
Region A Recovery Auditor (RA)

Date: [Current Date]

Subject: **Review Results Letter**
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) retained Performant Recovery, Inc. to carry out the Recovery Audit (RA) program in Region A, which includes all states located in the northeast region of the United States. The RA program is mandated by Congress to identify Medicare improper payments. Improper payments include overpayments and underpayments. Improper payments may occur because of incorrect coding, lack of sufficient documentation or no documentation, use of an outdated fee schedule, billing for services that do not meet Medicare's coverage and/or medical necessity criteria, or failure to follow other program requirements.

Our request for additional medical documentation, detailed in a letter dated xx/xx/xxxx, constituted reopening under §1869(b) (1) (G) of the Social Security Act (the Act) and 42 CFR 405.980(a) (1). Our good cause to reopen the claim, if required by 42 CFR 405.980(b) (2), was described in the letter as well.

Based on the medical documentation reviewed for the selected claim(s), Performant Recovery determined whether the services were reasonable and necessary as required by §1861 of the Act, or met the Medicare coverage requirements as required in §1862 of the Act, or met the requirements outlined in §1866 (a)(1)(A)(i) of the Act**.**

Along with our claims payment determination, we have made limitations of liability decisions for denials of those services subject to provisions of §1879 of the Act. Those claims for which we determined that you knew, or should have known, and the beneficiary did not know or could not have been reasonably expected to have known that the services were noncovered have been included in the results of this review. In addition, we have made determinations as to whether or not you are without fault for the overpayment under the provisions of §1879 of the Act. Those claims for which you are not without fault have been included in the results of this review. Detailed information regarding these claims and the findings identified during the review are attached to this letter.

If you disagree with our findings and wish to discuss this matter, please complete the "Discussion Period Request Form" posted on our Web site located at http://performantrac.com/sample.html and submit it as soon as possible following the instructions outlined on the form. For a denied claim, your request to discuss this matter must include evidence to support why you feel the services you provided are covered by Medicare and were properly coded and correctly billed. Please call our Customer Service Center at 866-201-0580 to ensure that your request has been received.

The claim(s) identified as improper will be sent to the Medicare Administrative Contractor (MAC). Adjustments will be made and a Demand Letter regarding repayment of funds will be mailed fromMAC.

Thank you for your prompt attention to this matter.

Sincerely,

Performant Recovery, Inc.
Region A
Recovery Auditor
Enclosure

**All applicable reviews have been conducted on the claim(s) and the results are indicated below. No further RA reviews will be performed.**

HICN #: xxxxxxxxxx
Beneficiary: Bene Name
Claim #: xxxxxxxxxxxxx
Patient Ctrl #:
Case ID: xxxxxxxxxx
Date(s) of Service: mm/dd/yyyy – mm/dd/yyyy

## Audit Determination Rationale:

*This note is for developers only: The below text should be hard coded.*

This claim has been selected and reviewed as part of a coding validation and/or clinical validation audit. Data analysis reveals a billing pattern that is potentially inconsistent with one or more of the following: CMS Internet-Only Manuals (IOMs), Publication 100-08; Medicare Program Integrity Manual (PIM), Chapter 6, Section 6.5.3 - DRG Validation Review; ICD-9-CM Coding Manual (for dates of service on claim); ICD-9-CM Addendums and Coding Clinics; Uniform Hospital Discharge Data Set (UHDDS) - Reporting of Inpatient Data Elements, July 31, 1985, Federal Register (Vol. 50, No. 147), Pages 31038-31040.

After auditing this claim by a coder and/or a clinician, the following determination has been made:

Coder DRG Validation/Sequencing:

*(RA shall include additional information here such as specific details on which coverage/medical necessity/coding payment policy or article was violated. This would include a statement as to what is at the core of the major issue, i.e., which rules apply and which provisions were violated, as well as the patient specific information, including the results of the individual review and rationale for the decision as well as any coding changes that will occur - if any).*

**Clinical Review Supporting Documentation:** [Optional]
*[Clinical Review Rationale]*.

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