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A Primer on RAC Appeals



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Now that the bid protests to the recovery audit contractor (“RAC”) program have been settled, implementation and national rollout of the RAC program is proceeding. Providers need to be prepared to file appeals quickly and without delay if they object to the RAC’s claim for overpayment. The timeframes for providers to object are short and if a provider has not thought through the appeals process beforehand, it may miss the opportunity to retain payments. This article provides a brief background of the RAC program, a short overview of the demonstration project results related to appeals, and a primer on the appeals process.

I. Background

The RAC program, authorized by Congress in the Medicare Modernization Act of 2003 and made permanent in the Tax Relief and Health Care Act of 2006, is intended to detect and correct improper payments in the Medicare program. More than 1 billion Medicare claims are submitted every year by providers and it is estimated that 3.9% of Medicare dollars paid do not comply with Medicare coverage, coding or billing rules. This results in approximately \$10.8 billion in under or overpayments.¹ In fact, Medicare is among the top three federal programs with improper payments, according to a January 2008 report by the Government Accountability Office (GAO). As a result, there is renewed focus by the Department of Justice and Office of Inspector General (OIG) to combat health care fraud and protect the Medicare trust funds. The RAC program aids existing program integrity efforts implemented by CMS by detecting improper payments (both over and underpayments) and correcting those improper payments (either by collecting money that was overpaid or repaying money where an underpayment exists).

II. Overview of RAC Process

Once improper overpayments are detected, the RAC contractors notify providers to collect any overpayment amounts. Notification is sent to providers pursuant to a demand letter that should contain the rationale behind any such adverse decision, the amount of the overpayment, and information on where to send the payment.

Once a provider receives a demand letter, the clock starts ticking on the appeals process. A provider should evaluate the rationale for any adverse RAC determinations upon receipt of the letter and review the medical records associated with any such determination. There are two basic avenues a provider can take in justifying appeal of a RAC determination: (i) identify why the underlying claim is meritorious, and/or (ii) identify and explain any legal defenses to the RAC’s adverse determination. Numerous legal defenses exist, so deciding which, if any, are applicable requires a facts and circumstances and providers should consult with legal counsel prior to pursuing an appeal. For example, if the demand letter states that the overpayment is based on a medical necessity claim, the provider may be able to appeal on the basis that the procedure was in fact medically necessary and provide medical charts and other evidence to support that payment was correct and often there is legal precedent that can be cited to give authority to this position.

If, after review, a provider believes that there is a solid basis for disputing with a given adverse RAC determination the provider should consider initiating efforts to appeal. The sections below highlight some key facts from the RAC demonstration, detail the timeline for filing appeals and outline the steps that a provider must take along each step of the five-tier appeals process.

¹ CMS, RAC Status Document, Status Report on the Use of Recovery Audit Contractors (RAC) in the Medicare Program, FY 2007.

III. Successful Appeals

During the RAC demonstration, there were approximately 525,133 claims with overpayment determinations. Providers appealed 118,051 of those claims or approximately 22.5% of all adverse RAC determinations.² Of providers who appealed a RAC determination, 34% obtained a decision in their favor that resulted in overturning of the RAC's findings.³

The chart below summarizes Part A and Part B appeals information during the demonstration project:

Part A Claims, as of 8/31/2008

Claims w/ overpayment determinations	Number appealed to FI % of total claims appealed	Number appealed to QIC % of total claims appealed	Number appealed to ALJ % of total claims appealed	Number appealed to DAB % of total claims appealed	Total # appealed
274,952	42,794 75%	11,548 20%	2,210 4%	197 1%	56,749

Source: The Medicare Recovery Audit Contractor (RAC) Program: Update to the Evaluation of the 3-Year Demonstration, The Centers for Medicare and Medicaid Services, January 2009.

Part B Claims, as of 8/31/2008

Claims w/ overpayment determinations	Number appealed to FI % of total claims appealed	Number appealed to QIC % of total claims appealed	Number appealed to ALJ % of total claims appealed	Number appealed to DAB % of total claims appealed	Total # appealed
250,181	45,927 75%	12,228 20%	3,147 5%	1	61,303

Source: The Medicare Recovery Audit Contractor (RAC) Program: Update to the Evaluation of the 3-Year Demonstration, The Centers for Medicare and Medicaid Services, January 2009.

As evidenced by the numbers, a majority of appeals were overturned at the first and second levels of appeal.

IV. The Appeal Process

The RAC appeal process mirrors the five-level Medicare claims appeal process through which fee-for-service providers appeal reimbursement decisions.⁴ The five levels of appeal include:

1. Redetermination by the Fiscal Intermediary;
2. Reconsideration by a Qualified Independent Contractor;
3. Administrative Law Judge Hearing;
4. Medicare Appeals Council Review; and
5. Judicial Review in U.S. District Court.

² The Medicare Recovery Audit Contractor (RAC) Program: Update to the Evaluation of the 3-Year Demonstration, The Centers for Medicare and Medicaid Services, January 2009. More data will be provided as the results of the demonstration project continue to be collected. Accordingly, the figures stated herein could change.

³ The Medicare Recovery Audit Contractor (RAC) Program: Update to the Evaluation of the 3-Year Demonstration, The Centers for Medicare and Medicaid Services, January 2009.

⁴ 42 CFR §405.902

Timing is critical in the appeals process. If RAC determination appeal requests are not filed within the specified timeframe for the applicable level of appeal, the opportunity to appeal is lost. The following chart provides a brief overview of the timeframes associated with each level of appeal.

Level of Appeal	Days a Provider Has to File	Days Until Issuance of Decision
Redetermination by the Fiscal Intermediary	120	60
Reconsideration by a Qualified Independent Contractor	180	60
Administrative Law Judge Hearing	60	90
Medicare Appeals Council Review	60	90
Judicial Review in U.S. District Court	60	--

As discussed in more detail below, once an appeal decision has been made, the written decision will contain information on the next level of appeal including filing requirements.

Below is a brief summary of each level of the RAC appeals process.

A. First Level Appeals – Redetermination by the Fiscal Intermediary

First level appeals, referred to as redeterminations, are made to the Medicare Fiscal Intermediary (“FI”) or carrier that initially processed the claim. First level appeals must be filed within 120 days after receipt of the determination by the RAC contractor.⁵ No monetary threshold is applied to first level appeals. In other words, any claim can be appealed no matter what amount of money is at issue. Redeterminations can be filed on Form CMS 20027. The form requires providers to list basic identifying information, as well as include a copy of the RAC determination letter. The provider must also provide an explanation of the reason for disagreement with the RAC determination. For example, the provider could either advocate for the underlying merits of the claim and/or raise legal defenses that support payment of the claim. The FI has 60 days from the date of receipt to issue a redetermination decision.⁶

If a provider disagrees with the FI’s redetermination the provider may seek the second level of appeal. The redetermination decision will contain information on the second level of appeal including timeframes and filing requirements.

B. Second Level Appeals – Reconsideration by a Qualified Independent Contractor

Second level appeals, referred to as reconsiderations, are made to a Qualified Independent Contractor (“QIC”). Like the first level appeal, no monetary threshold is applied to second level appeals, so claims of any size may be appealed. Reconsiderations must be filed by the provider within 180 days of receipt of the FI’s redetermination.⁷ A provider can file a reconsideration using Form CMS-20033. Form CMS-20033 requires the provider to list basic identifying information as well as the reason for disagreement with the redetermination and any additional information that should be considered. This information can also be filed through a written request.

All supporting documentation such as the initial demand letter, any evidence supporting the providers claim, and the FI’s redetermination should be submitted with the reconsideration request. Any documentation not submitted prior to issuance of the reconsideration decision may be excluded from subsequent levels of appeal. Therefore, it is very important to ensure that all relevant documentation and evidence accompany an appeal at the reconsideration level. Additional evidence or documentation may only be admitted in subsequent levels of appeal upon a showing of “good cause.”⁸

⁵ 42 CFR § 405.942(a).

⁶ 42 CFR §405.950

⁷ 42 CFR § 405.962(a).

⁸ 42 CFR §405.966(a)(2)

QIC reconsiderations are conducted on-the-record and there is no hearing. Where the appeal is a matter of medical necessity, a QIC is required to have an independent panel of physicians or other appropriate health care professionals review the claim.⁹ QIC's are appointed by CMS. For example, Maximus Federal Services, Inc. ("Maximus") provides QIC services for Part A Appeals. Maximus manages the Part A QIC process for the government, including appointing QIC panel members. The QIC typically has 60 days from the date of receipt to issue a reconsideration.¹⁰

If a provider disagrees with the result of the QIC's reconsideration, the provider may seek the third level of appeal. The reconsideration decision letter will contain information on the third level of appeal including timeframes and filing requirements.

If the QIC does not finish their reconsideration during the 60-day timeframe, the provider has the option to accelerate to the next level of appeal by filing directly with the Administrative Law Judge.¹¹

C. Third Level Appeals – Administrative Law Judge Hearing

Third level appeals, a hearing before an administrative law judge ("ALJ Hearing"), are available if the amount in controversy totals at least \$120.¹² A request for an ALJ Hearing must be filed within 60 days after receipt of the QIC reconsideration decision, and form CMS-20034 A/B may be used.¹³ This form requires similar information as those used for lower levels of appeal. The request must also be forwarded to the individuals who participated in the QIC panel.

An ALJ Hearing can be conducted by video-conference or telephone, or can occur off-the-record at the request of the provider.¹⁴ An in-person hearing is also available if the technology is not available or special circumstances exist.¹⁵

ALJ Hearing decisions are required by the regulations to be issued within 90 days after receipt of the hearing request, but the timeframe may be extended due a variety of circumstances.¹⁶ If the ALJ hearing decision is not issued within the applicable timeframe the provider may request to the ALJ that their appeal move forward to the fourth level of appeal.

If a provider disagrees with the result of the ALJ Hearing, the provider may seek the fourth level of appeal. The ALJ Hearing decision will contain information on the fourth level of appeal including timing guidelines and filing requirements.

D. Fourth Level Appeals – Medicare Appeals Council Review

Fourth level appeals are made to the Medicare Appeals Council ("MAC") and there is no monetary threshold, although all claims will be at least \$120. A request for a MAC review must be filed within 60 days of receipt of the ALJ Hearing decision, and can be filed on form DAB-10.¹⁷ This form requires similar information as those used for lower levels of appeal. The request must delineate why the ALJ Hearing decision is being appealed.

A MAC decision is required by the regulations to be issued within 90 days of receipt of the request for review, but the timeframe may be extended due to a variety of circumstances.¹⁸ If a MAC decision is not issued within the applicable timeframe, a provider may request that their appeal move forward to the fifth level of appeal.¹⁹

If a provider disagrees with the result of the MAC the provider may seek the fifth level of appeal. The MAC decision will contain information on the fifth level of appeal including timing guidelines and filing requirements.

⁹ 42 CFR §405.968

¹⁰ 42 CFR §405.970

¹¹ 42 CFR §405.970

¹² 42 CFR §405.1006(b)(1) provides that the amount in controversy must be \$100 increased by the percentage increase in the medical care component of the CPI for all urban consumers as measured from July 2003 to July preceding the current year. CMS published its amounts in controversy amounts on September 26, 2008. See 73 FR 55847 (Sept. 26, 2008).

¹³ 42 CFR §405.1002(a)

¹⁴ 42 CFR §405.1020(b)

¹⁵ *Id.*

¹⁶ 42 CFR §405.1046

¹⁷ 42 CFR §405.1102(a)(1)

¹⁸ 42 CFR §405.1110(d)

¹⁹ 42 CFR §405.1132

E. Fifth Level Appeals – Judicial Review in U.S. District Court

Judicial review in U.S. District Court is only available if the amount remaining in controversy totals at least \$1,220.²⁰ The request for judicial review must be filed within 60 days of receipt of the MAC decision.²¹ There is no timeframe for the judicial decision.

V. Conclusion

Adverse RAC determinations may result out of any audit, but they do not have to be the final outcome in instances where a solid basis for appeal exists. If appealed through to all five levels the total appeals process can take up to two years per claim. It is noteworthy, however, that during the demonstration project, a substantial majority of RAC appeals were overturned in the first and second levels of appeal. Timeframes for appealing decisions are short at all levels of appeal so providers should think through the appeals process and be prepared to appeal claims as soon as they receive notification from RAC of an overpayment. Providers should work with counsel to prepare for RAC audits and to address any potential claims for appeal.

²⁰ 42 CFR § 405.1006(c)(1) provides that the amount in controversy must be \$1000 increased by the percentage increase in the medical care component of the CPI for all urban consumers as measured from July 2003 to July preceding the current year. CMS published its amounts in controversy amounts on September 26, 2008. See 73 FR 55847 (Sept. 26, 2008).

²¹ 42 CFR §405.1130