PERFORMANT

CMS Recovery Audit Contractor
Provider Frequently Asked Questions

Contact Information

How can I contact Performant?

Phone:866-201-0580
Email: info@performantrac.com
Website: https://performanthealthcare.com/cms-rac/

Related 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	Diagnostic Related Group
esMD	Electronic Submission of Medical Records
HIH	Health Information Handler
ICD	International Classification of Diseases
LCD	Local Coverage Determinations
MAC	Medicare Administrative Contractor
NCD	National Coverage Determinations
NPI	National Provider Identifier
OIG	Office of Inspector General
RAC	Recovery Audit Contractor
RHIA	Registered Health Information Administrator
RHIT	Registered Health Information Technician
RRL	Review Results Letter
USPS	United States Postal Service

General

What States are included in CMS RAC Region 1 and 2?

REGION 1		REGION 2	
Connecticut	New Hampshire	Arkansas	Minnesota
Indiana	New York	Colorado	Missouri
Kentucky	Ohio	Iowa	Nebraska
Maine	Rhode Island	Illinois	New Mexico
Massachusetts	Vermont	Kansas	Oklahoma
Michigan		Louisiana	Texas
		Mississippi	Wisconsin

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Timeline Quick Reference

Claim Look-back Period:	3 years
Provider to Submit Documentation:	45 days(1)(2)
Performant to Complete Review and Send Review Results Letter:	30 days(1)
Provider Opportunity to Submit Discussion Request:	30 days(1)(2)
Provider to Submit Documentation Following a *Technical Denial* letter:	30 days(1)

(1) Calendar days
(2) Plus any extension

Additional Documentation Request Letter (ADR)

How does Performant obtain Provider contact information for where the ADR is sent, and can it be customized?
Performant initially receives Provider address/contact information directly from the MACs. Performant strongly recommends that you take advantage of our Secure Provider Portal to customize your contact information to ensure your ADR and other letters are received where you want them.

What method does Performant use to send ADRs, RRLs, and other letters?
Performant follows CMS' requirements to send all communication using First-Class mail, unless the Provider is enrolled in CMS' Electronic Submission of Medical Records (esMD). Using this method, providers can receive their ADRs and RRLs electronically.

Is there an alternative to receiving these letters by USPS?
Currently due to CMS' security requirements, email is not an approved mode of communication for the RACs. CMS requires RACs to send letters via First-Class mail. However, Performant is in the process of building this capability into the Secure Provider Portal to make ADRs available electronically.

I just received an ADR, but we have filed for bankruptcy. Are we excluded from this audit?
Not necessarily. If you have filed a bankruptcy petition or are involved in a bankruptcy proceeding, please contact your MAC immediately. Notify them of your current bankruptcy status so they may coordinate appropriately with the RAC, CMS and the DOJ.

If the Provider has been or is being reviewed by the CERT, OIG, DOJ or other government contractor for a specific claim(s), can the RAC also review and initiate a recoupment on those same claims?
No. These Medicare partners can access CMS' central data repository for contractors and can suppress and/or exclude the claim(s) to try to prevent this overlap. If a Provider receives an ADR for a claim(s) that has already been selected by another entity, please contact Customer Service at 866.201.0580.

When responding to an ADR letter, if a coding error is found, should the Provider rebill the claim at that point?
No. Rebilling will not negate the RAC audit. Respond to the ADR, and the Provider will be notified of the results and whether a difference in reimbursement is identified or not. If so, the MAC will ultimately adjust.

How long does the Provider have to submit documentation in response to an ADR?
45 calendar days from the date of the ADR. If an extension request is needed, contact Performant Customer Service 866.201.0580. Failure to respond to a request for documentation that supports the

billed charges would be considered non-compliant under §1833(e) of the SSA, and 42 CFR 424.5(a)(6). If the requested documentation is not received, the Provider will be sent a *Technical* Denial letter. The Provider has a final 30 days to submit the documentation, or the claim adjusted for by the MAC.

How do I know how many claims the RAC may request every 45 days (referred to as ADR Limits)?
ADR Limits are calculated by CMS and provided to the RACs. Your ADR Limits will be posted on your Secure Provider Portal and will be on your ADR letter itself. The CMS.gov website provides detailed information on ADR Limits and how they are calculated:

Institutional ADR Limits

Physician/Non-Physician ADR Limits

{If these links are not active for you, go to CMS.gov and search these terms}

What is the look-back period for RAC reviews?
It is up to three (3) years from the claim Paid Date.

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

Medical Record Submission

Once a Provider receives an ADR from Performant, how long do they have to respond? A Provider has 45 calendar days to provide medical records to Performant, and that will be stated in the letter. If an extension is needed (typically 14 days), please contact Performant's Customer Service at 866.201.0580.

Will Performant request complete records, specific items from records, or both?
While the ADR may request specific items or complete records, it will instruct the Provider to submit any documentation, such as clinical support notes, that will support the claim being paid as billed.

What is esMD and why is it the preferred method to submit documentation?
esMD stands for Electronic Submission of Medical Documentation. It is a system that CMS has built to make it easier for the exchange of records electronically. However, those who utilize it need to engage with their own Health Information Handler or HIH, but you would want an HIH that is on the esMD approved list. The HIH securely connects with you. On the other end, the HIH is securely connected with esMD. The HIH is your gateway to esMD. esMD serves as a conduit to other CMS contractors. Using esMD avoids printing, postage, and automatically sends your documentation into the appropriate workstream. For more information on esMD, go to CMS' esMD Web Page http://www.cms.gov/esMD

If I am sending medical records on a CD/DVD, is there a minimum or maximum as to how many files I can put on one disk?
No. Performant would like you to fit as many medical records as you can on one CD or DVD. We recommend you also retain a copy for yourself. Complete instructions on how to submit records are included in the ADR as well.

Is there particular software recommended for creating CD/DVDs?
No. You may use any kind of CD/DVD writing software you choose. However, the 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.

Is the cost for medical record copies reimbursed and does that include medical records sent on CD/DVD? Will the Provider need to invoice the RAC?
Yes, Performant is required to reimburse providers for the submission of medical records, and that includes those submitted on CD/DVD. The CMS Payment Integrity Manual Section 3.2.3.6 details the requirement. Medical record reimbursement does not apply to DMEPOS Suppliers. If you meet the definition of a PPS provider, payment will be $.12 cents per page plus shipping cost if mailed via USPS First-Class 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 $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. Reimbursement is automatic, and the Provider does not need to invoice the RAC.

Our facility utilizes a Health Information Handler for ADR submissions. We would prefer that the RAC issue medical record reimbursement payments to them directly. Is this a service that Performant offers?
No. Performant pays the Provider directly.

Audit Review

Who at Performant conducts the reviews?
Depending on the type of review, Performant uses experienced, licensed nurses, and/or certified coders with CCS, CPC, RHIA or RHIT certifications. Medical Directors provide audit oversight and conduct Peer-to-Peer reviews.

What type of reviews does Performant conduct?
Performant is authorized by CMS to perform both *Automated* and *Complex* reviews. All Approved Issues are listed on our website under *Provider Resources* > *Approved Issues*.

What is an Automated Review?
An Automated review does not require the provider to submit a medical record. The review is based solely on specific systematic edit parameters. It is also referred to as 'data mining'. The Provider will subsequently receive an Initial Findings Letter with the findings detail.

What is a Complex Review?
A Complex review means a medical record is required to conduct the review. Examples include Inpatient, Outpatient, Skilled Nursing Facility, Inpatient Rehabilitation Facility, Carrier Claims which are claims billed by physicians.

How do we know what Topics (also known as **Issues) Performant is reviewing?**
Once CMS approves a Review Topic, Performant places the Topic on their website under Provider Resources - *Approved Issues*. Check https://performanthealthcare.com/cms-rac/ regularly to see all current topics CMS has approved.

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.

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, Performant will consider reviewing underpayments for DRG and will report to the MAC for adjustment.

Does the RAC stay current with the continual changes in Medicare policies, amended policies, implementation dates of interim policies, and memos etc.?
The RACs must abide by current Medicare legal and regulatory policies in effect at the time when the services were provided, which includes the correct version of the LCD by the Medicare contractor who had jurisdiction. The RACs 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 RACs 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 adjust as appropriate, and the Provider will be notified of any difference in reimbursement. If you have questions, please contact your MAC.

How long after Performant receives my medical records will I be notified of the outcome?
Performant has 30 days to complete the review and send the Provider a Review Results Letter (RRL).

Audit Results

Is a Review Results Letter (RRL) the same as an Overpayment Demand letter?
No, an RRL is sent by Performant 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 RAC. The Overpayment Demand Letter is generated by the MAC. It provides information on the overpayment, and the Provider's appeal rights and timing.

Will there be any letter sent if the RAC review does not result in any findings?
Yes. An RRL is sent whether there were findings or not. In this case it would be referred to as a *No Findings Letter*.

Dispute Process

If the Provider disagrees with the outcome of a review, do they file a Discussion and/or an Appeal?
After a Review Results Letter is sent, a provider has 30 days to file a Discussion with the RAC. Performant highly encourages the Provider to file a Discussion first, because if the review determination is overturned at the Discussion level, no adjustment will be sent to the MAC and the review is closed. If the Provider is not satisfied with the outcome of the Discussion, they will have Appeal rights with the MAC. The MAC will subsequently send a Demand Letter to the Provider which will explain those rights.

During the Discussion Period, if an audit is discussed and the original decision is overturned, will the Provider receive an updated letter?
Yes. Performant will send a letter to the Provider with the outcome of <u>any</u> Discussion filed.

Will Performant accept missing/additional documentation during the Discussion Period? Yes. While Providers should provide all appropriate and complete documentation during the initial submission, missing/additional documentation can be sent during the Discussion Period.

MAC Adjustment, Demand Letter & Appeals

What procedure does Performant use to coordinate payment take-backs (also known as recoupments) with the MACs? Will the takebacks 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 (also known as Demand Letter) prior to recoupment stating that the adjustment is RAC-related and will have remittance advice code **N432**. If you have any questions, please contact Customer Service at 866.201.0580.

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.

Will the Providers receive individual Demand Letters for each claim or will letters list multiple claims 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.

How do I control to what address any Demand Letter is sent?
Since the Demand Letter is sent by the MAC, please contact the appropriate MAC to ensure the address they have on file is correct. Any address you customize with Performant will not be reflected in any communication you receive from your MAC.

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

If we have any questions regarding any aspect of the formal appeal process, who should we contact?
The RAC does not handle the appeal process. Any appeal-related questions should be directed to the MAC.

Provider Resources

How do I obtain a user **ID and password to access Performant's 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 no longer have access to that letter, or have any difficulty logging in, please contact Customer Service at 866.201.0580.

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