Physician’s Name/Clinic
Street Address
City, State Zip

Dear Dr., Ms., Mr. or Healthcare Provider (if payee letter):

Wisconsin Physicians Service (WPS) is the Medicare Administrative Contractor for this Jurisdiction. By contractual obligation with the Centers for Medicare and Medicaid Services (CMS), WPS routinely performs post-payment medical review/audits of services rendered by selected providers. Through statistical analysis, we have determined that your utilization of CPT or HCPCS code Code exceeds that of physicians of all specialties or your peers throughout the jurisdiction or insert applicable state.

CPT code Code is defined as: ________________

In accordance with the WPS Medicare Part-B Medical Review Current FY Strategy focus on insert strategy focus issue, Medical Review has analyzed data to identify providers with a high potential for billing errors in the area of focus. (Insert applicable benchmark(s) from PECA).

State reason provider was selected for review. Insert statistical data from PECA. Therefore, we are conducting a Probe review on CPT or HCPCS code Code. We are requesting copies of your medical records for the enclosed list of beneficiaries and dates of service.

Authorization to release medical records to the Medicare carrier (i.e. WPS) is granted by each beneficiary, or their designee, as a condition for payment of services rendered by Medicare certified providers. Beneficiaries authorize the release of any medical or other information necessary by signing either the CMS 1500 claim form or a “Statement to Permit Payment of Medicare Benefits to Provider” release form. Furthermore, the Health Insurance Portability and Accountability Act (HIPAA), effective April 21, 2003, does not prohibit the release of individual beneficiary medical records to the carrier for medical review of billed services.

Please note that it is the billing provider’s responsibility to provide the required pre-existing documentation necessary to conduct a medical record review. That documentation is due 30 days from the date of this letter (insert record due date). As part of the audit process, WPS utilizes the documentation in the medical records to make
review determinations for all services billed on the claims identified in the enclosed list. Providers must submit **ALL** the documentation that is necessary to support the medical necessity for each billed service and to substantiate the appropriate use of each billed procedure code. This may require you to contact other providers, agencies, and/or facilities to obtain the requested medical records. If an Advance Beneficiary Notice(s) (ABN) was obtained for the service(s), a copy of each ABN must be submitted with the medical records.

**All documentation must be legible.** Patient identification, date of service, and the provider of the service should be clearly identified on the pre-existing medical records. If any of the documentation should reference a dictated, or other, document that supports the service billed, be sure to include the referenced records with your submitted documentation. For clarity, you may need to submit transcriptions of the original preexisting medical record documentation. It is necessary that documentation include, but is not limited to: insert, and bullet (if appropriate), specific types of documentation required to substantiate the medical necessity for this particular service(s).

It is recommended that you submit an example of your signature and initials, if applicable. In the absence of adequate legible and pertinent documentation, WPS may determine that the medical necessity for the service billed has not been substantiated.

Please be aware that Medicare requires a legible identifier for services provided/ordered. If the signature on the documentation supporting the service(s) is illegible or missing, please submit an attestation statement with your documentation verifying who performed those service(s). To view a signature attestation statement example, please visit our website at:


or


While this form is not a Medicare mandated form, for your convenience it can be completed and submitted as an attestation statement if required.

Please submit these medical records by 30 days from the date of this letter (**date**). You must notify us if you are unable to meet this target date. If we do not receive the medical records by **date**, or have not received notification of your inability to meet the target date, we will proceed with our review. The services will be considered non-documented, which will result in an overpayment determination. **When no documentation has been received, the service(s) will be denied.**

**How to submit medical records to WPS:**

1. Enclose a copy of this letter with the medical records.
2. For your convenience, requested records/information may be submitted by mail in paper format or imaged files on CD/DVDs.
3. Mark CONFIDENTIAL on the lower left corner of the mailing envelope.
4. Send the medical records to:

WPS Medicare Medical Review
Attn: Analyst’s Name, R.N., Medical Review Analyst
1717 West Broadway
Madison, WI 53713

OR

WPS Medicare Medical Review
Attn: Analyst’s Name, R.N., Medical Review Analyst
8120 Penn Avenue South, Suite 200
Bloomington, MN 55431-1394

In the late summer, some MACs began accepting solicited documentation from providers sent via the Electronic Submission of Medical Documentation (esMD) mechanism. For more information about esMD, see www.cms.gov/esMD. (use only for J5 letters)

At the conclusion of our review process, we will inform you of our findings. We will provide you with a listing of the claims that were reviewed and our review determinations. If billing problems are identified, you will be notified of the specific reasons for denial, identification of denials that fall under §1879 of the Act and those that do not, our liability determination for those denials that fall under §1879 of the Act, our determination of whether you are without fault under §1870 of the Act, an explanation of why you are responsible for the incorrect payment, and the amount of the overpayment or underpayment.

CMS implemented a program to improve the processing and medical decision making involved with the payment of Medicare claims. This program is called Comprehensive Error Rate Testing (CERT) and has been implemented in order to achieve goals of the Government Performance and Results Act of 1993, which sets performance measurements for Federal agencies.

Under CERT, an independent Program Safeguard Contractor known as a CERT Review Contractor (CRC) will select a random sample of claims processed by each Medicare contractor. The CRC’s medical review staff (to include nurses, physicians, and other qualified healthcare practitioners) will then verify that contractor decisions regarding the claims were accurate. CMS and WPS will use these findings to determine underlying reasons for errors in claims payments or denials, and to implement appropriate education and corrective actions aimed toward improvements in the accuracy of claims processing. The medical records, themselves, will be requested in writing by a Program Safeguard Contractor known as a CERT Document Contractor (CDC).
As previously stated in this letter, when the medical records are requested by either the Medicare carrier (WPS) or the CDC for CERT, authorization to release them will have already been granted by each beneficiary or their designee as a condition for the payment of services rendered by Medicare certified providers. Beneficiaries authorize the release of any medical or other information necessary by signing either the CMS 1500 claim form or a “Statement to Permit Payment of Medicare Benefits to Provider” release form. Furthermore, the Health Insurance Portability Act (HIPAA), effective April 21, 2003, does not prohibit the release of individual beneficiary medical records to the carrier or the Program Safeguard Contractor for medical review of billed services.

You may receive requests for occasional additional information from the CDC for CERT. If you do, it is very important that you respond with the requested information in a timely manner.

For your convenience, WPS now offers an optional, no-cost Medicare e-News. Through the e-News, the most current Medicare Part B news will be delivered right to you. The list is free, and you can subscribe, and unsubscribe, at any time. For further details about subscribing to this service, please go to:


or


If you have any questions, please contact Analyst Name R.N., Medicare Medical Review Analyst at Analyst’s Direct Phone #.

Sincerely,

[Signature]

Your Name, R.N.
Medical Review Analyst or
Medical Review Program Analyst or
Medical Review Specialist
Medicare Medical Review

Enclosure
cc:
Your initials