PERFORMANT

CMS Recovery Audit Contractor (RAC) Program

Frequently Asked Questions by Providers

Contact Information

How can I contact Performant?
Phone: 1-866-201-0580
Email: info@performantrac.com
Fax: 325-224-6710

Acronyms

ADR Additional Documentation Request
CCS Certified Coding Specialist
CERT Contractor Error Rate Testing
CMS Centers for Medicare & Medicaid Services
CPC Certified Professional Coder
DOJ Department of Justice
DRG Diagnosis Related Group
FBI Federal Bureau of Investigation
HIH Health Information Handler
ICDs International Classification of Diseases
LCDs Local Coverage Determinations
MAC Medicare Administrative Contractor
NCDs National Coverage Determinations
NPI National Provider Identifier
OIG Office of Inspector General
PHI Protected Health Information
RA Recovery Auditor
RAC Recovery Audit Contractor
RHIA Registered Health Information Administrator
RHIT Registered Health Information Technician
RRL Review Results Letter
TIN Tax Identification Number
USPS U.S. Postal Service

General

What U.S. states are included in CMS RAC Region 1?
There are eleven (11) states: Connecticut, Indiana, Kentucky, Maine, Massachusetts, Michigan, New Hampshire, New York, Ohio, Rhode Island and Vermont.

What U.S. states are included in CMS RAC Region 2?
There are eleven (14) states: Arkansas, Colorado, Iowa, Illinois, Kansas, Louisiana, Mississippi, Minnesota, Missouri, Nebraska, New Mexico, Oklahoma, Texas, Wisconsin

PERFORMANT

What states are included in CMS RAC Region 5?
All 50 states are included in Region 5.

How do I obtain a user id and password to access the Secure Provider Portal?
When you receive your first ADR, you will also receive a Welcome Letter. The Welcome Letter includes your user id and password for access to the Secure Provider Portal (including claim status information).

Only Providers who have received their Welcome Letter will have a user id and password. If you have not received this letter and have received ADR notifications, please contact Customer Service at 1-866-201-0580.

I have not been able to access Performant's website and/or log into the Secure Provider Portal. What should I do?
Please contact Customer Service at 1-866-201-0580. Representatives are available Monday through Friday, 8:00 am to 4:30 pm EST.

Where is Performant's Customer Service staff located?
Customer Service is located in San Angelo, Texas.

What procedure does Performant plan to use to coordinate payment take-backs with the MACs? Will the take-backs appear on a separate voucher that identifies they are the result of a RAC audit?
The process will be the same currently administered by all the MACs. The MAC will notify the Provider by submitting a remittance advice prior to recoupment stating that the adjustment is RAC-related and will have a remittance advice code **N432**. If you have any questions, please contact Customer Service at 1-866-201-0580.

How will Performant communicate with Providers and Provider Associations regarding identified issues?
Once CMS approves an issue for review, Performant will place the issue on the Secure Provider Portal under *Approved Issues*. Providers should check the website Performant RAC Website (https://www.performantrac.com) regularly to see all issues approved by CMS.

Does Performant have enough qualified staff (i.e., medical director, coders, RNs, etc.)?
Performant has a pool of qualified clinical nursing staff with many years of healthcare experience working as auditors/medical reviewers. The coding audits will be performed by certified coders with CCS, CPC, RHIA, or RHIT certifications. Performant's Medical Director provides audit support and is available for Peer-to-Peer Reviews.

During the Discussion Period, if an audit is discussed and the decision is in the Provider's favor, will the Provider receive an updated letter?
Yes. Performant will generate a letter to the Provider regardless of the outcome on every Discussion Period Request filed.

If I opened a discussion with the RAC for Region 1 or Region 2 or Region 5, can I also file an appeal? In the current process, a Provider may file a Discussion Period Request during the first 30 days after the RRL is mailed. You may only file an appeal once a Demand Letter from the MAC has been received. Performant highly encourages the Provider to open a Discussion Period first. If the audit is overturned at the Discussion level, the Provider will never be sent to the MAC for the adjustment to be set up and the audit will then be closed.

Please clarify the procedure a Provider may follow if they disagree with Performant's denial in the audit and wish to discuss the results concerning the denial?
A Provider may file a Discussion Period Request during the first 30 days after the RRL or the Initial Findings Letter is mailed. All Discussion Period Requests must be filed individually by claim on the Discussion Period Request Form.

I just received an ADR, but I filed bankruptcy. Am I excluded from audits?
Not necessarily. If you have filed a bankruptcy petition or are involved in a bankruptcy proceeding, please contact your MAC immediately to notify them about the bankruptcy so that they may coordinate with the RAC, CMS and the DOJ to assure your situation is handled appropriately.

Timeline

What are the contracted time frames by which Providers will be notified by Performant of favorable and unfavorable decisions after audits?
Performant has 30 days to complete the review and send a Decision Letter.

Are the 30 days calculated as business or calendar days?
Performant uses calendar days to meet required timeframes.

What is the lookback period for RAC work?
Performant may look back up to three (3) years from the claim paid date to review claims.

How long will the Provider have the RRL before the Demand Letter will be issued?
Performant will forward the adjustment to the MAC 30 days after the RRL/Initial Findings Letter or after a Discussion Period has been completed. Once the MAC has created the appropriate accounts receivable, they will initiate the Demand Letter. If you have any questions about the Demand Letter, please contact your MAC or call Customer Service at 1-866-201-0580.

Correspondence

How will Performant obtain Provider contact information? If a Provider is part of a larger system of Providers, and the system staff will be coordinating the RAC activities, how will Performant adapt their processes to accommodate this?
Performant receives Provider address/contact information periodically from the MACs and uploads this information into Performant’s system. Performant strongly recommends that you take advantage of our Secure Provider Portal to customize your Provider contact information.

How will Performant send ADRs, RRLs, and other letters?
Performant will follow CMS' requirements to send all communication using first class mail as opposed to private carriers. Performant is prohibited from sending PHI in an electronic format.

How many letters will the Provider receive from Performant?
The Provider may receive up to three (3) letters from Performant, 1) ADR (request for medical records for Complex Reviews), 2) an Initial Findings Letter for Automated Reviews or an RRL for Complex Reviews, and 3) a Discussion Period Decision Letter (if a Discussion Period Request was filed).

Will the Providers receive individual Demand Letters for each account or will letters list multiple accounts for Complex and Automated Reviews?
The MAC is responsible for sending the Demand Letter. Please contact your MAC for more information regarding Demand Letter format.

Is a detailed RRL the same as an Overpayment Demand letter?
No, an RRL is sent prior to the Overpayment Demand Letter for an Automated or Complex Review. The RRL explains the findings of the review and explains Discussion Period options. The Overpayment Demand Letter is generated by the MAC. It provides the address where you need to send your payment, and the CMS regulatory appeal, rebuttal, and overpayment recoupment information.

If the Provider has been reviewed by the CERT, OIG or DOJ, etc., for a specific claim and the issue has been settled or the investigation is still in process, can the RA also review and initiate a recoupment on those claims?
No, certain Medicare partners (e.g., OIG, DOJ, FBI, claims processing contractors, CERT contractor) are able to access the CMS Data Warehouse and suppress and/or exclude the claim(s). These actions temporarily or permanently prevent a RA from reviewing all or part of a universe of claims for a specific Provider or claim type. If you receive a claim that has already been pulled by another entity, please contact Customer Service at 1-866-201-0580.

If during the preparation process (reviewing and preparing to forward records to the RAC based on an ADR notification) the Provider finds a coding error, should the Provider rebill at that point?
No, rebilling will not eliminate an audit. Once a claim has been selected, records should be submitted as requested for audit completion. The Provider will be notified of the results and if a difference in reimbursement has been identified.

Will there be any correspondence sent for Complex Review cases where the RA agrees with the original billing of the claim?
Yes, RRLs are sent on cases that the RA agrees with the original billing of the claim. They are entitled No Findings Letters.

What if the Provider received an Automated RRL or an Underpayment Notification Letter but has not received a Demand Letter?
As of January 1, 2016, you will not receive a Demand Letter until after a 30-day holding period after the date of the RRL or until the Discussion Period has been completed. If this period has lapsed, please contact Customer Service at 1-866-201-0580.

What if the Provider received a Demand Letter at a different address than what they placed on the Secured Provider Portal or the address provided to Performant's Customer Service team?
The MAC is responsible for sending the Demand Letter and uses the address they have on file for this claim. Performant cannot update the Provider address for the MAC. If you want the address changed for Demand Letters, please contact your MAC. Performant still sends the ADR notifications and will utilize the address provided to mail the Provider correspondence.

If I have questions about how my claim was adjusted and I don't think the amount requested back is correct, who do I call?
Please contact Customer Service at 1-866-201-0580.

Where can I go to request immediate offset?
Contact your MAC.

Medical Records

Once a Provider receives an ADR from Performant, how long will they have to respond?
A Provider has 45 calendar days to provide medical records to Performant.

Will Performant request complete records, specific items from records, or both?
Performant will request both specific items and the complete records and ask the Provider to submit any documentation, such as clinical support notes, to support the audited claim.

Is there a process for sending a single piece of information during Performant's review/discussion period?
Yes, you must use the Discussion Period Form which may be faxed or emailed to Performant's Customer Service at 1-833-366-6118 or info@performantrac.com.

Is there a limit to how many medical record files that should be put on one disk?
There is no limit; however, Performant would like you to fit as many medical records as you can on one CD or DVD. The process we recommend you use for sending CDs or DVDs is designed to ensure the information on your CD or DVD will be secure but we would suggest that you make a copy for yourself. We also recommend sending the records electronically through the CMS Electronic Submission of Medical Documentation System (esMD). For more information on how to be set up for esMD, go to CMS' esMD Web Page (http://www.cms.gov/esMD).

How will the Provider be notified by the RAC of the calculated ADR limit per 45-day cycle?
The ADR limits are calculated by CMS and provided to the RACs. The RAC will post the medical record limit. It will be provided on the Secure Provider Portal and can also be found on page 2 of the ADR.

Are RACs ever allowed to send documentation requests that exceed a provider's ADR Limit?
Yes. CMS often receives referrals of potential improper payments from the MACs, UPICs, and Federal investigative agencies (e.g., OIG, DOJ). At CMS discretion, CMS may require the RAC to review claims, based on these referrals. These CMS-Required RAC reviews are conducted outside of the established ADR limits.

Is there particular software recommended for creating CD/DVDs?
No. Providers may use any kind of CD/DVD writing software they choose. Image format must be in either PDF or TIFF format (PDF is preferred). Do not password protect individual PDF files. Instead, zip all PDFs into a WinZip file and encrypt it.

Instead of being dependent on the USPS and the mailroom for delivery of the ADR notifications, would Performant consider emailing them or giving electronic access to the letters on their Secured Provider Portal?
We do recognize this may be a more efficient method to communicate to the Provider; however, due to CMS' security requirements, email is not the approved mode of communication for the RACs. Currently, CMS requires RACs to send letters via first class mail.

What is the maximum number of records Performant may request from a Provider at any given time? Is the limit based on NPI or TIN?
Please see the CMS website for medical record information. **Medical documents submitted to Performant for review under an Automated Review are not computed into the limits sent for Complex Reviews.

Institutional ADR Limits

DME ADR Limits

Physician/Non-Physician ADR Limits

Will the RAC allow Providers to supply electronic transmission at any point? If a Provider uses an electronic medical records system, what documentation will they be required to provide to Performant?
For Providers with an electronic medical records system, the same information is required as when submitting a paper record. Currently, submission of PHI via paper, fax, CD/DVD, or transmission via Electronic Submission of Medical Documentation System (esMD) is allowed. Other forms of submission are not available. More information about esMD can be found on the following CMS website: CMS' esMD Web Page (http://www.cms.gov/esMD). Please contact Performant if you are able to send medical records via esMD to make arrangements.

Is the cost for medical record copies reimbursed and does that include medical records on CD/DVD? Will the Provider need to invoice the RAC for the number of pages copied per review?
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 $15 for all other submission types

Our facility utilizes an HIH for ADR submissions. We would prefer that the RAC issues payment directly to them. Is this a service that Performant offers?
No, Performant pays the Providers directly.

Audit Review

If Performant were to extrapolate error results, how would it work and what types of claim errors would be extrapolated?
Currently Performant is not using extrapolation, but we have been approved to perform this method of analytics. Appropriate communication will be provided on the Performant RAC website when we plan to perform this process.

If Performant requests a medical record for review and then is not able to review it within the specified timeframe, can they re-request the same record?
No. If Performant is not able to complete a review within the specified timeframe, we may request an extension from CMS.

Which utilization criteria will Performant apply to review medical necessity; Interqual, Milliman or another?
Performant will use Medicare's legal and regulatory documents and policies such as NCDs, LCDs and ICDs as guidelines. We may also choose to utilize clinical support software products such as Interqual and Milliman as screening tools. If such products are used, the information about this choice will be made available to the community on our CMS Provider Resources website.

Will Performant accept missing (additional) documents during the Discussion Period?
Providers should provide all appropriate and accurate documentation to support a case when the medical record is originally sent. If a circumstance arises where all documentation is not sent with the original record, then the Provider may submit this during the Discussion Period for review at the RAC's discretion.

If we have any question regarding any aspect of the appeals process who should we contact? Currently, Performant does not handle appeals. Provider should follow the same process for appeals they currently follow with their MAC. Any appeal-related questions should be directed to the MAC.

What is considered non-compliance by the ordering physician with regard to supplying medical documentation?
Any failure to respond to a request from CMS for documentation that supports the billed charges on a claim would be considered non-compliant under §1833(e) of the SSA, and 42 CFR 424.5(a)(6), which prohibits Medicare payment for any claim that lacks the necessary information. If documentation for Complex Review is not supplied in the time period request, the claim will be adjusted for full denial.

With regard to medical documentation, what is the Provider's extent of responsibility for supplying documentation? Example - The ordering physician telephones an order for DME to the Supplier and then faxes a written prescription, but neglects to supply medical records, despite numerous attempts on the part of the Supplier.
The Supplier who bills Medicare and receives payment is responsible for providing the documentation. Any failure to respond to a request from CMS for documentation that supports the billed charges on a claim would be considered non-compliant under §1833(e) of the SSA, and 42 CFR 424.5(a)(6), which prohibits Medicare payment for any claim that lacks the necessary information. If documentation for Complex Review is not supplied in the time period request, the claim will be adjusted for full denial.

Will Performant consider reviewing underpayments for DRGs? If they are re-coded to a higher DRG than what the Provider was paid, will this be sent as an underpayment?
Yes, and Performant will provide such adjustments.

Due to confusion and continually changing Medicare policies, how will the RAs be aware of the amended policies, as well as implementation dates of interim policies, memos and related correspondence?
The RAs must abide by the Medicare legal and regulatory policies in effect at the time when the services were provided, to include the correct version of the LCD by the Medicare contractor who had jurisdiction. The RA must diligently research this regulatory backup and cite the correct

authorities. If a Provider feels a document was not considered or an incorrect policy was invoked, they should bring this to the RA's attention during the Discussion Period.

If a DRG is down coded to a lower DRG after review, does the Provider have to rebill for payment of the lower DRG?
No, the MAC will make adjustments as appropriate and the Provider will be notified of any difference in reimbursement. If you have questions, please contact your MAC.

What types of reviews will Performant perform?
Performant is authorized by CMS to perform Complex and Automated Reviews. All Approved Issues are listed on our website under *Approved Issues*.

What is a Complex Review?
In a Complex Review, Performant requests sections of the medical record and reviews them to make clinical determination and/or a coding validation. The specifics of each type of issue and what document is requested can be found on the *Approved Issues* description page and will be included in the ADR notification.

What is an Automated Review?
In an Automated Review, Performant performs analysis of the claims data, makes a determination; no medical documents are requested or reviewed. The Provider will then receive an Initial Findings Letter that will explain the audit. At this point, the Provider can either agree with the audit findings or they will have 30 days from the date of the Initial Findings Letter to file a Discussion Period Request Form. The Provider can contact Customer Service with any questions at 1-866-201-0580.