Recovery Audit Contractor (RAC)

Reference Guide

Commonly used Acronyms

ALJ: Administrative Law Judge
CAFM: Contractor Accounting Financial Management System
CERT: Comprehensive Error Rate Testing
CMD: Contract Medical Director
CMS: Centers for Medicare and Medicaid Services Connolly: Connolly Consulting
CPT: Current Procedural Terminology
DCS: Diversified Collections 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
LCD: Local Coverage Determination
MAC: Medicare Administrative Contractor
MMA: Medicare Prescription Drug, Improvement, and Modernization Act of 2003
MSP: Medicare Secondary Provider
MRN: Medicare Re-determination Notice
NCD: National Coverage Determination
NDNH: National Database of New Hires
NPI: National Provider Identifier
OIG: Office of Inspector General
OMG: 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

Recovery Audit Contractors

All States have been, or will later be added to one of the four (4) RAC Regions

- **Region A**: Diversified Collection Services (DCS) -1-866-201-0580, www.dcsrac.com
  (Maine, New Hampshire, Vermont, Massachusetts, Rhode Island and New York)

- **Region B**: CGI -1-877-316-7222, e-mail: racb@cgi.com, http://racb.cgi.com
  (Michigan, Indiana and Minnesota)

- **Region C**: Connolly Consulting, Inc. -1-866-360-2507, www.connollyhealthcare.com/RAC, RACinfo@connollyhealthcare.com
  (Connecticut, in Region C, initially working in South Carolina, Florida, Colorado and New Mexico)

- **Region D**: HealthDataInsights, Inc.-Part A: 866-590-5598, Part B: 866-376-2319, e-mail: racinfo@emailhdi.com
  (Montana, Wyoming, North Dakota, South Dakota, Utah and Arizona)

Introduction

Q: What does RAC stand for?
A: Recovery Audit Contractors

Q: When was the RAC program established?
A: The Tax Relief and Healthcare Act of 2006 required a permanent and nationwide RAC program be implemented no later than January 1, 2010

Q: What is the purpose of the RAC program?
A: The RAC program has been established to identifying improper over and under payments for Medicare fee-for-service claims, with the overall purpose of implementing actions that will prevent future improper payments

Q: Who will be affected by the RAC program?
A: 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.

Q: Who will be conducting the RAC Audits?
A: The country has been divided into four Regions, with CMS awarding contracts to Recovery Audit Contractors in each region.

Q: How will these Recovery Audit Contractors audit our claims?
A: The Recovery Audit Contractors will use data-mining or analysis of data techniques to locate claims for review. Recovery Audit Contractors are required to first obtain approval from CMS for the types of issues they intend to target. Their audits and reviews are bound by the same Medicare policies as the provider, carriers, fiscal intermediaries, and Medicare Administrative Contractors.

Q: How will the Recovery Audit Contractors be paid?
A: The Recovery Audit Contractors will be paid contingency fees connected to the over and underpayments they identify. These fees must be returned if the Recovery Audit Contractor loses an appeal

Q: How much are these contingency fees?
A: Recovery Audit Contractors have individually established their fee within their contract with CMS. Currently these fees are anywhere from 9%-12.5%.

Audits for medical records have been in existence for some time, however, the overall size and scope of the RAC Program is much larger. Healthcare entities that bill Medicare fee-for-service claims must recognize the need to implement policies and procedures to correctly manage incoming requests, as well as the appeal and denial process.

The following reference guide can assist Healthcare practices on preparing for an audit, ensuring compliance within the RAC program, and implementing policies and procedures to ensure ongoing compliance.

AUDITS

Who?

Recovery Audit Contractors are instructed to investigate claims submitted by:

- Physicians
- Providers
- Facilities
- Suppliers

Anyone who provides Medicare beneficiaries 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.

Basis for an Audit

Recovery Audit Contractors receive files from CMS which contain data from the National Claims History (NCH) that have been processed in their assigned geographic region. After these initial files are sent, Recovery Audit Contractors will receive monthly updates, as well as information they can use to analyze claims concurrently as well as retroactively. Recovery Audit Contractors have a custom computer program with unique processes allowing them to utilize information and criteria on Medicare Regulations and Rules. This custom program will allow Contractors to review clinical standards of medical practice, coding, and billing policies, to identify where to begin their reviews.

Recovery Audit Contractors may reference specific services included the current work plan of the Office of the Inspector General's (OIG), as well as Government Accountability Office (GAO) and Comprehensive Error Rate Testing (CERT) findings. After all this information has been analyzed, Recovery Audit Contractors will identify situations and areas they believe to have claims with a high probability to be overpaid and underpaid in their assigned geographic region.

Recovery Audit Contractors are required to report potential fraud to CMS. Recovery Audit Contractors must employ professional clinicians, physicians, medical directors, nurses, therapists, and certified coders for their specific assessments.

Two types of Audits

Automated Reviews- Recovery Audit Contractors make a claim without a human review. This claim is performed at the system level using data mining. All errors found by Automated Reviews are required to be non-covered services, or faulty/incorrect application of coding rules, and must be supported by:

- Medicare Policy
- Approved Article
- Coding Guidance

Complex Reviews- Recovery Audit Contractors make a claim using a human review of the Medical Record. Complex reviews involve Records with a high probability of non-covered services or when the following do not exist:

- Medicare Policy
- Medicare Article
- Medicare-Sanctioned Coding Guideline

Recovery Audit Contractors are authorized to review all aspects of the supporting medical records including:

- Evaluation
- Management
- Services related to reimbursement in connection to the global security package
- Duplicate Claims

Currently, Recovery Audit Contractors are not authorized to question the level of some E/M codes. However, CMS and the American Medical Association (AMA) are in discussions about expanding the evaluation of E/M codes. In the event of expanded reviews, an official letter of notification will be dispersed, prior to Recovery Audit Contractors performing them.

PREPARATION

In preparation for an audit, healthcare providers should:

- Understand the importance of cooperation with audit activity.
- Establish a RAC team. This team should consist of the office manager, a coder, physician representative and additional staff that may have involvement.
- Ensure the practice has a written plan
- Ensure patient records are properly documented.
- Perform self-checks to ensure proper order.

- Understand the importance of not leaving an auditor alone, and understand your right to have an attorney present.

Records Requests

After a Recovery Audit Contractor has requested documentation, the provider has 45 calendar days to submit the information. Providers may request an extension; however the request must be received within 45 days. Providers should use the included "RAC Record Extension Request Letter."

Tracking Requests

Providers must implement a tracking system to properly manage the RAC process. Elements of the tracking system will include: length of time, request of final deposition, appeal, deadlines, and turnaround times. Providers may find established tracking systems from vendors to be of great help, however, providers can create their own tracking system.

Education/Training

RAC teams should identify those who should be trained on the RAC process.

Responsibilities of a RAC Coordinator

Duties/roles and responsibilities of the RAC coordinator:

- Oversee all RAC functions
- Coordinate training of staff
- Use tracking system to track all RAC activities
- Communicate between RAC coordinator and Administration, HIM/Coding, Business office, and case management
- Coordinate all RAC requests and appeals
- When applicable, invoice submitted records requests
- Manage timelines for requests and RAC responses
- Manage all external entities involved in the RAC process
- Perform analysis on audit and RAC findings
- Follow all RAC activity until complete, and complete all required reports

Policies and Procedures

Compliance with Recovery Audit Contractors

(Facility Name)
(City, State, Zip)
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.

Policy:
Our facility is compliant and has proper procedures in place to ensure compliance with Recovery Audit Contractor (RAC) appointed section 302 of the Tax Relief and Health Care Act of 2006. This includes prompt response to requests for medical records by the facility, evaluation of denials, and timely filing of appeals.

Procedure:
Our facility has formed a **RAC team**. Our team consists of: A RAC Coordinator, Senior Leadership, Health Information Management, Case Management, Legal Representative, and additional members deemed necessary.

The RAC team meets regularly to review the results of findings from the audit.

RAC TEAM RESPONSIBILITIES

- ☐ Identify payment errors
- ☐ Correct payment errors
- ☐ Locate helpful resources
- ☐ Monitor facility RAC requests
- ☐ Monitor the facility's results from the RAC findings from both automated and complex reviews
- ☐ Formulate appropriate responses to patient questions

RAC TEAM GOALS

1. Our team will consistently use a RAC tracking system to monitor the results of the process.

2. Our RAC coordinator and other key leaders will attend any RAC provider outreach educational programs held by the RAC and/or hospital associations.

3. Our RAC coordinator will ensure the RAC has appropriate current contact information for medical record requests and appeal process.

4. Our 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. (www.cms.hhs.gov/rac) or contractors Internet page. (They should notify you.)

5. Our RAC coordinator will be responsible for data analysis of our own data to determine potential areas where our practice may be vulnerable to correct those issues and/or re-file the claim appropriately.

6. Upon receipt of a request from the RAC for supporting documentation, the medical records must be submitted within 45 calendar days. We may ask for more time as long as an extension request is received by the RAC prior to the 45th day on our "RAC Record Extension Request Letter". All appropriate information will be entered into the RAC tracking system. We have determined the following:

   - RAC Information: RAC Contact____

     RAC Address____

     RAC Phone Number____

   - 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.

     Name and address of RAC:____

     ____

   - How to send for signature of receipt from the RAC (date and time)____

   - Response time limits (RAC has 60 days)___________________________________

   - Staff follow-up with the RAC to confirm payment of _____ cents per page for the records sent to them. (RACs may, but are not required to, pay for Part B Medical records.) (Suggested payment is 12 cents per page.)

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

8. Upon receipt of a Remittance Advice (RA) with the code N432: "Adjustment based on a Recovery Audit," we will use the RAC tracking system to determine if this was an automated review or a complex review. Our RAC coordinator will be notified and determine if we need to submit medical records to clarify the claim or appeal the review within 15 days.

   - We have determined that the following person will file and sign our

     appeals:____

9. We will 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.

STEPS FOR RAC PREPARATION

1. Designate Contact Persons for Record Requests
RACs are required to allow providers to customize their address for corresponding with the RACs. Providers should ensure that their RAC has accurate contact information on file, and that an individual is designated to receive, and trained to identify, mail from the RACs. Providers have 45 days to respond to the initial RAC letter. The time begins to run on the date that the RAC mails the letter. If the provider does not supply the RAC with the requested medical records within the 45 day timeframe, the RAC is permitted to find that the claims requested are all "overpayments" and initiate recoupment proceedings. Therefore, it is crucial that the correspondence from the RAC is sent to the correct address and that providers have trained individuals receiving the mail so that they immediately identify audit requests from the RACs. Providers may also consider establishing a separate mailing address for RAC audits, and assigning a specific individual to monitor the mail at that address, in order to ensure that the provider receives and responds to the requests in a timely fashion.

2. Designate a RAC Coordinator
Managing the RAC audit process will be labor intensive. One person at the provider's organization should be well-trained and prepared for "quarterbacking" responses to RAC record requests and managing the appeals process.

3. Create a System to Track all RAC Requests, Responses and Deadlines
Providers must either purchase or create a system to track many RAC-related data elements regarding records requests, responses, and appeals. Missing deadlines in the

RAC process means losing reimbursement. The system can also track the reimbursement that is at risk so that the provider is able to continuously monitor its financial exposure in a pending RAC audit(s).

4. Scan all Documents Provided to the RAC; Send Everything Certified With a Return Receipt

Providers should scan all documentation furnished to the RAC. Not only will scanning provide a record of what was provided in case it is lost, or in case of a later disagreement about what was sent to the RAC, but it will also help providers manage documentation during assessment and appeals. Providers will need to send the same information repeatedly to various internal personnel, outside attorneys and consultants, and appeal bodies. If the information is originally scanned onto a CD, providers can more easily reproduce the information for the many people who will need access.

5. Prepare PR Information for Patients

When a claim has been targeted for recoupment, even if the provider plans to appeal the recoupment, providers should consider notifying the patient whose claim is in issue to notify the patient that their claim is under review, to explain the process, and to explain that the claim may have to be repaid. Informing the patient in advance of the possible impact the review could have on the patient (e.g., refunds of deductibles), may be an important PR tool.

6. Pre-RAC Internal Auditing

Providers should conduct internal auditing on the main types of claims and issues that the RACs identified in the RAC demonstration program, and which providers expect will be the main targets during the permanent RAC program. Providers can extrapolate the results from the data mined during their pre-RAC internal audit in order to determine what to expect for financial exposure once the RAC audits begin. The internal auditing can also prepare providers for appeals as providers can determine proactively the criteria that they will look for in determining which claims to appeal. Additionally, internal auditing will help providers identify areas for improvement.

7. Implement Compliance Efforts Now

The RAC will identify improper payments resulting from non-covered services (including services that are not medically necessary; incorrectly coded services; and duplicate services. The RACs are required to conduct “targeted reviews” of claims that are likely to contain overpayments, as opposed to conducting a random review of claims. Providers can and should take steps immediately to reduce their risk of recoupment by identifying high risk and high volume services for proactive correction.

Providers should focus compliance education and training on documentation and coding issues that caused claims to be targeted during the RAC demonstration project. Providers should conduct internal reviews to ensure that they are in compliance with the Medicare standards, guidelines and criteria for these claims that are the likely target of the RAC audits. While the RACs are permitted to look back to paid records from October 1, 2007, it is possible that the RACs will request records from a more recent time period.

If a provider has taken steps to correct any problems during more recent time periods, the provider will have minimized its risk of recoupment.

8. Manage Time Frames to Ensure Critical Deadlines Are Not Missed
The RACs are not permitted to recoup funds for identified claims during the first two stages of appeal if the provider appeals within the correct timeframes. The appeals time frames will be difficult to manage unless providers carefully track deadlines. We recommend that providers put in place their appeal-tracking processes now, so that they are prepared to immediately track their deadlines as soon as they receive the initial audit letter from the RAC.

9. Become Familiar with the Appeals Process; Establish an Appeals Matrix
RAC appeals are quite complex. There are five levels of appeal. Many providers in the demonstration program had great success on appeal. Appeals can take 2 to 3 years, with different deadlines and processes for each of the five levels of appeals. Without proper appeals oversight mechanisms, providers could lose the opportunity to reverse improper RAC recoupment actions.

10. Identify Physicians to Assist
In certain appeals, such as appeals based on medical necessity, physician involvement will be key in helping the organization determine which claims to appeal, and in assisting with the appeals process. It is critical that health care providers identify physicians that will help review records, assess medical necessity of services rendered, and help develop arguments for appeal.

RAC Determination Response Checklist

What Needs to Be Included In a Cover Letter?

1) Cover letters should have your logo on the letterhead.
2) Gather address/contact information from each entity (RAC, Carrier, CMS, ALJ, etc.) depending on the level of appeal.
3) Save cover letters on a shared drive within your practice or within the RAC database (for example, "Appeal to Carrier cover letter").
4) Include the following items on the cover letter:
    - ☐ Date
    - ☐ Address of governmental entity for the correct level of appeal
    - ☐ Facility name and national provider identifier
    - ☐ Audit ID number
    - ☐ HIC number
    - ☐ Claim number
    - ☐ Medical Record number
    - ☐ Account
    - ☐ Date of service
    - ☐ Patient name

- ☐ Date of birth
- ☐ One or two sentences on why you disagree with denial
- ☐ 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, Carrier, 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, etc.)
6) Letter of support from attending physicians or physician advisor
7) Previous rebuttal letters

Who Will Submit the Appeal Letter?

Health information director, Coding manager, Case management director, Chief financial officer, Compliance officer, RAC coordinator or revenue integrity manager, Physician advisor or attending physician, Physician practice administrator, or Physician practice compliance officer

Where Do I Save the Appeal Information?

To save the appeal information, first, scan cover letter into shared drive or RAC tracking system, and then scan the appeal letter into shared drive or RAC tracking system.

RAC Appeals Submission Checklist

Level I Appeal: Re-determination

- Medical record
- Additional evidence documentation
- Appeal letter
- CMS form 20027 (optional if all required items are included in the appeal letter) http://www.cms.hhs.gov/cmsforms/downloads/CMS20027.pdf

Level II Appeal: Reconsideration

- Additional evidence documentation—this is the last time to submit without having to show "good cause."
- Appeal letter—be sure to address any new items that may have surfaced from the re-determination contractor's denial notice.
- CMS form 20033 (optional if all required items are included in the appeal letter) http://www.cms.hhs.gov/cmsforms/downloads/cms20033.pdf

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 20034a-b (optional if all required items are included in the appeal letter/brief) http://www.cms.hhs.gov/cmsforms/downloads/cms20034ab.pdf
- Additional forms may be requested to be completed by Office of Medical Hearings and Appeals (OMHA) www.hhs.gov/omha/forms/index

Medicare Appeals Process

Appealing Medicare Decisions

- Once an initial claim determination is made, providers, participating physicians and other suppliers have the right to appeal.
- Physicians and other suppliers who do not take assignment on claims have limited appeal rights.
- Beneficiaries may transfer their appeal rights to non-participating physicians, or other suppliers who provide the items or services and do not otherwise have appeal rights. Form CMS-20031 must be completed and signed by the beneficiary and the nonparticipating physician or supplier to transfer the beneficiary's appeal rights.
- All appeal requests must be made in writing.

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 FI, 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 (the Appeals Council)
- Judicial Review in U.S. District Court.

First Level of Appeal: Redetermination

A redetermination is an examination of a claim by the FI, carrier, or MAC personnel who are different from the personnel who made the initial determination. The appellant (the individual filing 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. A written request not made on Form CMS-20027 must include:

- Beneficiary name
- Medicare Health Insurance Claim (HIC) number
- Specific service and/or items for which a redetermination is being requested
- Specific dates of service
- Name and signature of the party or the representative of the party

The appellant 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.

Second Level of Appeal: Reconsideration

A party to the redetermination may request a reconsideration if dissatisfied with the determination. A QIC (Qualified Independent Contractor) 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 reconsideration.

Requesting a Reconsideration

A written reconsideration request must be filed within 180 days of receipt of the request. To request reconsideration, follow the instructions on your Medicare Redetermination Notice (MRN). A request for reconsideration may be made on Form CMS-20033.
This form will be mailed with the MRN. If the form is not used, the written request must contain the following information:

- Beneficiary name
- Medicare Health Insurance Claim (HIC) number
- Specific service and/or items(s) for which a redetermination is being requested
- Specific date(s) of service
- Name and signature of the party or the representative of the party

The request should clearly explain why you disagree with the redetermination. 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 submitted after the reconsideration request has been filed may result in an extension of the time frame a QIC has to complete its decision. Further, any evidence noted in the redetermination 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

Reconsideration decisions are conducted on-the-record and, in most cases, 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 time frame, it will inform the appellant of their right to escalate the case to an Administrative Law Judge (ALJ).

Third Level of Appeal: Administrative Law Judge Hearing

If at least $120* remains in controversy following the Qualified Independent Contractor's (QIC) decision, a party to the reconsideration may request an Administrative Law Judge (ALJ) hearing. Requests must be made within 60 days of receipt of the reconsideration. (Refer to the reconsideration letter for details regarding the procedures for requesting an ALJ hearing.) Appellants must also send notice of the ALJ hearing request to the QIC and verify this on the request form or in the written request.

ALJ hearings are generally held by videoconference (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.) Appellants 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 if the case has been escalated from the reconsideration level, with the submission of additional evidence not included with the hearing request. Extensions may be required with the request for an in-person hearing, with the appellant's failure to send notice of the hearing request to other parties, and with the initiation of discovery of CMS as 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.*

Fourth Level of Appeal: Appeals Council Review

If a party to the APJ hearing is dissatisfied with the ALJ's decision, the party may request a review by the Appeals Council. There are no monetary level requirements. The request for appeals council review must be submitted in writing within 60 days of receipt of the ALJ's decision. The request 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 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 a Judicial Review is increased annually by the percentage increase in the medical care component of the consumer price index for all urban consumers.

RAC Medical Record Extension Request

Date ____

RAC Contractor Name

____

Attn: (RAC Contractor Contact)

____

RAC Contractor Address (Contractor City, State, Zip) ________________

____

Subject: **Extension for Submission of Medical Record**

Facility/Practice/Center Name on record with CMS

____

NPI#: (National Provider Identifier)

____

Patient Name:

____

Account #: ____

Medical Record #

____

HIC #____

Date of Service:

____

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

Centers for Medicare and Medicaid Appeal

Date: ______________

CMS Appeals Department
Address
City, State, Zip

To: Whom It May Concern:
Re: Request for Re-determination

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

Facility Name and NPI #:____

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,
RAC Coordinator

Overpayment Determination Appeal

[Date]____

[Carrier Contact Name]
____

[Carrier Company Name]
____

[Carrier Address] [Carrier City, State, Zip]
____

To Whom It May Concern:

Re: Request for Re-determination 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 #:
____
Audit ID #:
____
Patient: (HIC#)
____
DOB:
____
Name:
____
Medical Record #:
____
Claim #: ______________________ DOS: __________________________

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

____

Please see attached appeal letter and supporting 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,
RAC Coordinator

Coding Appeal

[Date]____

[Carrier Contact Name]
____

[Carrier Name]
____

[Carrier state, Zip]
____

Medicare Beneficiary Name:
____

Medicare Number:
____

Dates of Service:
____

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 [Practice Name's (Provider No. XXXXXX) 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 coded differently. We have since reviewed the corresponding medical record (a copy of which is included with this submission), and have determined the appropriate AHA Coding Guidelines were followed.

Attached are copies of the applicable pages from the medical record.

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,

RAC Coordinator

Medical Necessity Appeal

[Date]____

[Carrier Contact Name]
____

[Carrier Company Name]
____

[Carrier Address]
____

[Carrier City, State, Zip]
____

Medicare Beneficiary Name:
____

Medicare Number:
____

Dates of Service:
____

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 [Practice Name and Provider No. XXXXXX)] intention to dispute the RAC's recent audit finding and to appeal the resulting overpayment determination for the above referenced patient.

You should know the [RAC name] determined that there was no medical necessity for this patient encounter and treatment. We have since reviewed the corresponding medical record (a copy of which is included with this submission) and have determined that the relevant criteria were met.

We request that you please reprocess the claim and re-remit the correct 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,
RAC Coordinator