

Recovery Audit Contractor

Region 1 & Region 2



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All processes and guidelines are undergoing continuous improvement and modification by Performant, a Machinify company, and the Centers for Medicare and Medicaid Services (CMS).

AGENDA

- ✦ Mission of the RAC program
- ✦ Performant's role & RAC accountability
- ✦ Walk-through of the process from end-to-end
- ✦ The dispute process
- ✦ Provider resources

MISSION OF THE RAC PROGRAM

Performant's Role

RAC Accountability

Medicare Fee for Service (FFS) Recovery Program



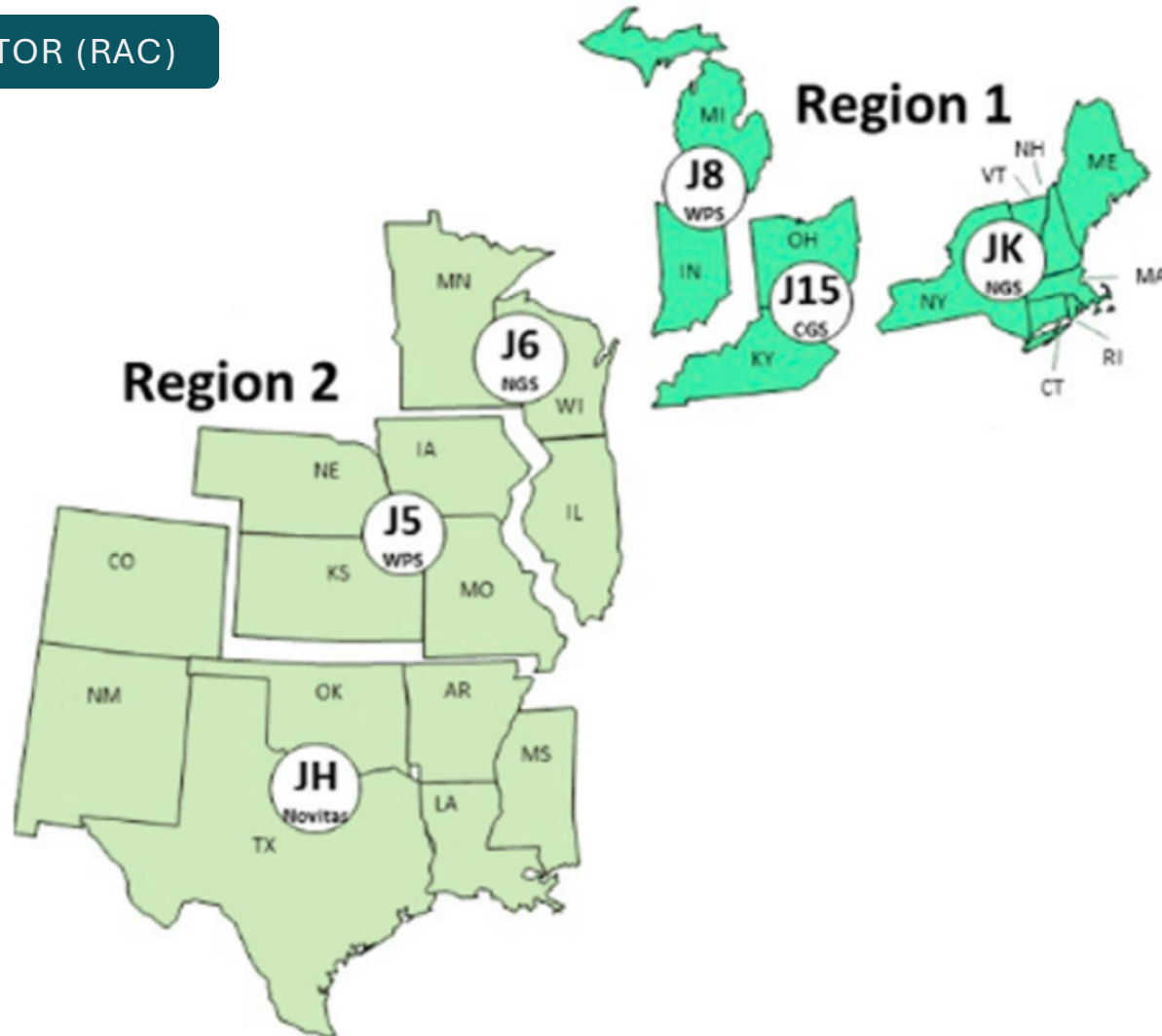
MISSION

To identify and correct Medicare improper payments through the detection of **overpayments** and **underpayments** made on claims of healthcare services provided to Medicare beneficiaries, so CMS can implement actions that will prevent **future** improper payments in all 50 states.

Recovery Audit Contractor (RAC) Accountability

RECOVERY AUDIT CONTRACTOR (RAC)

CMS Regions 1 & 2



Recovery Audit Contractor (RAC) Accountability

REVIEW TOPICS

- Limited to CMS-approved topics.
- CMS requires detailed review topic information on RAC websites.
RAC website <https://performanthealthcare.com/cms-rac>

GUIDELINES

- Adherence to Medicare rules, LCDs, NCDs, etc.
- Adherence to ADR limitation rules and lookback periods.

MONITORING

- Minimum 1st level appeal overturn rate: $\leq 10\%$
- Minimum monthly accuracy rate: 95%

Different types of reviews
How claims are selected

Review types

Automated

 No medical record documentation required

 Identified through systematic edit parameters

 Examples:
Facility vs non-facility reimbursement:
incorrect coding

Complex

 Requires medical record documentation to be reviewed for accuracy determination

 Examples:

- **IP** – Inpatient (DRG, etc.)
- **OP** - Outpatient
- **SNF** – Skilled Nursing Facility
- **IRF** – Inpatient Rehabilitation Facility
- **CAR** – Carrier claims (billed by physicians)

How claims are selected for review

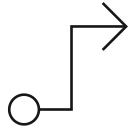
The RAC program does not target specific providers, facilities, suppliers, or patients.

CRITERIA & SELECTION

- Each review topic contains a set of edit parameters that guide selection criteria
 - all of which are approved by CMS.
- In accordance with the billing policies applicable to each review topic, a specific set of circumstances must be present/not present in the billing data to request records.
- Selection algorithms are based on data analysis that has identified a high error rate or a pattern of potential overutilization in:
 - a provider population.
 - a specific area of billing, coding or medical necessity.

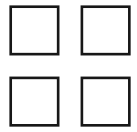
Walk-through of the
process from beginning-to-end

Additional Documentation Request (ADR)



PURPOSE

- Support billing and coding of the claims paid by CMS.



COMPONENTS OF THE ADR

- Facility/supplier/provider name, address, and NPI #
- Submission timeframe
- Consequences for non-compliance
- Record submission instructions
- List of requested medical records/documents

Courtesy Outreach Calls

STANDARD PRACTICE

Additional Documentation Request (ADR) letter is sent requesting specific records for review. Provider has 45 calendar days to respond.

THE CUSTOMER SERVICE TEAM

Conducts a courtesy outreach to every provider (based on tax ID groupings) that has not yet responded to the ADR letter.

PROCESS

- We make 1 or more courtesy outreach attempts to confirm receipt of the letter.
- We request to speak with someone that handles medical records requests.
- If we leave a message, we provide the letter ID #, the medical record due date, and our phone number and ask them to call and confirm receipt of the letter or request a copy if needed.
- If we are asked to fax a copy of the letter, we ask for NPI and/or TIN verification to protect personal health information (PHI). Make sure your team knows this information.
- We also ask for confirmation that the address we have on file is correct to ensure we have the most up-to-date and accurate contact information.
- We provide an extension if requested. Typical extensions are 14 calendar days.

Contact information customization

KEY FEATURES

- Notify the RAC of all address changes as soon as possible to avoid time sensitive letters from being misrouted.
- Letters can be customized to have different addresses and contacts based on letter types.
- Without customization, all letters will default to the ADR medical records request address on file.

CONTACT FOR RECOVERY MEDICAL RECORD REQUESTS	
Contact Person *	Telephone # *
Title	Fax #
Mailing Address *	City *
State *	Zip Code *
AL	
Alternate Contact Person	Telephone #

REVIEW RESULTS/DISCUSSION PERIOD RESULT LETTERS	
Contact Person	Telephone #
Title	Fax #
Mailing Address	City
State	Zip Code
AL	
Alternate Contact Person	Telephone #

What records to send

SUBMIT A COMPLETE MEDICAL RECORD

- Include all dictated, handwritten notes
- Documents supporting all the items billed on the requested claim
- All pertinent information to meet policies and billing requirements must be included

TIMELY DOCUMENTATION

- Include timely documentation for continued use and need for preceding 12 months, if applicable.
- You must send all requested documents at this time.

This is not an inclusive list – the ADR will specify based on the review type.

SAMPLE DOCUMENTATION

ADR will specify

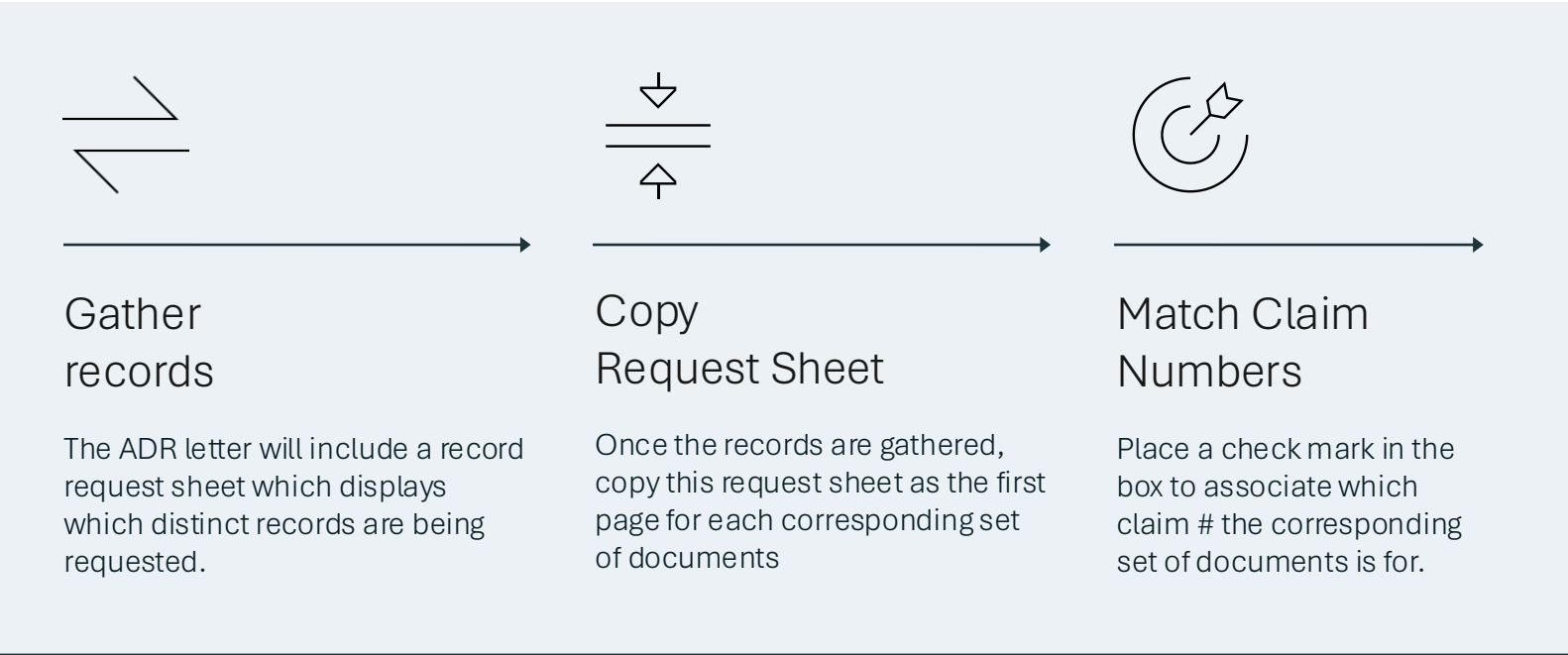
- Plan of care
- Physician certification(s) and recertification(s) assessment
- Start of care assessment
- History and physical physician orders
- Medication records
- Treatment records
- Wound care records, including measurements
- Change of therapy (COT) records and assessments
- Acute/post-acute care progress notes and/or discharge summary, if applicable
- Signature log or signature attestation for any missing or illegible signature within the medical record

Preparing records to send

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

*It is possible for multiple record sets to be requested. Records for each claim must be a separate and distinct bundle, with only 1 claim checked for each bundle.**

**Bundling multiple record sets together could lead to upload errors.*



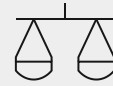
Sending records

- **Preferred method:** esMD
 - If you are not signed up with a gateway service yet, contact a Health Information Handler (HIH), and they will assist you with getting set up. [esMD for Medicare Providers and Suppliers](#)
- **Postal Mail** (CD or paper copies only)
 - Performant
P.O. Box 3568
San Angelo, TX 76902
- **Fax** (each record set per claim must be sent in a separate fax)
 - Fax: 325-224-6710
 - Faxes are received electronically and come in as a single PDF. Mixing claims into one fax can lead to upload errors.
 - Large record sets should be mailed or submitted via esMD.
- **USB drives are not accepted**

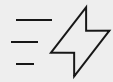
Medical record reimbursement

- The Medicare Program Integrity Manual (PIM) Section 3.2.3.6. provides guidance to RACs on reimbursement for medical records.
- Maximum reimbursement to a provider per medical record if sent via esMD shall not exceed \$27, or \$15 if sent by any other method.
- Performant automatically tracks record submissions and issues a check within 45 days. There is no requirement to invoice.

WHAT IF I DON'T RESPOND TO AN ADR LETTER?



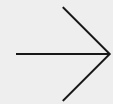
Failure to submit requested documents by the due date or extended due date (if one was requested) could result in a full recoupment of the claim paid.



If you do not submit records by the deadline, a Technical Denial notification letter is sent.



If still no documentation is received within 30 days, a full claim denial is sent to your Medicare Administrative Contractor (MAC). Please note, extensions are NOT granted on claims that have been technically denied.



If you do submit records within 30 calendar days of the date of the Technical Denial letter, the RAC will re-open the claim for review, and it will follow the normal process.

Consequences of not responding to ADR

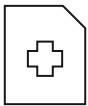
What if I disagree with the determination?



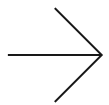
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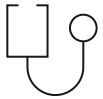
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Conducting the reviews

Who does the reviews?



Certified coders evaluate submitted documentation for billing and coding accuracy.



Licensed nurses review for medical necessity.



Medical directors have oversight of all reviews.



Subject matter experts, AKA Segment Specialists, that work in conjunction with the medical directors to create review guidelines for each review topic.

Review guidelines used

Hierarchy of policies and guidelines approved during review

The primary authority for all coverage provisions and subsequent policies is the Social Security Act.

Social Security Act	Commercial Policy	Code of Federal Regulations	CMS Rulings
National Coverage Determination (NCDs)	Local MAC Articles	AHA Coding Clinics	Local Coverage Determination (LCDs)
CMS Coding Policies	Coverage provisions in Interpretive Manuals or Internet Only Manuals (IOM), including medical review guidance in the Medicare Program Integrity Manual		

Coding-focused reviews

- Does the procedure, drug, lab, service, etc., meet Medicare guidelines as applicable?
- Was the procedure coded correctly? What service was rendered? Does it change payment?
- Were the units billed consistent with the documentation?
- Validate the modifier as appropriate?
 - Were modifiers added to override traditional edits?
 - Were procedures unbundled?
 - Were there unnecessary add-on codes?
- Is the procedure/service covered by Medicare?

Medical necessity-focused reviews

Medical necessity documentation encompasses the process of recording and showing the cause for the need of medical services or treatments given to patients.

It should support the medical necessity of the treatment plan and confirm that it adheres to accepted medical standards and guidelines. The services must be appropriate, rational, and necessary given the patient's diagnosis and condition.

Reviews may look for elements such as:

- Clear diagnosis
- Relevant medical history
- Justification for treatment
- Documentation that meets the specific medical necessity requirements that the regulatory guidelines mandate

Common errors

- Not following coding guidelines
- Improper coding
- Documentation provided does not support codes billed
- Violation of LCD, NCD, or Medicare guidelines and regulations
- Drugs: units and approved use
- Non-covered services

Notification of review outcome

After a review is finalized, a Review Result Letter (RRL) is sent.

Review Result Letter (RRL) - 4 types

- Initial finding (for automated reviews)
- No finding
- Overpayment
- Underpayment

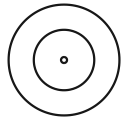
Review determination

- No finding – no billing errors were found - no further action
- Finding - an error was cited. An Audit Detail page with review rationale is included in the letter

The dispute process

Discussion Request

What if I disagree with the determination?



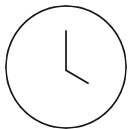
PURPOSE

To offer providers the opportunity to submit additional information - evidence to support why you believe the claim was properly coded, correctly billed, and/or supply documentation that was omitted from the original response to the ADR.



BENEFIT

If, during the Discussion Period, the original determination is overturned, the MAC will not be sent an adjustment. No further action will be taken.



TIMEFRAME

You have 30 calendar days from the date of the RRL to file a written request for Discussion. Please note, if additional time is needed, call customer service at 866-201-0580 and they will grant you an extension.

Submitting a Discussion Request

- The "Request for Discussion" form and submission instructions can be found on the Performant website in the Provider Resources section.
- Include evidence to support the belief that the claim was properly coded, correctly billed, and should be covered by Medicare.
- If requesting a Physician-to-Physician review, check the appropriate box and include the name and credentials of the physician who will attend the call; ensure the attending physician meets the credential requirements.

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 (MD, DO, DPM, DDS, DMD, OD) 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:** _____

Appeal with the MAC

APPEAL RIGHTS

If you are not in agreement with the outcome of the Discussion, you have additional appeal rights with the MAC and beyond.

REDETERMINATION

Performant does not handle appeals. Before your claim is adjusted, the MAC will send you a demand letter. It will provide instructions on how to file an appeal (AKA “Redetermination”) should you wish to do so. You will have 120 days from the date of the demand letter to file.

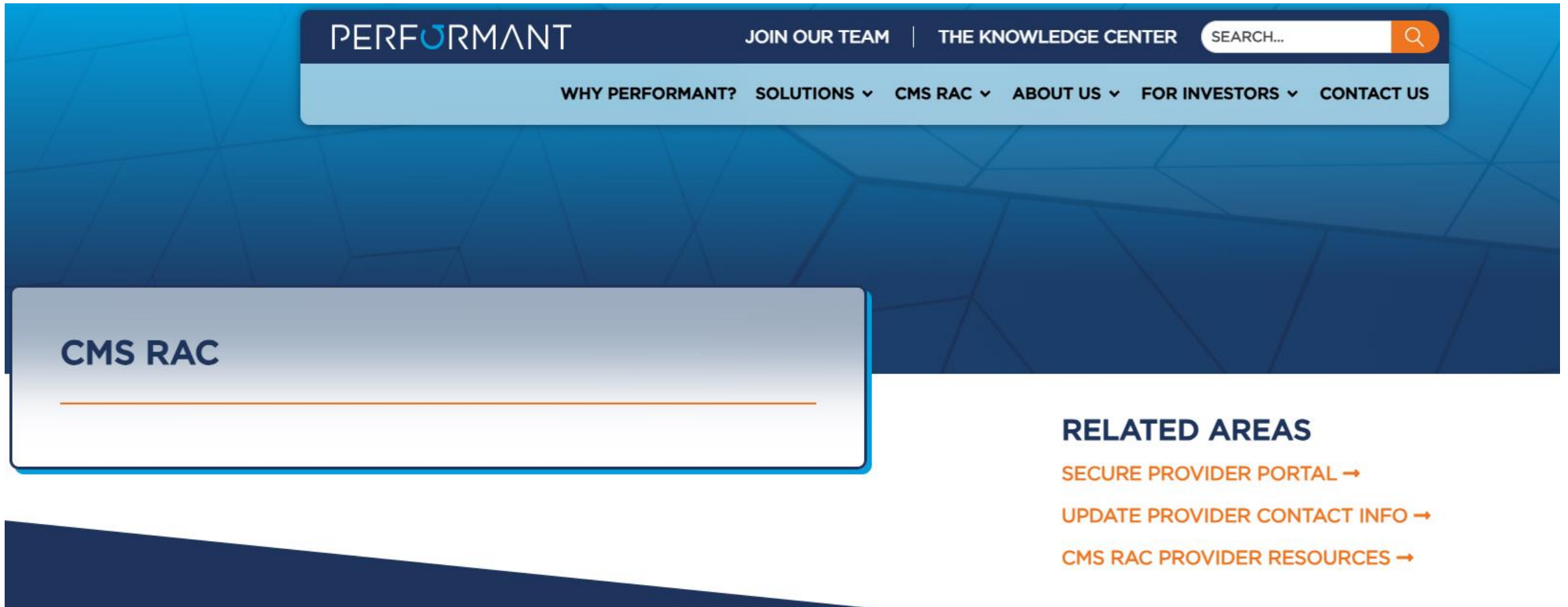
RAC WEB LINKS

Web links to the various MACs can be found on the Performant RAC website. Navigate to the corresponding RAC Region link and scroll to the External Resources section.

Provider resources

Performant

<https://performanthealthcare.com/cms-rac/>



Provider portal

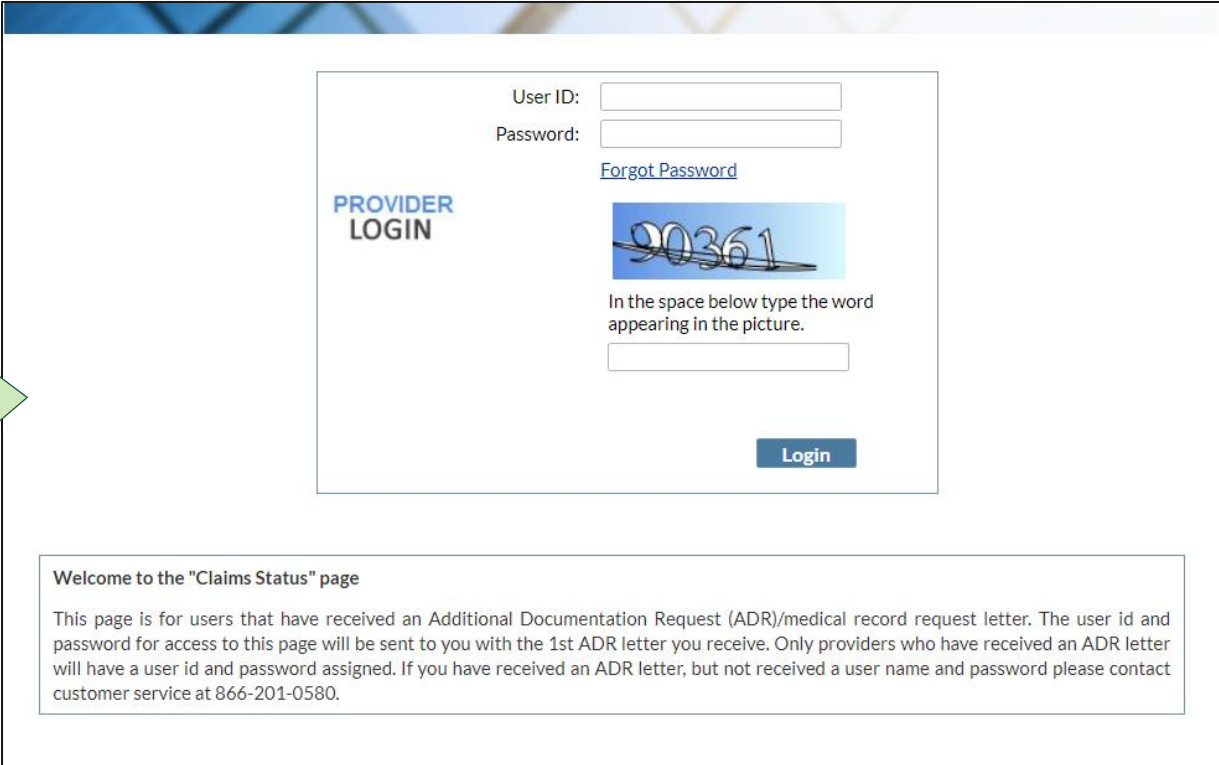
Access your claim review status, update your contact information, and more.

SECURE PROVIDER PORTAL →

After you accept the terms of usage this login screen will appear.

The information to log on to the website is provided to you in writing via a welcome letter from Performant.

If you cannot locate this information, contact our Customer Service team at 1-866-201-0580 and they will assist you.



User ID:

Password:

[Forgot Password](#)

**PROVIDER
LOGIN**



In the space below type the word appearing in the picture.

Login

Welcome to the "Claims Status" page

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.

Inside the provider portal

- 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 dates

Welcome HOSPITAL [19 92] [Update Contact Info](#)

Choose a region: ☐ Region 1 ☒ Region 2 ☐ Region 5 ☐ Region A ☐ All Regions

[Click here for ADR limits](#)

[Complex](#) [Automated](#)

Note: Performance did not audit your claims in RAC Region which is disabled

** 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

* Click on the label to sort by

RAC Case Id	Status	Service Date		ADR Letter			Audit		Review Results Letter		Discussion Period		
		From	To	Claim Paid Amt	Mailed On	ID	Audit Docs Rec'd on	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	\$16,912.34	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	\$21,251.64	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		

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Provider resources

REGION 1

REGION 2

REGION 1 RESOURCES

- [↪ Region 1 Approved Issues](#)
- [↪ Performant Region 1 Outreach 2021 \(download PDF here\)](#)
- [↪ Region 1 Provider MACs \(download PPT here\)](#)
- [↪ FAQs \(download PDF here\)](#)
- [↪ Forms and Sample Documents \(download PDFs here\)](#)
- [↪ Additional Documentation Submission Instructions \(download PDF here\)](#)
- [↪ Discussion Request Form \(download PDF here\)](#)
- [↪ Acronyms](#)

EXTERNAL RESOURCES

- [↪ Institutional \(i.e., Facilities\) Additional Documentation Limits](#)
- [↪ Physician/Non-Physician Practitioner Additional Documentation Limits](#)
- [↪ National Government Services \(NGS\)](#)
- [↪ CGS](#)
- [↪ WPS](#)
- [↪ American Hospital Association](#)

CMS-approved review topics (aka issues)

Filter by Region:

All Regions

[Download .XLS File](#)

Issue Name	Issue Number	Review Type	Provider Type	Region	State	Date Approved	Details
Transitional Care Management: Unbundling	_0224	Automated	Professional Services (Physician/non-physician practitioner)	Region-1, Region-2,	All Region 1 and Region 2 states	01/14/2025	Details
Transitional Care Management: Excessive Units	_0225	Automated	Professional Services (Physician/non-physician practitioner)	Region-1, Region-2,	All Region 1 and Region 2 states	01/13/2025	Details
Drugs and Biologicals in Multi-Dose Vials: Billed with JW Modifier	_0223	Automated	Outpatient Hospital, Professional Services	Region-1, Region-2,	All Region 1 and Region 2 states	12/01/2024	Details
Panniculectomy: Medical Necessity and Documentation Requirements	_0130	Complex	Ambulatory Surgical Center (ASC); Professional Services	Region-1, Region-2	All A/B MACs	08/01/2024	Details

- Clicking the Details hyperlink produces a pop-up window that provides details about the review topic
- The details can be exported to Excel
- Check for updates regularly

Who to contact for what

PERFORMANT

- ADR questions & submitting records
- Extension requests
- Discussion Request

CMS

- RAC & Program Integrity Manual
- CMS.gov [Medicare FFS Recovery Program](#)

MEDICARE ADMINISTRATIVE CONTRACTOR

- Billing & payments
- Response to demand letter or recoupment
- Level 1 appeal inquiries

Performant contact information

- Toll-free: 1-866-201-0580
- Medical record fax: 1-325-224-6710
- Discussion Request fax: 1-833-366-6118
- <https://performanthealthcare.com/cms-rac/>
- Email: Info@PerformantRAC.com

Q&A

PERFORMANT
a Machinify company