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Foreword

Clinical coding and reimbursement plays a significant role in healthcare and has gained more attention in the last decade with the introduction of present on admission (POA) indicators, Ambulatory Payment Classifications (APCs), MS-DRGs, and most recently ICD-10-CM/PCS.

While medical record audits have existed in the past to identify improper payments and prevent fraudulent claims, the Recovery Audit Contractor (RAC) program’s scope and volume of medical record requests is much greater. Healthcare entities must understand the RAC audit process and establish policies and procedures to appropriately manage the incoming requests, as well as the denial and appeal processes.

This toolkit provides guidance to health information management (HIM) professionals on how to prepare for and ensure compliance with the permanent program, including identifying an internal support team, developing policies and procedures, establishing an educational program, and following through with the responses to the RAC. While the information contained within this toolkit is specific to the RAC program, its guidance can be used for other anticipated regulatory audits. However, the appropriate modifications would need to be made to requirements for extensions, processes, etc.

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Introduction

HIM professionals should have a fundamental understanding of the entire RAC process in order to appropriately support and guide their healthcare entity in complying with the program.

Best practice guidance provided in this toolkit was developed for use across all healthcare entities. Therefore, the tools used may vary depending on the role of the individual and type of healthcare entity. All information included within the toolkit at the time of publication is current.

For the purposes of this toolkit, healthcare entity encompasses all providers: short-term acute care hospitals; long-term acute care hospitals; skilled nursing facilities and hospices; inpatient and outpatient psychiatric and rehabilitation facilities; home health facilities; hospital-based outpatient facilities and clinics; and all professional providers such as physician practices and other healthcare entities or professional providers that provide patient care solo or as part of a corporation and accept payment from Medicare. The healthcare entity uses the same policies and procedures throughout the components of the organization.

Background

In section 306 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), Congress directed the Department of Health and Human Services (DHHS) to conduct a three-year demonstration program using RACs to detect and correct improper payments in the Medicare Fee for Service (FFS) program.

The demonstration program was designed to determine whether the use of RACs was a cost-effective means of ensuring correct payments to providers and suppliers and, therefore, protecting the Medicare Trust Fund.

The RAC demonstration program was successful in returning dollars to the Medicare Trust Fund and identifying monies that need to be returned to providers. It provided the Centers for Medicare and Medicaid Services (CMS) with a new mechanism for detecting improper payments made in the past and has also given CMS a valuable new tool for preventing future inappropriate payments.

Therefore, section 302 of the Tax Relief and Health Care Act of 2006 makes the RAC program permanent and requires the DHHS Secretary to expand the program to all 50 states by no later than January 1, 2010. Each RAC will be responsible for identifying overpayments and underpayments in approximately a quarter of the country. The new RAC jurisdictions match the durable medical equipment Medicare administrative contractors (DME MACs) jurisdictions. Please reference the CMS Web site www.cms.hhs.gov/RAC/ for information on the RAC jurisdiction map, schedule, and contractor information.
Audit Process

Who Is Eligible to Be Audited?

RACs are authorized to investigate claims submitted by all physicians, providers, facilities, and suppliers—essentially everyone who provides Medicare beneficiaries in the fee for service program with procedures, services, and treatments and submits claims to Medicare (and/or their fiscal intermediaries (FI), regional home health intermediaries (RHHI), Part A and Part B Medicare administrative contractors (A/B/MACs), durable medical equipment Medicare administrative contractors (DME MACs), and/or carriers. More information on those eligible for RAC audits can be found within the “Preparation Checklist” in appendix A.

Basis for the Audit

Now that the RACs have been assigned for a specific region of the country, they will receive a claim’s file from CMS. The file contains the past claim’s data from the National Claims History (NCH), compiling the claims that have been processed and paid after 10/01/07 in that assigned region. Monthly updates, including the current fiscal year, will be sent thereafter.

RACs employ their own custom-designed computer programs and processes, utilizing their uniquely developed criteria based on Medicare rules and regulations, accepted clinical standards of medical practice, and coding and billing policies, to determine which specific sectors to review. They may also reference specific services included in the current year Office of the Inspector General’s (OIG) work plan as well as Government Accountability Office (GAO) and Comprehensive Error Rate Testing (CERT) findings. From this foundational information, the RAC will identify those situations in which claims have a high probability to be overpaid (and underpaid) in their region. These qualifiers are then entered into the RAC database for each claim to identify providers and begin the analysis and recoupment process.

Similar to FI Audits, but…

RAC audits are based on proprietary methodologies developed by each contractor using CMS rules and regulations, national and local coverage determinations, etc. This method is similar to those conducted by FIs when they are looking to identify improper payments and fraudulent claims. However, RACs are paid by contingency fees based on the amount of over- and underpayments they identify. This means their motivations may be slightly different. Additionally, it is important to note the RAC will report potential fraud to CMS and potential quality issues to quality improvement organizations (QIOs).

All RACs are required to employ professional clinicians, including a physician, medical director, nurses, therapists, and certified coders for their assessments.

Types of Audits

There are two types of audits: automated reviews and complex reviews. An automated review occurs when a RAC makes a claim determination at the system level without a human review of the medical record, such as data mining. Errors found must be clearly noncovered services or
incorrect application of coding rules and must be supported by Medicare policy, approved article, or coding guidance.

A complex review, on the other hand, occurs when a RAC makes a claim determination utilizing human review of the medical record. Records requiring a complex review are those with high probability of noncovered service or when no definitive Medicare policy, Medicare article, or Medicare-sanctioned coding guideline exists.

RAC audits can review all aspects of the supporting medical records including, but not limited to, evaluation and management (E/M) services as related to those that should be reimbursed as a component of a global surgery package, as well as those on duplicate claims. At this point in time, RAC audits may not question the level of some E/M codes. However, CMS and the American Medical Association (AMA) will be jointly investigating the possibility of expanding the evaluation of E/M codes. Official notification will be distributed prior to RACs being allowed to perform these reviews.

1 Audit Timelines

<table>
<thead>
<tr>
<th>Recovery Audit Contractor (RAC) Timelines</th>
</tr>
</thead>
<tbody>
<tr>
<td>RAC Determination</td>
</tr>
<tr>
<td>Medical Records Request</td>
</tr>
<tr>
<td>Letter RECEIVED</td>
</tr>
<tr>
<td>Request extension</td>
</tr>
<tr>
<td>Comply with records</td>
</tr>
<tr>
<td>RAC records review</td>
</tr>
<tr>
<td>Rebuttal/Review</td>
</tr>
<tr>
<td>Appeal - 1st level (F2/MIC)</td>
</tr>
<tr>
<td>Notice of Decision</td>
</tr>
<tr>
<td>Appeal - 2nd level (QIC)</td>
</tr>
<tr>
<td>Appeal - 3rd level (ALJ)</td>
</tr>
<tr>
<td>Appeal - 4th level (DAB)</td>
</tr>
<tr>
<td>Appeal - 5th level (US District Court)</td>
</tr>
<tr>
<td>Provider action deadline</td>
</tr>
<tr>
<td>Agency action deadline</td>
</tr>
</tbody>
</table>
Preparation Checklist
In preparing for the RAC audits, it is important for each healthcare entity to understand who needs to be involved in the process, develop appropriate policies and procedures and education initiatives to support the program, be familiar with the different types of records\requests and timelines, and distinguish the various types of appeals to ensure the healthcare entity secures each claim. The “Preparation Checklist” found in appendix A provides a “big picture” overview to help HIM professionals understand these action steps.

Hierarchy of Authority
It is important for a healthcare entity to have a hierarchy of authority established defining the role of all multidisciplinary team members who will be working together in responding to the RAC program. The resources provided in this toolkit are meant for hospitals or /large physician groups, physician practices, and other (e.g., skilled nursing facility, inpatient rehabilitation facility, etc.) healthcare entities. Hierarchy of authority sample documents can be found in appendix B.

In addition, the RAC coordinator is an essential role in any program, as this individual is the focal point for all RAC activity, helping manage and oversee the internal process. For a sample job description for a RAC coordinator, see appendix C.

Internal Policies and Procedures
It is critical for a healthcare entity to write and implement official organizational policies to ensure corporate support, clear communication, and systematic procedures based on the hierarchy of authority. See appendix D for “Policy and Procedure Sample.”

Medical Records Requests
Once a provider has received a request from the RAC for supporting documentation, the medical records must be submitted within 45 calendar days. More time may be asked for by the provider as long as the extension request is received by the RAC prior to the 45th day. A “RAC Record Extension Request Sample Letter” can be found in appendix E. Further guidance specific to the record limits requested of providers can be found in the “RAC Presentation Sample” in appendix G.

When responding to the medical record request, it is critical to understand the importance of the release of information (ROI) role. Specifically, policies and procedures should be developed for the following:

- What is to be copied from the chart
- Numbering of pages in the chart
- How many copies should be made and to whom they should be distributed
- The importance of confirming the correct name and address of the contractor
- How to send for signature of receipt from the RAC (date and time)
- Response time limits
• Staff follow-up with RAC to confirm payment of 12 cents per page for inpatient hospital records.

For more information regarding the provisions of electronic health records (EHRs), please reference the appropriate RAC.

**Tracking RAC Requests**

Effectively managing the RAC process in healthcare entities will require the use of some form of tracking system. The volume of requests along with the length of time that can be involved from receipt of request to final disposition including appeals will need a mechanism to track status, manage deadlines, and ensure that the healthcare entity and RAC are meeting the required turnaround times.

Healthcare entities can develop their own tracking system, purchase one from a vendor, or obtain one from other organizations that are developing support tools for the RAC program. Identifying the best system for the healthcare entity’s needs should follow the same process as that of any software or database selection.

Some considerations for a tracking system include:

• The volume of requests the healthcare entity will likely be handling for each batch of requests. Will there be a way to enter requests into the system automatically or in a very efficient manner?
• Types of data needed to track requests, including items like dates (request, delivery, determination, appeals, final disposition); location of records (especially if records need to be obtained from off-site and stored locally until review is complete); and individuals responsible for retrieving, reviewing, copying, and sending records.
• Who will be responsible for entering or updating and reviewing information into the tracking system. Will it be multiple individuals, requiring a system that can be shared or accessed via a network?
• Types of reports needed to monitor the status of each batch of requests, notify the user of pending due dates, and provide trending data for productivity, turnaround times, and disposition of cases. Can the system create custom reports and send e-mails for follow-up to individuals in the healthcare entity?
• The type of system required to support this type of data tracking and reporting. Simple spreadsheet applications are not enough.
• Additional software purchases for the system. Can it easily be updated to add or modify data elements based on changes in the RAC requirements?
• Be sure the tracking system is capable of handling multiple audit requests such as CERT, PERM, etc. RAC Scope of Work prevents repeat audits.

A tracking system that is easy to implement and use and provides access to all the required data will be crucial to ensuring the healthcare entity can meet deadlines and identify opportunities for improvement in its RAC process. Creating a list of requirements and then evaluating potential
systems to determine if they meet a healthcare entity’s needs will be an important step in getting a RAC program up and running.

**Education**

HIM professionals need to identify who in the healthcare entity should be educated on the RAC program, recognize the educational opportunities from CMS, and develop an internal training program accordingly. In addition, this is an opportunity to educate providers on improving clinical documentation.

For a sample outline on how to develop a RAC education program, see appendix F. For a sample RAC presentation, see appendix G. For a listing of RAC acronyms, see appendix H.

**Appeals**

This section of the toolkit focuses on the appeal process, specifically what needs to be included in a cover letter, in the response, who will submit the appeal letter, and recommendations for where the letter(s) should be saved. Flow diagrams are provided to illustrate the appeal process, and sample letters are also provided for the different levels of appeals. These documents can be referenced in appendices I–M.

It is important to note the appeal letter should be signed by an authorized person who is familiar with the arguments contained in the letter. Such individuals include:

- Chief financial officer (CFO)
- Chief operating officer (COO)
- Medical director, acute rehabilitation unit
- Medical director
- HIM director for DRG coding appeals
- Hospital RAC appeals coordinator
- Physician (medical necessity)
- Case management director
Resources
Updated January 19, 2010


CMS. “Recovery Audit Contractor Overview.” Available online at www.cms.hhs.gov/RAC.


Connolly Healthcare. “CMS RAC Program Information.” Available online at www.connollyhealthcare.com/RAC.


Mallon, Deborah, and Bridgette Krueger. “Recovery Audit Contractor (RAC) and the Proactive Application for Dealing with the RACs.” Presentation. Coding Community CoP for Colorado’s RAC Coding Roundtable, March 27, 2009.

Appendix A
Preparation Checklist

A: Select RAC Team from Key Departments and Identify Their Role in the RAC Process
- Senior leadership
- Finance/revenue cycle
- Clinical documentation management
- Health information management (operations, coding, and ROI)
- Case management/care coordination
- Corporate compliance
- Business office (operations, Medicare specialist, and denials management)
- Information technology (IT) support services
- Clinical departments (as needed)
- Legal (internal and external) medical management

B. Develop Departmental Policies and Procedures
- Identify primary POC (point of contact) and back-up.
- Know RAC contact numbers.
- Establish in-house contact numbers.
- Create job description for RAC coordinator.
- Maintain tracking system.
- Prepare extension request letter.
- Prepare appeal letters.
- Ensure payment for copies has been received.

C. Educate Key Players Through Team Meetings
- Know the rules for RAC.
- Know Medicare policies. (According to the RAC Statement of Work, the RAC shall not help providers with policies.)
- Know difference between automated and complex reviews. Develop proactive approach for education. (Perform a RAC audit before CMS performs a RAC audit.)
- Educate RAC team.
- Educate other personnel.

D. Attend Provider Outreach Sessions
Prior to entering state, all contractors are required to hold a meeting.
- Identify times and dates on CMS Web site (www.cms.hhs.gov/rac) or contractors Internet page. (They should notify you.)

E. Develop Tracking and Appeals Process
- Identify tracking system, database or file.
- Know five levels of appeal. (Get to know the RAC contact.)
- Develop cover letter for each level of appeal (form).
- Determine who will decide if appeal will be submitted.
- Determine who should submit the letter.
F. Know Time Frames
- **45 Days**: records not received within 45 days can be declared an overpayment with no appeal rights for provider
- **15 Days**: discussion period for determination
- **3-Year**: look-back period from October 1, 2007
- **August 2009 RAC audit activity begins**
- **30 Day**: write check to avoid interest
- **41 Day**: Recoupment Period

G. Identify Eligibility For RAC Possibilities
- Inpatient
- Outpatient
- Therapy
- Surgical procedures
- Incomplete documentation and/or interpretation
- Evaluation and management (E/M) levels
- DRG
- Coding errors
- Medical necessity
- Lab, radiology
- Infusion and transfusion
- Social worker services in facilities
- Place of service errors
- Incident-to-error
- Stark violations
- Duplicate billing
- Debridement coding
- E/M utilizing modifier 24
- Pharmaceutical coding in physician offices

H. Know RAC Will Not Review a Claim that Has Been Previously Reviewed by Another HHS Contractor Including:
- RACs can correct improper payments when the CMS FI or MAC did not apply the proper edits – NCCI, OCE, MUE, MCE.
- Carrier/FI/ MAC Medical Review (MR) (prepayment/post-payment claim review program)
- Comprehensive Error Rate Testing (CERT) Program (post-payment claim review program)
- Quality Improvement Organization (QIO)
- Zone Program Integrity Contractor (ZPIC) Former Program Safeguard Contractor
- Fraud investigations by the Department of Justice (DOJ), Office of Inspector General (OIG), or the state Attorney General (AG).

I. Know RAC Contractors
- Diversified Collection Services—Region A
- CGI—Region B
- Connolly Consulting—Region C
- Health Data Insights—Region D

**J. Know RAC Subcontractors**
- VIANT—Region C
- PRG-Schultz—Regions A, B, D
## Appendix B
### Hierarchy of Authority Samples

**RAC Contacts—Hospital/Large Physician Group**

This document is to be used by the RAC coordinator to record the education provided to each team member. The Interview Date/Time column can be used to record the initial date and time the information was shared.

<table>
<thead>
<tr>
<th>Department/Position</th>
<th>Role</th>
<th>Contact Name</th>
<th>Position</th>
<th>Contact Number</th>
<th>E-mail Address</th>
<th>Interview Date/Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Administration</td>
<td>Executive champion</td>
<td></td>
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<td></td>
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</tr>
<tr>
<td>RAC Coordinator</td>
<td>Focal point of all RAC activity</td>
<td></td>
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</tr>
<tr>
<td>Health Information Management (Operations)</td>
<td>Assist with documentation improvement, medical necessity, and data mining; be part of the solution</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Health Information Management (Coding)</td>
<td>Assist with data mining and respond to RAC denials; identify difficult to code areas; be part of the solution</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Health Information Management (ROI)</td>
<td>Provide medical documentation</td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Medical Staff</td>
<td>Improve documentation</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Business Office</td>
<td>Identify charging/billing issues; assist with</td>
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<td></td>
</tr>
</tbody>
</table>

* For the context of this RAC toolkit, CMS defines large physician group as having 16 or more positions.
<table>
<thead>
<tr>
<th>Department/Position</th>
<th>Role</th>
<th>Contact Name</th>
<th>Position</th>
<th>Contact Number</th>
<th>E-mail Address</th>
<th>Interview Date/Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>data mining, and respond to RAC denials</td>
<td>Information Technology (IT)</td>
<td>Provide IT support for data mining, software installation, provision of electronic records</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Provide assistance on ad hoc basis; identify difficult to charge scenarios; ad hoc member of the RAC team; be part of the solution</td>
<td>Clinical Department Managers</td>
<td></td>
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</tr>
<tr>
<td>Track/trend improvements; create solutions</td>
<td>Quality Management/Performance Improvement</td>
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</tr>
<tr>
<td>Assist with medical necessity reviews or wrong setting issues and respond to RAC denials; work with medical staff</td>
<td>Utilization Management/Case Management</td>
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<tr>
<td>Provide information regarding clinical trials and any charging/coding difficulties</td>
<td>Research</td>
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<tr>
<td>Develop compliance action plan on identified issues; assist with self-reporting/disclosure;</td>
<td>Compliance</td>
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</tbody>
</table>

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<tr>
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<th>Role</th>
<th>Contact Name</th>
<th>Position</th>
<th>Contact Number</th>
<th>E-mail Address</th>
<th>Interview Date/Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Finance/Reimbursement</td>
<td>assist in problem solving; liaison with legal contact</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Contract Management</td>
<td>Track financial exposure</td>
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<td></td>
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<td></td>
</tr>
<tr>
<td></td>
<td>Identify other payers for follow-up audits; assist in identifying difficult to code/charge/bill areas</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Office of General Counsel</td>
<td>Provide support to any litigation or identified legal issue</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient Access/Scheduling/Registration</td>
<td>Assist with medical necessity, patient type issues; be part of the solution</td>
<td></td>
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</tr>
</tbody>
</table>
RAC Contacts—Physician Practice

<table>
<thead>
<tr>
<th>Department/Position</th>
<th>Role</th>
<th>Contact Name</th>
<th>Position</th>
<th>Contact Number</th>
<th>E-mail Address</th>
<th>Interview Date/Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>RAC Coordinator/Practice Administrator</td>
<td>Receive all RAC requests and manage RAC internal process</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Coder</td>
<td>Assist in identifying potential areas of concern; assist in responding to RAC denials; identify and correct issues; assist with documentation improvement and</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Physician</td>
<td>Act as executive champion; assist in writing denials when appropriate</td>
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</tr>
<tr>
<td>Business Office/Billing Company</td>
<td>Proactively identify potential charging/billing issues; assist in writing responses for denials; correct identified problems</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Information Technology (IT) Contact</td>
<td>Provide IT support for data analysis; provide recommendations for IT solutions to identified problems</td>
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</tbody>
</table>

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<table>
<thead>
<tr>
<th>Department/Position</th>
<th>Role</th>
<th>Contact Name</th>
<th>Position</th>
<th>Contact Number</th>
<th>E-mail Address</th>
<th>Interview Date/Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>CFO/Accountant</td>
<td>Track financial exposure</td>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Office of General Counsel/Compliance</td>
<td>Act as a subject matter expert when billing issues are identified; provide support to any litigation or identified legal issue; assist in self disclosure strategy</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Contract Management</td>
<td>Identify other payers with follow-up audits; assist in identifying difficult to code/charge/bill areas</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Research</td>
<td>Provide information regarding clinical trials and any charging/coding difficulties</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Front Office/Scheduling/Registration</td>
<td>Assist with medical necessity, patient type issues; correct identified issues</td>
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</tr>
</tbody>
</table>

*For the context of this RAC toolkit, CMS defines large physician group as having 16 or more positions.*
## RAC Contacts—Other Provider Organization

<table>
<thead>
<tr>
<th>Department/Position</th>
<th>Role</th>
<th>Contact Name</th>
<th>Position</th>
<th>Contact Number</th>
<th>E-mail Address</th>
<th>Interview Date/Time</th>
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<tbody>
<tr>
<td>RAC Coordinator/Practice Administrator</td>
<td>Receive all RAC requests and manage RAC internal process</td>
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<tr>
<td>Coder</td>
<td>Assist in identifying potential areas of concern; assist in responding to RAC denials; identify and correct issues</td>
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<tr>
<td>Physician/Subject Matter Expert</td>
<td>Act as executive champion; assist in writing denials when appropriate</td>
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<tr>
<td>Business Office/Billing Company</td>
<td>Proactively identify potential charging/billing issues; assist in writing denials; correct identified problems</td>
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<tr>
<td>Information Technology (IT) Contact</td>
<td>Provide IT support for data analysis; provide recommendations for IT solutions to identified problems</td>
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<td></td>
</tr>
<tr>
<td>Office of General Counsel</td>
<td>Act as a subject matter expert when billing issues are</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

*For the context of this RAC toolkit, CMS defines large physician group as having 16 or more positions.*
For the context of this RAC toolkit, CMS defines large physician group as having 16 or more positions.

<table>
<thead>
<tr>
<th>Department/Position</th>
<th>Role</th>
<th>Contact Name</th>
<th>Position</th>
<th>Contact Number</th>
<th>E-mail Address</th>
<th>Interview Date/Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>CFO/Accountant</td>
<td>Track financial exposure</td>
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<tr>
<td>Front Office/Scheduling/Registration</td>
<td>Assist with medical necessity, patient type issues; correct identified issues</td>
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</tbody>
</table>
Appendix C
RAC Coordinator Job Description Sample

The attributes of the RAC coordinator are:
- Strong organizational skills
- Strong interpersonal skills
- Detail-oriented
- Proficient with spreadsheets and database applications
- Super-user knowledge of RAC tracking system

The RAC coordinator may or may not be a full-time role, depending on the volume of RAC requests and job functions outside RAC.

Duties/roles and responsibilities of the RAC coordinator:
- Conduct oversight of all RAC functions
- Develop internal training program
- Track status of all RAC activity using automated tracking system
- Open communication between RAC coordinator and
  - Administration/CFO
  - HIM/Coding/ROI
  - Business office/financial services
  - Case management/physician advisor for clinical review
  - RACs/CMS
- Coordinate all activities associated with RAC requests, appeals, etc.
- Manage and track hand-offs between departments
- Invoice submitted records requests, if applicable
- Manage and track RAC timelines for requests and RAC responses
- Communicate with all affected external entities involved in the RAC process
- Analyze audit and RAC findings
- Follow all RAC activity to closure
- Coordinate the RAC committee with reports to corporate compliance

Other functions needed (outside of RAC coordinator):
- Clinical review
- Clerical/administrative support for RAC tracking system data entry
- Release of information (ROI) process/function
Appendix D
Policy and Procedure Sample
Compliance and Recovery Audit Contractors

[Facility Name]
[City, State]
[Department]

Policy and Procedure: Compliance with Recovery Audit Contractors

Prepared by: _____________________________ Director Health Information Management

Approved by: _____________________________ Administration

Approved by Policy Committee: [Date]

Policy Effective: [Date]

Background: Section 302 of the Tax Relief and Health Care Act of 2006 required the Secretary of the Department of Health and Human Services to utilize RAC under the Medicare Integrity Program to recoup overpayments and improper payments for the Medicare Program for Parts A and B. This was based on the findings during the demonstration period for the use of RACs as set forth by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, section 306.

Purpose: To ensure compliance and adherence to the needs of Recovery Audit Contractors appointed by Medicare.

Policy: Facility will be compliant and have proper procedures in place to ensure compliance with Recovery Audit Contractor (RAC). This will include prompt response to requests for medical records by the facility, evaluation of denials, and timely filing of appeals.

Procedure:
1) Facility will form a RAC team. This team will consist of RAC coordinator (primary point of contact and back-up contact), representatives from senior leadership, finance/revenue cycle, health information management, case management, compliance, patient financial services, clinical departments (as needed), and legal representative. Additional members may be added or deleted based on the type of healthcare entity—hospital, physician, and other provider organization (refer to appendix B). The team will meet regularly to review the results of findings from the audit and to discuss any process improvement methods which resulted from the RAC audit. (This may be weekly, biweekly, monthly, or quarterly depending on the healthcare entity’s needs).

   Team member responsibilities:
   • Perform internal audits to determine any areas of potential vulnerability.
• Identify and correct any areas of payment errors.
• Identify appropriate resources for RAC process.
• Monitor facility RAC requests on an ongoing basis.
• Monitor the facility’s results from the RAC findings from both automated and complex reviews on an ongoing basis.
• Identify appropriate scripting for patient financial services staff to answer questions from patients.

2) The team will consistently use a RAC tracking system to monitor the results of the process.

3) The RAC coordinator and other key leaders will attend any RAC provider outreach educational programs held by the RAC and/or other service association or society.

4) The RAC coordinator will ensure the RAC and other service associations have appropriate current contact information for medical record requests and appeal process.

5) The RAC coordinator and team members will sign up for e-mail updates from CMS and the RAC to ensure awareness of areas that are under review so monitoring can occur within the healthcare entity.

6) The RAC coordinator will be responsible for data analysis of the healthcare entity’s own data to determine potential areas where the facility may be vulnerable to correct those issues and/or refile the claim appropriately.

7) Upon receipt of a request from the RAC for supporting documentation, the medical records must be submitted within 45 calendar days. Providers may ask for more time as long as an extension request is received by the RAC prior to the 45th day. (A “RAC Record Extension Request Sample Letter” can be found in appendix E.) All appropriate information will be entered into the RAC tracking system.

8) Prior to sending the records, the RAC coordinator will ensure a pre-audit is performed.

9) Upon receipt from the MAC, a Remittance Advice (RA) with the code N432: “Adjustment based on a Recovery Audit,” use the RAC tracking system to determine if this was an automated review or a complex review. The RAC coordinator will be notified and determine if the facility needs to submit medical records to clarify the claim or appeal the review within 15 days.

10) Use denials to identify problems in processes, get the information to key people to evaluate, and improve processes and compliance with medical necessity, documentation, charging, and coding.
Appendix E
RAC Medical Record Extension Request Sample

[Date]

[Contractor Name]
Attn: [Contractor Contact]
[Contractor Address]
[Contractor City, State, Zip]

Subject: Extension for submission of medical record

Healthcare Entity Name: [Facility/Practice/Center Name on record with CMS]
NPI#: [National Provider Identifier]
Patient Name: [Patient Name]
Account #: [Account Number]
Medical Record #: [Med Rec Number]
HIC #: [HIC Number]
Date of Service: [Admit Date] – [Discharge Date]

As a follow-up from our [phone call or e-mail] with [contact name] on [date], this letter serves to document that you have agreed to grant us an extension for the submission of medical records on the above referenced account through [date]. We expect to have the records delivered to you on or before this timeframe.

Thank you for granting the extension. Please contact me at [phone number] if you have any questions.

Sincerely,

[RAC coordinator name]
RAC Coordinator
[Healthcare Entity Name and Address]
Appendix F
Developing a RAC Education Program

Purpose: Identify the educational needs for healthcare providers when implementing internal processes and procedures for the RAC program.

A. Prepare for education.
   1. Identify who needs to be educated.
      - Use the hierarchy of authority worksheet to identify the key roles and departments having some level of responsibility for the RAC program.
      - This list can serve as the audience for education, and assist the healthcare entity identify the level of information each group will need and how to provide it.
   2. Identify level of education needed.
      - Senior management/stakeholders—this group will need to understand the high-level program requirements and the level of internal resources required to manage the program. Department heads will need to understand their level of involvement in the program and how it will relate to other departments.
      - Medical staff—the medical staff education should receive an overview of the RAC program and how it impacts the healthcare entity and where they may be impacted in terms of documentation practices. In addition, since individual providers will also be subject to RAC requests, education can help them understand how their own office staff will be impacted and what they will need to do in preparation.
      - Staff responsible for processing RAC audit requests—these staff will need the most detailed education in understanding the processes and procedures to follow to fulfill RAC requests, manage requests, and the appeals process.
   3. Create an educational schedule and determine method(s) of education.
      - Healthcare entity should determine whether existing meetings (medical staff, senior management) can be used to provide initial high-level education.
      - The education schedule should be developed according to timelines that will coordinate with implementation of the program and when the healthcare entity needs to start preparing. Senior management may need earlier education to understand the resource requirements needed and approve the selection of the key contacts and department roles.
      - Healthcare entity should create multiple methods of education including face-to-face presentations, newsletters, and fact sheets to tailor the information needs to the audience and reinforce important information over time. Short, focused presentations followed by fact sheets or frequently asked questions (FAQs) may be appropriate for certain audiences.
   4. Identify individuals responsible for planning and providing education.
      - Healthcare entity should determine whether it has an internal training staff that can help in the development of materials and coordinate the training program
whether it needs to identify an internal or external resource to serve in this capacity.

- Healthcare entity should provide trainer(s) with the necessary education, support materials, and external resources to learn the RAC program.
- Healthcare entity should provide any external background material and sample educational material to develop/tailor presentations to the entity.
- Healthcare entities can use examples of educational programs from other entities or sample templates to help develop its materials.

B. Identify key concepts and resources needed to support RAC education.

- Identify key concepts that are needed in your educational program including:
  i. What a RAC is and where it came from
  ii. How the RAC program works
  iii. The types of providers included in the current RAC program
  iv. The general RAC process (request for records, submission, tracking, appeals, etc.)
  v. How the RAC process will be managed in the facility, key staff, process flow, overall management responsibility, etc.
  vi. RAC acronyms (appendix H).
Medicare Recovery Audit Contractor (RAC) Program

Educational Presentation Material
Topics

• What is the RAC program
• Who is affected by RACs
• Timeline for Implementation
• How does the RAC program work
• Getting Ready for your RAC
What is the RAC Program

• Tax Relief and Healthcare Act of 2006 (section 302) requires a permanent and nationwide RAC program be implemented no later than January 1, 2010
• The RAC program is charged with identifying improper over and under payments for Medicare fee for service claims
• Ultimate goal is to implement actions that will prevent future improper payments
What is the RAC Program

• CMS has divided the country into four geographic locations and awarded contracts to different organizations for each of these locations

• These four contractors in turn have subcontractors for certain functions (this was the resolution of the protest filed after the initial contracts were awarded)
RAC Phase-In Schedule

March 1, 2009
March 1, 2009
August 1, 2009 or later

Reference: http://www.aha.org/aha/issues/RAC/contractors.html
RAC Subcontractor Information

Region A: DCS
Subcontractors: PRG Shultz, iHealth Technologies and Strategic Health Solutions

Region B: CGI
Subcontractor: PRG Schultz

Region C: Connolly Consulting
Subcontractor: Viant, Inc.

Region D: HDI
Subcontractor: PRG Schultz

What is the RAC Program

- RACs will use data mining techniques to identify claims for review
- RAC must get approval from CMS for the types of issues they want to target
- Their review must follow the same Medicare policies as carriers, fiscal intermediaries and MACs
- RACs are required to employ clinical and certified coding staff as well as a medical director
What is the RAC Program

- RACs are paid by contingency fee based on the amount of over and under payments they identify.
- Contingency fee must be returned if RAC loses at any level of an appeal.
- Each RAC’s contingency fee is established by their contact with CMS and will vary by RAC (currently 9.0% - 12.5%).
Who is affected

• Any provider who bills fee for service Medicare claims will be subject to RAC review
• Volume of claims reviewed will vary based on type of provider and the number of Medicare claims they submit
• Implementation of program will be staggered through end of 2009 by provider type
Timelines for Implementation – Initial Steps to be Completed

• CMS will schedule in-person education and outreach sessions for each region
• Audits and record reviews will not start in a state until educational sessions have been conducted
• RAC must complete the process for obtaining claims data and establishing agreements with claims processing contractors
• RAC requests CMS approval for types of reviews it wishes to conduct
• Activity will phase in over the spring and summer of 2009 – exact timeline will be based on region and type of claims review
How Does the RAC Program Work

• Two types of reviews are performed
  – Automated (does not require submission of medical records)
  – Complex (provider submits copies of medical records)
• RACs will be reviewing claims paid on or after October 1, 2007 (they can go back up to three years from when claim is paid)
• RACs have a limit on the numbers records they can request per NPI
Automated Reviews

• Performed using software tools to detect certain types of error conditions
• Potential errors identified must be clearly a non covered service or incorrect application of coding rules
• Must be supported by Medicare policy, approved article or coding guideline
Complex Reviews

• Determination is made based on review of the medical record
• Potential issues requiring complex review are those with high probability of non-covered service or there is no definitive Medicare policy, Medicare article or Medicare-sanctioned coding guideline
• RAC must use appropriate medical literature and clinical judgement when determining medical necessity
Complex Reviews

• Provider has 45 days to submit medical record to RAC from date of the request letter
• RAC must make one additional contact with provider if a record is not received in the time allotted before it denies the claim for failure to submit documentation
• Review must be completed within 60 calendars days from receipt of the record
Record Limits – All claim types

*Updated December 2, 2009*

- Information posted on RAC website:

- The RAC first must calculate the relevant provider’s documentation limit and, therefore, must ensure that the number does not exceed the applicable cap as follows:
  - 1% of all claims submitted by the provider in the previous calendar year/45 days (regardless of paid or denied claim status) with a cap of 200 for the first 6 months
  - Limits will be based on the servicing provider/supplier’s Tax Identification Number (TIN) and the first three positions of the ZIP code where they are physically located.
Record Limits – All claim types  
*Updated December 2, 2009*

- Applies across all of a provider’s claim types, including professional service claims
- RAC has discretion to the actual composition of the requests. Example: RAC may request up to the full limit of one particular type of claim (ie. inpatient) even though this type may only represent a fraction of the provider’s total claim volume.
- Caps will be based on submitted claim volume (greater than 100,000 annual claims may have cap of 300)
- Caps may be exceeded if RAC has been granted permission
RAC Determinations

• Coverage – if service is not covered the RAC can identify partial or full overpayment
• Coding – if service coded incorrectly the RAC can identify partial or full over or under payment
• Other – the RAC can identify partial or full over or under payment for other conditions such as failure to apply correct payment policy or duplicate claim submission
Reviewing RAC Determinations and the Appeal Process

- This process starts with a demand letter (automated review) or review results letter (complex review)
- ‘discussion period’ for denied claims allows provider to submit additional information or documentation if it disputes the finding
- Appeals timeline starts when letter received by provider
- Five levels of appeal starting with fiscal intermediary and ending with judicial review in US District Court
Getting Ready for Your RAC

This section should comprise the facility specific slides that describe what they have and/or are doing so far to prepare for the RAC
Describe Your Hospital RAC Process

• Identify key staff and their roles
• Describe your process flow
  – Receiving, processing and tracking requests
  – Managing appeals
• Describe process for corrective actions taken based on internal or RAC findings
Getting Ready for Your RAC

• Review demonstration RAC findings (www.cms.hhs.gov/rac) and permanent RAC findings (when available) to identify the types of improper payments found

• Look for patterns of review by OIG and CERT reports for ideas of other potential review areas
Getting Ready for Your RAC

• Perform internal reviews to determine compliance with Medicare requirements
• Use data mining techniques to identify if you have any patterns similar to issues identified by past RAC reviews
• Review RAC contractor URLs across all regions to help identify overlap of target areas and anticipate what might be coming.
Managing Record Requests

• Determine how to handle off site or electronic documents until review and/or appeal process is complete
• Use tracking system to manage request process and status of each record
Appendix H
RAC Acronyms

ALJ: Administrative Law Judge
CAFM: Contractor Accounting Financial Management System
CERT: Comprehensive Error Rate Testing
CMD: Contractor Medical Director
CMS: Centers for Medicare and Medicaid Services
DCS: Diversified Collection Services
DHHS: Department of Health and Human Services
DME: Durable Medical Equipment
DOJ: Department of Justice
DRG: Diagnosis Related Group
ERRP: Error Rate Reduction Plan
FFS: Fee for Service
HCPCS: Healthcare Common Procedure Coding System
HDI: Health Data Insights
HIC: Health Insurance Claim
IRF: Inpatient Rehabilitation Facility
LCD: Local Coverage Determination
MAC: Medicare Administrative Contractor
MMA: Medicare Prescription Drug, Improvement, and Modernization Act of 2003
MSP: Medicare Secondary Payer
MRN: Medicare Redetermination Notice
NCD: National Coverage Determination
NDNH: National Database of New Hires
NPI: National Provider Identifier
OIG: Office of Inspector General
OMB: Office of Management and Budget
PRG: PRG-Schultz
PSC: Program Safeguard Contractor
QIC: Qualified Independent Contractor
QIO: Quality Improvement Organization
RAC: Recovery Audit Contractor
RFP: Request for Proposals
ROI: Release of Information
RVC: RAC Validation Contractor
SNF: Skilled Nursing Facility
TRHCA: Tax Relief and Health Care Act of 2006
VDSA: Voluntary Data Sharing Agreement
ZPIC: Zone Program Integrity Contractor
Appendix I
RAC Determination Response

What Needs to Be Included In a Cover Letter?
1) Develop cover letters with the healthcare entity’s logo on the letterhead.
2) Gather address/contact information from each entity (RAC, FI, CMS, ALJ, etc.) depending on the level of appeal.
3) Save cover letters on a shared drive within the healthcare entity or within the RAC database (for example, “Appeal to FI cover letter”).
4) Include the following items on the cover letter:
a) Date
b) Address of governmental entity for the correct level of appeal
c) Facility name and national provider identifier number
d) Audit ID number
e) HIC number
f) Claim number
g) Medical Record number
h) Account number
i) Date of service
j) Patient name
k) Date of birth
l) One or two sentences on why the healthcare entity disagrees with denial
m) Contact information of person signing the letter

What Needs to Be Included In the Response?
1) Cover letter
2) Determination letter from the governmental entity (RAC, FI, CMS, etc.)
3) Detailed reasoning behind the appeal in a letter format
4) Copy of complete health record with highlighted pages to support appeal
5) Copies of supporting documentation (AHA Coding Clinic, Interqual, or Milliman criteria)
6) Letter of support from attending physicians or physician advisor
7) Previous rebuttal letters

Who Will Submit the Appeal Letter?
1) Health information director
2) Coding manager
3) Case management director
4) Hospital chief financial officer
5) Compliance officer
6) RAC coordinator or revenue integrity manager
7) Physician advisor or attending physician
8) Vice president of medical affairs
9) Physician practice administrator
10) Physician practice compliance officer
**Where Do I Save the Appeal Information?**

1) Scan cover letter into shared drive or RAC tracking system.
2) Scan appeal letter into shared drive or RAC tracking system.
Appendix J
Appeals Process Workflow

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Appendix K
Medicare Appeals Process

Background
Section 521 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) included provisions aimed at improving the Medicare fee-for-service appeals process. Part of these provisions mandate that all second-level appeals (for both Part A and Part B), also known as recombinations, be conducted by Qualified Independent Contractors (QICs).

The recombinations that are conducted by the QICs have replaced the Hearing Office Hearing process for Medicare Part B claims and established a new second level of appeal for Medicare Part A claims.

Medicare Contractors
The Centers for Medicare & Medicaid Services (CMS) contracts with private insurance companies, called carriers for Part B, fiscal intermediaries (FI) for Part A, or Medicare Administrative Contractors (MACs) to perform many processing functions on behalf of Medicare, including local claims processing and the first level appeals adjudication functions.

NOTE: Medicare Contracting Reform (MCR) (also referred to as MAC Rebalancing Reform) Medicare Contracting Reform is intended to improve Medicare’s administrative services to beneficiaries and providers by replacing all Medicare work performed by Fiscal Intermediaries and Carriers with the new Medicare Administrative Contractors (MACs). In this manner, Medicare Contracting Reform is intended to improve Medicare’s administrative services to beneficiaries and providers. All Medicare work performed by Fiscal Intermediaries and Carriers will be replaced by the new MACs.

Five Levels in the Appeals Process
Medicare offers five levels in the Part A and Part B appeals process. The levels, listed in order, are:
- Redetermination by an FL, carrier or MAC
- Reconsideration by a QIC
- Hearing by an Administrative Law Judge (ALJ)
- Review by the Medicare Appeals Council within the Departmental Appeals Board (Commonwealth’s Attorney’s Office)
- Judicial review in U.S. District Court

First Level of Appeal: Redetermination
A redetermination is an examination of a claim by the FL, carrier or MAC personnel who are different from the personnel who made the initial determination. The appellant (the individual filling the appeal) has 120 days from the date of receipt of the initial claim determination to file an appeal. A minimum monetary threshold is not required to request a redetermination.

Requesting a Redetermination
A request for a redetermination may be filed on Form CMS-20027 available at http://www.cms.hhs.gov/CMSForms/CMSFormsList.asp?ScTemplate. A written request form must be on Form CMS-20027 must include:
- Beneficiary name
- Medicare Health Insurance Claim (HIC) number
- Specific service and/or item(s) for which a redetermination is being requested
- Specific date(s) of service
- Name and signature of the person or the representative of the party

The request should attach any supporting documentation to their redetermination request. Contractors will generally issue a decision (either a letter or a revised remittance advice) within 60 days of receipt of the redetermination request. The redetermination request should be sent to the contractor that issued the initial determination.

NOTE: Contractors retain control over review points and decisions on claims through the appeals process. For information on how to contact review points and decisions, please see the following MCR NFRM article: 5B950. Located at http://www.cms.hhs.gov/5B950NFRMArticle/downloads/5B950NFRM531950.pdf on the CMS website.

Second Level of Appeal: Reconsideration
A party to the redetermination may request a reconsideration if dissatisfied with the redetermination. A QIC will conduct the reconsideration. The QIC reconsideration process allows for an independent review of medical necessity issues by a panel of physicians or other health care professionals. A minimum monetary threshold is not required to request a reconsideration.

Requesting a Reconsideration
A written reconsideration request must be filed within 180 days of receipt of the reconsideration. To request a reconsideration, follow the instructions on your Medicare Redetermination Notice (MRN). A request for a reconsideration may be made on Form CMS-20023. This form will be mailed with the MRN. If the form is not used, the written request must contain all of the following information:
- Beneficiary name
- Medicare Health Insurance Claim (HIC) number
- Specific service and/or item(s) for which the reconsideration is requested
- Specific date(s) of service
- Name and signature of the party or the authorized or appointed representative of the party
- Name of the contractor that made the reconsideration

The request should clearly explain why you disagree with the reconsideration. A copy of the MRN, and any other useful documentation should be sent with the reconsideration request to the QIC identified in the MRN. Documentation that is submitted after the reconsideration request has been filed may result in an extension of the timeframe a QIC has to complete its decision. Further, any evidence noted in the reconsideration as missing and any other evidence relevant to the appeal must be submitted prior to the issuance of the reconsideration decision. Evidence not submitted at the reconsideration level may be excluded from consideration at subsequent levels of appeal unless you show good cause for submitting the evidence late.

Reconsideration Decision Notification
Reconsiderations are conducted on a timely basis. If the QIC will send its decision to all parties within 60 days of receipt of the request for reconsideration. The decision will contain detailed information on further appeal rights if the decision is not fully favorable. If the QIC cannot complete its decision in the applicable timeframe, it will inform the appellant of their right to escalate the case to an ALJ.

Third Level of Appeal: Administrative Law Judge Hearing
If the QIC does not issue a decision to all parties within 60 days of receipt of the reconsideration, a party to the reconsideration may request an ALJ hearing within 60 days of receipt of the reconsideration. (Refer to the reconsideration decision letter for details regarding the procedures for requesting an ALJ hearing.) Appellants 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-conference (VTC) or by telephone. If you do not want a VTC or telephone hearing, you may ask for an in-person hearing. An appellant must demonstrate good cause for requesting an in-person hearing. The ALJ will determine whether an in-person hearing is warranted on a case-by-case basis. An appellant may also ask the ALJ to make a decision without a hearing (on-the-record). 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, the submission of additional evidence not included with the hearing request, the request for an in-person hearing, the appellant'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, you may ask the ALJ to escalate the case to the Appeals Council level.

*NOTE: The amount in controversy required to request an ALJ hearing is increased annually by the percentage increase in the medical care component of the consumer price index for all urban consumers. The amount in controversy threshold for 2008 is $120.*

### Fourth Level of Appeal: Appeals Council Review

If a party to the ALJ hearing is dissatisfied with the ALJ's decision, the party may request a review by the Appeals Council. There are no requirements regarding the amount of money in controversy. The request for Appeals Council review must be submitted in writing within 60 days of receipt of the ALJ's decision, and must specify the issues and findings that are being contested. (Refer to the ALJ decision for details regarding the procedures to follow when filing a request for Appeals Council review.)

In general, the Appeals Council will issue a decision within 90 days of receipt of a request for review. That timeframe may be extended for various reasons, including but not limited to, the case being escalated from an ALJ hearing. If the Appeals Council does not issue a decision within the applicable timeframe, you may ask the Appeals Council to escalate the case to the Judicial Review level.

### Fifth Level of Appeal: Judicial Review in U.S. District Court

If at least $1,180 or more is still in controversy following the Appeals Council's decision, a party to the decision may request judicial review before a U.S. District Court judge. The appellant must file the request for review within 60 days of receipt of the Appeals Council's decision. The Appeals Council's decision will contain information about the procedures for requesting judicial review.

*NOTE: The amount in controversy required to request judicial review is increased annually by the percentage increase in the medical care component of the consumer price index for all urban consumers. The amount in controversy threshold for 2008 is $1,180.*

### For More Information

For more information about the Medicare appeals process, please visit the Medicare Fee-For-Service Appeals website located at http://www.cms.hhs.gov/OrgModFFSAppeals/ on the CMS website.

### Medicare Learning Network

The Medicare Learning Network (MLN) is the brand name for official CMS educational products and information for Medicare fee-for-service providers. For additional information visit the Medicare Learning Network’s website at http://www.cms.hhs.gov/MLNInfo/ on the CMS website.

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Appendix L
Sample Appeal Letters

Date: ______________

CMS
Appeals Department
Address
City, State, Zip

To Whom It May Concern:

Re: Request for Determination Contractor denial

We wish to exercise our right to appeal the recent overpayment determination made by [RAC name] for the following account:

Facility Name and NPI #: #111111 Hospital A
Audit ID #: ____________

Patient: (HIC#): ____________________ DOB: __________________________
Name: ______________________________________________________________
Medical Record #: ______________________ Claim #: _______________________
DOS: ___________ Service Through Date: _________________________

We do not believe an overpayment was made based on the following:
_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________

Enclosed for your review is a copy of additional supporting documentation. If you have any questions please me directly at [phone number], or by fax at [fax number].

Sincerely,

Director Health Information Services
FI Sample Appeal Letter

[Date]

[Fiscal Intermediary Contact Name]
[FI Company Name]
[FI Address]
[FI City, State, Zip]

To Whom It May Concern:

Re: Request for Redetermination of [RAC name] denial

We wish to exercise our right to appeal the recent overpayment determination made by [RAC name] for the following account:

Facility Name and NPI #: [#111111 Hospital A]

Audit ID #: ___________________

Patient: (HIC#) ___________ DOB: __________________

Name: ______________________________________________

Medical Record #: ___________ Claim #: ______________________

DOS: ___________ Service Through Date: ________________

We do not believe an overpayment was made based on the following:
_____________________________________________________________________

Please see attached appeal letter and supporting [Interqual] documentation:
_____________________________________________________________________

Enclosed for your review is a copy of additional supporting documentation. If you have any questions please me directly at [phone number], or by fax at [fax number].

Sincerely,

Case Management Director
FI Sample Appeal Letter (Coding)

[Date]

[Fiscal Intermediary Contact Name]
[FI Company Name]
[FI Address]
[FI City, State, Zip]

Medicare Beneficiary: [Doe, Mary]
Medicare Number: [333333333A]
Dates of Service: [date-to-date]

Dear Sir or Madam:

In accordance with the appeal provisions outlined within the CMS Recovery Audit Contractor (RAC) Program, this correspondence is intended to serve as formal notification of [Hospital A’s (Provider No. 111111)] intention to dispute the RAC’s recent audit finding and to appeal the resulting overpayment determination for the above referenced patient. You should know that the [RAC name] determined that this patient encounter should have been classified into DRG XXX.

We have since reviewed the corresponding medical record (a copy of which is included with this submission, along with a completed Medicare Part A Redetermination Form), and have determined the appropriate AHA Coding Guidelines were followed. More specifically, the clinical documentation supports the code and DRG assignment.

Attached hereto are copies of the applicable pages from the [insert supporting resources, and any applicable discharge reference].

This patient was admitted with cough and shortness of breath. Her workup in the ER revealed an X-ray that showed bilateral diffuse interstitial prominence suggestive of interstitial disease. EKG showed sinus rhythm without ischemic changes. In the ER the patient was placed on oxygen. Patient had no chest pain. Auscultation revealed faint expiratory wheezes in both lung fields. Her assessment listed acute exacerbation of bronchitis with hypoxemia as number one and mild CHF, rule out MI as number 2 diagnosis. Under the plan she was admitted to the telemetry unit for monitoring as well as given Rocephin and Azithromycin, continued oxygen supplement, initiated bronchodilator therapy, and complete myocardial workup.

A follow-up chest X-ray obtained during the hospital stay revealed pneumonia, which was also treated. On the discharge summary, the physician lists:
   1) Community Acquired Pneumonia
   2) Acute Bronchitis
   3) Acute Myocardial Ischemia
You stated in your decision letter dated 01/31/08: “In this case the myocardial infarction should be the principal since this condition required more extensive invasive treatment than acute bronchitis. ICD 410.71 was sequenced as principal diagnosis consistent with documentation provided.”

As far as deciding which diagnosis required more extensive therapeutic invasive treatment, I have not been able to locate official coding advice or guidelines that state when deciding upon the principal diagnoses choose the most extensive therapeutic invasive treatment?

We are asking that you please review the enclosed record and reassess the appropriateness of the DRG/code assignments. If you conclude, as we have, that the claim was originally billed and coded correctly, we would ask that you please reprocess the claim and re-remit the original DRG based payment.

Thank you for your time and assistance in this regard, and please contact me at [phone number] or via e-mail [e-mail address], should you have any questions or need any additional information.

Sincerely,

Director Health Information Management
FI Sample Appeal Letter (Medical Necessity)

[Date]

[Fiscal Intermediary Contact Name]
[FI Company Name]
[FI Address]
[FI City, State, Zip]

Medicare Beneficiary:  [Doe, John]
Medicare Number:  [999999999A]
Dates of Service:  [date-to-date]

Dear Sir or Madam:

In accordance with the appeal provisions within the CMS Recovery Audit Contractor (RAC) Program, this correspondence is intended to serve as formal notification of [Hospital A’s (Provider No. 112233)] intention to dispute the RAC’s recent audit finding and to appeal the resulting overpayment determination for the above referenced patient. You should know that the [RAC name] determined that this patient encounter should have been classified and billed as an outpatient surgery, because there was no medical necessity for an inpatient admission.

We have since reviewed the corresponding medical record (a copy of which is included with this submission, along with a completed Medicare Part A Redetermination Form), and have determined that the relevant [surgery/trauma] [InterQual] criteria were met for an acute inpatient admission. More specifically, the clinical documentation supports a clinical finding of [post ambulatory surgery > 24hr observation care for which routine review < 2 days was performed].

Attached hereto are copies of the applicable pages from the [InterQual] manual (with the relevant criteria circled).

We are asking that you please review the enclosed record and reassess the appropriateness of an inpatient admission and corresponding inpatient claim submission. While we understand that various facts and circumstances must be considered in determining the necessity for an inpatient level of care (such as the admitting physician’s clinical judgment and the complexity of the patient’s condition and health history), in this case, the requisite [InterQual] level of care criteria were met for [an acute care inpatient admission] (as stated above). If you conclude, as we have, that the claim was originally billed correctly [on an inpatient basis], we would ask that you please reprocess the claim and re-remit the original DRG based payment.

Thank you for your time and assistance in this regard, and please contact me at [phone number] or via e-mail [e-mail address], should you have any questions or need any additional information.

Sincerely,

Director Case Management
DRG Sample Appeal Letter

[Date]
Via [Mode of Delivery: Certified Mail/Federal Express/etc.]

[Contractor Name]
Attn: [Contractor Contact]
[Contractor Address]
[Contractor City, State, Zip]

Subject: Request for Reconsideration/Redetermination

Facility Name: [Facility Name on record with CMS]
Provider ID: [National Provider Identifier (NPI)]
Patient Name: [Patient Name]
Audit #: [Audit/Reference Number]
Account #: [Account Number]
Medical Record #: [Med. Rec. Number]
HIC #: [HIC Number]
Date of Service: [Admit Date] – [Discharge Date]

By way of this letter, we timely dispute the denial of payment for this claim and request a reversal of this decision. The initial determination on this claim was made on [date]. [RAC name] reopened the claim and denied it on [date]. [Attach supporting documentation for the dates.]

The [RAC name] provided the following explanation for the denial: [short summary of RAC’s reason for denial].

We are appealing this denial and provide the following justification for its reversal.

This following clinical documentation supports the code assignment and reporting of [XX] which in turn supports the assignment of DRG [DRG number and description]:

   Physician documentation found in the [progress note, consultation, etc.] from [date here] states [supporting medical record references and clinical statements from the provider justifying code assignment]

Official Coding Guidelines state [list AHA official coding guidelines supporting the justification. If applicable, refer to the RAC DRG denial resource document on Atlas for specific diagnosis/DRG justification].
[Enclosed/attach supporting documentation (e.g., copy of progress note, physician reviewed comments) if applicable.]
Based on the preceding information, we respectfully request a written response that results in a favorable decision for the [healthcare entity]. Please contact me at [phone number] or via e-mail [e-mail address] if you have any questions or need further clarification.

Sincerely,

[Reviewer’s name]
[Reviewer’s title]
Enclosures
Appendix M
RAC Appeals Submission Checklist

Level I Appeal: Redetermination
- Medical record
- Additional evidence documentation
- Appeal letter
- CMS form 20027 (optional if all required items are included in the appeal letter)

Level II Appeal: Reconsideration
- Additional evidence documentation—this is the last time to submit without having to show “good cause.”
- Appeal letter—be sure address any new items that may have surfaced from the redetermination contractor’s denial notice.
- CMS form 2033 (optional if all required items are included in the appeal letter)

Level III: Administrative Law Judge (ALJ)
- Appeal letter or legal brief
  - Thorough record of circumstances surrounding the review and previous appeals (chronological record of events leading up to the request for ALJ hearing)
  - Include all clinical justification including specific references to the medical record documentation or additional evidence submitted
  - References to CMS regulations, LCDs, NCDs, screening criteria, etc.
  - Any additional supportive legal arguments related to the case
- CMS form 2034a-b (optional if all required items are included in the appeal letter/brief)
- Additional forms may be requested to be completed by Office of Medical Hearings and Appeals (OMHA) (www.hhs.gov/omha/forms/index.html)