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RECOVERY AUDIT CONTRACTOR STANDARDS FOR AUDITS

Policies and Procedures to Increase Transparency

EXECUTIVE SUMMARY

This document is designed to assist nursing home and long term care providers understand the recovery audit process via specific instructions and procedural suggestions. In an effort to gain control over millions of lost dollars, CMS created Recovery Audit Contractors (RAC); whose focus is to recover improper payments to healthcare providers from CMS. RACs focus primarily on coding errors and are not tasked with identifying civil or criminal fraudulent payments. In 2006, the Tax Relief and Health Care Act (TRHCA) required Health and Human Services to make the RAC program permanent and to expand it nationwide NO LATER THAN January 1, 2010. RACs will start with reviewing all claims that were paid to providers that occurred on or after October 1, 2007.

The purpose of this document is to help your facility with accurate documentation and ensure that Medicare and Medicaid revenue received by your facility is correct, so that, on subsequent internal or external audit, the revenue received will not need to be returned and the opportunity to subsequently bill the claim correctly will not be lost. In addition, we want your facility to receive full value from services purchased by Medicare, Medicaid and other insurers for resident and patient care. We encourage a thorough examination of claims to ensure that all submitted claims are in compliance with the Medicare Benefit Policy Manual, specifically Chapter 8 on Skilled Care Benefits. It is our intent that this explanation of the RAC program will save you valuable time. After reviewing this document, you will have improved your knowledge and confidence that Medicare funds paid to your facilities and organizations will not be subject to RAC recoupment.

This document will provide you with an in depth understanding of the RAC process and its possible effects on CMS repayment not only for your facilities, but for your physicians as well. During the RAC demonstration period, of the $1 billion in RAC recoveries, approximately $119 million were recovered from skilled nursing facilities and $125 million were recovered from physicians. In this ever changing environment, we strive to provide our customers with relevant and helpful information, to not only improve patient and staff satisfaction, but to increase overall facility and organizational performance. For further assistance, we have provided a flowchart that can be used as a checklist to guide you through the RAC appeals process; in addition we have attached the CMS forms needed for every level in the appeals process. Please feel free to contact us if you have any questions.

Questions about the material contained in this report may be addressed to John Sheridan, President, eHDS at jsheridan@ehealthdatasolutions.com

THE PURPOSE OF RECOVERY AUDIT CONTRACTORS (RAC)

The Department of Health & Human Services (HHS) has been measuring improper payments in the Medicare program since 1996. Since this effort began, CMS has reduced the Medicare fee-for-service error rate from 13.8 percent to 3.9 percent. With these findings as a model, the Improper Payment Information Act (IPIA) was enacted in 2002. IPIA requires all federal agencies to review their programs and activities annually in order to identify those areas susceptible to significant improper payments.

In January of 2008, the Office of Management and Budget reported that Medicare is one of the top three federal programs making improper payments. In fiscal year 2007 alone, an estimated $10.8 billion in improper payments were made.

In light of these staggering numbers, and in order to meet the IPIA's statutory requirement to safeguard the fiscal integrity of the Medicare program, CMS has developed a variety of tools to reduce payment errors in the Medicare program while ensuring the proper use of taxpayer dollars.

One part of the CMS effort to gain control over the loss of millions of dollars in improper payments, is the advent of the Recovery Audit Contractors. To this end, the Recovery Audit Contractors focus primarily on coding errors and are not tasked with identifying civil or criminal fraudulent payments.

RAC DEMONSTRATION SUMMARY

It is in the context of these significant Medicare payments errors that Congress passed Section 306 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA). This legislation directed HHS to conduct a three-year demonstration program using RACs to detect and correct improper payments in Parts A and B of the Medicare program.

During this time frame, the demonstration corrected a total of more than $1 billion in improper payments in its three-year run. It is notable that this amount includes both overpayments collected from providers and underpayments refunded to providers. Of the $1 billion in RAC recoveries, approximately $119 million were recovered from skilled nursing facilities and approximately $125 million was recovered from physicians. In addition to the large amount of recovered monies, the RAC demonstration program only cost 20 cents for every dollar it collected.

While this $1 billion in improper payments is significant, it is also worth noting that these errors were identified from a universe of $317 billion in Medicare payments available for review by the RACs during the demonstration period. This number ($1 billion) amounts to a 0.3 percent error rate, significantly lower than the rate that the national Medicare fee-for-service study found, of 3.9 percent.

As a result of this successful demonstration, Congress authorized the RAC process to become nationwide starting with a review of all claims paid to providers on or after October 1, 2007.

TRANSITION TO PERMANENT RACS

Because the demonstration program was successful in identifying and correcting improper payments, Congress, in Section 302 of the Tax Relief and Health Care Act of 2006 (TRHCA), required HHS to make the RAC program permanent and to expand it nationwide by no later than January 1, 2010. While still under review, a comprehensive report is expected to be issued which will discuss optimal approaches for expanding the RAC program so as to be consistent with Section 302 of TRHCA.

Evaluation of the project has focused on valuable lessons that were learned throughout the course of the demonstration. As a result of the feedback and experience of the demonstration, CMS has already made some important improvements and protections that will be in place when the permanent RAC program begins.

For example, both medical directors and certified coding experts will be required to be employed by all permanent RACs, whereas, in the original demonstration project, no medical director was required, and coding experts were optional. Additionally, during the initial project, RACs were only required to pay back their contingency fees if they lost a first-level appeal, but not at subsequent levels. Revisions to the project require that permanent RACs must pay back their fees if they lose at any level of appeal.

New too, is the fact that permanent RACs will also be able to review claims in the current fiscal year, whereas, the demonstration program RACs were not able to review current claims. In the demonstration, there was no maximum look-back date. In the permanent program, RACs will be able to look back for improper payments for up to three years, although not at claims paid earlier than October 1, 2007.

Additional changes to the program include the CMS requirement that the permanent RACs operate web-based systems so that providers who are involved in an audit will have secure online access to information that explains the status of their claims in the RAC audit process. Previously, none of the RACs in the demonstration program had this capability. Also different from the demonstration period, is that CMS did not set a limit on the number of medical records that could be requested by a RAC for an individual facility. In the national RAC program, CMS will establish a record limit that will vary by a biller's size to protect small providers from undue administrative burden.

Most importantly, under the permanent and nationwide RAC program, CMS will place a much greater emphasis on provider education and training as part of the program. For example, CMS will require RACs to seek CMS approval before beginning medical necessity reviews of provider claims. These reviews sometimes involve unclear areas of Medicare policy. CMS oversight will ensure that providers are not unduly burdened or second-guessed by the RACs. Additionally, CMS will require the permanent RACs to identify and publish vulnerability analyses so that the provider community can better understand where mistakes are being made and have the opportunity to correct those errors before an audit begins.

As a result of the efforts of CMS to assure Medicare and Medicaid benefits are appropriately used within the health care industry, long term care providers have a special obligation and need to respond.

PROTOCOLS AND STANDARDS FOR INCIDENT RAC AUDITS

Reporting Stage – Centralized Communication

All notifications from Recovery Audit Contractors to our community will be from the RAC Auditor approved for our service area. Upon receipt of a RAC audit or RAC investigation letter, the Administrator will immediately notify the:

1. Director of Corporate Compliance
2. Regional VP and Regional Finance Director
3. Chief Financial Officer
4. Chief Operating Officer

Any official RAC audit process will be sent from one of the four RAC Auditors:

Region A: Diversified Collection Services (DCS), 866-201-0580

Region B: CGI, 877-316-7222, e-mail: racb@cgi.com

Region C: Connolly Consulting, Inc., 866-360-2507

Region D: HealthData Insights, Inc., Part A: 866-590-5598, Part B: 866-376-2319, e-mail: racinfo@emailhdi.com

The four RACs will work as follows, adding states throughout 2009 per approval by CMS:

Diversified Collection Services, Inc. of Livermore, California, in Region A, initially working in Maine, New Hampshire, Vermont, Massachusetts, Rhode Island and New York.

CGI Technologies and Solutions, Inc. of Fairfax, Virginia, in Region B, initially working in Michigan, Indiana and Minnesota.

Connolly Consulting Associates, Inc. of Wilton, **Connecticut**, in Region C, initially working in South Carolina, Florida, Colorado and New Mexico.

HealthData Insights, Inc. of Las Vegas, Nevada, in Region D, initially working in Montana, Wyoming, North Dakota, South Dakota, Utah and Arizona.

Additional states will be added to each RAC region in 2009 as shown below.

The Centers for Medicare & Medicaid Services (CMS) implemented the Recovery Audit Contractor program to efficiently and cost-effectively identify and correct the significant number of improper payments made under the Medicare program. While the strategies used by the RACs have been prevalent among private payors for some time, these are new techniques for government contractors. RACs will detect and correct improper payments by Medicare and its fiscal intermediaries to providers.

In addition, this is the first time that a government contractor is being paid on a contingency fee basis (i.e., earning a percentage of what they recover).

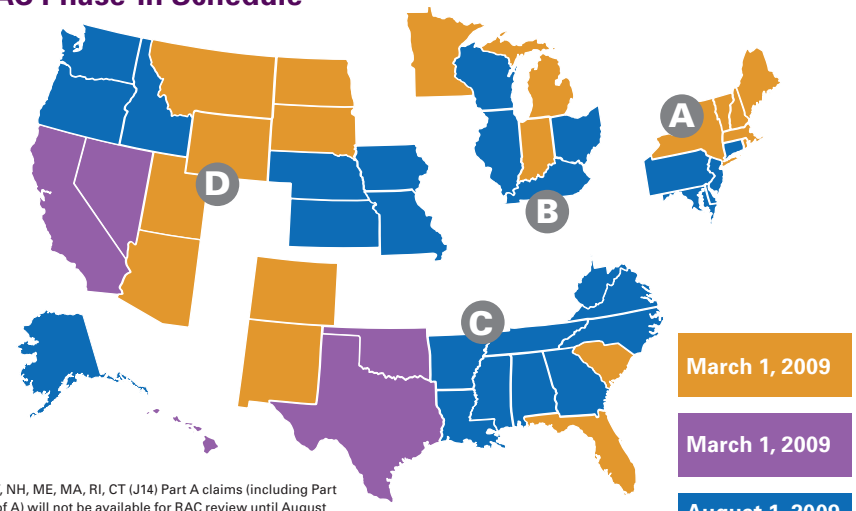
RAC responsibilities are threefold:

1. Conduct Data Analysis from the Medicare Common Working File
2. Review Medical Records to Further Analyze Claims
3. Identify and Correct Improper Payments

To identify improper payments, RACs search for payments made to providers for services rendered that may not be supported by evidence based care. The goal for recouping funds is $10.8 billion from Medicare payments to health care providers. Approximately 5% of this ($500 million) is anticipated to be recovered from skilled nursing facilities.

The process for RAC recovery of improper payments begins with the data analysis of the Medicare claims information. The RAC organizations must then present their findings from data review to CMS and CMS then authorizes the RACs to further review and recover improper payments. There are two types of RAC reviews: the Automated (no medical record needed – just claims) and the Complex (medical record required). The automated review is 80% of the audit process that detects either items with mistakes on claims, 5% of the recovered

RAC Phase-In Schedule



* VT, NH, ME, MA, RI, CT (J14) Part A claims (including Part B of A) will not be available for RAC review until August 2009 due to the MAC transition. All other Part B claims are available for RAC review beginning March 1, 2009.

funds, or items that the UB-04 does not reflect in the MDS assessment files, 95% of the recovered funds. The complex RAC review of medical records for further claims analysis begins with a RAC request to providers for copies of medical records.

When a RAC performs an automated review, no subsequent review of records is needed. The findings from an automated review allow the RAC to request the right to recoup the inappropriate payments. If CMS grants this request, the fiscal intermediary will immediately re-direct future Medicare payments to the RAC until the repayment amount is satisfied. The notice of recoupment will be provided in the remittance report sent to providers at the time when expected payments are anticipated.

An instance where an automated review may occur would be if a double payment was made to the provider by CMS or the fiscal intermediaries. The automated review identifies the double payment and the adjustment is made until the monies are repaid. As stated previously, this type of review results in 5% of the recovered funds from RACs.

An example of a complex review may be a situation where the data shows that extensive physical therapy was provided as a treatment to a patient with a urinary tract infection (UTI). Without extenuating findings that are expected to be in the patient's record, such therapy for a UTI is not typically medically necessary. Since the Medicare Benefit Policy Manual limits benefits to those treatments that are deemed medically necessary, this finding would trigger a complex review. This mandates a request for the records, involves the Medical Director, and requires code reviewers to examine the care provided as well as the Medicare funds provided. Most likely, in this instance, part of the Medicare funds may be recouped by the RAC. Complex reviews were clearly a majority source of the savings found in the demonstration project, at 95%.

As of 2009, RACs may request up to 10% of the average monthly Medicare claims, with a maximum of 200 records every 45 days, from inpatient providers such as hospitals, skilled nursing facilities, inpatient rehabilitation facilities, and hospice. This means that in a nursing home with 30 Medicare claims per month, the RAC may request 3 record reviews every 45 days. Based on this fact, this same skilled nursing home, that submits 30 Medicare claims on average per month, could reasonably expect a request for 24 complex record reviews annually.

Because of the limitation imposed on the RACs for the number of record requests that they can make, we believe that it is quite possible that skilled nursing facilities will receive extra attention and diligence from the RACs in this process. As such, we look to the CMS to further provide clear guidance on what is or is not considered a proper payment.

RAC FOLLOW-UP PROCEDURE
INITIATED AFTER RECEIPT OF A RAC REQUEST FOR REVIEW OF MEDICAL RECORDS

Part of administration oversight of the process when a request for records is made, is for the administration to monitor the number of requests for each month. As RAC requests are not allowed to exceed 10% of your average monthly Medicare claims per facility, a variation from this review guideline is a basis for appeal. This may result in a denial for recovery of funds.

Preparation for RAC audits and assurance of Medicare rules compliance consists of seven steps:

1. Review of data sources (MDS, UB-04 and chart)
   a. Assemble the complete medical record for the Medicare benefits paid – as is appropriate and is standard practice with medical records, **Do not alter or change the record in any way.**
   b. It is suggested that a separate record index and catalog be assembled for the patient's record, including a table of contents. **NOTE: This is a separate document from the medical record and since it is prepared as a facilitative service to the reviewers, it needs to be so designated.**
   c. Create an abstract and summary finding for the record.
   d. Based on a-c above, request consultant reviews:
      i. Your skilled nursing facility has a medical records consultant – this person should be the individual assigned the responsibility to assemble the medical record – they should create the index, catalog, and table of contents
      ii. Have the assembled record reviewed by the most advanced medical records librarian in your community. This may be the Director of Medical Records at a local hospital, an attorney, or other expert.
      iii. Prior to sending off the record, have it reviewed by your compliance officer and director of nursing services.
2. Audit how the chart is converted to MDS and UB-04
   a. Clarify start and stop of Medicare benefits.
   b. Research when Medicare benefits start and stop.
3. Research items difficult to code and bill
   a. Remember the 022 service code on the UB-04 is the PPS claim invoiced. The dates of service for this claim must match the MDS assessment reference date. (A3a date in the MDS).
   b. Clarify if a 3-day hospital stay is still a valid part of the record.
   c. Double check the admitting and principal diagnosis – make sure these diagnoses are consistent with the demands of Chapter 8 of the Medicare Benefit Policy manual.
4. Review each issue identified
   a. If there are items missing from the record (not part of the original medical record) but records available in other components or services given within the benefit period in question, then add these "new" findings to the record to assure a complete history of events is available for review. Note any added elements in the table of contents, the index, and the catalog. Be sure to use a reference point in the original record copy to point out that additional information is available.
   b. Know claims in suspension or with ADR.
   c. Match claims paid shown in remittance advice with UB-04s billed.
5. Perform chart and claim audits
6. Communicate results of these steps over and over until each record request is individually assembled for transmission to the RAC
7. Send the RAC requested records to the RAC with certified receipt and signature requested upon receipt

If the skilled nursing facility or other provider has completed steps 1-6 diligently, it is highly likely that the missing elements of the record that triggered the complex review will be found. This may result in no monitory recoupment by the RAC and the review being successfully defended at the crucial first stage – namely discovery.

Once the requested records are sent, the RAC process continues as follows.

In the effort to recover improper payments, the RAC reviews data from Medicare payments and identifies patterns in the data that suggest overpayment for Medicare Services. The RAC demonstration project found such overpayments for services in the following major areas of Medicare beneficiary services delivered:

1. Short stay claims – were inpatient services justified based on patient need and/or condition?
2. Debridement – were operating room (major surgery code) CPT codes billed with no anesthesia and operating room services?
3. Back Pain – does data suggest possible overutilization of services? Do many providers appear in the common working file? Does this indicate that better coordination would have been appropriate and lowered the cost of care?
4. Outpatient versus inpatient surgeries – would an outpatient surgery have been more appropriate and of lower cost?

5. Transfer patients – was the initial service provided by the "wrong" provider, therefore duplicative, and unnecessary?
6. Skilled nursing facility services were provided without the 3-day required hospital stay.
7. Therapies provided do not match the principal or admitting diagnosis.

Top reasons for the collection of funds recouped by the RAC as overpayments or denied services, were issues associated with:

1. Services as delivered and as documented
   a. were found to be medically unnecessary
   b. were incorrectly coded
   c. had insufficient documentation in the record to support the treatment and services billed
   d. contained other inconsistencies in the record and quality of care processes suggestive of billing that lead to overpayment.

The RACs must use a targeted approach in selecting which claims to review. They cannot randomly select claims or choose high dollar claims; therefore, the RACs are required to show "good cause" for their selections. Furthermore, CMS must approve in advance of the RAC recovery process, the good cause for the claims selected and subject to the complex review. Additionally, in the process of RAC determination or judgment regarding provider claims, RACs must notify the providers prior to recapture of Medicare overpayment or possible underpayment. In the case of underpayments, the RACs will refer any identified underpayments to the appropriate fiscal intermediary, carrier, or MAC to adjust the claim or pay the provider.

During an automated review, RACs use proprietary techniques (e.g., software algorithms) to identify claims with noticeable errors. They can only conduct this type of review if the error or improper payment is obvious and the appropriate policy document describes the coverage conditions in exact details. This type of review does not involve a request for medical records. Additionally, in an automatic review, RACs must notify providers only when they find overpayments.

The complex review is triggered by findings in the claim data which are suggestive of possible overpayment. The complex review requests medical records from the provider when the pure review of data is insufficient to reach a "fair" judgment on behalf of the Medicare beneficiary. The function of the complex review is to identify discrepancies between the medical record and the claim.

If the RAC's initial determination indicates an underpayment, the RAC will first notify the appropriate Medicare contractor to validate the findings. Once validated, the RAC will send written notification to the organization. This notification is sent to the organization only if the RAC conducted a complex review. The written notice contains information about the specific claims and details of the beneficiaries.

In the case of an automated review, the appropriate fiscal intermediary, carrier, or MAC will simply adjust the claim or pay the provider. The RACs are not required to notify providers about underpayments when they conduct an automated review. While there is no appeals process available for underpayments, organizations can submit a rebuttal to the appropriate RAC.

Once a RAC has requested records, it has accomplished its first step of the complex review. Specifically, this means that the RAC has identified some inconsistency or lack of compliance with Medicare policy by a provider.

With the result of the complex review determination, the RAC must send providers a determination letter with its overpayment or underpayment findings. For complex reviews, CMS requires the RACs to notify organizations of all results of the audit within 60 days of receipt of medical records. This includes notifying organizations of both overpayments and underpayments. This finding is called the ***initial determination***. **Once the records are sent by the provider to the RAC, the RAC must provide the initial determination of finding within 60 days.**

Under the RAC permanent program, a RAC Validation Contractor (RVC), an independent contractor, must confirm that the RAC's determinations are accurate prior to notifying the provider of any overpayments or underpayments.

The current RVC is Provider Resources, Inc, of Erie, PA. The RAC Validation Contractor (RVC) will work with CMS and the RACs to approve new findings that the RACs want to pursue for improper payments. They also perform accuracy reviews on a sample of randomly selected claims on which the RACs have already collected overpayments. The RVC is another tool CMS will use to provide additional oversight and ensure that the RACs are making accurate claim determinations in the permanent program.

After the requested records are sent for review, the skilled nursing facility must carefully monitor the 60 day period, beginning with the confirmed receipt by the RAC of the records requested for complex review. If the initial determination favors the pro-

vider, the record review is complete and no recoupment occurs.

If the RAC's initial determination involves an overpayment, they are required to recover the overpayments. Regardless of whether the RAC conducted an automated or complex review, they are required to communicate all overpayments to the provider.

In the case of validated overpayments, the RAC will communicate the initial determination to the provider in the form of a "demand letter". The RACs must issue these letters in accordance with applicable laws and regulations. The letters must include, but are not limited to:

- Provider's identity
- Reason for the review
- List of claims, with findings, reasons for any denials, and amount of the overpayment for each claim
- Explanation of Medicare's right to charge interest on unpaid debts
- Instructions on paying the overpayments
- Explanation of the provider's right to submit a rebuttal statement and/or an appeal
- Description of the overpayment situation, including the reasons for the overpayment and suggested corrective actions
- Other demand letter requirements for written notifications, including the citation of the specific coverage, coding, or payment policies that the organization may have violated leading to the overpayment

One of the key places where payment policy violations often occur is in the difference between billing practices and the treatment and benefits described in the Medicare Benefit Policy manual.

The Medicare Benefit Policy Manual (Chapter 8) states that care in a skilled nursing facility is covered when four factors are met:

1. The patient requires skilled nursing services or skilled rehabilitation services, i.e. services that must be performed by or under the supervision of professional or technical personnel; are ordered by a physician and the services are rendered for a condition for which the patient received inpatient hospital services; or for a condition that arose while receiving care in a skilled nursing facility for a condition for which the individual received inpatient hospital services.
2. The patient requires these skilled services on a daily basis.
3. As a practical matter, considering economy and efficiency, the daily skilled services can be provided only on an inpatient basis in a skilled nursing facility.
4. The services must be reasonable and necessary for the treatment of a patient's illness or injury, i.e., be consistent with the nature and severity of the individual's illness or injury, the individual's particular medical needs, and accepted standards of medical practice. The services must also be reasonable in terms of duration and quality.

A complex review of skilled nursing facility care will perform a thorough audit of the medical record of events and services provided to a patient. It will also test to determine whether each of the treatments and services meets the standards and policy established by the Medicare Benefit Policy Manual. The Benefit Policy Manual further states:

If any one of these four factors is not met, a stay in a skilled nursing facility, even though it might include the delivery of some skilled services, is not covered. For example, payment for a skilled nursing facility level of care could not be made if a patient needs an intermittent rather than daily skilled service.

Organizations should not simply accept the results (be they positive or negative) of their audit. Organizations should carefully review the results to ensure that the RAC accurately applied coverage, coding, and/or payment policies.

It is good practice for your organization to identify a person as the RAC liaison and to establish a RAC oversight subcommittee to lead the review. As part of the review process, the organization may also want to consider involving individuals who are familiar with the issues specific to the claims being reviewed. For example, a patient case manager can help review claims that were denied due to medical necessity issues. Similarly, the organization may want to consider engaging internal or outside counsel, auditors, and health care experts to review the results of the audit.

Conducting your own RAC review will help your organization identify next steps. For example, by carefully reviewing the results of the audit, the organization can determine how they will proceed with refunding the overpayment, if an overpayment is determined. On the other hand, if the organization believes the determination is unjust or inaccurate, they may decide to file a rebuttal or appeal. Finally, by reviewing the results, the organization can identify weaknesses in internal policies and procedures that warrant corrective action.

In the situation where the initial determination is made that funds are demanded

from the provider, a five step appeals process begins (see below). **There is a one time opportunity for the provider to rebut the RAC's review which must occur within 15 calendar days of receipt of the initial determination/ demand letter.** In order to be successful, the rebuttal needs to be clear, unambiguous and concise. A key element in avoiding the negative determination is to submit an accurate and complete initial record.

While there are five steps of continuous appeal that providers can use to clarify the record of care and argue that overpayment did not occur, if a rebuttal is issued within 15 calendar days of the initial demand letter date, then the organization has successfully created an opportunity to submit additional information or documentation to the RAC.

In this policy, the rebuttal is labeled as "Step ½." This is due to the fact that **a rebuttal does not stop the recoupment process and does not change the time requirements for filing an appeal.** The rebuttal does, however, demonstrate that the provider is organized and has made every effort to be transparent and accountable in assuring value provided in Medicare service.

The rebuttal needs to include a clear statement describing and explaining why the organization disagrees with the RAC determination. The RAC liaison assigned to the review should prepare the rebuttal and present it to the RAC oversight committee. The committee then determines whether outside assistance and review at this stage of "pre-appeal" may be helpful. It is possible that the RAC may accept the description and explanation regarding the review and reverse its finding without initiating the 5-step appeals process.

If upon receiving a rebuttal, the RAC withdraws the demand letter; such finding should be communicated in written form and kept as evidence of provider compliance with CMS policy. Such reversal of the RAC finding will, if appropriately communicated by the RAC to the intermediaries, stop the recoupment process. The RAC liaison and RAC oversight committee also need to review and monitor this step closely. As part of this process, the RAC liaison should also maintain an up to date agenda for the RAC oversight committee.

Under the first level of the 5 step appeals process, organizations can request a redetermination of a claim through the appropriate Medicare contractor, such as the fiscal intermediary, carrier, or Medicare Administrative Contractor (MAC). Within 120 days of the initial determination date, the organization must file this appeal in writing or by using CMS Form 20027. ***If the organization files a formal appeal within 30 days of the date on the demand letter, the recoupment process will stop until the FI/Carrier/MAC renders a decision.*** If the 30 day formal appeal time frame is not met, the recoupment may occur as early as day 31.

The Five Steps/Levels of RAC Appeal

Step/ Level		
½	**Rebuttal**	Within 15 calendar days of the initial demand letter date, organizations can file a rebuttal requesting the RAC to re-evaluate their decision. This allows the provider to submit additional information or documentation to the RAC that may not have been available at the time the medical records were submitted.
1	**Redetermination**	If the organization files a formal appeal within 30 days of the date on the demand letter, the recoupment process will stop until the FI/Carrier/MAC renders a decision. Otherwise 120 days for appeal. Download the form by visiting the link below. http://www.cms.hhs.gov/cmsforms/downloads/CMS20027.pdf
2	**Reconsideration**	This is the last opportunity to provide new information to the process and it goes to the QIC. The QIC is not compensated on commission and is an independent CMS contractor. Download the form by visiting the link below. http://www.cms.hhs.gov/cmsforms/downloads/CMS20033.pdf
3	**Administrative Law Judge**	The ALJ guideline is the Medicare Benefit Policy Manual. Download the form by visiting the link below. http://www.cms.hhs.gov/cmsforms/downloads/CMS20034AB.pdf
4	**Medicare Appeals Council/ Departmental Appeals Board**	http://www.cms.hhs.gov/MMCAG/Downloads/DAB101.pdf
5	**United States District Court**	

A written request for a ***redetermination*** must include, at a minimum, the following information:

- Beneficiary name
- Medicare Health Insurance Claim (HIC) number
- Specific service and/or item(s) for which a redetermination is being requested. ***This should include the information gathered in the rebuttal, offering new information from the record sent for the complex review that may not have been available when the requested records were submitted. An example might be doctors' notes or medical directors' notes from a QA meeting, or doctor's office which is not typically a part of the institutional skilled nursing facility record.***
- Specific date(s) of service
- Signature of the party or the authorized / appointed representative of the party

If the FI/Carrier/MAC upholds the initial RAC determination as described in the demand letter, organizations can then file a request for ***reconsideration*** with a Qualified Independent Contractor (QIC). This is the second level of the appeals process. The QIC who reveals the reconsideration appeal must process the appeal within 60 days of the request.

The QICs are mandated by the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act (BIPA) of 2000.There are currently four QICs that conduct the reconsideration appeals for the following jurisdictions: Part A East, Part A West, Part B North, Part B South, and DME.

The RAC will reissue its decision within 60 days from the reconsideration request. If the recoupment is still proposed, the RAC will inform the provider where the reconsideration request can be filed by including the address of the QIC in the letter sent to the provider.

Organizations must file the appeal for reconsideration within 180 days of the redetermination. To file a request for an appeal at this level of the process, organizations should follow the instructions in the Medicare Redetermination Notice (MRN). The request can be made in writing using either CMS' standard form (CMS Form 20033) or the reconsideration request form provided in the Medicare Redetermination Notice (MRN). If organizations do not use the CMS form, they can submit a letter requesting reconsideration that must, at a minimum, include the following information:

- Beneficiary's name
- Beneficiary's Medicare health insurance claim (HIC) number
- Specific service(s) and item(s) for which the reconsideration is requested, and the specific date(s) of service
- Name and signature of the party or representative of the party
- Name of the contractor that made the redetermination

The RAC liaison should assemble the reconsideration appeal and present the completed appeal to the RAC oversight committee prior to responding to CMS. In the organization's request, it is important to include a clear explanation of why the organization disagrees with the redetermination.

Note: If more than one RAC audit has occurred, the RAC liaison should have an RAC audit summary and tracking report to monitor the RAC experience. This should apply to each automated review and to each complex review.

The documentation that organizations submit during this level of the appeals process will be used for all subsequent levels of the process; therefore, it is critical that organizations submit all pertinent documentation. This includes a copy of the medical record, the MRN, and specifically, the information that the redetermination noted was missing from the documentation submitted at the first level of the appeals process. **The reconsideration appeal is the last opportunity that providers have to introduce new information to the process.**

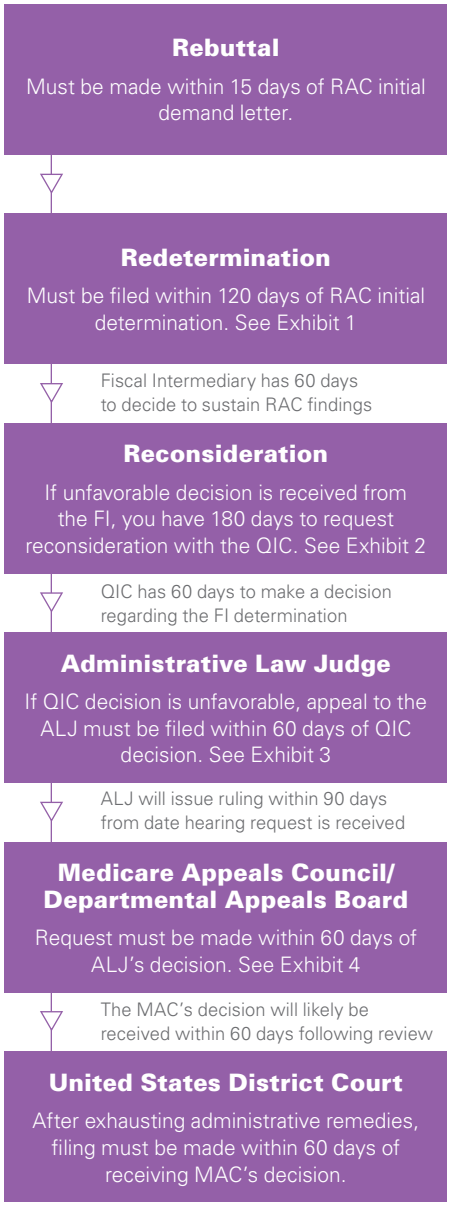
Should the QIC decide that the recoupment of Medicare funds from the provider has merit; a difficult decision must be made by the provider. There are still three more steps in the appeals process; however, these final steps require substantial investment of staff time and resources for the appeal.

Preparing for a hearing before a CMS Administrative Law Judge (ALJ) may proceed under the supervision of the RAC oversight committee. Sound judgment would require the facility or organization hire an outside contractor such as a lawyer or other specialist consultant in medical effectiveness, reasonableness of medical care and CMS policy. To have an ALJ hearing, the amount in dispute must be at least $120.00.

Should the ALJ decision support recoupment of funds, the provider wishing to continue to appeal may now present an appeal to the Medicare Appeals Council. The provider may request a review by the Medicare Appeals Council (MAC). Requests must be made to the MAC in writing within 60 calendar days from the date on the ALJ's decision letter and must be sent to the location listed in the ALJ's decision letter.

After a written decision is received from the Medicare Appeals Council, if you are in disagreement with the decision, a review by a Federal Court may be requested. The request in writing must be made within 60 calendar days from the date of the MAC's decision notice. You should check with the clerk's office of the Federal court for instructions about how to file the appeal. The court location will be listed in the MAC's decision notice. To get a review by a Federal court, the amount in question must be equal to or exceed $1,220.00. You may be able to combine claims to meet this dollar amount.

The following chart can be used as a checklist to ensure that all steps in the RAC Appeals process are followed.



Reference Sources

The information in this report has been compiled from different CMS sources and eHDS staff participation in seminars focused on RAC policies.

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