[2]
esMD Submission	Above reimbursement rates per page plus a $2.00 per transaction reimbursement in lieu of postage

[1] Providers under a Medicare reimbursement system (e.g., critical access hospitals) receive no photocopy reimbursement.

[2] Maximum reimbursement to a provider per medical record if sent via esMD shall not exceed $27 (including a $2 transaction reimbursement) or $15 (including first class postage) if sent any other method.

RAC WEBSITE RESOURCES

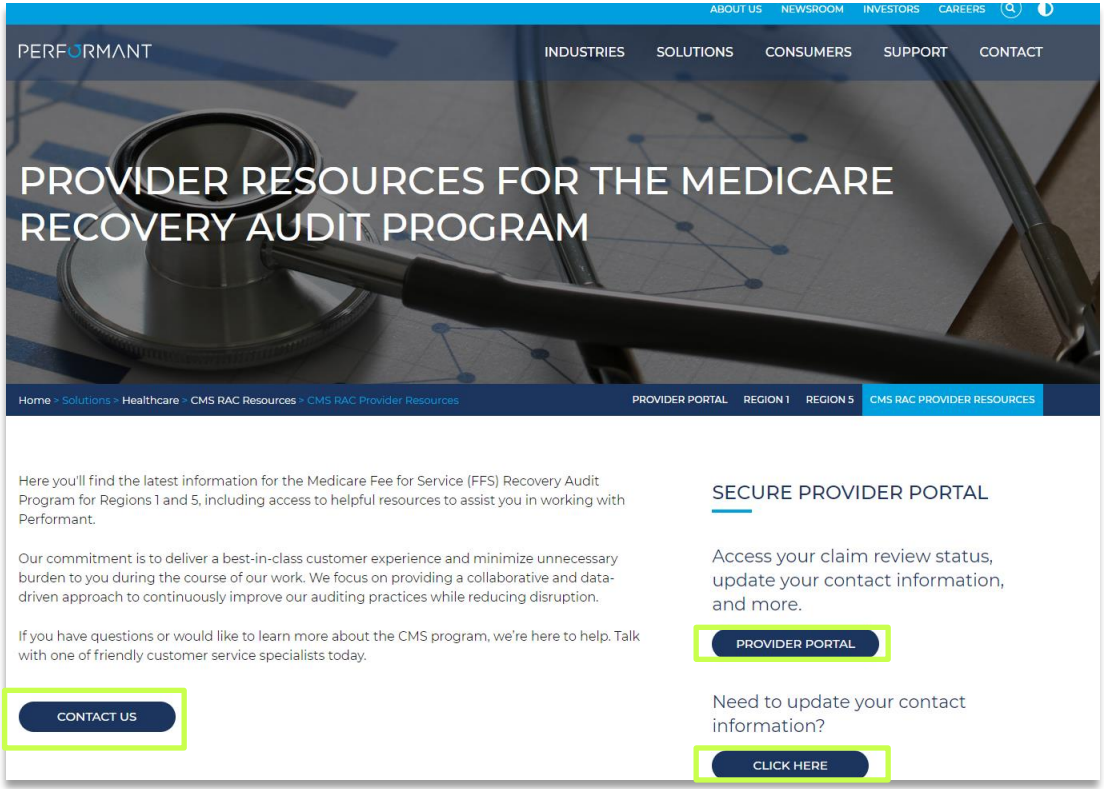
RAC WEBSITE RESOURCES

Website Communications: https://performantrac.com

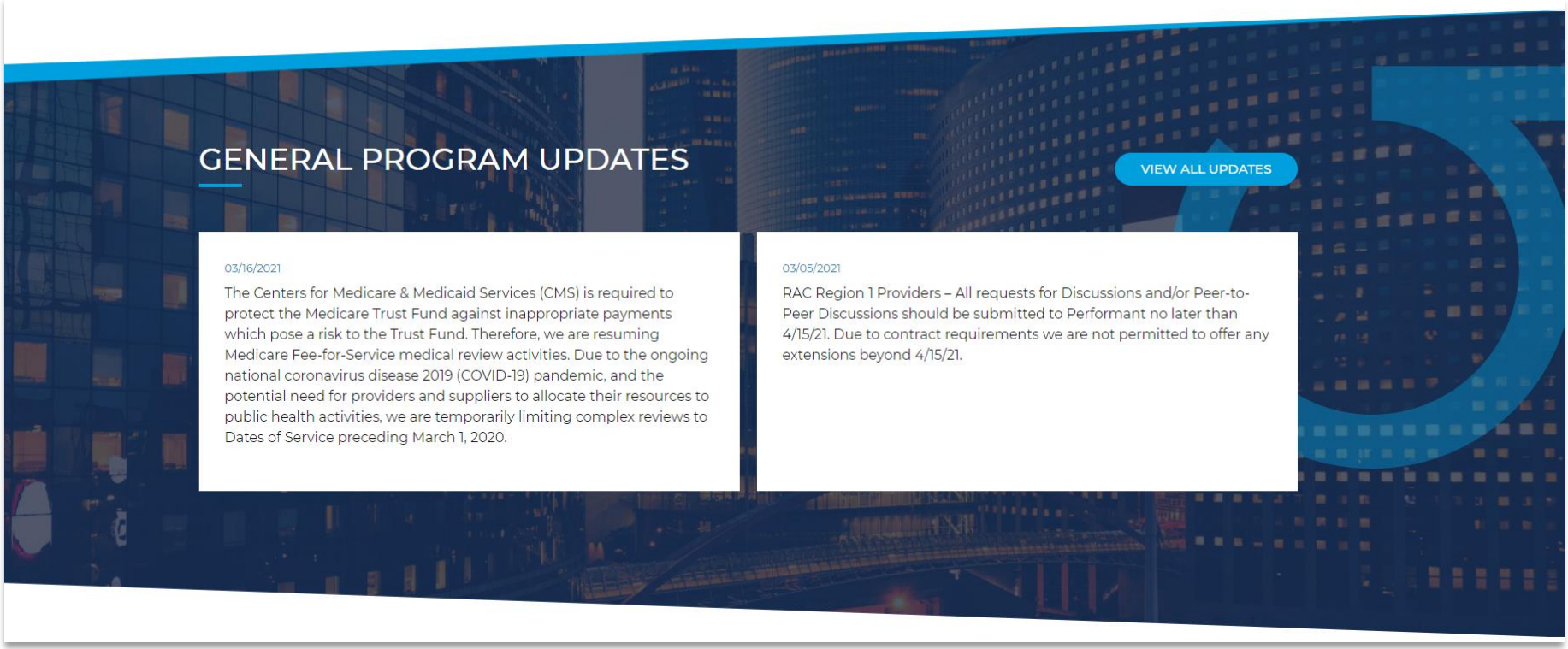
AVAILABLE RESOURCES

- Options to contact us
- Secure Provider Portal link
- Update your provider contact information
- Recent program updates
- Frequently asked questions (FAQs)
- Approved Issues
- Forms and sample documents
- Additional documentation submission requirements
- Links to CMS resources and MAC resources
- CMS ADR limit links
- Review claims audit status

RAC WEBSITE RESOURCES (CONT.)



RAC WEBSITE RESOURCES (CONT.)



RAC WEBSITE RESOURCES (CONT.)

SUPPORTING RESOURCES

- APPROVED ISSUES
- FAQS (DOWNLOAD PDF HERE)
- SAMPLE DOCUMENTS (DOWNLOAD PDFS HERE)
- ADDITIONAL DOCUMENTATION SUBMISSION INSTRUCTIONS (DOWNLOAD PDF HERE)
- DISCUSSION REQUEST FORM

EXTERNAL RESOURCES

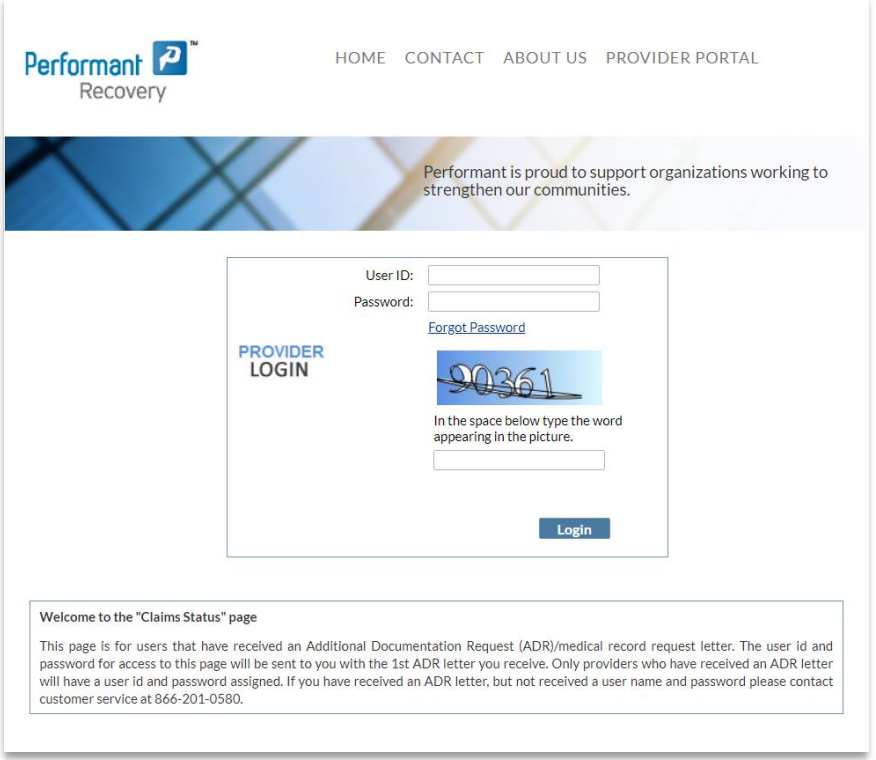
- CMS RECOVERY WEBSITE
- CMS MANUALS
- UNDERSTANDING REMITTANCE ADVICE
- INSTITUTIONAL (I.E., FACILITIES) ADDITIONAL DOCUMENTATION LIMITS
- DURABLE MEDICAL EQUIPMENT (DME) ADDITIONAL DOCUMENTATION LIMITS
- PHYSICIAN/NON-PHYSICIAN PRACTITIONER ADDITIONAL DOCUMENTATION LIMITS
- AMERICAN HOSPITAL ASSOCIATION

If you are a provider seeking additional information for Region 1 support, Click Here

If you are a DMEPOS supplier or Home Health or Hospice provider seeking additional information for Region 5 support, Click Here

PROVIDER PORTAL: LOGIN

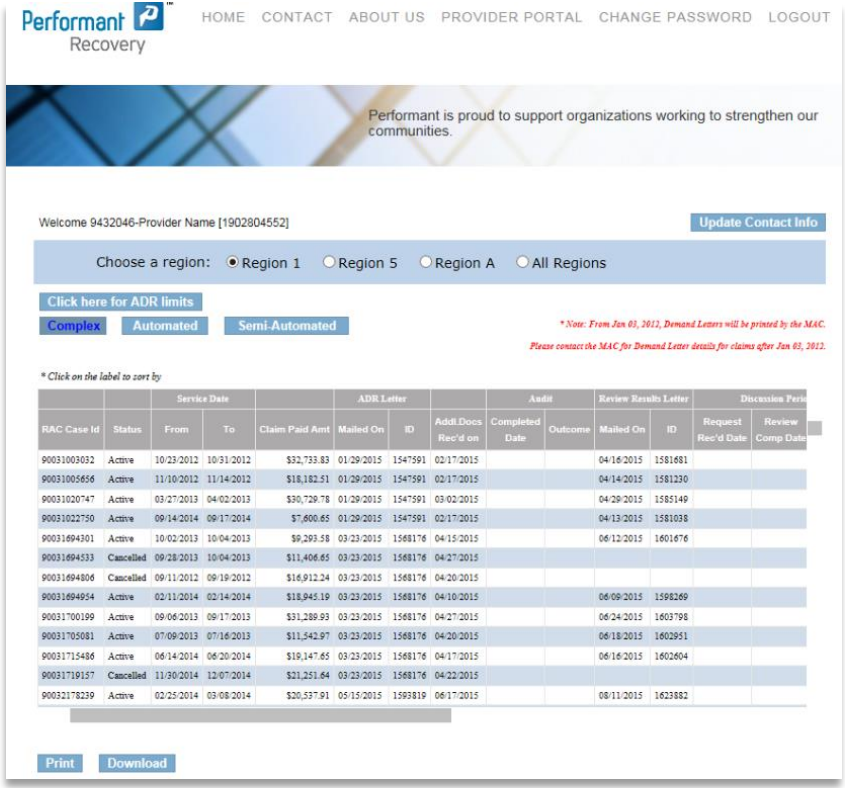
After you accept the terms of usage this login screen will appear. The information to log onto the website is provided to you in writing via a "Welcome Letter" from Performant. If you cannot locate this information, contact Performant's Customer Service team at 1-866-201-0580 and they will assist you.



PROVIDER PORTAL: WHAT'S INSIDE

- Provider's overall ADR limit
- ADR letter mailed date
- Medical documentation received date
- Medical review completed date
- Outcome of the review (overpayment, underpayment, no finding)
- Discussion Period information
- Appeals outcomes
- Case closure date
- Update contact information

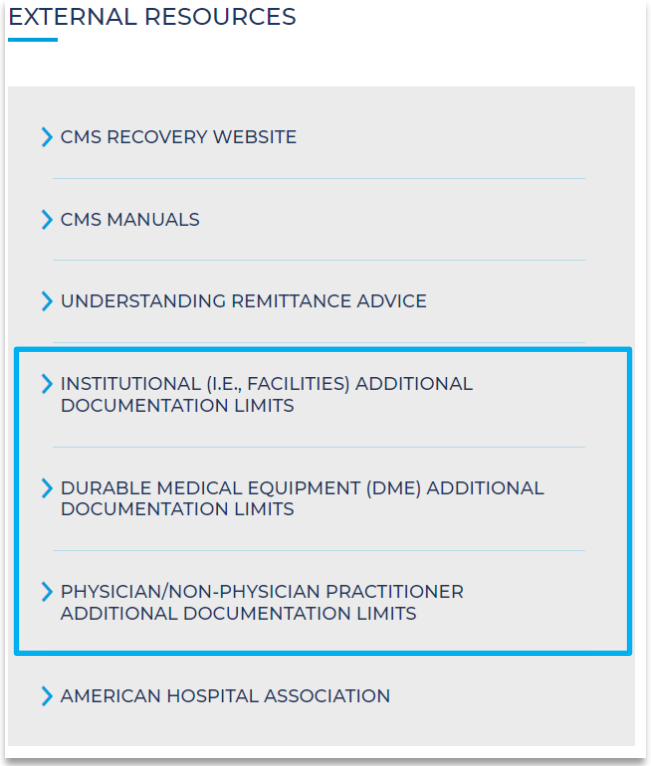
NOTE: The portal is updated nightly.



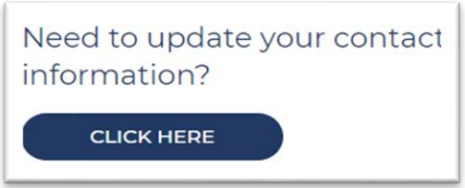
ADR LIMITS

The 3 different types of Additional Documentation Requests (ADR) Limits

- Institutional
- Physician/Non-physician limits
- DME (only applies to Region 5)



PROVIDER CONTACT INFORMATION CUSTOMIZATION



UPDATE YOUR CONTACT INFORMATION HERE.

RAC REQUEST FOR PROVIDER CONTACT INFORMATION

Performant Recovery is the Recovery Audit Contractor (RAC) for Regions 1 and 5. Please provide your contact information for both Medical Record Requests and Review Results Letters/Discussion Period Letters below. If you represent multiple facilities/providers, please complete this form for each facility/provider or you can complete the Excel spreadsheet linked below. If you utilize the Excel spreadsheet, email the completed form to our RAC Customer Service Team.

ProviderAddressUpdateSpreadsheet

CONTACT FOR RECOVERY MEDICAL RECORD REQUESTS
REVIEW RESULTS/DISCUSSION PERIOD RESULT LETTERS

CONTACT INFORMATION

- Performant
  - Toll-free: 1-866-201-0580
  - Medical Record Fax: 1-325-224-6710
  - Discussion Request Fax: 833-366-9118
  - Website: https://PerformantRAC.com
  - Email: info@performantRAC.com
  - Hours of Operation: 8:00 a.m. – 4:30 p.m.

- CMS
  - Website: https://www.cms.gov/research-statistics-data-and-systems/monitoring-programs/medicare-ffs-compliance-programs/recovery-audit-program/

- MAC
  - Primary contact for all processes related to payments, recoupments, refunds, and Level 1 appeals inquiries.
  - Region 1
    - WPS: Jurisdiction 8 (J8) – Michigan & Indiana
    - CGS: Jurisdiction 15 (J15) – Ohio & Kentucky
    - NGS: Jurisdiction K (JK) – New York, Vermont, New Hampshire, Maine, Massachusetts, Rhode Island& Connecticut

QUESTIONS & ANSWERS