FAQ Table of Contents

RAC Contacts
General Process
Timeline
Correspondence
Medical Records
Audit Review
Information for PIP Providers

RAC Contacts

Question: Who are the Performant Recovery Audit (RA) contacts for provider staff?
Answer:

- Performant Recovery Customer Service Department at 1-866-201-0580
- Email Info@Performantrac.com
- Fax Number 325-224-6710

Back to the top

General Process

Question: What states are in Performant Recovery' CMS RA Region A?
Answer: There are twelve (12) states: Connecticut, Delaware, District of Columbia, Maine, Maryland, Massachusetts, New Hampshire, New Jersey, New York, Pennsylvania, Rhode Island and Vermont.

Question: What states are included in the CMS RA Region A MAC Jurisdictions (J12, J13 & J14)?
Answer: The MAC Jurisdictions are as follows: J12 - DC, MD, DE, PA, NJ; J13 - NY, CT; J14 - NH, VT, ME, MA, RI.

Question: How do I obtain a user id and password to access the "Claims Status" page?
Answer: You must have received your first ADR Letter and a Welcome to PerformantRac.com letter. The welcome letter will include your user id and password for access to the "Claims Status" page. Only providers who have received their Welcome to PerformantRac.com letter will have a user id and password assigned. If you have not received the Welcome to PerformantRac.com letter and have received ADR letters, please contact Customer Service at 1-866-201-0580.

Question: I have not been able to access the Performant Recovery website and/or log into "Claim Status", page. What can I do?
Answer: Please call our Customer Service office at 1-866-201-0580. They are available to help you with your access into the "Claim Status" site.

Question: Where is the Performant Recovery customer service staff located?
Answer: The Performant Recovery customer service staff is located in San Angelo, Texas.

Question: What procedure does Performant Recovery plan to utilize to coordinate payment take-backs with the MACs? Will the take-backs appear on a separate voucher that identifies they are the result of a RA audit?
Answer: The process will be the same currently administered by all the MAC's. The MAC will notify the provider by submitting a remittance advice prior to recoupment stating that the adjustment is RAC related and will have a remittance advice code N432. Should you have any questions please contact Customer Service at 1-866-201-0580.

Question: How will Performant Recovery communicate with providers and provider associations regarding identified issues?
Answer: Once CMS approves an issue for review, Performant Recovery will place the issue on the Performant Recovery website. Providers should check the http://www.performantrac.com/ regularly to see all issues approved by CMS.

Question: How often will Performant Recovery staff provide update forums either in person, via audio conference, or Web conference?
Answer: Performant Recovery may provide periodic conference calls/webinars. However, the primary source of information should always be the Performant Recovery Web site. If you wish for an outreach or conference call for a provider group, facility or association, please contact Performant Recovery Customer Service at 1-866-201-0580 to help coordinate.

Question: Will Performant Recovery review only Medicare Fee for Service (FFS) claims or will you also review Medicare Advantage claims?
Answer: Performant Recovery will only review Medicare FFS claims.

Question: Will Performant Recovery be sending correspondence to providers for all audits, or will some come from subcontractors like PRGX?
Answer: ~~PRGX is the only subcontractor to send correspondence to providers in MAC Region J-14. PRGX also audits Home Health and Hospice for Performant Recovery. PRGX uses the Performant Recovery logo and signature. All other MAC Regions are managed by Performant Recovery~~ .

Update: 12/22/2015 - For all PRGX inquiries please contact Performant Recovery at 866-201-0580 and we will facilitate the response to your inquiry.

Question: How will the Performant Recovery RA escalate issues customer service representatives cannot resolve?
Answer: Performant Recovery RA customer service representatives have an escalation process to answer questions and address issues as efficiently as possible by the best qualified person. This will, of course, include the involvement of the Performant Recovery Leadership as needed.

Question: Does Performant Recovery have enough qualified staff (i.e.: medical director, coders, RNs, etc.)? For example, if a case pertains to hematology or pediatrics, will the individual reviewing the case have the same background?
Answer: Performant Recovery has a pool of qualified clinical staff with many years of healthcare experience working as auditors/medical reviewers. Our Chief Medical Director is also involved with support from to other physicians to help determining what medical issues need their review and medical opinion. Nurses will be utilized for medical necessity complex reviews as well as clinical validation on coding audits. The coding auditors will be performed by certified coders with CCS, CPC, RHIA, or RHIT certifications.

Question: During the Discussion Period, if an audit is discussed and the agreement is the provider's favor, will the provider receive an updated letter?
Answer: Yes. Performant Recovery will generate a letter to the provider regardless of the outcome on every discussion period request filed.

Question: If I opened a discussion with the RA Region A, can I also file an appeal?
Answer: Yes, Providers may file an appeal once a Demand Letter from the MAC has been received. Please note once an appeal has been filed with the MAC, the RA will close the Discussion Period and send a letter advising that the appeal process will supersede the Discussion Period.

Question: Please clarify the procedure a provider may follow if they disagree with Performant Recoverys denial in the audit and wish to discuss the results concerning the denial?
Answer: This is called a Discussion Period. The RA discussion period begins from the date of the review results letter (RRL) for both automated and complex reviews. If a provider has any questions after receiving a letter they should contact Performant Recovery immediately to ask questions. The Discussion Period continues for 30 days from the date of the Review Results Letter. All Discussion Period requests must be filed individually by claim on the Discussion Period request form.

Performant Recovery Discussion Period Request Form

Question: I just received an ADR but we filed bankruptcy. Am I excluded from audits?
Answer: If you have filed a bankruptcy petition or are involved in a bankruptcy proceeding, please contact your MAC immediately to notify them about the bankruptcy so that they may coordinate with the Recovery Auditor, CMS and Department of Justice to assure your situation is handled appropriately.

Back to the top

Timeline

Question: What are the contracted time frames by which providers will be notified by the RA of favorable and unfavorable decisions after audits?
Answer: Performant Recovery has up to 60 calendar days to review the medical records and make a determination for medical records requested (ADR) prior to 12/31/15. By day 60, Performant Recovery will issue a review results letter advising of the favorable or unfavorable decision. If a decision cannot be made or a letter cannot be sent by day 60, Performant Recovery will request an extension from CMS. For medical record requests (ADRs) sent after 01/01/16, Performant Recovery has 30 days to complete the review and send a decision letter. Lack of adherence to the 60/30 day requirement of notification does not negate the improper payment finding or the recoupment of the improper payment by CMS.

Question: How are the 30 days utilized, business days or calendar days?
Answer: The RA utilizes calendar days to meet required time frames.

Question: What is the time period for RA work? Will they work from 10/1/2007 forward or will they begin by reviewing current charts?
Answer: Performant Recovery may "look back" up to 3 years to review claims and may not review claims prior to October 1, 2007.

Question: How long will the provider have the Review Results Letter before the Demand Letter will be issued?
Answer: There are a few factors into this timetable. (1) Performant Recovery will forward the adjustment to the MAC 30 days after the Review Results Letter or after a Discussion Period has been resulted. (2) Once the MAC has created the appropriate Accounts Receivable, they will inform Performant Recovery . (3) The MACs are responsible for sending the Demand Letter. If you have any questions about the Demand Letter please contact the MAC. If you are in Novitas Jurisdiction 12, please call 877-235-8073. NGS Jurisdiction 13, please call 877-567-7205 or if in NHIC Jurisdiction 14, please call 866-590-6731 or may call customer service at 1-866-201-0580.

Back to the top

Correspondence

Question: How will Performant Recovery obtain provider contact information? If a provider is part of a larger system of providers, and the system staff will be coordinating the RA activities, how will Performant Recovery adapt their processes to accommodate this?

Answer: Performant Recovery receives provider address/contact information periodically from the MAC's. We strongly recommend that you utilize the provider portal to customize your provider contact information via our web page.

Question: How will Performant Recovery send Additional Documentation Requests, Review Result Letters, and other letters?
Answer: Performant Recovery will follow CMS' requirements to send all communication using first class mail as opposed to private carriers. Performant Recovery is prohibited from sending Protected Health Information (PHI) in an electronic format.

Question: How many letters will the Provider receive from Performant Recovery ?
Answer: The Provider may receive up to three letters from Performant Recovery , 1) Additional Documentation Requests (request for medical record) and 2) Review Results Letter for the Automated and Complex review, and 3)Discussion Period decision letters.

Question: Will the providers receive individual demand letters for each account or will letters list multiple accounts for complex and automated reviews?
Answer: The MAC is responsible for sending the Demand Letter as of January 3, 2012. Please contact them for more information about the letter. If you are in Novitas Jurisdiction 12, please call 877-235-8073. NGS Jurisdiction 13, please call 877-567-7205 or if in Noridian Jurisdiction A, please call 866-419-9458.

Question: Will the RA be assigning a claim number for each review or will a unique batch ID be generated by the auditor for each request and maintained through all future correspondence?
Answer: There is no batch ID generated by Performant Recovery on correspondence. Performant Recovery references the Medicare claim number in letters. The Performant Recovery Letter also contains a HIC number, beneficiary name, letter id, and date of service.

Question: Is a Detailed Review Results letter the same as an Overpayment Demand letter?
Answer: No, a Review Result letter is sent prior to the Overpayment Demand Letter for an Automated or Complex review. The **Review Results Letter** explains the findings of the review and explains Discussion Period options. The **Overpayment Demand Letter** is generated by the MAC. It provides the address where you need to send your payment, and the Centers for Medicare and Medicaid Services (CMS) regulatory appeal, rebuttal, and overpayment recoupment information.

Question: If the provider has been reviewed by the Contractor Error Rate Testing (CERT), Office of Inspector General (OIG) or Department of Justice (DOJ), etc. for a specific claim and the issue has been settled or the investigation is still in process. Can the RA also review and initiate a recoupment on those claims?
Answer: No, certain Medicare partners (e.g., OIG, DOJ, FBI, claims processing contractors, CERT contractor, etc.) are able to access the CMS Data Warehouse and suppress and/or excludes the claim(s). These actions temporarily or permanently prevent a RA from reviewing all or part of a universe of claims for a specific provider or claim type.

Question: Is there a document that defines the differences in MAC vs. RA in terms of discussion /rebuttal periods timeframes, appeal time frames, etc.?
Answer: The objectives of the Medicare Administrative Contractors (MAC) and the Recovery Auditors (RA) are addressed in their respective CMS Statement of Work (SOW). The RA SOW is posted on the CMS RAC Web site (www.cms.gov/rac). The MACs adjust claims against local coverage rules and Medicare policy. After the payments are made, the RAs detect and correct suspected improper payments through sophisticated algorithms and detailed audits. The RAs, are also required to comply with all CMS contractual, statutory and regulatory authorities when performing reviews and making determinations. This includes all provisions and timeframes reflected in the Social Security Act, Code of Federal Regulations, and local and national coverage policies.

Question: Will Performant Recovery be issuing informational reports to summarize types and rates of denials and appeal outcomes?
Answer: No, CMS releases an annual report to Congress released in the new calendar year and available to the public. It is a high level report which

includes information you may find useful.

Question: Will the RA appeal process mirror the regular Medicare appeal process?
Answer: The Medicare Appeals process will remain the same for physicians under Part B and Part A non-inpatient claims. The only difference under Part A is for the inpatient hospital claims under the Prospective Payment System (PPS). In the current appeals process, the first level appeal will go to the Quality Improvement Organization (QIO); however, the RA appeals will go to the Medicare Administrative Contractor that processed the claim.

Question: If during the preparation process (reviewing and preparing to forward records to the RA based on an Additional Documentation Request (ADR) letter) and we (the provider) find a coding error; should we rebill at that point?
Answer: No, Rebilling will not eliminate an audit. Once a claim has been selected, records should be submitted as requested for audit completion. You will be notified of the results and if a difference in reimbursement has been identified.

Question: Will there be any correspondence sent for complex review cases where the RAC auditor agrees with the original billing of the claim?
Answer: Yes, review results letters are sent on cases the RA agrees with the original billing of the claim.

Question: What if the Provider received an Automated Review Results Letter or an Underpayment Notification Letter but has not received a Demand Letter?
Answer: As of January 1, 2016 you will not receive a demand letter until after a 30 day holding period after the date of the Review Results Letter or until the Discussion Period has been resulted. If this period has lapsed please contact your MAC to discuss why you have not received a Demand Letter. If you are in Novitas Jurisdiction 12, please call 877-235-8073. NGS Jurisdiction 13, please call 877-567-7205 or if in NHIC Jurisdiction 14, please call 866-590-6731.

Question: What if the Provider received a Demand Letter at a different address then what they placed on the Performant Recovery website, or the address provided to the Performant Recovery Customer Service Team?
Answer: The MAC is responsible for sending the Demand Letter as of January 3, 2012 and uses the address they have on file for this claim. Performant Recovery cannot update the provider address at the MAC. If you want the address changed for Demand Letters please contact the MAC. If you are in Novitas Jurisdiction 12, please call 877-235-8073. NGS Jurisdiction 13, please call 877-567-7205 or if in NHIC Jurisdiction 14, please call 866-590-6731. Performant Recovery still sends the Additional Documentation Request letters and will utilize the address provided to mail the provider correspondence.

Question: If I have questions about how my claim was adjusted and I don't think the amount requested back is correct, who do i call?
Answer: Please call Performant Recoveyr Customer Service at 866-201-0580, 8a.m. - 4:30p.m. EST

Question: Where can I go to request immediate offset?
If you have questions and you are in Novitas Jurisdiction 12, please call 877-235-8073. NGS Jurisdiction 13, please call 877-567-7205 or if in NHIC Jurisdiction 14, please call 866-590-6731

Back to the top

Medical Records

Question: Once a provider receives an additional documentation request from Performant Recovery , how long will they have to respond?
Answer: A provider has 45 calendar days to provide medical records to Performant Recovery .

Question: Will Performant Recovery request complete records, specific items from records, or both?

Answer: Performant Recovery will request both specific items and the complete record and ask the provider to submit any documentation, such as clinical support notes to support the audited claim.

Question: Is there a process for sending a single piece of information during Performant Recovery ' review/discussion period?
Answer: Yes, you must use the discussion period form which may be faxed or mailed to Performant Recovery . The RA Email is Info@PerformantRac.com and the Fax Number 325-224-6710

Question: Is there a limit to how many medical record files that should be put on one disc?

Answer: There is no limit; however, we would like you to fit as many medical records as you can on one CD or DVD.. The process we recommend you use for sending CDs or DVDs is designed to ensure the information on your CD or DVD will be secure but we would suggest that you make a copy for yourself. We also recommend sending the records electronically through the CMS electronic submission of Medical Records Program (esMD). To be setup on esMD, please contact at Customer Service 1-866-201-0580.

Question: How will the provider be notified by the RAC of the calculated chart limit per 45 days per NPI?
Answer: The medical record limit will be provided on the provider claim status portal webpage.

Question: Which imaging company is Performant Recovery affiliated with or endorse?
Answer: As an agent of CMS, Performant Recovery cannot endorse companies and we are not affiliated with any imaging company.

Question: Is there particular software recommended for creating CD/DVDs in Region A?
Answer: No. The providers may use any kind of CD/DVD writing software they choose. Image format must be in either PDF or TIFF format (PDF is preferred). Do not password protect individual PDF files, instead, zip all PDF's into a WinZip file and encrypt it.

Question: Does CMS have a standard encryption process or is this the decision of each healthcare organization?
Answer: Each healthcare provider may decide how or if they want to encrypt their medical records. CMS recommends electronic protection be used in sending records. Lost records prior to receipt of Performant Recovery will the responsibility of the provider and subject to the rules under HIPAA for compromised PHI records.

Question: Instead of being dependent on the United State Postal Services (USPS) and the mailrooms for delivery of the Additional Documentation Request (ADR) letters, would Performant Recovery consider emailing them or giving an electronic access to the letters on their Web site?
Answer: We do recognize this may be a more efficient method to communicate to the provider, however, due to CMS security requirements, email is not the approved mode of communication for the RA. Currently, CMS requires RA's to send our letters via first class mail.

Question: What is the maximum number of records Performant Recovery may request from a provider at any given time? Is the limit based on NPI or TIN?
Answer: Please see the CMS website for medical record information. **Medical documents submitted to Performant Recovery for review under a Automated review are not computed into the limits sent for complex reviews.

Institutional ADR Limits

DME ADR Limits

Physician/Non-Physician ADR Limits

Question: Will the RAC allow providers to supply electronic transmission at any point? If a provider uses an electronic medical records system, what documentation will they be required to provide to Performant Recovery ?
Answer: For providers with electronic medical records system the same information is required as when submitting a paper record. Currently, submission of PHI via paper, fax, CD/DVD, or transmission via electronic submission of Medical Records (esMD) is allowed. Other forms of submission are not available. More information about esMD can be found on the following CMS information web page: https://www.cms.gov/ESMD/. Please contact us if you are able to send medical recordsvia EsMD to make arrangements.

Question: Is the cost for medical record copies reimbursed and does that include medical records on CD/DVD? Will we need to invoice the RAC for the number of pages copied per review?
Answer: Performant Recovery will reimburse $.12 per page up to a maximum of $25 (excluding duplicates and blank pages) plus first class postage for medical record copies for complex reviews, but will not reimburse for Semi-Automated reviews (section E.1.8 on RA SOW).. This does include medical records on CD/DVD and sent through the Electronic Submission of Medical Documents (esMD). Performant Recovery utilizes a system that tracks the number of pages of medical records scanned (paper) or imported (CD or esMD) into the system. Important to note, since Performant Recovery does the image count, the provider does not invoice the RA. The RA will submit payment based on the record count.

Question: Our facility utilizes a Health Information Handler for ADR submissions. We would prefer that the RA issues payment directly to them. Is this a service that Performant Recovery Inc. offers?

Answer: Yes. Providers and their vendors will need to complete the HIH Enrollment Form located in the Forms & Sample Documents section of our website.

Back to the top

Audit Review

Question: If Performant Recovery denies hospital's claims for services, will they also deny the physician claims for services?
Answer: Currently, there is no such "automatic cross-over". It is possible that referencing between hospital and physician claims may occur in the future. Any action involving denying physicians' claims would have to be approved as a separate issue by CMS.

Question: If Performant Recovery were to extrapolate error results, how would it work and what types of claim errors would be extrapolated?
Answer: Currently we are not using extrapolation, but have been approved to perform this method of analytics. Performant Recovery is in the process of performing extrapolation in the near future. Appropriate communication will be provided on the Performant Recovery RA website when we plan to perform this process.

Question: If Performant Recovery requests a medical record for review and then is not able to review it within the specified timeframe, can they re-request the same record?
Answer: No, If Performant Recovery is not able to complete a review within the specified timeframe, Performant Recovery may request an extension from CMS.

Question: Is it required we send the physician query form if it is not an approved part of the medical record?
Answer: Providers may submit a physician query form. However, the medical record must stand alone. The query form may only serve for clarification.

Question: Will Performant Recovery perform automated reviews for 'rate-regulated hospitals' claims?
Answer: Yes, Performant Recovery is able to perform automated reviews on all service types and hospitals stipulated in the RA SOW.

Question: What areas does Performant Recovery intend to request CMS' approval for auditing?
Answer: Performant Recovery will look at Part A and B claims service types. Performant Recovery will leverage the CERT, QIOs' Pepper, and the OIG reports for possible issues. In addition, Performant Recovery uses data mining analytics on other possible issues based on the team experience hospital and health plan settings.

Question: Which utilization criteria will Performant Recovery use to review medical necessity; Interqual, Milliman or another?
Answer: Performant Recovery will use Medicare's legal and regulatory documents and policies, such as National Coverage Determinations (NCDs) and Local Coverage Determinations (LCDs), and ICDs as guidelines. We may also choose to utilize clinical support software products such as Interqual and Milliman as screening tools. If such products are used, the information about this choice will be made available to the community.

Question: What will Performant Recovery accept from the provider when supporting a medical necessity denial? If the provider has their own algorithm for medical necessity can this be used to support the decision?
Answer: The basis for the audit is not on algorithms, but the decisions made by the clinicians on the patient's clinical situation against the background of Medicare's rules and regulations. Should the provider submit algorithms or other non-medical support, that is the decision of the provider and will not be used in the audit determination.

Question: Will Performant Recovery accept missing (additional) documents during the discussion period?
Answer: Providers should provide all appropriate and accurate documentation to support a case when the medical record is originally sent. If a circumstance arises where all documentation is not sent with the original record, then the provider may submit this during the discussion period for review at the RAs discretion.

Question: If we have any question regarding any aspect of the appeals process who should we contact?
Answer: Currently, Performant Recovery does not handle appeals. Providers should follow the same process for appeals they currently follow with their MAC. Any appeal related questions should be directed to the MAC. If you are in Novitas Jurisdiction 12, please call 877-235-8073. NGS Jurisdiction 13, please call 877-567-7205 or if in NHIC Jurisdiction 14, please call 866-590-6731

Question: Can multiple accounts (denied for the same reason) be appealed using one appeal letter or are individual letters required?
Answer: Currently, Performant Recovery does not handle appeals. Providers should follow the same process for appeals they currently follow with their MAC. Any appeal related questions should be directed to the MAC. If you are in Novitas Jurisdiction 12, please call 877-235-8073. NGS Jurisdiction 13, please call 877-567-7205 or if in NHIC Jurisdiction 14, please call 866-590-6731.

Question: Can we send additional information at the first level of appeals/any level of appeal? If a provider appeals, and the appeal is denied, is a letter sent explaining why?
Answer: Currently, Performant Recovery does not handle appeals. Providers should follow the same process for appeals they currently follow with their MAC. Any appeal related questions should be directed to the MAC. If you are in Novitas Jurisdiction 12, please call 877-235-8073. NGS Jurisdiction 13, please call 877-567-7205 or if in NHIC Jurisdiction 14, please call 866-590-6731.

Question: What is considered non-compliance by the ordering physician with regard to supplying medical documentation?
Answer: Any failure to respond to a request from CMS for documentation that supports the charges on a claim would be considered non-compliance under §1833 (e) of the SSA, and 42 CFR 424.5(a)(6), which prohibits Medicare payment for any claim that lacks the necessary information. If documentation for complex review is not supplied in the time period request, the claim will be adjusted for full denial.

Question: With regard to medical documentation, what is the provider's extent of responsibility for supplying documentation? Example - The ordering physician telephones an order for DME to the supplier and then faxes a written prescription, but neglects to supply medical records, despite numerous attempts on the part of the supplier.
Answer: The supplier who bills Medicare and receives payment is responsible for providing the documentation. Any failure to respond to a request from CMS for documentation that supports the charges on a claim would be considered non-compliance under §1833 (e) of the SSA, and 42 CFR 424.5(a)(6), which prohibits Medicare payment for any claim that lacks the necessary information. If documentation for complex review is not supplied in the time period request, the claim will be adjusted for full denial

Question: Will Performant Recovery consider reviewing underpayments for DRG's? If they are re-coded to a higher DRG than what the provider was paid, will this be sent as an underpayment?
Answer: Yes and we have provide such adjustments.

Question: Due to confusion and continually changing Medicare policies, how will the RA auditors be aware of the amended policies as well as implementation dates of interim policies, memos and related correspondence?
Answer: The Recovery Auditors (RA) must abide by the Medicare legal and regulatory in effect at the time when the services were provided, to include the correct version of the Local Coverage Determination (LCD) by the Medicare contractor who had jurisdiction. The RA must diligently research this regulatory backup and cite the correct authorities. If providers feel a document was not considered or an incorrect policy was invoked, they should bring this to the RA's attention during the discussion period.

Question: What specific documentation is the supplier required to maintain within their company files with regard to the KX modifier?
Answer: The KX modifier states: "Specific required documentation on file." There are numerous Local Coverage Determinations that further define this. As a general rule, the information in the medical documentation must support the medical necessity by Medicare's criteria for the services rendered.

Question: If a Diagnosis Related Group (DRG) is down coded to a lower DRG after review, do we have to rebill for payment of the lower DRG.
Answer: No, the MAC will make adjustments as appropriate and you will be notified of any difference in reimbursement.Should you have questions, please contact your MAC. If you are in Novitas Jurisdiction 12, please call 877-235-8073. NGS Jurisdiction 13, please call 877-567-7205 or if in NHIC Jurisdiction 14, please call 866-590-6731

Question: What types of reviews will Performant Recovery perform?
Answer: Performant Recovery is authorized by CMS to perform Complex, Automated and Semi-Automated Reviews.

Question: What is a Complex Review?
Answer: A complex review requests sections of the medical record and reviews them to make clinical determination and/or a coding validation. The specifics of each type of issue and what document is requested can be found on the issues description page and will be included in the additional documentation request letter.

Question: What is an Automated Review?
Answer: In an Automated Review, Performant Recovery performs analysis of the claims data, makes a determination; no medical documents are requested or reviewed.

Question: What is a Semi-Automated Review?
Answer: It is a two-part review. The first is the identification of a billing aberrancy through an automated review using claims data. The second part includes a notification letter sent to the provider explaining the potential billing error identified. The letter also indicates the provider has 45 days to submit documentation to support the original billing. If the provider decides not to submit documentation, or if the documentation provided does not support the way the claim was billed, the claim will be sent to the Medicare claims processing contractor for adjustment and a demand letter will be

issued. However, if the submitted documentation does support the billing of the claim, the claim will not be sent for adjustment and the provider will be notified that the review has been closed.

Back to the top

Information for PIP (Periodic Interim Payments) Providers

Question: PIP Hospitals - Hospitals do not receive notification of a recoupment if a cost report is closed. Have you looked into implementing a notification requirement before significant review of PIP hospitals begin?
Answer: CMS has implemented the new automated process which is included in CR 7601. The HIGLAS system, which is the automated CMS accounting system, will create receivables and generate demand letters for the PIP payments. With this automated system, RA will not have to wait until the cost report is closed, and will not need to send notifications.

Question: PIP hospitals will receive notifications of all RA recoupment regardless of the status of the cost report, since the HIGLAS system will generate the Demand Letters. Is that correct?
Answer: Yes.

Question: What is PIP?
Answer: Periodic Interim Payments (PIP) are biweekly payments made to a Provider enrolled in the PIP program, and are based on the hospital's estimate of applicable Medicare reimbursement for the current cost report period. Further details may be found at 42 CFR 413.64(h).

Question: Are claim audits from PIP providers different from other RA claim audits?
Answer: No. Improperly paid claims audited from a PIP provider do not differ from any other RA audit. The claim identified as improperly paid would be shared with the claim processing contractor and adjusted as appropriate.

Question: What is the appeal process for PIP providers?
Answer: The current appeal process does not change, and the timelines still apply. Please see the Remittance Advice (R/A) for any applicable appeal rights or contact the appropriate claim processing contractor.

PrePay FAQs:

Question: I did not receive my Prepay ADR letter. Who do I contact?
Answer: You will need to contact your MAC who sends out the ADR letter, or go online through the DDE system to access it. Unfortunately, Performant Recovery does not have a copy available.

Question: I did not receive my Prepay Demand Letter. Who do I contact?
Answer: You will not receive a demand letter for Prepay Audits. Instead, you will receive the Review Results Letter from Performant Recovery and a Remittance Advice from the MAC.

Question: How long do I have to send the medical records to Performant on a Prepay Audit?
Answer: You have 30 days from the date of the ADR Letter.

Question: Where do I send the medical records on a Prepay Audit?
Answer: Paper medical records can be mailed to Performant Recovery at 2819 Sothwest Blvd., San Angelo, TX 76904. Medical records may also be

sent via electronic media such as CD or EsMD. Refer to the link below for instructions:

https://www.performantrac.com/Documentation.aspx

Question: What if I already sent the medical records to the MAC?
Answer: The MAC may forward prepay medical records they receive in error to Performant Recovery. In order to avoid delays, we recomment the records be sent directly to Performant Recovery. Refer to the link below for mailing instructions.

Question: Can I file a discussion on a Prepay Audit?
Answer: No. CMS does not have a provision for a discussion period in the case of Prepay audits.

Question: Do you have a link to the Prepay Audit outreach open door forum conducted?
Answer: It is located on the CMS website. Here is the link:

http://www.cms.gov/Outreach-and-Education/Outreach/OpenDoorForums/downloads/TransSODFRACPrePayReviewDemo122111Final.pdf

Therapy Cap

Question: Why is CMS conducting manual review on therapy claims?
Answer: On January 2, 2013 President Obama signed into law the American Taxpayer Relief Act of 2012. This law extends the Medicare Part B Outpatient Therapy Cap Exceptions process through December 31, 2013. Section 603 of this Act contains a number of Medicare provisions which directly impacts outpatient therapy caps and manual medical review (MR) threshold. Revisions of the Financial limitations for Outpatient Therapy Services - Section 3005 of the Middle Class Tax Relief and job Creation Act of 2012 requires Original Medicare to temporarily apply therapy caps (and related Provisions) to the therapy services furnished in an outpatient hospital between the dates of January 1, 2013 through December 31, 2013.

Question: How do providers request exceptions for therapy services subject to manual medical review?
Answer: Providers shall submit claims with the KX modifier to request an exception for services above the threshold. Claims for services at or above the therapy cap or thresholds for which an exception is not granted will be denied as a benefit category denial for which the provider will be liable.

Question: What triggers the manual medical review process?
Answer: Claims at or above $3700 where the beneficiaries therapy services have exceeded the threshold cap for the year will require manual medical review. The trigger of one or both of two separate thresholds initiates this process. The separate caps are:

A $3700 cap for Occupational Therapy (OT) services per year, per beneficiary.
A $3700 combined cap for Physical Therapy (PT) and Speech Language Pathology (SLP) services per year, per beneficiary. Note that although PT and SLP services are combined for triggering the threshold, the medical review will be conducted separately by discipline.

Question: What settings apply to the therapy cap?
Answer: All Part B Outpatient Therapy settings and providers include:

Private Practices
Part B Skilled Nursing Facilities
Home Health Agencies (TOB 34x)

Outpatient Rehabilitation Facilities (ORFs)
Rehabilitation Agencies (comprehensive Outpatient Rehabilitation Facilities)
Hospital Outpatient Departments (HOPDs)

Question: Are all Hospital Outpatient Departments affected?
Answer: The therapy cap only applies to outpatient hospitals as detected by:

TOB 12x (excluding CAHs) or 13x
Revenue code or 042x or 44x
Modifier GN, GO, or GP; and
Date of Service on or after January 1, 2013

Question: What role will the Medicare Administrative Contractor (MAC) and Recovery Auditor play in the manual medical review process?
Answer:

MACs

Providers will continue to submit claims to the MACs for claims processing. MACs will conduct prepayment review on claims researching the $3700 threshold and processed between January 1, 2013. CMS requested MACs conduct these manual medical reviews within 10 days.

Recovery Auditors

Providers will continue to submit claims to the MACs for claims processing. Beginning April 1, 2013, the Recovery Auditors will complete manual medical review on claims reaching the $3700 threshold. The Recovery Auditors will conduct both pre and post payment review.

Prepayment Review

If a claim is submitted in a Recovery Auditor Prepayment Review Demonstration state, the Recovery Auditor will conduct prepayment review. These states are Florida, California, Michigan, Texas, New York, Louisiana, Illinois, Pennsylvania, Ohio, North Carolina, and Missouri.

All claims will continue to go to the MACs, but in these states, the MAC will send an Additional Documentation Request to the provider requesting the additional documentation be sent to the Recovery Auditor.

The Recovery Auditor will conduct prepayment review within 10 business days of receiving the additional documentatin and will notify the MAC of the payment decision.

Back to the top

333 NORTH CANYONS PARKWAY, SUITE 100 | LIVERMORE, CA 94551
TOLL FREE 1 866 201-0580