PERFORMANT

Region [Region #] Recovery Audit Contractor (RAC)

Date [*Printed Date*]

[*Facility Point of Contact*]
[*Physician Practice Name*]
[*Street Address Line 1*]
[*Street Address Line 2*]
[*City, State ZIP*]

SAMPLE

NPI:
PTAN:
Phone:
Fax:
Letter Request ID:
Batch ID:

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.

CMS continually strives to reduce the improper payment of Medicare claims. The Recovery Audit Program, mandated by Congress, has been developed to assist in accomplishing this goal. Our 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. If an underpayment or overpayment is identified, there is a 30-day Discussion Period in which a request may be submitted to the RAC for the opportunity to discuss the results and provide additional information to support the original payment. Additional information about the program, regulations, and RACs can be found at the following:

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/cms-rac/cms-rac-resources/cms-rac-provider-resources/default.aspx

CMS has established a 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/files/document/adr-limits-institutional-provider-facilities-may-1-2022.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/ADR-Limits-Supplier-April_1_2022.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/ADR-Limits-Physician-February-14-2011-.pdf

ADR Limits:

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.

Risk-Based, Adjusted ADR Limits are established after three (3) 45-day ADR cycles (135 Days). CMS calculates (or recalculates) a provider's Denial Rate, which reflects their compliance with Medicare rules. The Denial Rate will be calculated using the number of claims containing improper payments that resulted in overpayments (less any determinations that are overturned during appeal) divided by the total number of claims reviewed, expressed as a percentage. CMS will perform this calculation using data from the most recent 12-months of completed reviews.

If no reviews were completed in the most recent 12-months period, CMS applies baseline annual baseline limits to calculate ADR limits for three (3) 45-day ADR cycles. Details of how baseline limits are calculated are available at:
https://www.cms.gov/data-research/monitoring-programs/medicare-fee-service-compliance-programs/medicare-fee-service-recovery-audit-program/resources

If a provider's 45-day ADR limit is calculated as less than one, but their total 135-day limit is greater than one (e.g., 1 or 2), they will receive one documentation request per 45-day cycle until the full 135-day limit is met.

Bill Type	Effective Date Range	ADR 135-day Limit	ADR 45-day Limit	Bill Type	Effective Date Range	ADR 135-day Limit	ADR 45-day Limit
21x	04/14/2025 To 08/26/2025	2	1	21x	04/14/2025 To 08/26/2025	2	1

Bill Type	ADR 45 Day Limit	Annual ADR Limit
PHYS	1	8

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 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.

Please refer to the enclosed Claim(s) and Issue(s) Selected for Review and Bar Code Sheet(s) for a list of selected claims.

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 requested information. Providers may request at least one extension for the submission of additional documentation by contacting Customer Service via email at info@performantrac.com or phone (866) 201-0580.

Requests by Medicare contractors for provider's/supplier's provision of supporting documentation are addressed in the following Medicare legal and regulatory documents: 42 United States Code (USC), §§ 1320(c)(5)(a)(3) , 1395(ddd)(f)(4) and (7), 1395(g)(a), 1395(l)(e) Social Security Act §§ 1156, 1815(a), 1833(e) and 1893(f)(4) and (7) and Medicare Program Integrity Manual, Ch. 3, § 3.2.3.

When the review is complete, you will be notified of the results. Performant's goal is to complete the review and deliver the results to providers/suppliers within 30 days of receipt of all medical records needed for the review.

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. Upon this, providers/suppliers will receive a Technical Denial Letter. Providers/Suppliers who wish to submit records may request to do so within 30 days from the date of the Technical Denial Letter. If no action is taken, once the 30-day grace period has

passed, these claims will be sent to your Medicare Administrative Contractor (MAC) to initiate claims adjustments or overpayment recoupment actions for these undocumented services.

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:

The RAC is required to reimburse providers for the submission of medical records for the following claim types: Acute Care Inpatient Prospective Payment System Hospital Claims, Long Term Care Hospital Claims, non-PPS institution, and practitioners.

If you meet the Medicare definition of one of these provider types, you will be reimbursed for the cost of providing copies of the additional documentation. Payment will be issued to you within 45 days of receiving the additional documentation.

Providers/suppliers may submit this documentation in any of the following ways:

Via postal mail (either on paper or as images on Encrypted CD/DVD):

1. Include a copy of the ADR letter with your documents.
2. If you choose to password protect the CD/DVD, please use password: [CD Password]
3. Requirements for submitting imaged documentation on CD or DVD can be found on https://www.performantrac.com/
4. Mail to the following:

Performant Recovery, Inc.
[Address 1]
[Address 2 (if necessary)]
[City, State, Zip]

For Hospital Inpatient Prospective Payment System (PPS) Facilities and Long-Term Care Facilities, reimbursement for records submitted via mail is 12 cents per page; plus, the cost of First-Class postage, if applicable; $15.00 maximum per record.

For non-PPS Institutions and Practitioners, reimbursement for records submitted via mail is 15 cents per page; plus, the cost of First-Class postage, if applicable; $15.00 maximum per record.

Via fax to:

1. (325) 224-6710
2. Include a copy of the ADR letter with your documents.

For Hospital Inpatient Prospective Payment System (PPS) Facilities and Long-Term Care Facilities, reimbursement for records submitted via fax is 12 cents per page; plus, the cost of First-Class postage, if applicable; $15.00 maximum per record.

For non-PPS Institutions and Practitioners, reimbursement for records submitted via fax is 15 cents per page; plus, the cost of First-Class postage, if applicable; $15.00 maximum per record.

Via Electronic Submission of Medical Documentation (esMD):

1. Include a copy of the ADR letter with your documents.
2. Submit your documentation to your CONNECT-compatible gateway or HIH.
3. More information on esMD can be found at (https://www.cms.gov/ESMD/)

For Hospital Inpatient Prospective Payment System (PPS) Facilities and Long-Term Care Facilities, reimbursement for records submitted via esMD is 12 cents per page; plus $2.00 transaction fee, per record; $27.00 maximum per record.

For non-PPS Institutions and Practitioners, reimbursement for records submitted via esMD is 15 cents per page; plus $2.00 transaction fee, per record; $27.00 maximum per record.

Questions:

To confirm receipt of submitted documents and/or check claim review status information, log into the Secure Provider Portal link on our website at https://secure.performantrac.com/

Questions regarding any updates, login procedures, or this request should be directed to Customer Service at 1-866-201-0580.

Sincerely,
Performant
Region [Region #]
Recovery Audit Contractor
Enclosure

Attachments / Supplementary Information

Attachments:

- Claim(s) and Issue(s) Selected for Review
- Bar Code Sheet(s)

Supplementary Information:

- Link to RAC list of approved issues: https://www.performantcorp.com/solutions/healthcare/cms-rac-resources/cms-approved-audit-issues/default.aspx

- Link to CMS list of approved issues: https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Recovery-Audit-Program/Approved-RAC-Topics
- CMS link to Additional Documentation Limits for Institutional Providers: https://www.cms.gov/files/document/adr-limits-institutional-provider-facilities-may-1-2022.pdf
- CMS link to 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/ADR-Limits-Supplier-April_1_2022.pdf

- CMS link to 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/ADR-Limits-Physician-February-14-2011-.pdf

Requested Claims

Issue: [CMS Issue Number] [Concept Name]

[Optional paragraph describing the issue(s) identified - "Good Cause" section]

Providers are encouraged to review the above references that support proper payment and reopening of claims:

[List of references related to the issue(s) identified - "Claims List"]

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]	Target Code(s) – [HCPCS/HIPPS from target line (audit pick = "Y")]			
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]	Target Code(s) – N/A			
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:

[List of required MR Sections]
[Free for text for additional instructions]

Please include the below barcode cover page with the requested additional documentation. If you send paper, please copy the barcode cover page as the first page for each document and check mark the barcode associated with the documents attached. Please include the barcode page with faxed documents. **Documentation submitted without proper identifying documentation will not be loaded**. Questions regarding this request should be directed to Customer Service at 1-866-201-0580.

Beneficiary Information		DOB & DOS		Case #	
Name:	Smith, John	**DOB:**	11/11/1931	**Check Box**	
Claim#:	5012345678901234ABC	**HIC/MBI**	1234567890A		900054683245
PT Cntrl:	501234567890.23456	**DOS**	01/06/08 - 01/08/08		
Amount:					[Bar Code]
Name:	Doe, Jane	**DOB:**	11/11/1931	**Check Box**	
Claim#	501234567890	**HIC/MBI**	1234567890A		900054683245
PT Cntrl	501234567890	**DOS**	01/06/08 - 01/08/08		
Amount					[Bar Code]
Name:	Rodriquez, Jesus	**DOB:**	11/11/1931	**Check Box**	
Claim#	501234567890	**HIC/MBI**	1234567890A		900054683245
PT Cntrl	501234567890	**DOS**	01/06/08 - 01/08/08		
Amount					[Bar Code]
Name:	Smith, John	**DOB:**	11/11/1931	**Check Box**	900054683245
Claim#	5012345678901234ABC	**HIC/MBI**	1234567890A		
PT Cntrl	501234567890.23456	**DOS**	01/06/08 - 01/08/08		
Amount					[Bar Code]
Name:	Doe, Jane	**DOB:**	11/11/1931	**Check Box**	900054683245
Claim#	501234567890	**HIC/MBI**	1234567890A		
PT Cntrl	501234567890	**DOS**	01/06/08 - 01/08/08		
Amount					[Bar Code]

Performant Recovery, Inc.
[Address 1]
[Address 2 (if necessary)]
[City, State, Zip]

866-201-0580 TOLL FREE
325-224-6710 FAX
www.performantrac.com