Region A Recovery Auditor (RA)

Subject: Additional Documentation Request Date [Request Date]

Letter Request ID: [Letter Request ID]

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

Re: [Provider Name] [Provider NPI]

Dear Medicare Provider,

The Centers for Medicare & Medicaid Services (CMS) has retained Performant Recovery, Inc. to carry out the Recovery Auditor (RA) program in Region A which includes all states located in the northeast region of the United States. The RA program, mandated by Congress, is aimed at identifying Medicare improper payments.

The results of our data analysis justified reopening your claim(s) under §1869(b) (1) (G) of the Social Security Act and 42 CFR 405.980(a) (1). These results also serve as good cause to reopen the claim(s), if required by 42 CFR 405.980(b) (2).

In accordance with 42 USC 1320(c) (5) (A) (3) and §1833 of the Social Security Act, you must provide documentation upon request to support claims for Medicare services. This request is in compliance with the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule, which allows release of information without explicit patient consent for treatment, payment and health care operations. All documentation should be submitted to the address or fax number below within 45 days of the date of this notice. Your response is required even if you are unable to locate the requested documentation.

CMS has established a maximum number of medical records that can be requested from a provider per 45 day period. This cap is established per campus. A campus unit, which is defined by the servicing provider's/supplier's Tax Identification Number (TIN) and the first three positions of the zip code where they are physically located, may consist of one or more separate facilities/practices under a single organizational umbrella. Each limit is based on that unit's submitted Medicare claims, irrespective of paid/denied status and/or individual lines in 2010.

The maximum number of medical records that may be requested from you per 45 days is [Medical Record Limit].

[Insert only for inpatient hospital claims that qualify for copying reimbursement] You will be reimbursed for the cost of providing copies of the requested documentation. ***Payment will be issued to you within 45 days of the RA receiving the documentation. Payment will be in the amount of*** [Provider Pmt Rate] ***dollars per page plus first class postage (if mailed).***

[Insert only for inpatient hospital claims that qualify for copying reimbursement]
Please note – effective April 1, 2012, reimbursement will be limited to $25.00 for each medical record submitted (inclusive of per page costs and shipping charges).

A copy of the attached barcode page should be affixed to the requested additional documentation. Please bundle documents for each claim separately, with the barcode page on top, to enable us to confirm receipt of documents.

- Please be sure all documentation submitted is **legible.**
- **All Blank pages should be OMITTED** (Note: Provider will not be paid for blank pages)
- Free of staples, paperclips or holes of any kind.
- Records must be copied on **only one side**
- 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**
- Multiple charts can be sent on one CD/DVD but each chart request must be a separate PDF/TIFF file.

You may submit this documentation by postal mail (either on paper or as images on CD/DVD), via fax, or esMD. Documentation can be mailed to:

Performant Recovery, Inc.
2819 Southwest Boulevard
San Angelo, TX 76904

Documentation can be faxed to: 325-224-6710.

Please visit the following CMS web page for background on esMD: https://www.cms.gov/ESMD/

Questions regarding this request should be directed to Performant Recovery RA Region A Customer Service at 1-866-201-0580.

If you choose to password protect the CD/DVD please use password: [CD Password]
Requirements for submitting imaged documentation on CD or DVD can be found at http://www.performantrac.com/documentation.aspx

Sincerely,
Performant Recovery, Inc.
Region A
Recovery Auditor
Enclosure

Requested Claims

Issue: [CMS Issue Number] [Concept Name], [Code Type] [List of Codes]

Good Cause: [Required paragraph 1]
[Optional paragraph 2]
[Optional paragraph 3]

Our analysis of your Medicare billing history suggests that you have submitted claims for this/these service in excess of that which could reasonably be expected of a provider/supplier, which constitutes new and material evidence that established good cause for reopening claims(s) as required under 42 CFR 405.980(b).

Beneficiary Information		Medical Record / Patient Control /Claim #		Dates of Service RA Case #	
Name:	[Name]	**MR#**	[MR#]	**Fm:**	[FM]
DOB:	[DOB]	**Control#**	[Control #]	**To:**	[TO]
HIC#	[HIC#]	**Claim#**	[Claim #]	**RA Case #:**	[RA Case#]
Amount:	[Amount]				
Name:	Doe, Jane	**MR#**	XYZ1234567	**Fm:**	4/7/2008
DOB:	11/11/1932	**Control#**	XZ1234567JW	**To:**	4/7/2008
HIC#	1234567891A	**Claim#**	401122334455	**RA Case #:**	900045677777
Amount:	[Amount]				
Name:	Rodriquez, Jesus	**MR#**	NNN1234567	**Fm:**	6/6/2008
DOB:	11/11/1933	**Control#**	YZ1234567FF	**To:**	6/6/2008
HIC#	1234567892A	**Claim#**	309988776655	**RA Case #:**	900054683245
Amount:	[Amount]				

Please submit the following components of the medical record corresponding to claim date(s):

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

Issue: [CMS Issue Number] [Concept Name], [Code Type] [List of Codes]

Good Cause: [Required paragraph 1]
[Optional paragraph 2]
[Optional paragraph 3]

Our analysis of your Medicare billing history suggests that you have submitted claims for this/these service in excess of that which could reasonably be expected of a provider/supplier, which constitutes new and material evidence that established good cause for reopening claims(s) as required under 42 CFR 405.980(b).

[Note, this is not included in the letter, this table heading should break to a new page if the number of lines left are less than five. Repeat heading on subsequent pages]

Beneficiary Information		Medical Record / Patient Control /Claim #		Dates of Service RA Case #	
Name:	Smith, John	**MR#**	ABC1234567	**Fm:**	01/06/2008
DOB:	11/11/1931	**Control#**	XY1234567NN	**To:**	01/08/2008
HIC#	1234567890A	**Claim#**	501234567890	**RA Case #:**	900012345677
Amount:	[Amount]				
Name:	Doe, Jane	**MR#**	XYZ1234567	**Fm:**	4/7/2008
DOB:	11/11/1932	**Control#**	XZ1234567JW	**To:**	4/7/2008
HIC#	1234567891A	**Claim#**	401122334455	**RA Case #:**	900045677777
Amount:	[Amount]				
Name:	Rodriquez, Jesus	**MR#**	NNN1234567	**Fm:**	6/6/2008
DOB:	11/11/1933	**Control#**	YZ1234567FF	**To:**	6/6/2008
HIC#	1234567892A	**Claim#**	309988776655	**RA Case #:**	900054683245
Amount:					

Please submit the following components of the medical record corresponding to claim date(s):

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

Issue: [CMS Issue Number] [Concept Name], [Code Type] [List of Codes]

Good Cause: [Required paragraph 1]
[Optional paragraph 2]
[Optional paragraph 3]

Our analysis of your Medicare billing history suggests that you have submitted claims for this/these service in excess of that which could reasonably be expected of a provider/supplier, which constitutes new and material evidence that established good cause for reopening claims(s) as required under 42 CFR 405.980(b).

Beneficiary Information	Medical Record / Patient Control /Claim #	Dates of Service RA Case #

Name:	Smith, John	**MR#**	ABC1234567	**Fm:**	01/06/2008
DOB:	11/11/1931	**Control#**	XY1234567NN	**To:**	01/08/2008
HIC#	1234567890A	**Claim#**	501234567890	**RA Case #:**	900012345677
Amount:	[Amount]				
Name:	Doe, Jane	**MR#**	XYZ1234567	**Fm:**	4/7/2008
DOB:	11/11/1932	**Control#**	XZ1234567JW	**To:**	4/7/2008
HIC#	1234567891A	**Claim#**	401122334455	**RA Case #:**	900045677777
Amount:	[Amount]				
Name:	Rodriquez, Jesus	**MR#**	NNN1234567	**Fm:**	6/6/2008
DOB:	11/11/1933	**Control#**	YZ1234567FF	**To:**	6/6/2008
HIC#	1234567892A	**Claim#**	309988776655	**RA Case #:**	900054683245
Amount:					

Please submit the following components of the medical record corresponding to claim date(s):

[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 Performant Recovery RA Region A Customer Service at 1-866-201-0580.

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

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

[Note, this is not included in the letter, this table should be sorted by Beneficiary Name. Repeat heading on subsequent pages. Please make the bar code the largest font that will fit into the box possible (at least 12 point font). Barcode font selected needs to be one that has the digits of the barcode showing at the bottom.]