Region [x] Recovery Auditor Contractor (RAC)

Date [*Request Date*]
Letter Request ID: [*Letter Request ID*]

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

Re: [*Provider Name*] [*Provider NPI*]
Subject: Automated Review Initial Finding Notification

Dear Medicare Provider/Supplier,

The Centers for Medicare & Medicaid Services (CMS) has retained Performant Recovery, Inc. (Performant) to carry out the Recovery Auditor Contractor (RAC) program in Region [x] which includes MI, IN, CT, OH, VT, NH, ME, MA, RI, CT, and NY. The RAC program, mandated by Congress, is aimed at identifying 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payments may occur because of incorrect coding, lack of sufficient documentation or no documentation, use of an outdated fee schedule, or billing for services that do not meet Medicare's coverage and/or medical necessity criteria etc.

This overpayment was identified through data analysis. It shows that an aberrant billing pattern exists or the service does not meet national or local coverage criteria. Based upon this data analysis there is a high probability this claim has been paid in error. The data analysis identifying the improper claims paid and the detailed explanation regarding the policy in violation can be found on the attached enclosure. The results of our data analysis justified reopening your claim 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, if required, by 42 CFR 405.980(b) (2).

If you believe this improper payment determination was made in error, you have an opportunity to enter into a Discussion Period with Performant. Please complete the "Discussion Period Request Form" posted on Performant's RAC Forms and Samples page (http://performantrac.com/FormsandSamples.aspx) and submit it within 30 days from the date of this letter. Any documentation you submit in support of your claim will be reviewed within 30 days. Performant will send you a letter informing you of the results of our review. If the submitted documentation supports the billing of the claim, the claim will not be sent for

adjustment and you will be notified that the review has been closed. If the submitted information does not sufficiently support the claim's billing, the claim(s) identified as improper will be forwarded to the Medicare Administrative Contractor (MAC) and the adjustment(s) will be made. A demand letter will follow identifying the overpayment amount, repayment options and appeal rights.

Questions regarding this request should be directed to Customer Service at 1-866-201-0580.

Thank you for your prompt attention to this matter.

Sincerely,

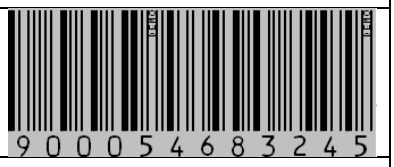
Performant
Region [x]
Recovery Auditor Contractor
Enclosure

Issue: [CMS Issue Number] [Concept Name]

Good Cause: : [Required paragraph 1.] – Vulnrabilitycodes.demandtext
[Optional paragraph 2] - Vulnrabilitycodes.demandtext1
[Optional paragraph 3] - Vulnrabilitycodes.demandtext2

Beneficiary Information/ Date of Service		**Medical Record / Patient Control /Claim #/ Estimated Amount**		**RA Case #**
Name:	Smith, John	**MR#**	ABC1234567	
DOB:	11/11/1931	**Control#**	XY1234567NN	
HIC#	1234567890A	**Claim#**	501234567890	
DoS	01/06/08 to 01/08/08	**Amount**	$12,2345.00	

Line # [.] DOS MM/DD/YYYY-MM/DD/YYYY
Provider Billed: HCPCS: xxxxxx **Modifiers:** xx xx xx xx **Units: ### POS: ###**
RAC Suggested: HCPCS: xxxxxx **Modifiers:** xx xx xx xx **Units: ### POS: ###**
Reference Claim: [Claim Number or N/A] **Line Number :** xx **Paid On:** mm/dd/yy

Name:	Smith, John	**MR#**	ABC1234567	
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Issue: [CMS Issue Number] [Concept Name], [Code Type (blank if not applicable)] [List of Codes (blank if not applicable)]

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

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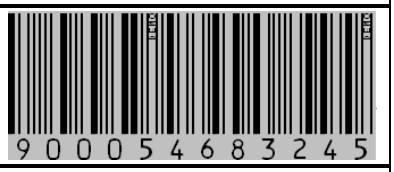
Name:	Smith, John	**MR#**	ABC1234567	
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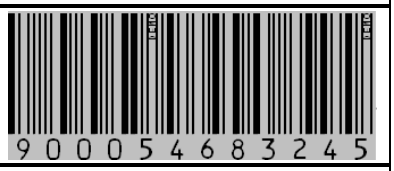
Name:	Smith, John	**MR#**	ABC1234567	
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Issue: [CMS Issue Number] [Concept Name], [Code Type (blank if not applicable)] [List of Codes (blank if not applicable)]

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

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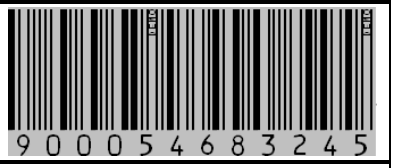
Name:	Smith, John	**MR#**	ABC1234567	
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