American Hospital Association **Member Advisory** AHA Audit Education Series

June 14, 2012

THE MEDICARE APPEALS PROCESS

AT A GLANCE

The Issue:

Hospitals are experiencing a significant increase in audit activity by contractors for the Centers for Medicare & Medicaid Services (CMS). These audits have resulted in an increase in Medicare claims denials for hospitals.

Although the AHA is urging Congress and CMS to address hospitals' concerns with the growing number of Medicare and Medicaid payment audits, it is important that hospitals use the Medicare appeals process to fight inappropriate auditor denials.

Filing an appeal requires knowledge of the complex, five-stage Medicare administrative appeals process, which recently was altered. This advisory reviews the Medicare appeals process, including its recent changes, and the distinct protocols for appealing payments denied by Recovery Audit Contractors (RACs).

This information is provided only as a guideline. Consult with your hospital leadership and legal counsel to determine the appropriate system for managing your organization's appeals.

What You Can Do:

Share and discuss this advisory with your executive, medical and financial leaders, and legal counsel. Your audit team should pay close attention to the special RAC section of this advisory, which highlights several unique processes for RAC appeals. You also should consider participating in the upcoming **AHA Audit Education Series**' webinars during which appeals experts will discuss strategies for successfully navigating the appeals process. For more information about the education series and to register for the webinars, visit www.aha.org/auditseries

Further Questions:

Please contact Rochelle Archuleta, senior associate director of policy, at (202) 626-2320 or rarchuleta@aha.org, or Lawrence Hughes, AHA assistant general counsel, at (202) 626-2346 or lhughes@aha.org.

A 15-page, in-depth examination of this issue follows.

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THE MEDICARE APPEALS PROCESS

BACKGROUND

In 2010, the president announced three goals for cutting improper Medicare payments by 2012: reducing overall payment errors by $50 billion, cutting the Medicare fee-for-service error rate in half, and recovering $2 billion in improper payments.

In response to the president and Congressional requests to reduce improper payments, the Centers for Medicare & Medicaid Services (CMS) has significantly increased provider audits, and hospitals now are experiencing a significant amount of Medicare payment denials.

Although the AHA is urging Congress and CMS to address hospitals' concerns with the growing number of Medicare and Medicaid payment audits, it is important that hospitals use the Medicare appeals process to fight inappropriate auditor denials.

This advisory reviews the five-stage Medicare administrative appeals process, including recent changes. Each phase of the process has its own purpose, review entity, filing deadlines, recoupment timeframes and other distinctions. The five stages are administered, respectively, by a provider's primary Medicare claims processing contractor; a qualified independent contractor (QIC); administrative law judge (ALJ); the Medicare Appeals Council; and a federal district court, as detailed below and depicted in Appendix A. A separate section of this advisory describes several process exceptions specific to appealing Medicare Recovery Audit Contractor (RAC) denials.

Regulatory Background. The Medicare appeals process is established in statute, regulation and other Medicare guidance. In 2000, Congress passed the *Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act*, which significantly revamped the appeals process. Congress authorized further modifications to the appeals process in the *Medicare Modernization Act of 2003* (MMA). CMS issued final regulations, effective January 8, 2010, implementing these changes. The statutory changes established a uniform process for handling Part A and B appeals, revised the timeframes for filing an appeal and added a new reconsideration stage, among other things. Several key appeals documents from CMS and other related resources are included in Appendix B.

Medicare Claims Processing Contractor. The type of provider and service rendered determines the CMS contractor that processes and reviews claims:

- Most Medicare claims are submitted to a hospital's fiscal intermediary (FI) or Medicare Administrative Contractor (MAC),[1] including all inpatient, most outpatient and clinical laboratory claims.
- For employed physicians and any non-physician practitioners who have reassigned their benefits to the hospital, the hospital bills the Part B carrier or MAC for associated professional services.
- Hospital-based skilled nursing facilities, long-term care hospitals and inpatient rehabilitation hospitals submit their claims to FIs and MACs.
- Hospitals with a durable medical equipment (DME) supply unit submit claims to the DME MAC. Hospital-based home health agencies submit claims to a regional home health intermediary (RHHI).

For this advisory, the phrase "claims processing contractor" refers to these CMS contractors, which administer the payment of Medicare claims, review claims for payment accuracy and receive and conduct the first level of an appeal.

In addition to these entities, Medicare claims may be audited by the Department of Health & Human Services' Office of the Inspector General, CMS's Comprehensive Error Rate Testing contractor, RACs and CMS-contracted Zone Program Integrity Contractors (ZPICs). Claims denials by any of these entities may be appealed to the provider's claims processing contractor and are processed like any other Medicare appeal. For more information on these and other auditing entities, see the AHA's Advisory on Reducing Vulnerabilities to Payment Denials.

Acknowledgements. The AHA would like to thank the CMS personnel specializing in appeals, interest, recoupment and RACs for their input into this advisory.

The appeals information in this advisory is provided only as a guideline. Please consult with your leadership and legal counsel to determine the appropriate system for managing your organization's appeals.

[1] This advisory discusses both Medicare administrative contractors and the Medicare Appeals Council. This document solely uses the acronym "MAC" to refer to the former, the Medicare contractor that processes both Part A and Part B claims.

THE MEDICARE APPEALS PROCESS

Appeals Basics

Medicare contractors' decisions may be overturned through one of two processes described below: the administrative appeals process or the reopening process.

Demand Letter Reports Denial and Starts Appeals Time Clock. After an audit, a Medicare claims processing contractor notifies a provider of a Medicare payment denial by issuing a demand letter to the provider stating the contractor's findings and reporting the overpayment amount and pending recoupment date via electronic remittance advice notice. For pre-payment reviews, this demand letter must be issued within 60 calendar days after review of the claim. For post-payment denials, the demand letter must be issued to the provider within 60 calendar days of the receipt of the medical record. Demand letters specifically must explain:

- The amount of the denial;
- The method for calculating the denial;
- The reason the original payment was incorrect;
- The regulatory and statutory basis for the denial;
- The provider's option to submit a rebuttal statement (described on page 4);
- The provider's appeal rights, which are separate from the rebuttal process; and
- The recoupment, payment and interest options for the provider, with associated timelines.

All denials are communicated via a demand letter. The date on which the provider receives the demand letter begins the appeals time clock and serves as the starting point for the recoupment timeframe. The hospital's claims processing contractor should send a remittance advice notice to the hospital on the same date of the demand letter.
At the conclusion of each stage of the appeals process, a provider receives a written notice explaining the outcome of that stage. For denied appeals, the written notice also must specify the reasons for the denial and explain the rebuttal and processes for the next appeals stage. All appeals correspondence from CMS contractors is to be written in a manner that is easily understandable.

Rebuttal Process. A rebuttal option is available for the first three levels of the appeals process and is administered by the claims processing contractors. Rebuttal instructions are provided in the initial demand letter and apply for all three stages. To initiate a rebuttal, a provider issues a written statement to its primary claims contractor within 15 days of the date of the written notification on the review outcome. The rebuttal is the provider's written explanation of why the recovery of a denied claim should not proceed. Medicare contractors are required to respond to the rebuttal in writing within 15 days of receipt. *A rebuttal does not affect or delay the timeframe of the formal appeals process and is not a substitute for filing an appeal*. Many providers use the rebuttal process simultaneously to preparing an appeal to ensure compliance with the appeals deadlines.

Timely Submission of Appeals. As noted above, the time clock for a Level 1 appeal begins on the date of receipt of the initial demand letter, with the time clock for subsequent appeals stages beginning on the date of receipt of the respective appeals decision notice. Per federal regulation, CMS considers the date of receipt to be five calendar days from the date of the correspondence to allow time for mailing. To be considered timely, an appeal submitted by a provider must be received by the contractor by the appeals deadline for the applicable appeals stage, rather than being postmarked by that date.

A provider may request an extension of the filing deadline if "good cause" exists for missing the original deadline. In this circumstance, the "good cause" standard typically requires a provider to prove that: 1) the contractor gave the provider incorrect or incomplete information about when and how to file an appeal; 2) the provider did not receive the notice of denial; or 3) the provider sent its appeal within the timeframe but the appeal did not reach the relevant contractor until after the deadline. Good cause may also exist in other situations.

Successful Appeals. If an appeal is favorable to the provider, in whole or in part, the provider will be reimbursed for covered items or services. In addition, any recouped funds and interest paid by the provider will be repaid. If the appeal is decided in favor of the provider by an ALJ (Level 3) or at a later stage, Medicare regulations require that interest be added to the refund of an overpayment, as described on page 9.

Discontinuing an Appeal. At any point in the appeals process, a provider may discontinue an appeal by electing not to proceed to the next appeals stage, or by withdrawing an active appeal prior to a decision being issued. However, the denied amount will be due immediately, with interest, assessed from the day of the initial demand letter to the date of repayment. Requests for discontinuation are submitted to the entity with whom the appeal is currently being processed.

Reopening a Medicare Payment. Medicare contractors' decisions may be overturned through one of two processes: the administrative appeals process discussed in this advisory, or the reopening process. A reopening – a review of a prior Medicare payment – is an action taken by a claims processor on its own accord, or at the request of a related provider or beneficiary within established guidelines, when there is reason to believe that the previous decision may need to be revised. ALJs and the Medicare Appeals Council may also initiate a reopening. Reopenings can be requested for any reason within one year from the date of the:

- Initial payment by the Medicare program;
- Date of a contractor's correspondence noting the outcome of a claim audit; or
- Date of the letter noting the outcome of a claims appeal.

However, to reopen a claim paid between one and four years from the date of a final determination, the party requesting the reopening must demonstrate "good cause" for the request. The "good cause" standard for reopenings is defined as new evidence that was not available or known at the time a payment or appeals decision was made, or evidence that clearly shows the payment or appeal decision involved an obvious error or fraud.

Medicare reviewers are not required to inform providers of a reopening, but must give notice if the reopening leads to a revision to the prior payment determination. Reopenings that result in a denial will trigger the appeals process. The reopening process is intended to adjust clear-cut payment errors; however, it has been used by several CMS contractors – RACs and ZPICs, for example – to review older, paid claims for other purposes such as medical necessity review.

The Five Appeals Levels

Each of the five stages of the Medicare administrative appeals process is detailed below and depicted in a flow chart in Appendix A. A separate section describes the protocol differences for appealing RAC denials.

Level 1 – Redetermination. Providers may file a Level 1 appeal within 120 calendar days of the receipt of the initial demand letter, according to the filing instructions provided by the claims processing contractor. All Level 1 appeals go to a provider's claims processing contractor. The claims processing contractor has 60 calendar days from receipt of the appeal request to mail the redetermination notice to the provider, which explains the basis for a denial and the provider's rights for the next appeals stage. A provider may present new evidence during the redetermination decision. If the provider sends additional evidence to the contractor after the submission of a request for redetermination, the contractor's decision-making timeframe may be extended by up to 14 additional days.

Level 2 – Reconsideration. Requests for reconsideration by a Qualified Independent Contractor (QIC) must be filed within 180 calendar days of the receipt date of the notice of an unfavorable redetermination decision. Level 2 appeals are submitted to a QIC for independent review absent good cause. It is crucial to note that the reconsideration stage is the last stage of the appeals process that allows providers to present new evidence for consideration during appeals review. While QICs may disregard local coverage determinations, manual instructions and program guidance such as program memoranda and manual instructions, federal regulation says that they shall give substantial deference to these policies if they are applicable to a particular case. A QIC may decline to follow these standards if it determines that the policy does not apply to the facts of the particular case.

A QIC is required to issue its decision in writing within 60 calendar days of receiving the request for reconsideration, including the basis for an unfavorable finding. The clock on the 60-day period can be reset in several situations. If the 60-day deadline is not met, the QIC sends an "escalation option letter" (see Appendix C) to the provider that offers the options of waiting indefinitely for the QIC to complete the decision or requesting an escalation to Level 3 – an ALJ hearing. If an escalation is requested, the QIC has five calendar days in which to issue a decision or forward the appeal to an ALJ.

For denials based on the lack of medical necessity, the QIC's reconsideration involves a panel of medical professionals who make a decision based on their clinical experience, the patient's medical records and any medical, technical and/or scientific evidence contained

in the record. A physician is required to take part in the panel review if the denied services were provided by a physician.

Level 3 – Administrative Law Judge (ALJ). An ALJ hearing request may be filed for any claim decided by a QIC if the disputed amount meets the established threshold, which in 2012 is $130. The request must be filed by a provider within 60 calendar days from the receipt date of the QIC's reconsideration decision. To do so, the provider must follow the appeals instructions provided in that correspondence. The ALJ must issue a decision on the appeal within 90 calendar days of receipt of the request for a hearing and explain any unfavorable findings. If the case has been escalated because the QIC did not meet its 60-day deadline, the ALJ has 180 days from receipt of the request for escalation to issue a decision. If the ALJ does not issue a decision on time, a provider may request escalation to the Medicare Appeals Council by filing a request with the ALJ and the council. Medicare regulations authorize a variety of scenarios in which the 90-day deadline for ALJ decisions may be extended.

As with QIC decisions, ALJ decisions are to be based on statute, regulations, CMS's rulings[2] and national coverage determinations. Also, like the QICs, ALJs are required to give substantial deference to local coverage determinations, manual instructions and program guidance, but upon providing a rationale for doing so, may choose not to follow them in issuing decisions. For ALJ hearings, providers have the option of providing oral testimony through video, telephone or an in-person hearing, which may involve the provider, legal counsel, clinical experts and any other participants arranged by the provider. No new evidence (with the exception of oral testimony) can be presented to the ALJ without a specific reason given for the provider's failure to present such evidence by the time of the reconsideration. No hearing will occur if the ALJ elects to decide a case wholly in favor of the provider on the basis of the written appeal record.

Level 4 – Medicare Appeals Council. A review by the Medicare Appeals Council may be initiated in one of three ways. First, following the receipt of an unfavorable ALJ decision, a provider may file a request for Medicare Appeals Council review within 60 calendar days in order to continue the appeals process. The Medicare Appeals Council must accept all provider requests for review and issue a decision, which should explain any unfavorable findings, within 90 days. Second, CMS may request appeals council review of a claim within 60 days of receipt of the ALJ decision, although the council may decline CMS's request. A Medicare Appeals Council review that is made upon CMS's request also must be decided within 90 days of the ALJ decision. Finally, the Medicare Appeals Council may, on its own motion, elect to review an ALJ's decision on a claim, which must be initiated within 60 days of the ALJ decision and decided within 90 days. The council's decision deadlines may be extended if the appealing provider does not comply with certain procedural requirements, such as submitting new evidence or failing to send a copy of the request for Medicare Appeals Council review to all other parties to the appeal. If the council does not issue a decision on a provider-initiated review within 90 days, the

[2] "Rulings" is a term of art that refers to CMS's formal pronouncements. More specifically, they are decisions made by the CMS Administrator that serve as precedent final opinions and orders and statements of policy and interpretation. CMS's rulings are unique from other Medicare determinations and are posted at http://www.cms.hhs.gov/Rulings/CMSR/list.asp#TopOfPage

provider may request escalation to Level 5 – federal district court – by filing a request with the appeals council.

When conducting a review, the Medicare Appeals Council generally does not hold an evidentiary hearing and instead bases its decision on the administrative record of the case, including the recording of the oral testimony before the ALJ. While rare, the Medicare Appeals Council may accept oral argument. Council reviews of ALJ decisions are required to be conducted on a "de novo" basis, which means the council must conduct a new examination of all facts of the case without giving deference to any prior appeals determinations or findings. No new evidence may be presented to the council without a specific reason explaining the provider's failure to present such evidence by the Level 2 reconsideration.

Selected Medicare Appeals Council decisions are posted at http://www.hhs.gov/dab/macdecision.

Level 5 – Judicial Review in Federal Court. A provider has 60 days from receipt of the Medicare Appeals Council decision to file a request for judicial review with the relevant federal district court. The value of the claim(s) must exceed a certain amount, $1,350 in 2012, in order to file an appeal. There is no specified timeframe for the court to issue a decision on a Medicare appeal.

Recoupment & Interest

The recoupment of Medicare overpayments is administered by a hospital's claims processing contractor. Appeals decisions rendered at all five levels may be fully favorable to the provider, partially favorable or wholly unfavorable. For fully favorable appeals, the claims processing contractor will issue payment (for pre-payment denials) or a refund (for post-payment denials on which money was recouped). Claims processing contractors are responsible for calculating revised payment amounts, issuing refunds and collecting overpayments, as applicable. The recoupment or refund of high-cost claims may be achieved over more than one remittance.

Repayment Options. Following a denial, providers have several repayment options:

- A provider may pay the denied amount to its claims processing contractor within 30 calendar days of the date of the initial demand letter, in which case no interest will accrue. The provider may elect to appeal the denial within 120 calendar days of the initial demand letter. A provider may request an extended repayment schedule, which does not affect a provider's appeal rights.
- A provider may file a rebuttal with the claims processing contractor within 15 calendar days of the initial demand letter to request no recoupment due to financial hardship or technical problems with the denial, such as an incorrect provider number or incorrect address. A stay on recoupment will not be authorized through the rebuttal process due to a challenge to the basis for the denial. As noted previously, rebuttals do not change the appeals deadlines.

- If not repaid or appealed within 30 calendar days from the date of the initial demand letter, the claims processing contractor will begin recoupment on the 41st calendar day after the date of the initial demand letter of the denied amount plus interest from the date of the initial demand letter to day 30.
- Following a denial decision at the redetermination stage (Level 1), a provider must repay the denied amount or appeal within 60 calendar days from the date of the redetermination decision letter to avoid recoupment of the denied amount plus interest. Recoupment will occur 76 calendar days after the date of the redetermination letter with interest accruing from the date of the initial demand letter. A provider may request an extended repayment schedule, which does not affect a provider's appeal rights. If the denied claim is paid, the provider preserves the option to file a Level 2 appeal within the 180-day window.

Option to Prevent Recoupment. As noted on the first page of this advisory, the MMA (Section 935) changed the recoupment process by authorizing an option to avoid recoupment if certain Level 1 and Level 2 appeal requirements are met. While further rulemaking on this issue is pending, the agency implemented Transmittal 141 on September 29, 2008, to put these options into effect. Under Transmittal 141, Medicare contractors are prohibited from recouping alleged overpayments during the redetermination and reconsideration stages if an appeal is filed within certain, reduced time limits:

- Level 1 Option. To avoid recoupment following an initial denial, a provider must file a full appeal within 30 days, rather than the full 120 days allowed for this stage. To qualify for a stay on recoupment, the redetermination request must be received and date stamped in the Medicare contractor's mailroom within 30 calendar days of the date of the demand letter. The recoupment will then be postponed, at least until a redetermination decision is made. (Note that voluntary payments made as a lump sum or through an extended repayment plan are not considered recoupment(s) subject to this limitation on recoupment.)
- New Level 2 Option. If a Level 1 appeal is not decided in favor of the provider, the option exists to extend the stay on recoupment through the reconsideration stage. To do so, a Level 2 appeal must be filed within 60 calendar days of the date of the redetermination decision. If the QIC also denies the appeal, recoupment will resume after the 30th day following the QIC's decision letter, even if a further appeal is pursued with an ALJ.

Once a claims processing contractor receives notice of a timely and valid appeal, recoupment must stop. However, it is possible that funds could be erroneously recouped if the claims processing contractor is not informed that a provider filed an early appeal in time to prevent the recoupment. It is likely that any money recouped by the government under this scenario will continue to be held by the Medicare contractor throughout the appeals process, unless and until a favorable decision is obtained by the provider.
If provider appeals during Levels 1 and 2 avoided recoupment and the appeal advances to Level 3, the claims processing contractor will be triggered to recoup the overpayment amount plus interest, with interest due from the date of the initial demand letter. Any funds associated with the overpayment that are still in the provider's possession when a Level 3

appeal is requested will be recouped by CMS, plus interest, on the 30th day following a QIC's denial decision.

Interest. Providers can avoid paying interest on a denied claim in two ways: pay the denied amount in full within 30 calendar days of the date of the initial demand letter, or win the appeal. If neither of these occurs, interest will be assessed from the date of the original demand letter to the date the denied amount is recouped. If payment is made after the initial 30 days and recoupment starts, the provider will pay the denied amount plus any interest due at that point. No additional interest will accrue beyond that point. However, any funds recouped to that date will not be returned to the provider unless and until the appeal is settled in favor of the provider.

If an appeal is successful at the ALJ level or later, the provider already will have paid interest on the funds recouped. In this instance, the payment and interest recouped from the provider (post-payment denial) shall be refunded to the provider. In addition, the MMA authorized interest to be paid by Medicare for appeals won at the ALJ level or later on the principal portion of the denied claim. This interest add-on is calculated from the date of recoupment for each full 30-day period. (Note that voluntary payments made as a lump sum or through an extended repayment plan are not considered recoupments that are eligible for postponement, and are ineligible for any interest if the appeal is won at the ALJ level or thereafter.)

Interest paid to a provider is assessed in 30-day increments, and if payment is made mid-way through a 30-day period, the interest for the partial 30-day window is waived. The interest rate used by CMS contractors applying interest during recoupment or when repaying a provider following a successful appeal that is eligible for interest is the higher of the following two rates – the "current value of funds rate" or the "private consumer rate" – both of which are set by the Department of the Treasury.

CMS updates these rates on approximately a quarterly basis and communicates them to the primary claims review entities via transmittal. The interest rate used for these purposes as of January 19, 2012, is 10.5 percent. To calculate interest accrued on recouped funds, divide this interest rate by 12 and multiply that amount by the number of full 30-day periods between the recoupment and the final decision date. This sum is then multiplied by the amount of the recouped funds to determine the amount of interest to be paid. Also, a provider is entitled to additional interest if a refund is not issued by the claims processing contractor within 30 days of the ALJ decision date (or, if applicable, the revised written final determination date).

Appealing RAC Denials

Like other claims auditors, RACs use the reopening process to review claims that already have been paid. RAC appeals follow the Medicare administrative appeals process described in this advisory, with the exceptions noted below. RACs and Medicare claims processing contractors have established agreements to share information on the status of RAC denials and appeals. In addition, standard processes should be established for the

transfer of medical records reviewed by a RAC to the claims processing contractor responsible for adjudicating Level 1 appeals.

More information on the RAC program, including an advisory on the RAC Permanent Program, the AHA Audit Education Series and the AHA *RAC*Trac initiative, is available at www.aha.org/rac.

For Complex Reviews, RACs Report Denials through Two Written Notices. Complex review by a RAC involves an audit of the medical record. Rather than receiving one written notice following a complex review, as is the case with other Medicare denials, providers receive two pieces of correspondence associated with RAC denials: a "review results letter" and a demand letter. The review results letter is issued by the RAC and informs the provider of the outcome of the claim audit and describes the provider's option to utilize a RAC "discussion period." The demand letter is issued by the provider's claim processing contractor and serves the same function as the letters issued by other Medicare reviewers by articulating the denied amount, the basis for the denial, repayment options and the provider's appeal rights. The date of the demand letter triggers the start of the appeals process.

For automated RAC reviews that result in a denial, a provider will receive one form of notification – a demand letter – which will trigger the appeals process.

Calculating the Three-year Look-back Period for Complex RAC Reviews. RACs are authorized to review claims for up to three years after the date the claim is paid, not including claims paid prior to October 1, 2007. This three-year look-back period is counted starting from the date of the initial determination and ending with the date the RAC issues the medical record request letter (for complex reviews) or the date of the overpayment notification letter (for automated reviews).

RAC Discussion Period. Three concurrent processes are initiated by a RAC denial. In addition to the appeals and rebuttal processes (described on pages 3 and 4), which apply to all Medicare denials, a RAC denial also triggers a simultaneous "discussion period."

According to the CMS RAC Statement of Work (http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Recovery-Audit-Program/Downloads/090111RACFinSOW.pdf), all providers receiving a demand letter and/or review results letter from a RAC are availed an opportunity to discuss the improper payment with the RAC. The RAC must grant all requests by a physician (or a physician employed by a hospital) to speak with a RAC about the denial. Providers must submit all discussion period requests in writing, and the RAC must respond to the request within 30 days of receipt, unless the RAC is notified by the affiliated contractor of a provider initiated appeal. RACs are required to terminate the discussion period once a hospital has initiated the appeal process.

If the RAC modifies the original improper payment determination during the discussion period, the RAC must send written notification to the provider. If the claim has already

been forwarded to the MAC for adjustment, the RAC must immediately notify the MAC that the claim no longer requires adjustment or needs to be re-adjusted.

It is important to remember that use of the discussion period will not delay the appeals process and the discussion period is available only following the initial denial.

RAC Code on the Remittance Advice. Pending RAC recoupments are flagged on the remittance advice with the distinct RAC code "N432," along with the recoupment amount indicated in the corresponding demand letter.

RACs Are Not Involved in Recoupment. Payments denied by a RAC are recouped by the provider's claims processing contractor.

Filing an Appeal. Like other appeals, RAC appeals are filed with the contractor that processes the particular type of payment that has been denied by the RAC.

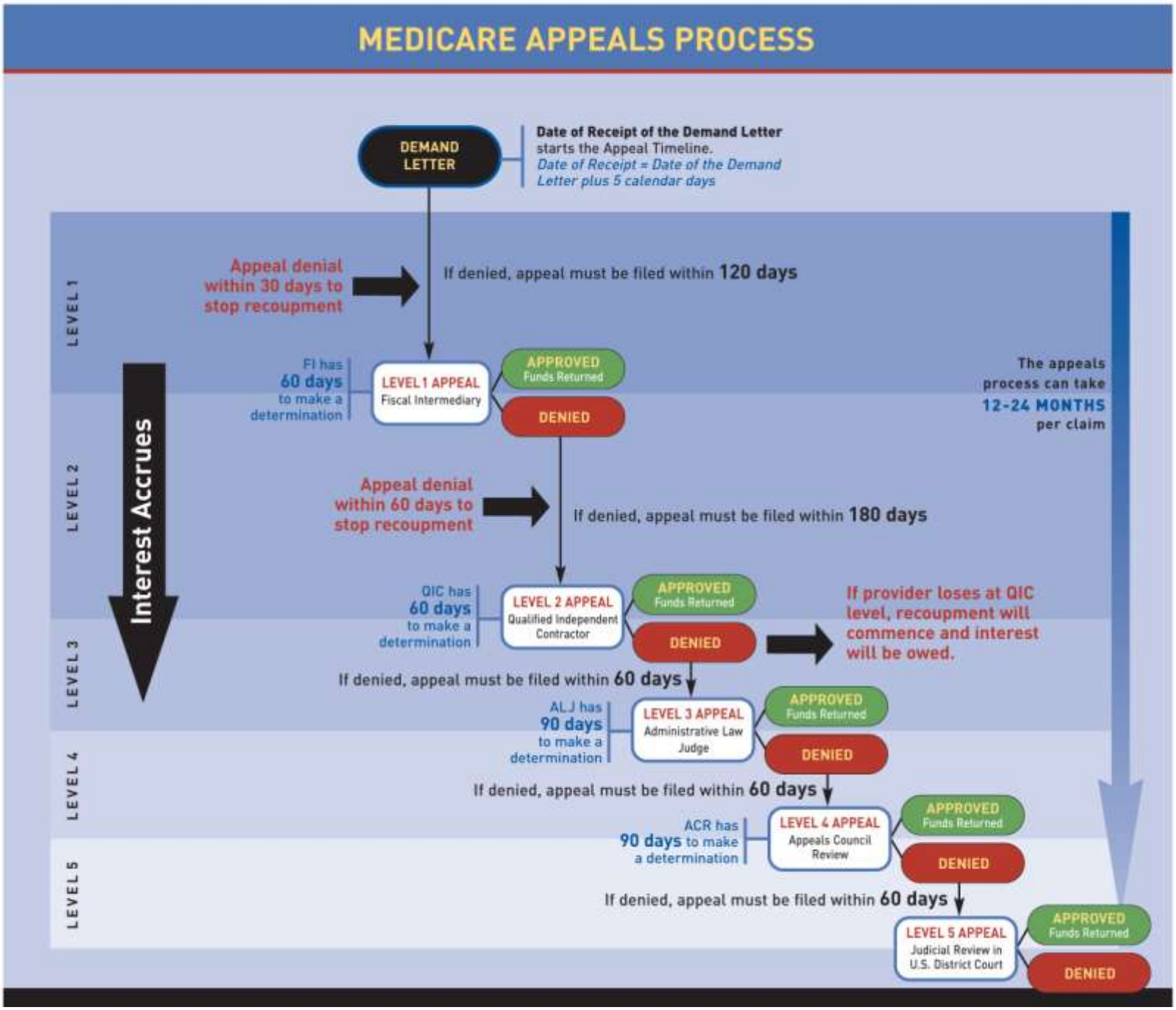
NEXT STEPS

Discuss this advisory with your hospital leadership, billing and finance staff, legal counsel, RAC team and other staff involved in appealing Medicare denials. In addition, we encourage your participation in our AHA Audit Education Series webinars. For more information and to register, visit: www.aha.org/auditseries

FURTHER QUESTIONS

Please contact Rochelle Archuleta, senior associate director of policy, at (202) 626-2320 or rarchuleta@aha.org, or Lawrence Hughes, AHA assistant general counsel, at (202) 626-2346 or lhughes@aha.org.

Appendix A. AHA Appeals Process Flow Chart



Appendix B.
Medicare Appeals Resources

- **CMS Medicare Appeals Process Brochure.** January 2011. **http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/MedicareAppealsProcess.pdf**

- **CMS's MLN Matters Article Number 6183: Limitation on Recoupment (935) for Providers, Physicians and Suppliers Overpayments.** September 12, 2008. http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6183.pdf

- **CMS's Transmittal 1671. Clarification of Requirements for New and Material Evidence as Good Cause for Reopening.** January 16, 2008 (Effective February 16, 2009). http://www.cms.hhs.gov/transmittals/downloads/R1671CP.pdf

- **CMS' Transmittal 141: Limitation on Recoupment (935) for Providers, Physicians, and Suppliers Overpayments.** September 12, 2008. http://www.cms.hhs.gov/Transmittals/Downloads/R141FM.pdf

- **Medicare Financial Management Manual. Chapter 4 Debt Collection. Section 30: Interest Assessment/Payment on Overpayments and Underpayments** (Pages 22-31). http://www.cms.hhs.gov/manuals/downloads/fin106c04.pdf

Resources on Auditors

- **AHA Audit Education Series:** www.aha.org/auditseries
- **RAC section of the AHA Web page**: http://www.aha.org/rac
- **CMS RAC Web page:** http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/recovery-audit-program/index.html?redirect=/recovery-audit-program/

- **Medicare Learning Network® (MLN) Products Provider Compliance Web page:** (http://www.cms.gov/MLNProducts/45_ProviderCompliance.asp#TopOfPage

Appendix C. CMS's Sample Escalation Option Letter

Medicare Appeal Number:

MAXIMUS Federal Services

If you have questions, write or call:

MAXIMUS Federal Services
QIC Part A East
1040 First Avenue
Suite 400
King of Prussia, PA 19406

Provider Inquiries

Visit: www.q2a.org
Or
Call: 484-688-2000

Beneficiary Inquiries

Call: 1-800-Medicare
Or
1-800-633-4227

Who we are:

We are MAXIMUS Federal Services. We are experts on appeals. Medicare hired us to review your file and make an independent decision.

[Date written out in full]

Appellant Address

RE: Beneficiary:
HIC #:
Appellant:
Dates of Service:

Dear:

This letter is about your request for a reconsideration of the services listed on the next pages. Medicare requires that we issue a decision on your appeal within 60 days of receipt of an appeal request. If we cannot issue a Reconsideration decision within 60 days, Medicare requires that we inform you of this and provide you with options.

We do not believe that we will be able to complete our review of your appeal and issue a Reconsideration decision within the 60-day timeframe.

Your Options:

You have 2 choices:

1. You can do nothing and we will finish reviewing your appeal and send you our decision;

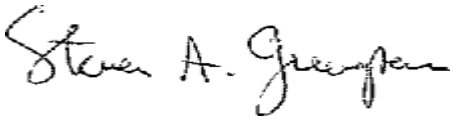
2. You can choose to escalate your appeal to the next level, an Administrative Law Judge (ALJ) Hearing. If you choose to escalate, we will have 5 days to complete our reconsideration or we will send your case to an ALJ for a hearing. If your appeal is sent to the ALJ, the ALJ may take up to 180 days to make a decision.

What you need to do:

If you choose to escalate your appeal to an ALJ, please send your request for escalation to the address in the Contact Information Box on the left side of this page. Please include your name, address, signature and date together with the Medicare appeal number and a statement telling us you wish to escalate this appeal to an ALJ.

If you have any questions, you can call 1-800-MEDICARE (1-800-633-4227) or check www.Q2A.org for a status update.

Sincerely,



Steven A. Greenspan, J.D., LL.M.
Project Director

SAG/

cc: Provider or Beneficiary

Appeal Details

THIS IS NOT A BILL – Keep this letter or a copy for your records.