

June 3, 2009

## Medicare's Recovery Audit Contractor Program: RAC Reviews and Appeals

In order to ensure accurate payments under the Medicare fee-for-service program, the Centers for Medicare & Medicaid Services ("CMS") has implemented the Recovery Audit Contractor (RAC) program. RACs utilize a post-payment targeted review process employing data analysis techniques in order to identify those Medicare claims most likely to contain overpayments. The RAC review is either automated, for which a decision can be made without requesting a medical record, or complex, for which the RAC will contact the provider in order to review the medical records to make a decision about the payment. A RAC may review initial determinations within three years from the date of notice of the initial determination or redetermination if there is good cause. However, RACs will not be able to review any claims paid prior to October 1, 2007. This Health Care Alert provides the most recent information from CMS regarding the start dates for automated and complex reviews, "good cause" claim reopenings, the five-level Medicare appeals process, limitations on recoupment of alleged overpayments, and charts on the RAC process and Medicare appeals process.

### Claim Reopenings

Medicare's claims processing contractors (Medicare Administrative Contractors, Fiscal Intermediaries and Carriers) and claims review contractors (RACs and Program Safeguard Contractors) may reopen a prior Medicare payment or determination on their own accord (or at the request of a provider or beneficiary pursuant to established guidelines) when a reason exists that the claim decision should be changed. Claim reopenings may occur at any time if reliable evidence exists of fraud (or similar fault) in the initial claim determination, or if a clerical error unfavorable to Medicare, the provider or beneficiary, occurred on which the claim determination was based.

Claims may be reopened within one year from the date of initial determination for any reason. Medicare's contractors do not inform providers of claim reopenings unless the reopening results in a revision to the initial claim determination. If the claim reopening results in a denial of a previously paid claim, the appeals process and payment recoupment process begins upon the provider's receipt of notice of the revised determination.

A contractor may not reopen a claim between one and four years from its initial determination without showing good cause. "Good cause" exists when: 1) there is new and material evidence that was not available or known at the time of the determination or decision that may result in a different conclusion; or 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. Evidence may include any record used in the provision of medical care that supports whether or not the service was covered, medically necessary or provided as billed. Medical records that were not requested at the time of the initial determination constitute new evidence. Data analysis identifying high error rates or patterns of potential overutilization satisfies the good cause standard as evidence unavailable or unknown at the time of the determination. In determining whether good cause exists for reopening a claim, the contractor considers whether evidence is new and material from the perspective of the person or entity requesting or initiating the reopening.

A contractor's decision to reopen based on the existence of good cause, or refusal to reopen after determining good cause does not exist, is not subject to appeal.<sup>1</sup> When conducting a post-payment medical review of claims, contractors must adhere to the reopening rules. CMS assesses a contractor's compliance with federal laws, regulations and manual instructions during audits and evaluations of the contractor's performance. In the final rule, CMS considered and expressly declined to establish an evidentiary burden of proof to reopen or to create enforcement mechanisms for the good cause standard. CMS oversight of the good cause standard is limited to its periodic evaluation and monitoring of contractors' performance. No Medicare appeals panel has jurisdiction to consider whether a contractor has good cause to reopen a claim. This lack of jurisdiction extends whether or not the contractor meets the regulatory good cause standards for reopening claims.<sup>2</sup>

### **RAC Automated Review**

RACs may make claim determinations without a review of the medical record as part of an automated review using proprietary software designed to detect certain kinds of errors. In order to make a coverage or coding denial using automated review, both of the following conditions must apply. First, there must be certainty that the service is not covered or is coded incorrectly. Second, there must be a written Medicare policy, Medicare article or Medicare-sanctioned coding guideline supporting the determination. For example, an automated review could identify when a provider is billing for more units than allowed on one day.

The exception to these conditions is for "clinically unbelievable" issues. In these cases, while there may be certainty that a service is not covered or is incorrectly coded, there may not be any written Medicare policy or guidelines on the issue. In such cases, the RAC is required to seek approval from CMS in order to proceed on every issue for which it wishes to conduct an automated review.

The RAC may use automated review when making other types of administrative determinations (e.g., duplicate claims, pricing mistakes) when there is certainty that an underpayment exists, even if written policies do not exist.

CMS anticipates automated reviews to begin in late June or July, 2009.

### **RAC Complex Review**

Complex review occurs when a RAC makes a claim determination using review of the medical record by the RAC's personnel. Complex review is used when there is a high probability that a service is not covered, or where no Medicare policy, guidance or Medicare-sanctioned coding guideline exists. In complex reviews, the RAC will review the medical record to determine whether or not a payment error occurred. A provider has forty-five (45) days plus 10 calendar days mail time to submit medical records upon request of a RAC. Most complex reviews are medical necessary audits that assess whether care provided was medically necessary and provided in the appropriate setting.

Complex reviews for which no written Medicare policy or guidelines exist are referred to as "individual claim determinations." In these reviews, the RAC must use appropriate medical literature and apply appropriate clinical judgment. The RAC's medical director must actively examine the evidence used in making individual claim determinations where the Medicare guidelines or literature are unclear.

CMS will begin some complex reviews later this year but will not conduct complex reviews for medical necessity until 2010.

<sup>1</sup> 42 C.F.R. 405.980(a)(5).

<sup>2</sup> See *In the Case of Critical Care of North Jacksonville*.

### RAC Discussion Period

RACs will conduct a “discussion period” for providers that wish to dispute alleged overpayments. The discussion period does not delay the time period for submitting the request for first-level appeal in the Medicare appeals process. Participation in the discussion period does not affect a provider’s right to appeal or appeal/recoupment time frames.

For an automated review, the provider may institute a discussion with the RAC within fifteen (15) days of its receipt of a demand letter from the RAC. The demand letter states the claims adjusted or denied, the alleged overpayment amounts, appeal rights and the recoupment process. The discussion period commences on the demand letter date and ends forty-one (41) days from such date.

For a complex review, the RAC issues a review results letter after examining the medical records submitted by the provider for a time period not to exceed sixty (60) days. The review results letter does not communicate the alleged overpayment amounts and appeal rights but discusses any findings from the RAC’s review. If the letter cites a finding, the RAC notifies the claims processing contractor and issues a demand letter to the provider. The discussion period begins with the date of the results review letter and ends with the date recoupment begins of the overpayment – forty-one (41) days after the date of the demand letter.

### Medicare Appeals Process

Once an initial claim determination, or a revised determination based on a reopening, is made, Medicare providers have a right to appeal. There are five levels in the Medicare appeals process. In order, the levels are:

- 1) Redetermination by the Medicare claims processing contractor;
- 2) Reconsideration by a qualified independent contractor (QIC);
- 3) Hearing by an administrative law judge (ALJ);
- 4) Review by the Medicare Appeals Council within the Departmental Appeals Board (Appeals Council);  
and
- 5) Judicial review in a U.S. District Court.

It is up to the provider to submit evidence and prove that its claims were appropriate, medically necessary and compliant with billing, coding and claims submission rules.

#### **First Level: Redetermination**

At the first level of appeal, a provider must file a written request for a redetermination by the Medicare claims processing contractor. The provider must submit all relevant documentation with the request. The request for redetermination must be made within 120 days from the date of receipt of the revised claim determination. The examiner will issue a decision by letter or a revised remittance advice within 60 days of receipt of the redetermination request.

### ***Second Level: Reconsideration***

If necessary, a provider may submit a written request to a QIC for a reconsideration of the Medicare claims processing contractor's decision within 180 days of the date of receipt of the redetermination. The request must clearly explain why the provider disagrees with the redetermination. All useful documentation should be sent with the request as any evidence not submitted for the reconsideration may be excluded from consideration at subsequent levels of appeal. The QIC reconsideration process allows for an independent review of medical necessity issues by a panel of physicians or other health care professionals with the appropriate clinical expertise to review the claim. Members of a QIC's panel who conduct reconsiderations must have sufficient medical, legal, and other expertise, including knowledge of the Medicare program. When the panel reviews denied services or items ordered by a physician, the panel will consist of at least one physician. However, the regulations do not require the panel physician to be in the same specialty as the physician.<sup>3</sup>

Reconsiderations are conducted on the record and must be completed within 60 days of receipt of the request for reconsideration. The QIC must include a detailed explanation of the decision, including any pertinent facts and applicable regulations and, in the case of a medical necessity denial, an explanation of the medical and scientific reason for the decision.

### ***Third Level: Hearing by an ALJ***

Providers dissatisfied with a QIC decision have a right to a hearing by an ALJ if the amount in controversy equals or exceeds \$120. The request for a hearing must be made within 60 days of receipt of the QIC reconsideration. Providers must also send notice of the ALJ hearing request to all parties to the QIC reconsideration and verify this on the hearing request form or in the written request.

ALJ hearings are generally held by video teleconference (VTC) or by telephone. If a provider does not want a VTC or telephone hearing, an in-person hearing may be requested. The ALJ will determine whether an in-person hearing is warranted on a case-by-case basis. Providers may also ask the ALJ to make a decision without a hearing. Hearing preparation procedures are set by the ALJ. CMS or its contractors may become a party to, or participate in, an ALJ hearing after providing notice to the ALJ and all parties to the hearing.

The ALJ will generally issue a decision within 90 days of receipt of the hearing request. This timeframe may be extended for a variety of reasons including, but not limited to, the case being escalated from the reconsideration level due to the QIC failing to meet its deadline, the request for an in-person hearing, the provider's failure to send notice of the hearing request to other parties and the initiation of discovery if CMS is a party. If the ALJ does not issue a decision within the applicable timeframe, a provider may ask the ALJ to escalate the case to the Appeals Council level.

### ***Fourth Level: Review by the Medicare Appeals Council***

If dissatisfied with the ALJ decision, a provider may file a request for a review with the Appeals Council within 60 days of receipt of the ALJ decision and must specify the issues and findings that are being contested. CMS has the same time period to appeal an ALJ decision. The Appeals Council may elect on its own motion to review an ALJ decision. In general, the Appeals Council will issue a decision within 90 days of receipt of a request for review. The Appeals Council bases its decision on the administrative record, and oral argument is rarely accepted. That timeframe may be extended for various reasons, including but not limited to, the case being escalated from an ALJ

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<sup>3</sup> 42 C.F.R. § 405.968(c).

hearing. If the Appeals Council does not issue a decision within the applicable time frame, the provider may ask the Appeals Council to escalate the case to the Judicial Review level.

### ***Fifth Level: Judicial Review in the U.S. District Court***

If at least \$1,180 or more is still in controversy following the Appeals Council's decision, the provider may request a judicial review before a U.S. District Court judge within 60 days of receipt of the Appeals Council's decision. The review must name the Secretary of Health and Human Services as the defendant and must be filed in the same federal district in which the provider is located. The Appeals Council's decision will contain information about the procedures for requesting judicial review.

### **Recoupment/Offset and Abatement**

Formerly, Medicare could choose to collect overpayments regardless of whether a provider had elected to appeal an overpayment determination. A recent change in the law now protects providers by limiting Medicare's ability to recover overpayments during the initial stages of the appeal process. For overpayments that are subject to the limitation on recoupment, Medicare may not recoup the overpayment until the decision on the redetermination and/or reconsideration have been delivered. Claims for benefits under Medicare that were denied after payment had been made, and for which a written demand letter was issued to the provider for repayment, are subject to the limitation on recoupment.

If Medicare chooses to adjust the claim after post-payment review, a demand letter is issued to the provider. The demand letter will:

- State that the provider may rebut the proposed recoupment action;
- State that in order to stop recoupment, the provider must request a redetermination of the overpayment within 30 days from the date of the demand letter;
- Explain how the overpayment arose, the amount of the overpayment, how the overpayment was calculated and why the original payment was not correct;
- Explain why the provider knew or should have known the services would not be covered or why the provider was found to be at fault in causing the overpayment; and
- Explain that recoupment will begin on the 41<sup>st</sup> day from the date of the first demand letter if payment is not received in full, an acceptable request for extended repayment schedule is not received or a valid request for a carrier's redetermination is not date stamped in the Medicare contractor's mailroom by the 30th day of the demand letter.

Providers who receive a demand letter giving notice of an impending recoupment action are entitled to rebut the recoupment action. The provider must submit a statement within 15 days of the receipt of the demand letter indicating why the recoupment action should not take place. The Medicare claims processing contractor will review the rebuttal and consider whether to proceed or stop the recoupment action. During the appeal process, while Medicare cannot recoup or demand the debt, interest continues to accrue and once both levels of appeal are completed and if the overpayment determination is affirmed, collection activities may resume within the designated time frames.

Upon receipt of a valid request for a redetermination of an overpayment, Medicare will cease recoupment of the overpayment that is the subject of the appeal, or will not initiate recoupment if it has not yet started.

If the redetermination decision affirms the overpayment determination, Medicare will issue another demand letter which will state that they can begin the recoupment action no earlier than the 61<sup>st</sup> calendar day from the redetermination. However, the provider can stop Medicare from recouping any payments at a second point in the recoupment process by filing a valid request for reconsideration with the QIC within 60 days of the second demand letter. When the Medicare carrier receives notification from the QIC of the valid and timely request for a reconsideration, they will not initiate recoupment if it has not yet begun.

If the QIC reconsideration results affirm the redetermination decision, recoupment may be initiated on the 30<sup>th</sup> calendar day after the date of the notice of the reconsideration decision. Whether or not the provider continues to appeal the overpayment demand and QIC reconsideration decision, Medicare will initiate the recoupment process at the third level of appeal, the ALJ, until the debt is satisfied in full. Two charts are attached to this Health Care Alert that display the information discussed in the Alert: RAC Process and RAC Review Appeals Process.

Haynes and Boone, LLP draws upon a team of attorneys from our Health Care and White Collar Criminal Defense Practice Groups to assist health care providers with RAC audits, PSC reviews, overpayment extrapolations and claims denials by Medicare's claim processing. We represent acute and specialty care hospitals, physicians, ambulatory surgery centers, home health agencies and other health care providers in the Medicare fee-for-service claims appeal process. Our legal services include:

- Compliance program assistance for auditing and monitoring activities;
- Denials management strategies and analysis;
- Appeals process counsel; and
- Appeals submissions preparation and review.

If you need advice or assistance with Medicare's Recovery Audit Contractor Program, please contact one of the attorneys below.

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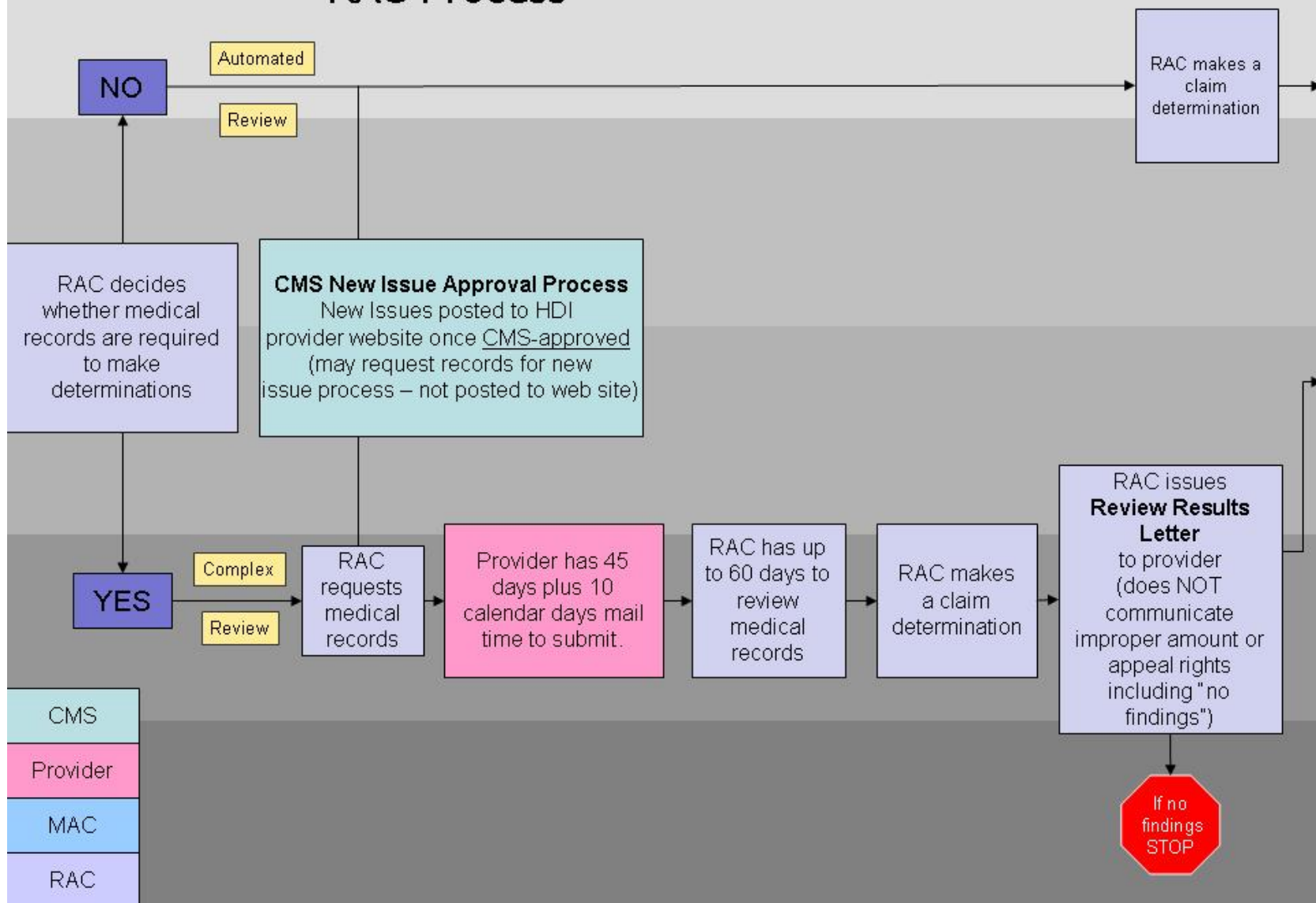
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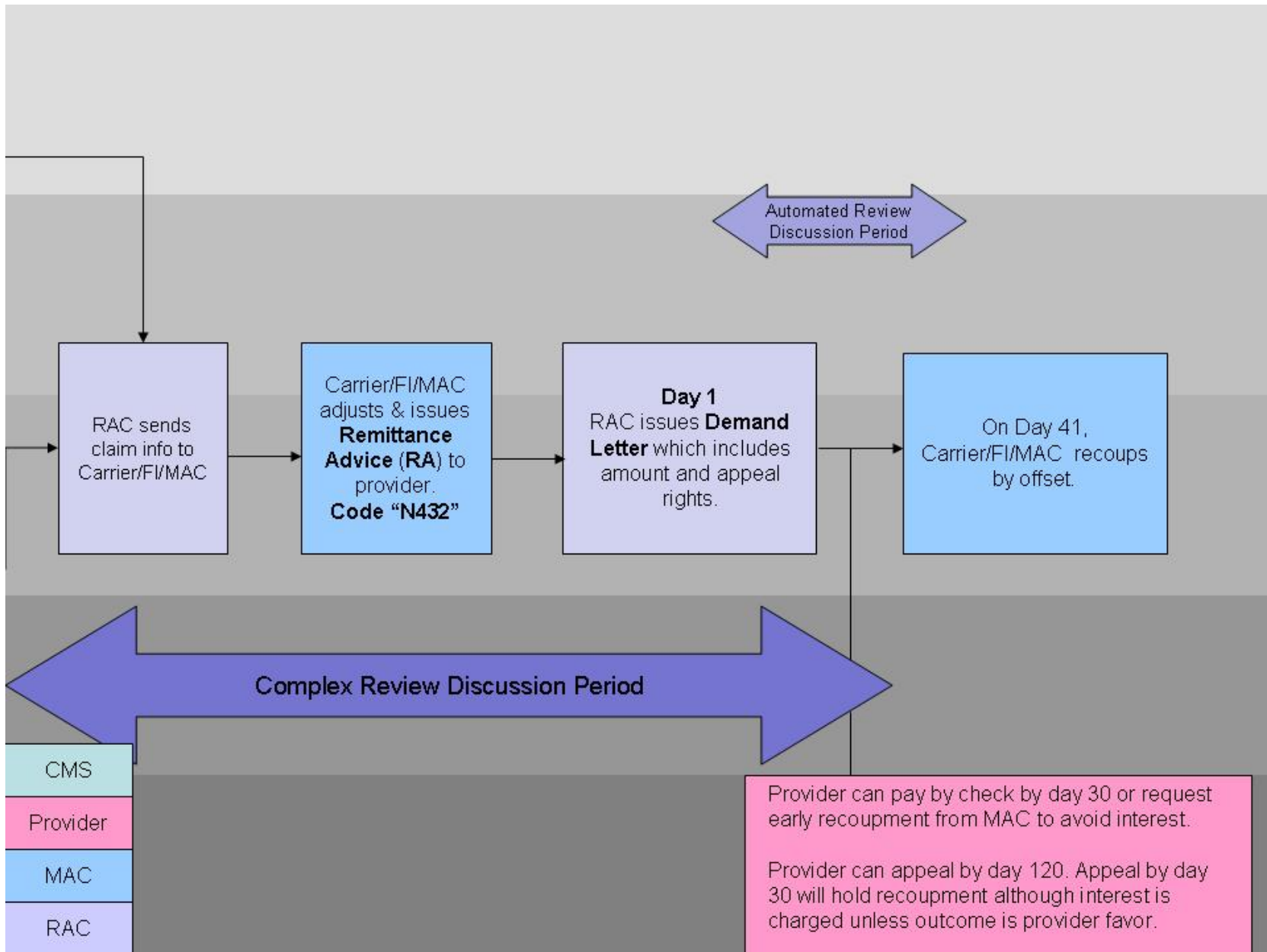
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# RAC Process





# RAC REVIEW APPEALS PROCESS

