Region _4_ Recovery Audit Contractor (RAC)

Informational Letter

Date

Attention:
Address Line 1
Address Line 2

Dear Medicare Provider,

The Centers for Medicare & Medicaid Services (CMS) has retained HMS Federal Solutions (HMS Federal) to carry out the Recovery Audit Contract (RAC) program in Region 4. The RAC program is mandated by Congress and has a primary goal of 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 Improper payments may occur because of incorrect coding, lack of sufficient documentation or no documentation, use of outdated fee schedule or billing for services that do not meet Medicare's coverage and/or medical necessity criteria, etc.

This letter is to notify you that HMS Federal believes that Medicare has potentially made an improper payment to you. A description of the claims associated with the improper payment can be found on the attached Audit Detail page. Data analysis shows that the claims paid by Medicare include a potential aberrant billing pattern for the reasons listed on the attached Audit Detail. 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 that this improper payment determination was made in error, you may submit a request for a discussion period to support the billed services. The information must be submitted to HMS Federal at the below referenced fax number or address within thirty (30) days of the date of this letter.

HMS Federal
Attention: Part A Discussion Period Review
9275 West Russell Road, Suite 100
Las Vegas, Nevada 89148
Fax: (702) 240-5595

Please submit a copy of the Audit Detail page along with your supporting documentation for each claim.

- **Discussion Period**: The Discussion Period begins with the Review Results Letter for a complex medical record review or with the Informational Letter date for an automated review. The discussion period is the opportunity to submit a statement and accompanying evidence to the RAC indicating why the adjustment should not be initiated. A physician may also submit a request to discuss an improper payment finding with HMS Federal's Contractor Medical Director within thirty (30) days from the date of this letter. The request may be submitted via fax at (XXX) XXX-XXXX or by contacting a Provider Relations Representative at (XXX) XXX-

XXXX. The outcome of the discussion process could change how or if the claim will be submitted for adjustment. The RAC will advise you of its decision in writing. Please include a copy of the discussion form for each claim, along with your supporting documentation. The Discussion Form is located at https://www. racinfo.hms.com.

To ensure that the request is received and processed timely we encourage you to submit the discussion period request immediately upon receipt of this letter.

If the discussion period request is not received within thirty (30) days from the date of this letter, or if the RAC determines that the submitted documentation does not support the billed service(s), the claim will be submitted to your Medicare Administrative Contractor (MAC) for adjustment. A demand letter will follow which identifies the overpayment amount and outlines repayment options as well as appeal rights. Per CMS' directive, the RAC cannot accept and review discussion period request received on or after the thirty-first (31st) day of this letter. You may track the status of your discussion period review at https://www. racinfo.hms.com.

Notice: "Good Cause" Language: Why HMS Federal Solutions (HMS Federal) Selected These Claims

Pursuant to applicable Medicare reopening regulations, including without limitation the Medicare Claims Processing Manual, Chapter 34, Section 10[1], the claims noted on the attached Audit Detail were selected for review for an underpayment or overpayment, as applicable, for the following reasons:

1. There is New and Material Evidence that was not available or known at the time of the determination or decision and may result in a different conclusion; and
2. The evidence that was considered in making the determination or decision clearly shows on its face that an Obvious Error was made at the time of the determination or decision.

New and Material Evidence and Obvious Error made at the time of the initial determination include:

a. Improper or incorrect application of Medicare billing or coding requirements;
b. The medical or other necessary records associated with the claim were not reviewed prior to the initial determination, a coverage or coding determination based upon the information on the claim and its attachments could not be made and there is a high probability that the records do not support the services paid or the service is not covered, and copies of medical records are therefore needed to provide support for the claim; and
c. At the time of the initial determination, data analysis techniques, editing and/or review processes were not applied to the claim.

HMS Federal has reviewed the claims noted on the attached Audit Detail. In accordance with CMS regulations, HMS Federal's data analysis techniques coupled with periodic OIG Reports (www.oig.hhs.gov/oei/reports/oei-03-01-00430.pdf; www.oig.hhs.gov/oei/reports/oei-07-06-00340.pdf, www.oig.hhs.gov/oei/reports), quarterly PEPPER Reports (The Program for Evaluating Payment Patterns Electronic Report, see http://www.PEPPERResources.org/), National and Local Coverage Determinations (NCD/LCD), Coding Clinic, CPT, CPT Assistant, DRG Expert, and National Correct Coding Initiatives Edits (NCCI) resources do not support the services paid, the services would therefore not be covered, and a billing or coding error therefore exists.

[1] A reopening is a remedial action taken to change a final determination or decision that resulted in either an overpayment or an underpayment, even though the determination or decision was correct based on the evidence of record. Reopenings are separate and distinct from the appeals process. Reopenings are a discretionary action on the part of the contractor. A contractor's decision to reopen a claim determination is not an initial determination and is therefore not appealable. Pub 100-4, Chapter 34, § 10

Thank you for your cooperation and prompt attention to this improper payment. If you have any questions regarding this letter or would like to discuss the improper payment identification, please direct your inquiry to Provider Relations at (XXX) XXX-XXXX.

Sincerely,

HMS Federal Solutions

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