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Customer Service Program Director

RECOVERY AUDIT CONTRACTOR (RAC) REGION 2

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.

The identification of an organization or product in this information does not imply any form of endorsement.

AGENDA

- Scope of RAC Regions
- Performant Introduction
- Recovery Audit Goals
- Review Types
- Additional Documentation Requests (ADR letters)
- Record Submissions and Reimbursement
- Review Result Letters
- Discussion and Appeal Process
- RAC Website Resources Review
  - Resource links
  - Provider portal
  - ADR limits
  - Contact names, phone #'s and addresses
- Questions & Answers

SCOPE OF RAC REGIONS

REGION 2 CONTRACT TRANSITION

- On March 24, 2022, CMS awarded Performant Recovery, Inc., the new Recovery Audit Contractor (RAC) Region 2 contract.

- RAC Region 2 includes the following Medicare Administrative Contractor (MAC) jurisdictions: J5(WPS), J6(NGS), and JH (NOVITAS).

- Cotiviti, LLC, the RAC previously responsible for reviews in Region 2, remains under contract with CMS to support the RAC Program from an administrative and appeals perspective in this region. Please contact Cotiviti in regards to reviews conducted by Cotiviti. All notification of improper payments, including review results letters (complex reviews), informational letters (automated reviews) and no findings letters (complex reviews) were completed by Cotiviti, in Region 2, on or before Friday, September 16, 2022.

- Performant anticipates to begin reviews in the Spring (2023). RAC Region 2 providers can rely on the review completion date specified in the review results letter, as well as the RAC's name on the letter, to identify which contractor to reach for inquiries.

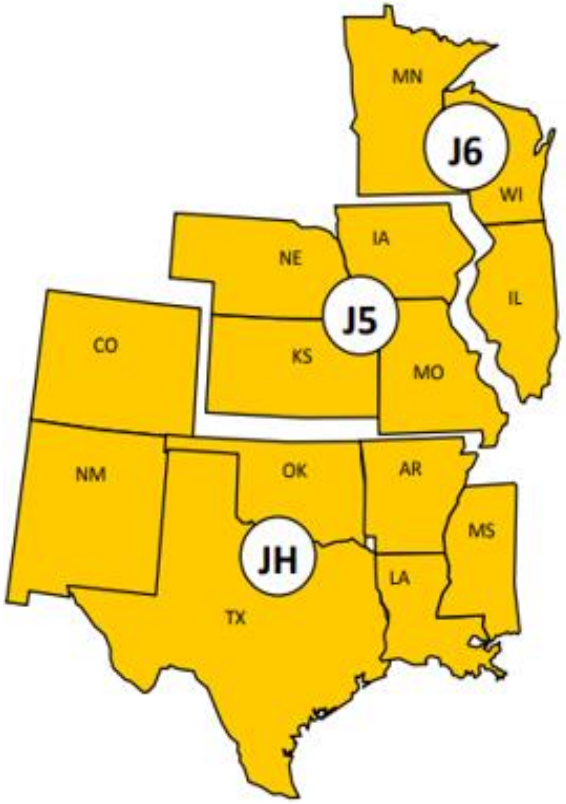
- If Performant receives inquiries in regards to reviews conducted by Cotiviti, Performant customer service will inform providers to reach out to Cotiviti (1-866-360-2507) and vice versa.

RECOVERY AUDIT CONTRACTORS (RACs)

Medicare Fee-for-Service (FFS) RACs

REGION 2: STATES & MAC JURISDICTIONS

- Minnesota, Wisconsin, Illinois
  - J6 NGS MAC jurisdiction
- Nebraska, Iowa, Kansas, Missouri
  - J5 WPS MAC jurisdiction
- Colorado, New Mexico, Oklahoma, Texas, Arkansas, Louisiana, Mississippi
  - JH Novitas MAC jurisdiction



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

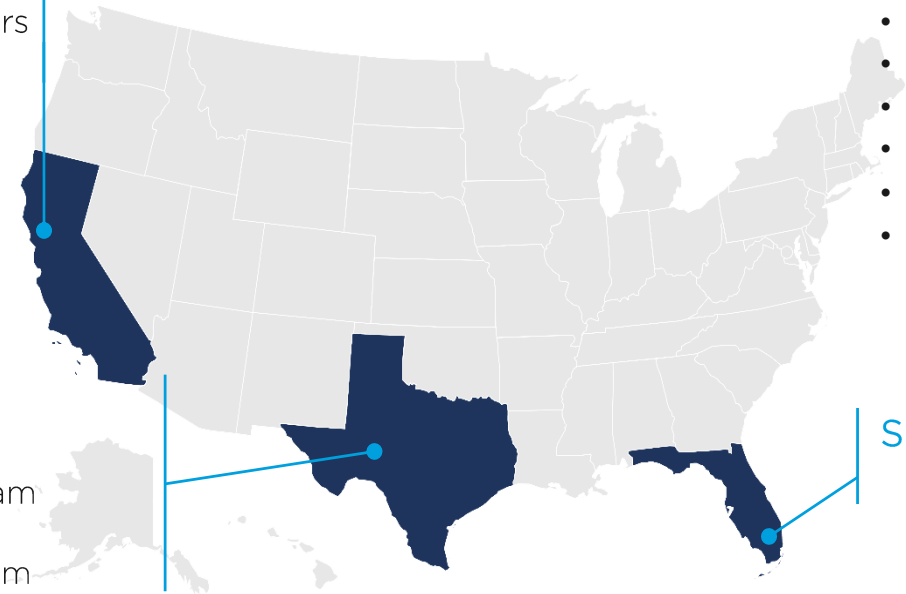
PERFORMANT LOCATIONS

LIVERMORE, CA

- Corporate Headquarters
- IT and Data Analytics

REMOTE STAFF

- RAC Leadership Team
- Contractor Medical Directors
- New Issue Team
- Nurse Auditors
- Certified Coder Auditors
- Segment Specialists



SAN ANGELO, TX

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

SUNRISE, FL

- Data Analytics & Reporting

COMMITMENT TO INTEGRITY: OUR TEAMS

CUSTOMER SERVICE

- Average of 10 to 12 years of experience
- We are committed to being the best customer service team in the industry.
- 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

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.

RECOVERY AUDIT GOALS

The goals of the Recovery Audit Program are to conduct reviews to ensure the right amount to a legitimate provider has been paid 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 on both the CMS and Performant RAC websites

TRANSPARENCY: APPROVED ISSUES

Home > Solutions > Healthcare > CMS RAC Resources > CMS Approved Audit Issues

PROVIDER PORTAL | REGION 1 | REGION 5 | CMS RAC PROVIDER RESOURCES

This list includes all CMS-approved audit 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.

DOWNLOAD .XLS FILE

Show All Regions

ISSUE NAME	ISSUE NUMBER	REVIEW TYPE	PROVIDER TYPE	REGION	STATE	DATE APPROVED	DETAILS
Total Knee Arthroplasty: Medical Necessity and Documentation Requirements	_0185	Complex	Inpatient Hospital (IP), Outpatient Hospital (OP), Ambulatory Surgical Center (ASC), Professional Services (PNPP)	Region-1 Region-2	All Region 1 and Region 2 states	8/16/2020	details
Duplex Scans of Extracranial Arteries: Medical Necessity and Documentation Requirements	_0186	Complex	Outpatient	Region-1 Region-2	All Region 1 and Region 2 states	8/16/2020	details

TOTAL KNEE ARTHROPLASTY: MEDICAL NECESSITY AND DOCUMENTATION REQUIREMENTS

ISSUE NAME: Total Knee Arthroplasty: Medical Necessity and Documentation Requirements

ISSUE NUMBER: _0185

REVIEW TYPE: Complex

PROVIDER TYPE: Inpatient Hospital, Outpatient Hospital, Ambulatory Surgical Center, Professional Services

REGION: Region-1

STATE: 1 - All Region 1 states

DATE APPROVED: 8/16/2020

DATES SERVICE: Claims that have a "claim paid date" which is less than 3 years prior to the ADR letter date.

DESCRIPTION: For purposes of coverage under Medicare, Total Knee Arthroplasty (TKA), also referred to as a joint replacement, has proven to be an important medical advancement. Knee Arthroplasty is most commonly performed for diseases which affect the function of the knee joint (the lower end of the femur, the upper end of the tibia and patella). Occasionally, there may be a need to redo a TKA, often referred to as a revision total knee. In revisional surgery it is important to provide replacement of the components of the previous surgery responsible for the failure. The goal of total knee replacement surgery is to relieve pain and improve or increase functional activity of the beneficiary. This review only focuses on total (involving the entire joint) knee arthroplasties. The documentation will be reviewed to determine if a TKA is medically necessary according to the guidelines outlined in the LCDs and LCAs of FCSO, Novitas, NGS, Palmetto, and Noridian. Affected codes: CPT 27445, 27447, 27486, 27487
PCS Codes (FCSO ONLY) - 0SPC0JZ, 0SPD0JZ, 0SRC069, 0SRC06A, 0SRC06Z, 0SRC07Z, 0SRC0EZ, 0SRC0J9, 0SRC0JA, 0SRC0JZ, 0SRC0M9, 0SRC0MA, 0SRC0MZ, 0SRC0N9, 0SRC0NA, 0SRC0NZ, 0SRD0EZ, 0SRD0M9, 0SRD0MA, 0SRD0MZ, 0SRD0N9, 0SRD0NA, 0SRD0NZ, 0SRC0KZ, 0SRD069, 0SRD06A, 0SRD06Z, 0SRD07Z, 0SRD0J9, 0SRD0JA, 0SRD0JZ, 0SRD0KZ, 0SRT07Z, 0SRT0J9, 0SRT0JA, 0SRT0JZ, 0SRT0KZ, 0SRU07Z, 0SRU0J9, 0SRU0JA, 0SRU0JZ, 0SRU0KZ, 0SRV07Z, 0SRV0J9, 0SRV0JA, 0SRV0JZ, 0SRV0KZ, 0SRW07Z, 0SRW0J9, 0SRW0JA, 0SRW0JZ, 0SRW0KZ, 0SWC0JZ, 0SWD0JZ

REFERENCES: 1. SSA, Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer
2. SSA, Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits
3. 42 CFR §405.929- Post-Payment Review
4. 42 CFR §405.930- Failure to Respond to Additional Documentation Request
5. 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions,

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

ACCOUNTABILITY: IN AUDIT

Minimum overturn rate RACs must maintain at the first level of appeal.

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

RAC REVIEW TYPES

RAC REVIEW TYPES

AUTOMATED

- Does not require review of medical record documentation for claim determination
- Claims are selected using 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 calendar days from the IFL date to file a Discussion Request with the RAC if they disagree with the finding
- Claims may be submitted to MAC for adjustment on day 31 or after the Discussion review is finalized.

COMPLEX

- Requires medical record documentation to be reviewed for claim determination.
- Claims are selected using systematic edit parameters based on Medicare regulations/policies and billing guidelines.
- ADR letters are sent in accordance with CMS Approved Provider ADR Limits
- RAC issues ADR letter to provider requesting records
- Provider furnishes documentation to RAC
- Clinical and/or coding review completed within 30 calendar days of receipt of provider's documentation
- Provider has 30 calendar 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

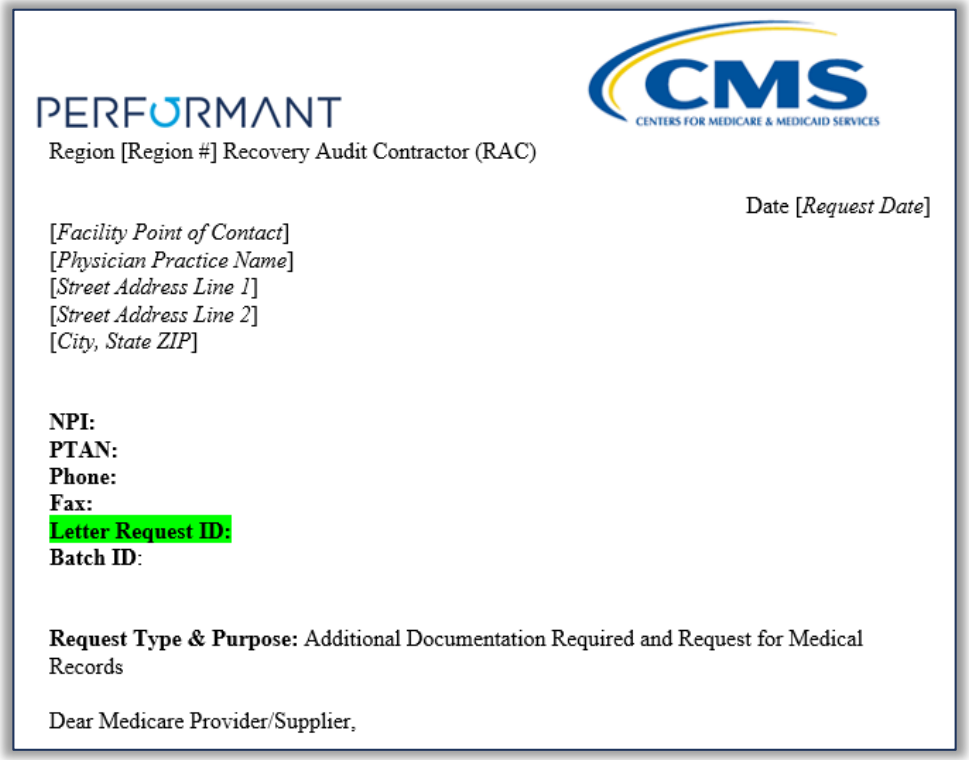
- RAC is **required by CMS** to perform provider specific reviews on approved issues that CMS has referred to them
- Not subject to and/or counted towards CMS approved provider ADR Limits
- RAC issues ADR letter to provider
- Provider to furnish documentation to RAC
- Clinical review completed within 30 calendar days of receipt of provider's documentation
- Provider has 30 calendar 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

Note: Call Customer Service if additional days to submit requested records and/or to submit a Discussion are needed

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

- Upon establishing good cause, 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.
- 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
- States consequence 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:

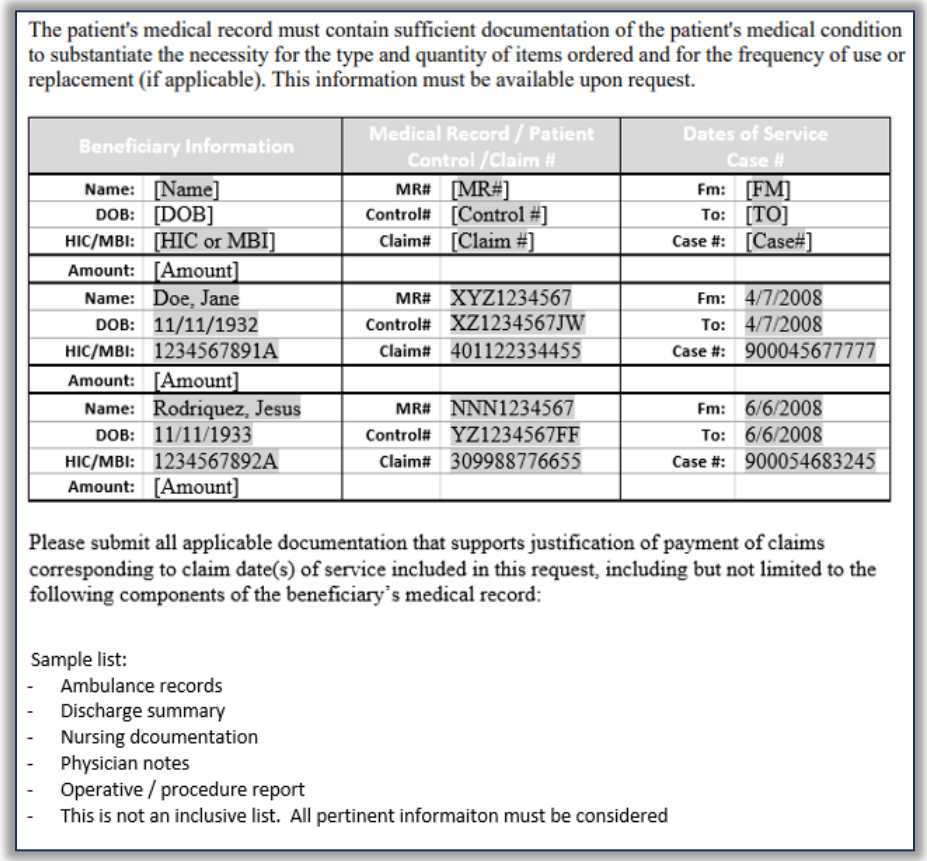
Performant accepts documents via paper, fax, CD/DVD, and electronic submission of medical documentation (esMD).

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

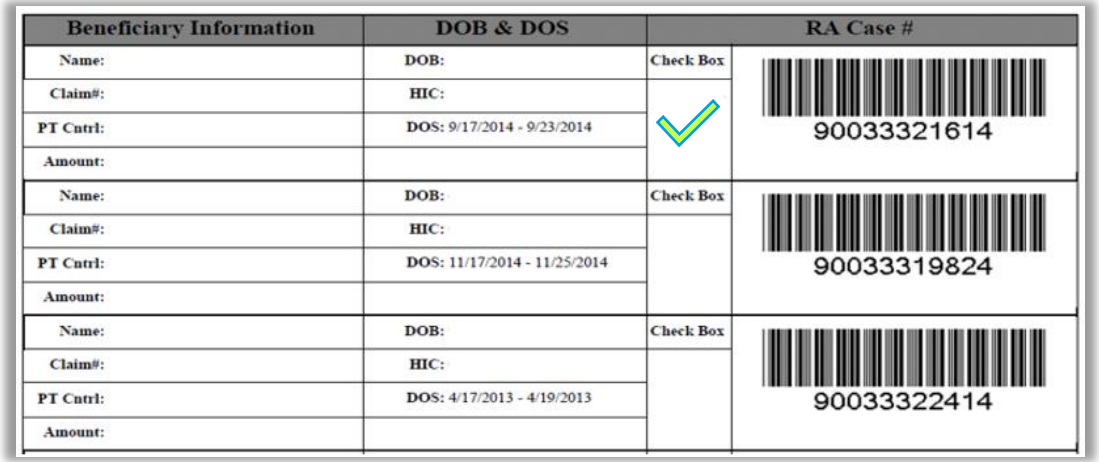
- Requested documentation can be submitted via:
  - esMD – preferred method
  - Postal mail as either
    - Images on CD/DVD or
    - Paper copies
  - Fax
- The records should be submitted by the date designated in the ADR letter.
  - If for any reason, extra time is needed to gather and submit records, 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 as a single PDF document. 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:			

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) or DMEPOS providers 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.

Review Result Letters

REVIEW RESULTS LETTER (RRL)

Certified Coders evaluate submitted documentation for billing and coding accuracy. Licensed Review Nurses review for medical necessity. After a review is finalized, the RAC will send a letter to the provider/supplier/facility clearly documenting the rationale for the review determination. This rationale shall include a detailed description of the Medicare policy or rule that was violated and a statement as to whether the violation resulted in an improper payment. The RAC shall ensure they are identifying pertinent facts contained in the medical record/documentation to support the review determination. Each rationale shall be specific to the individual claim under review and shall also include your right to a discussion if you disagree with the review determination.

- Sample RRL letters are available on the RAC website under the Supporting Resources section.
  - No finding letters
  - Finding letters
  - Underpayment letters

Performant Financial - CMS RAC - CMS RAC Resources - Forms and Sample Documents (performantrac.com)

Discussions and Appeals

DISCUSSION PERIOD

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

PROCESS:

You have 30-calendar days from the date of the RRL to file a Discussion (call Customer Service if an extension is needed). The RAC considers the additional information submitted, reaudits the account, and either upholds, modifies, 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.

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):

_____

_____

_____

_____

_____

_____

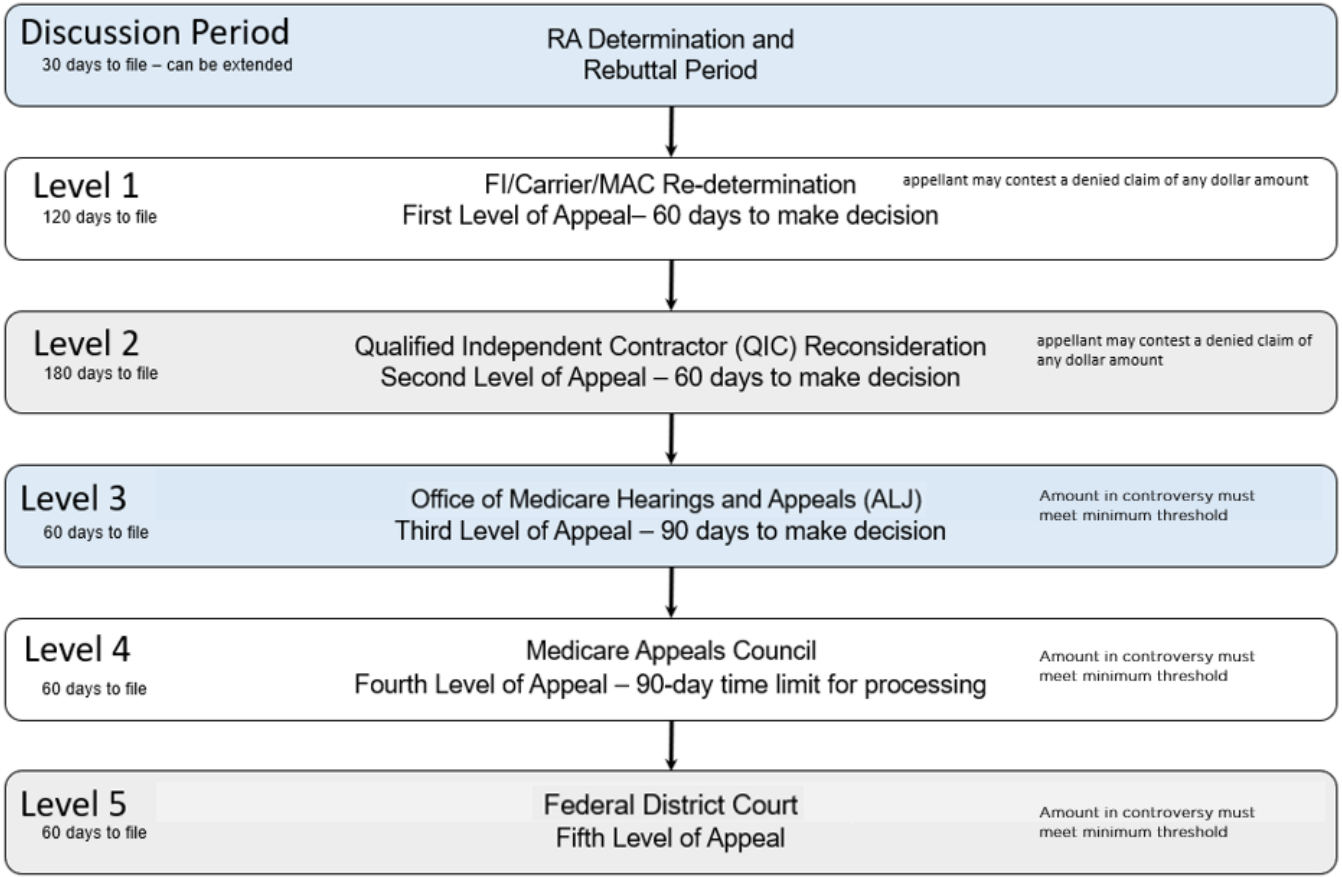
Please submit additional page(s), if necessary.

Signature: _____ Date: _____

Printed Name: _____ Phone: _____

E-mail: _____

APPEAL PROCESS SEQUENCE CHART



RAC WEBSITE RESOURCES

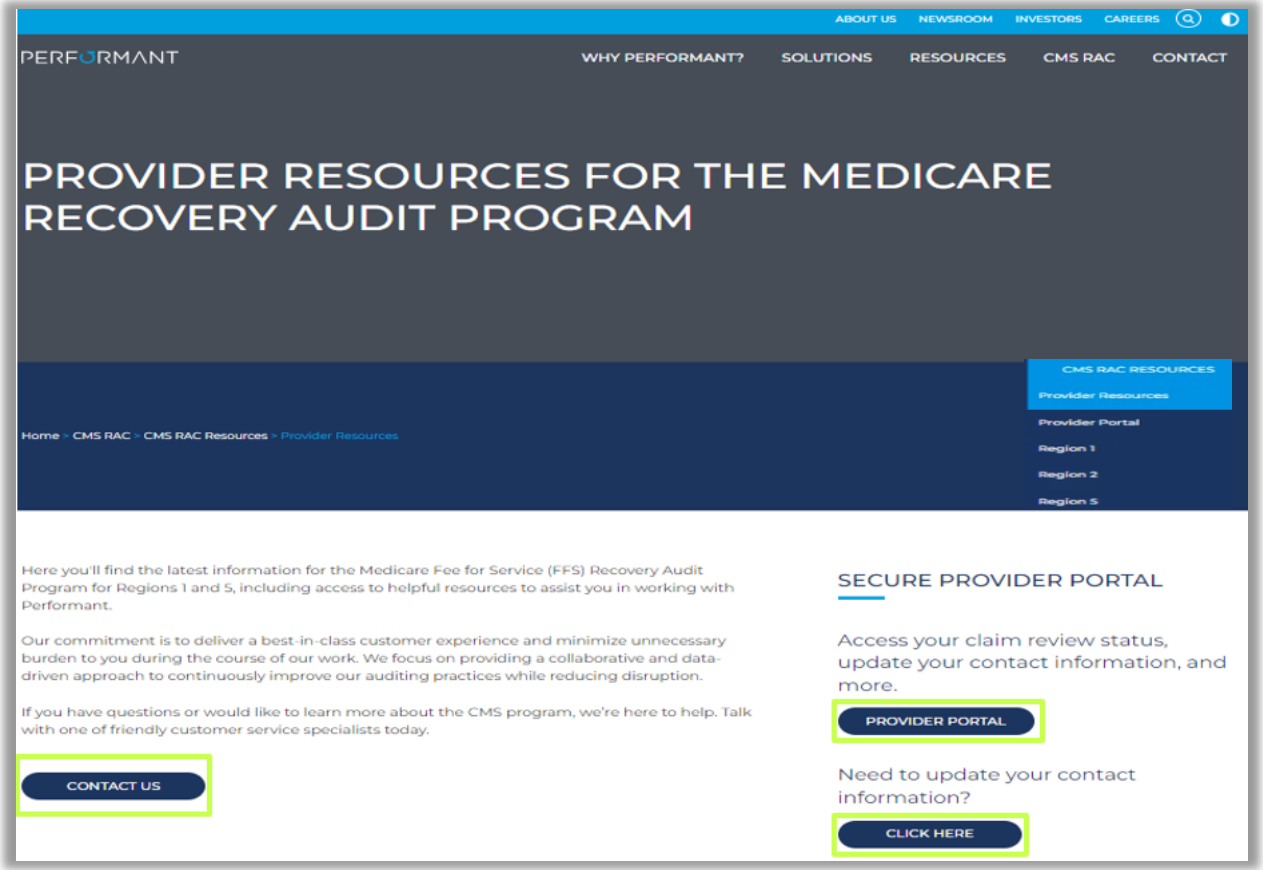
RAC WEBSITE RESOURCES

Website Communications: https://performantrac.com

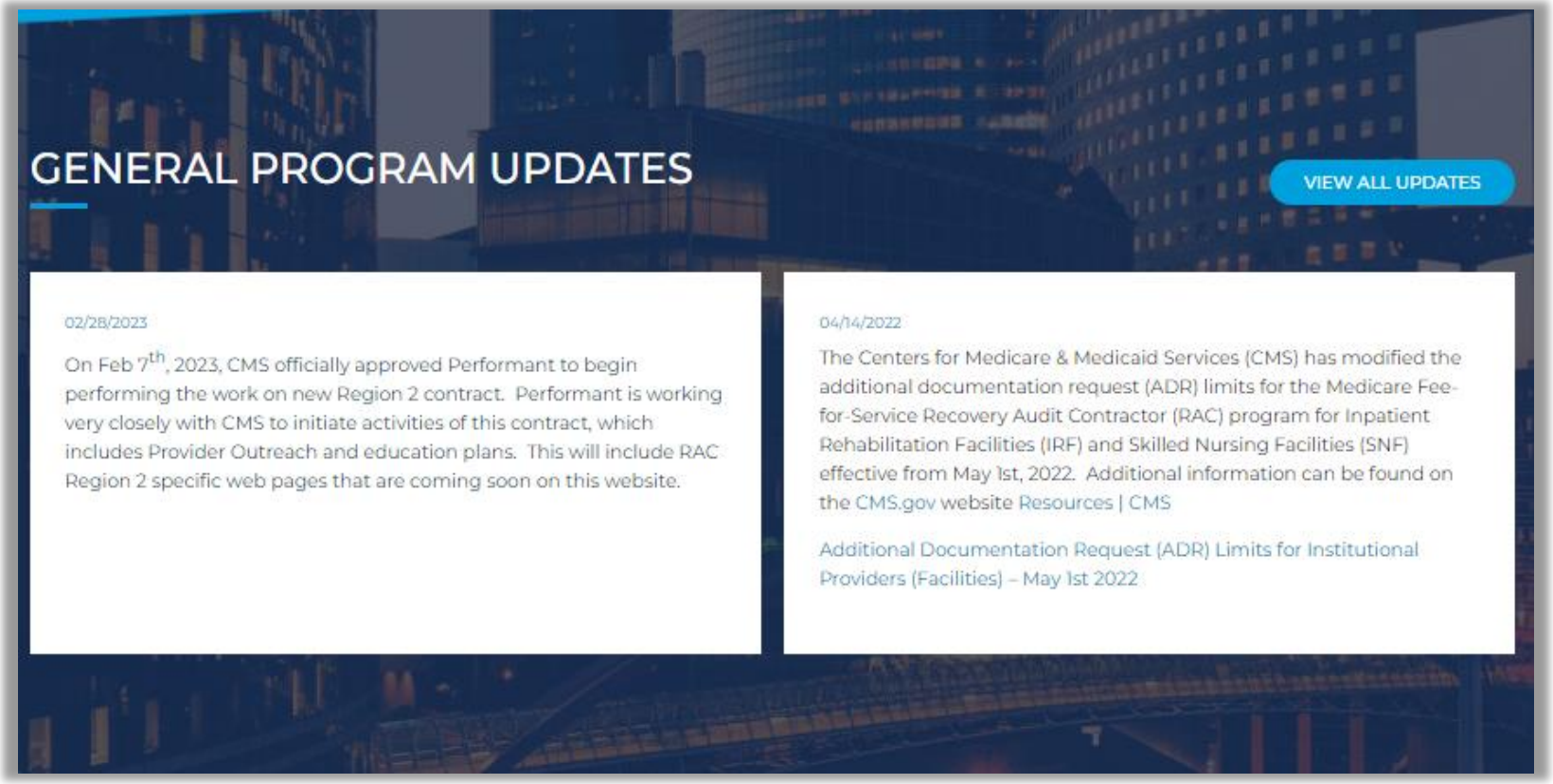
AVAILABLE RESOURCES

- 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

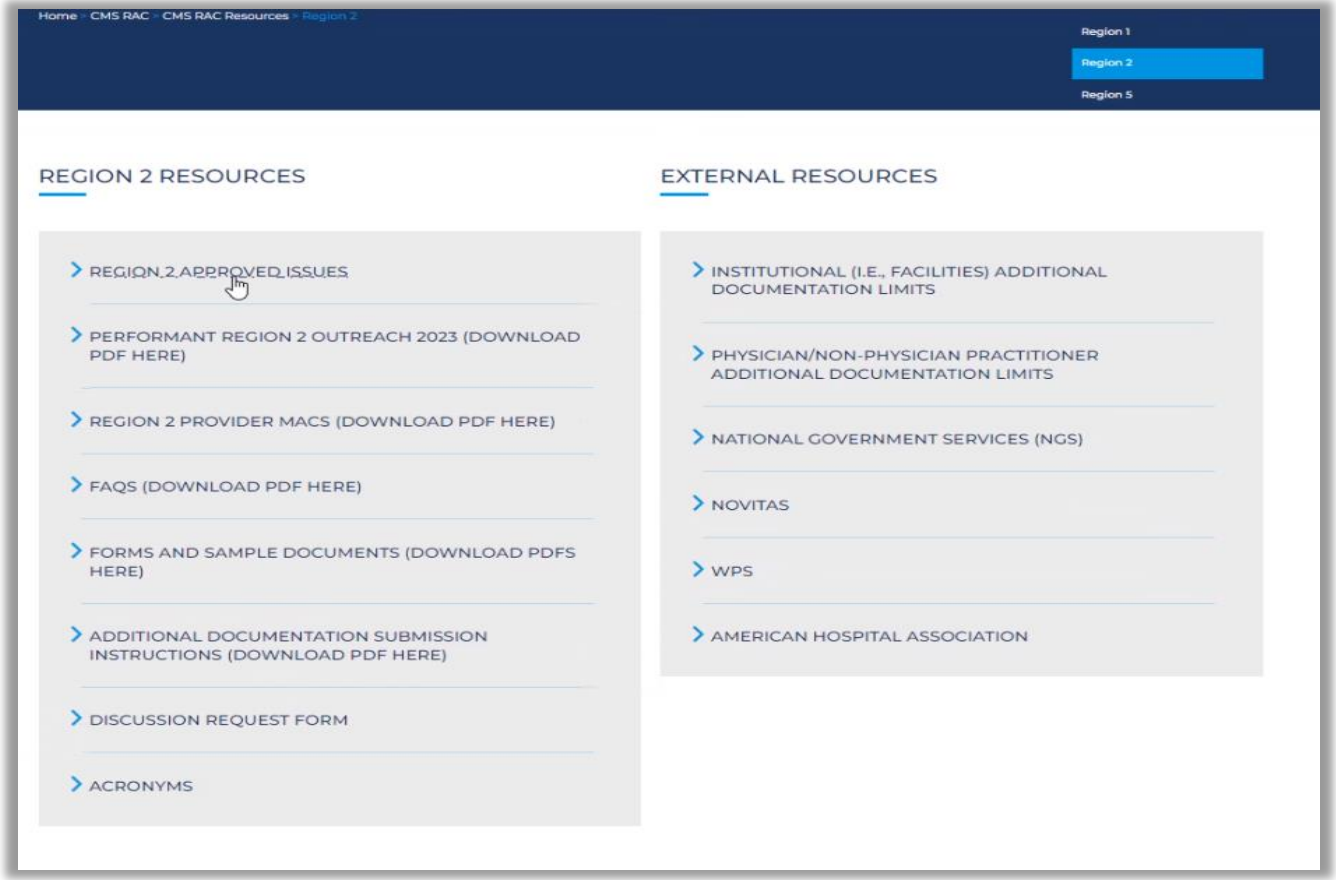
RAC WEBSITE RESOURCES (CONT.)



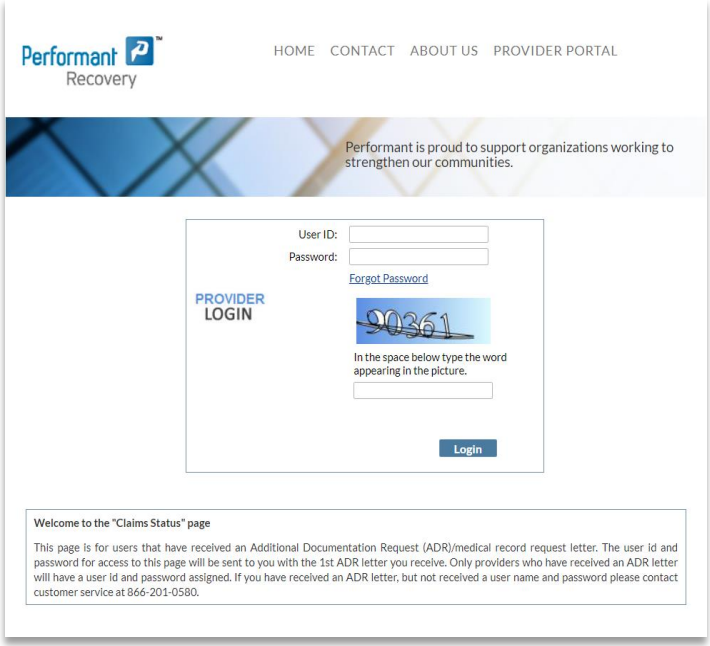
RAC WEBSITE RESOURCES (CONT.)



RAC WEBSITE RESOURCES (CONT.)



PROVIDER PORTAL: LOGIN

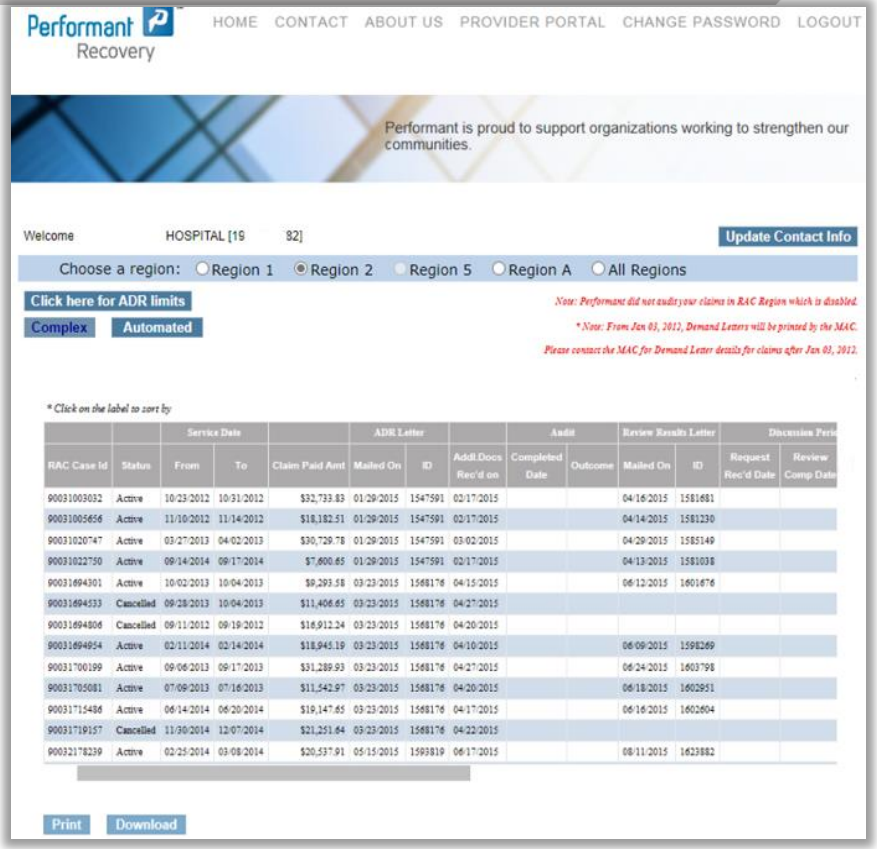


After you accept the terms of usage this login screen will appear. The information to log onto the website is provided to you in writing via a "Welcome Letter" from Performant. If you cannot locate this information, contact Performant's Customer Service team at 1-866-201-0580 and they will assist you.

PROVIDER PORTAL: WHAT'S INSIDE

Beneficiary Information	DOB & DOS	RA Case #	
Name:	DOB:	Check Box	90033321614
Claim#:	HIC:		
PT Cntrl:	DOS: 9/17/2014 - 9/23/2014		
Amount:			

- 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

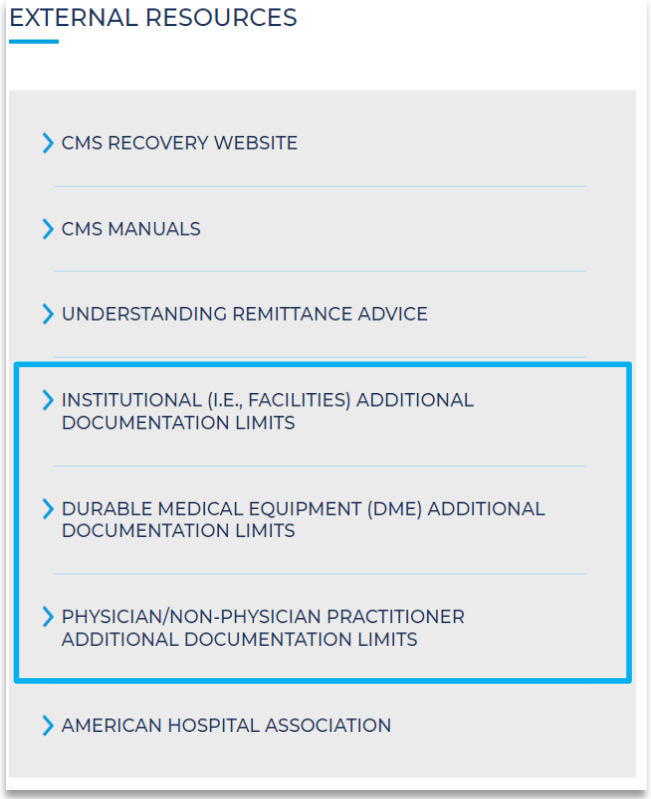


NOTE: The portal is updated nightly.

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

Need to update your contact information?

CLICK HERE

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.
  - For Region 2 reviews completed prior to September 16, 2022 please contact Cotiviti (1-866-360-2507)
- 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 2
    - NGS: Jurisdiction 6 (J6) – Minnesota, Wisconsin, Illinois
    - WPS: Jurisdiction 5 (J5) – Nebraska, Iowa, Kansas, Missouri
    - Novitas: Jurisdiction H (JH) – Colorado, New Mexico, Oklahoma, Texas, Arkansas, Louisiana, Mississippi

QUESTIONS & ANSWERS

RAC-FAQs-v5.docx (live.com)