



Five Steps to the RAC Appeals Process

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This is the final installment in our three-part series on **RAC: Recovery Audit Contractors**. In Part One, we provided you with a step-by-step guide to get ready for RAC. In Part Two, we discussed the eight things you should know about handling a RAC request. In this final article, we will explain the five-step appeals process.

RAC audits are designed to identify **improper Medicare payments** made to providers – both underpayments and overpayments. Overpayments, though, represent the overwhelming majority of improper payments uncovered as part of the RAC process.

Once you have sent a requested record as part of a RAC audit, the RACs are required to determine their findings and report them to you within 60 days of receipt of that record. If an overpayment has been identified, your practice will receive a letter from your RAC requesting payment.

At this point, **the clock starts ticking**.

Please find listed below the steps you can take as part of the appeals process and the important timelines/deadlines you must keep in mind. It is important to remember that if appeal requests are not filed in a timely manner, the opportunity to appeal is lost.

1. **Contact your RAC within 15 days** of receipt of an overpayment letter to discuss the overpayment. Send any additional documentation or evidence you have to counter the determination. Please keep in mind, though, that making this call to your RAC is not a formal appeal.
2. The next step is to formally appeal. **There are five levels of appeal:**
 - a. **First Level – Redetermination**

Claims denials or overpayments must initially be appealed to the appropriate Medicare Administrative Carrier within **120 days** of the RAC's initial decision. There is no minimal dollar amount required at this level.

[**Note:** Even though you have 120 days to file the appeal, if you do so within **30 days** of receipt of the overpayment letter, you avoid a Medicare recoupment action. The American Hospital Association's Regulatory

Advisory published on March 27, 2009, says, “*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.*”]

b. Second Level – Reconsideration

If a provider is dissatisfied with the outcome of the Level 1 appeal or Redetermination, a request can be made to an appropriate Qualified Independent Contractor (QIC) within **180 days of Redetermination**.

c. Third Level – Administrative Law Judge Hearing

If a provider is not satisfied with the Level 2 decision, a hearing before an Administrative Law Judge can be requested. The request must be filed within **60 days** of receipt of the reconsideration decision. At this level, the amount in controversy must be a minimum of **\$120.00**.

d. Fourth Level – Medicare Appeals Council

If the decision from the Administrative Law Judge (ALJ) is considered unfavorable to the provider, you may appeal to the Departmental Appeals Board (DAB). A request must be filed within **60 days** notice of the ALJ’s decision.

e. Fifth Level – Federal Court Review

The final step of the appeal process is at the US Federal level. This appeal must be filed within **60 days** of the DAB decision. The minimum amount in controversy must be **\$1,130.00**.

According to statistics, providers are winning approximately 35 percent of RAC appeals. So the bottom line on appeals is this: RAC audits will result in negative determinations. If you have a solid basis for appeal – do so. But do it in a timely manner.

Please email us at editor@efficiencyinpractice.com if you have any specific questions on the RAC Appeals Process.