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RECOVERY AUDIT CONTRACTOR (RAC) REGION 1



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

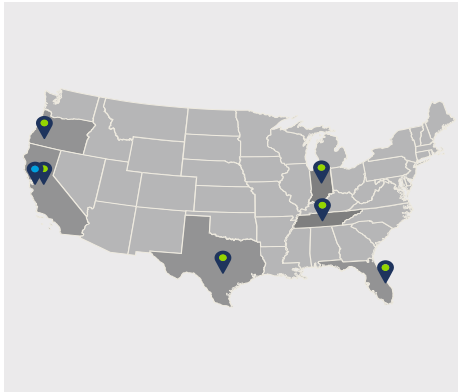
- Performant Introduction
- Scope of RAC Regions & Key Contract Characteristics
- Recovery Audit Goals
- Review Types
- Additional Documentation Requests (ADR letters)
- Record Submissions and Reimbursement
- RAC Website Resources Review
 - Resource links
 - Provider portal
 - ADR limits
 - Contact names,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





PERFORMANT LOCATIONS

LIVERMORE, CA

- Corporate Headquarters
- IT and Data Analytics

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

SUNRISE, FL

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

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)

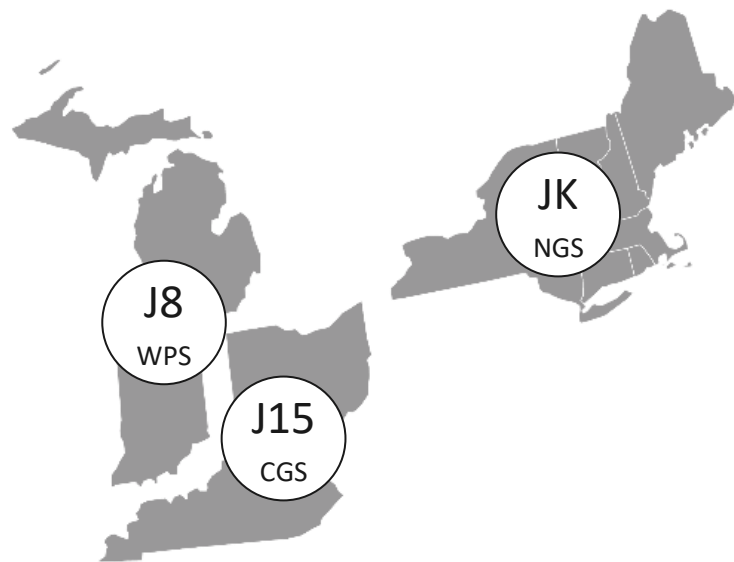
Medicare Fee-for-Service (FFS) RACs





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

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

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

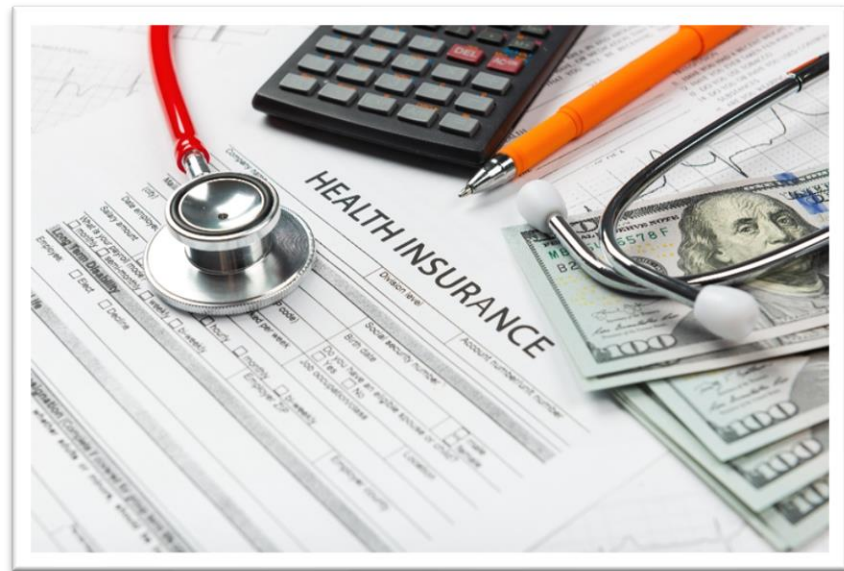
ISSUE NAME	ISSUE NUMBER	REVIEW TYPE	PROVIDER TYPE	REGION	STATE	DATE APPROVED	DETAILS
Total Knee Arthroplasty: Medical Necessity and Documentation Requirements	_0185	Complex	Inpatient Hospital (IP), Outpatient Hospital (OP), Ambulatory Surgical Center (ASC), Professional Services (PNPP)	Region-1	1 - All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

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 \(performantrac.com\)](http://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.

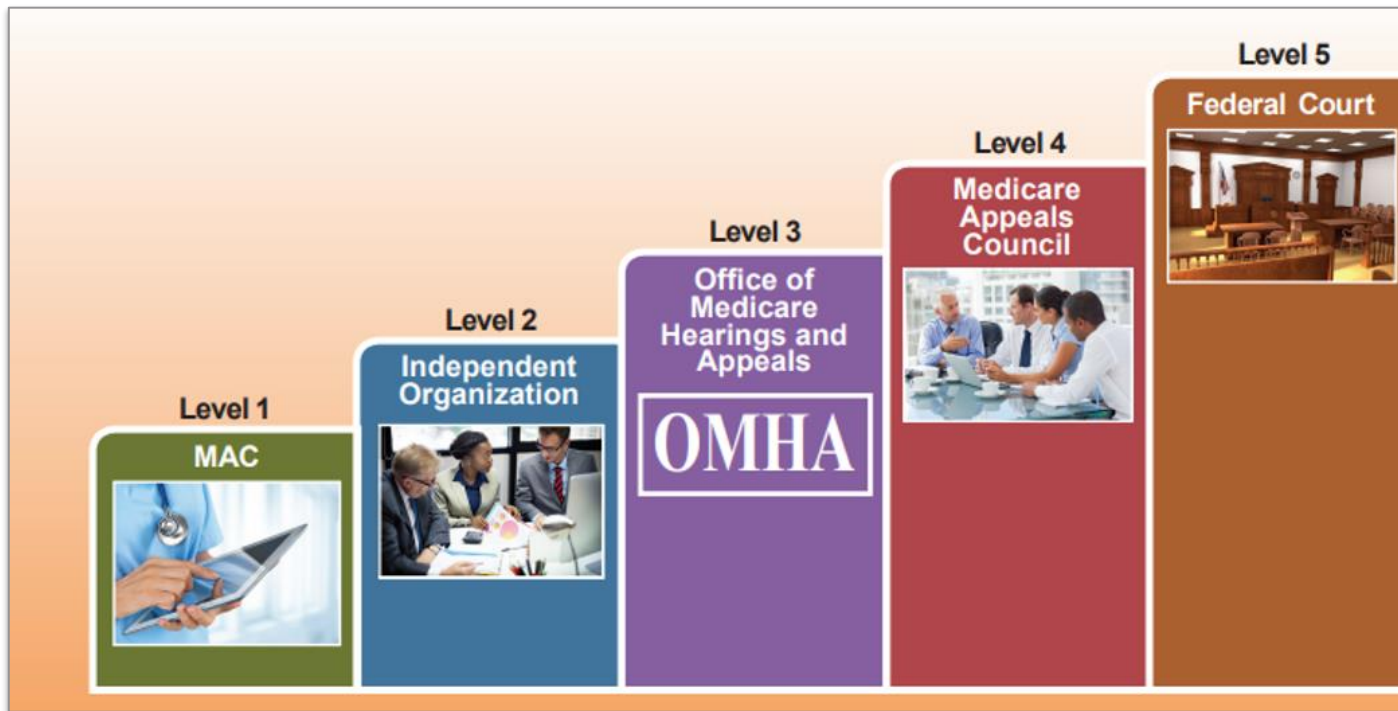
Signature: _____ Date: _____

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 documentation
- Physician notes
- Operative / procedure report
- This is not an inclusive list. All pertinent information 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	<input checked="" type="checkbox"/>	
Claim#:	HIC:				
PT Cntrl:	DOS: 9/17/2014 - 9/23/2014				
Amount:					
Name:	DOB:	Check Box	 90033319824	<input type="checkbox"/>	
Claim#:	HIC:				
PT Cntrl:	DOS: 11/17/2014 - 11/25/2014				
Amount:					
Name:	DOB:	Check Box	 90033322414	<input type="checkbox"/>	
Claim#:	HIC:				
PT Cntrl:	DOS: 4/17/2013 - 4/19/2013				
Amount:					



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.)

The screenshot shows the Performant website's 'Provider Resources for the Medicare Recovery Audit Program' page. The page features a blue header with navigation links: ABOUT US, NEWSROOM, INVESTORS, CAREERS, and a search icon. Below the header is a dark blue navigation bar with links for INDUSTRIES, SOLUTIONS, CONSUMERS, SUPPORT, and CONTACT. The main content area has a background image of a stethoscope and a network diagram. The title 'PROVIDER RESOURCES FOR THE MEDICARE RECOVERY AUDIT PROGRAM' is prominently displayed. A breadcrumb trail reads: Home > Solutions > Healthcare > CMS RAC Resources > CMS RAC Provider Resources. A secondary navigation bar includes links for PROVIDER PORTAL, REGION 1, REGION 5, and the active page, CMS RAC PROVIDER RESOURCES. The main text explains that users will find the latest information for the Medicare Fee for Service (FFS) Recovery Audit Program for Regions 1 and 5, including helpful resources. It also states Performant's commitment to a best-in-class customer experience and minimizing unnecessary burden. A call to action asks if users have questions or want to learn more, offering to help with friendly customer service specialists. Two buttons are highlighted with green boxes: 'CONTACT US' and 'PROVIDER PORTAL'. A section titled 'SECURE PROVIDER PORTAL' offers access to claim review status, contact updates, and more, with a 'CLICK HERE' button also highlighted in green.

PERFORMANT

ABOUT US NEWSROOM INVESTORS CAREERS

INDUSTRIES SOLUTIONS CONSUMERS SUPPORT CONTACT

PROVIDER RESOURCES FOR THE MEDICARE RECOVERY AUDIT PROGRAM

Home > Solutions > Healthcare > CMS RAC Resources > CMS RAC Provider Resources

PROVIDER PORTAL REGION 1 REGION 5 CMS RAC PROVIDER RESOURCES

Here you'll find the latest information for the Medicare Fee for Service (FFS) Recovery Audit Program for Regions 1 and 5, including access to helpful resources to assist you in working with Performant.

Our commitment is to deliver a best-in-class customer experience and minimize unnecessary burden to you during the course of our work. We focus on providing a collaborative and data-driven approach to continuously improve our auditing practices while reducing disruption.

If you have questions or would like to learn more about the CMS program, we're here to help. Talk with one of friendly customer service specialists today.

[CONTACT US](#)

SECURE PROVIDER PORTAL

Access your claim review status, update your contact information, and more.

[PROVIDER PORTAL](#)

Need to update your contact information?

[CLICK HERE](#)



RAC WEBSITE RESOURCES (CONT.)

GENERAL PROGRAM UPDATES

[VIEW ALL UPDATES](#)

03/16/2021

The Centers for Medicare & Medicaid Services (CMS) is required to protect the Medicare Trust Fund against inappropriate payments which pose a risk to the Trust Fund. Therefore, we are resuming Medicare Fee-for-Service medical review activities. Due to the ongoing national coronavirus disease 2019 (COVID-19) pandemic, and the potential need for providers and suppliers to allocate their resources to public health activities, we are temporarily limiting complex reviews to Dates of Service preceding March 1, 2020.

03/05/2021

RAC Region 1 Providers – All requests for Discussions and/or Peer-to-Peer Discussions should be submitted to Performant no later than 4/15/21. Due to contract requirements we are not permitted to offer any extensions beyond 4/15/21.



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.

The screenshot shows the Performant Recovery website's provider portal login page. At the top left is the Performant Recovery logo. To the right are navigation links: HOME, CONTACT, ABOUT US, and PROVIDER PORTAL. Below the navigation is a banner with the text: "Performant is proud to support organizations working to strengthen our communities." The main content area features a "PROVIDER LOGIN" section with the following elements: "User ID:" and "Password:" labels, each followed by a text input field; a "Forgot Password" link; a CAPTCHA image showing the number "90361" with a blue highlight; a text prompt: "In the space below type the word appearing in the picture." followed by a text input field; and a "Login" button. Below the login form is a "Welcome to the 'Claims Status' page" section with a paragraph of text: "This page is for users that have received an Additional Documentation Request (ADR)/medical record request letter. The user id and password for access to this page will be sent to you with the 1st ADR letter you receive. Only providers who have received an ADR letter will have a user id and password assigned. If you have received an ADR letter, but not received a user name and password please contact customer service at 866-201-0580."



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.

The screenshot shows the Performant Recovery Provider Portal. At the top, there is a navigation bar with links for HOME, CONTACT, ABOUT US, PROVIDER PORTAL, CHANGE PASSWORD, and LOGOUT. Below the navigation bar is a banner with the text: "Performant is proud to support organizations working to strengthen our communities." The main content area includes a welcome message: "Welcome 9432046-Provider Name [1902804552]" and an "Update Contact Info" button. There is a "Choose a region:" section with radio buttons for Region 1 (selected), Region 5, Region A, and All Regions. Below this are buttons for "Click here for ADR limits", "Complex", "Automated", and "Semi-Automated". A note states: "* Note: From Jan 03, 2012, Demand Letters will be printed by the MAC. Please contact the MAC for Demand Letter details for claims after Jan 03, 2012." A table with columns for RAC Case Id, Status, Service Date (From/To), Claim Paid Amt, Mailed On, ID, Add'l Docs Rec'd on, Audit (Completed Date/Outcome), Review Results Letter (Mailed On/ID), and Discussion Period (Request Rec'd Date/Review Comp Date) is displayed. The table contains 15 rows of data. At the bottom, there are "Print" and "Download" buttons.

RAC Case Id	Status	Service Date		ADR Letter			Add'l Docs Rec'd on	Audit		Review Results Letter		Discussion Period	
		From	To	Claim Paid Amt	Mailed On	ID		Completed Date	Outcome	Mailed On	ID	Request Rec'd Date	Review Comp Date
90031003032	Active	10/23/2012	10/31/2012	\$32,733.83	01/29/2015	1547591	02/17/2015			04/16/2015	1581681		
90031005656	Active	11/10/2012	11/14/2012	\$18,182.51	01/29/2015	1547591	02/17/2015			04/14/2015	1581230		
90031020747	Active	03/27/2013	04/02/2013	\$30,729.78	01/29/2015	1547591	03/02/2015			04/29/2015	1585149		
90031022750	Active	09/14/2014	09/17/2014	\$7,600.65	01/29/2015	1547591	02/17/2015			04/13/2015	1581038		
90031694301	Active	10/02/2013	10/04/2013	\$9,293.58	03/23/2015	1568176	04/15/2015			06/12/2015	1601676		
90031694533	Cancelled	09/28/2013	10/04/2013	\$11,406.65	03/23/2015	1568176	04/27/2015						
90031694806	Cancelled	09/11/2012	09/19/2012	\$16,912.24	03/23/2015	1568176	04/20/2015						
90031694954	Active	02/11/2014	02/14/2014	\$18,945.19	03/23/2015	1568176	04/10/2015			06/09/2015	1598269		
90031700199	Active	09/06/2013	09/17/2013	\$31,289.93	03/23/2015	1568176	04/27/2015			06/24/2015	1603798		
90031705081	Active	07/09/2013	07/16/2013	\$11,542.97	03/23/2015	1568176	04/20/2015			06/18/2015	1602951		
90031715486	Active	06/14/2014	06/20/2014	\$19,147.65	03/23/2015	1568176	04/17/2015			06/16/2015	1602604		
90031719157	Cancelled	11/30/2014	12/07/2014	\$21,251.84	03/23/2015	1568176	04/22/2015						
90032178239	Active	02/25/2014	03/08/2014	\$20,537.91	05/15/2015	1593819	06/17/2015			08/11/2015	1623882		



ADR LIMITS

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

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

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



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.
- 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

