SUMMARY OF CMS AUDITS PROCEDURES

RACs, ZPICs AND OTHER APPEALS:
TIMELINES, RECOUPMENT, AND ACCRUAL OF INTEREST

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I. RECORDS REQUESTS:
The first time a provider usually becomes aware that they are about to take a long journey through the CMS audit and appeals process is when the provider receives a letter from a Medicare auditor ("Auditor") requesting medical records and documents for certain patients. The provider is usually given 30-45 days within which to send the records to the Auditor. Once the records are received by the Auditor, it generally takes quite some time to hear any results. In some cases, it can take a year or more.

(1) While the letter may only request specific items in the chart, providers should carefully prepare their submission and send the entire chart. At a minimum, include other portions of the patient’s chart that are reasonably related to the requested documents.
(2) Make sure the medical records are uniformly organized.
(3) In order to ensure the reviewer doesn’t have to hunt for the records, include a table of contents.
(4) Transcribe any difficult to read handwritten notes.

II. AUDIT RESULTS LETTER:
After the Auditor completes its review of records, it will send the provider a letter outlining the results of the audit. If the audit was conducted after the Medicare claims were filed and paid ("Postpayment Review") and the Auditor finds that the provider was “overpaid,” the results letter (“Audit Results Letter”) will state the amount of the alleged overpayment and give the reasons for those findings. Note that when an Auditor reviews claims before payment has been made ("Pre-payment Review"), there may not be any Audit Results Letter; the provider may only receive remittance advice showing that the claim(s) was denied. The appeals process is the same for Pre-payment and Postpayment Reviews.
III. **Demand Letter: First Level – Redetermination Appeal Deadline – 30 Days.**

After the Auditor issues the Audit Results Letter, the A/B MAC will issue a letter demanding that the provider refund the amount allegedly overpaid (“Demand Letter”). Note, if the audit was conducted on a pre-payment basis, the remittance advice serves as the “demand letter” and starts the appeal deadlines running. Upon the issuance of the Demand Letter, the provider has three options:

1. **File the First Level Appeal (Redetermination):** To avoid recoupment, the provider must file a Request for Redetermination so that it is received by the pertinent Medicare contractor **within thirty (30) days** from the date of the Demand Letter.

   (a) The Provider will actually have 120 days from the Demand Letter to appeal the results. The 30-day appeal deadline is critical because it **statutorily prohibits** the MAC from recouping any of the demanded funds.

   (b) **If the A/B MAC does start recouping and the appeal was filed and received within 30 days of the Demand Letter, the monies prematurely recouped can be refunded.** Unfortunately, this happens frequently so it is important for the provider to keep a close eye on its payments and remittance advice.

   (c) If the provider files this first appeal on its own, it is important to send the appeal to the MAC with tracking information to provide proof of the MAC’s receipt of the appeal.

   (d) The MAC can start recouping the demanded funds 41 days after the Demand Letter date if it has not received an appeal. If the provider files an appeal after the 30 day deadline, but before the 120 deadline, the A/B MAC must stop recoupment going forward. CMS will retain any funds already recouped.

   – OR –

2. **Pay Back the Alleged Overpayment & Appeal:** Another option is for the provider to voluntarily pay the overpayment on or before Day 30 from the date of the Demand Letter or enter into an Extended Repayment Plan (“ERP”) to repay it over time. Approval of an ERP requires that he provider show financial hardship.

   (a) If the provider pays the overpayment demand within 30 days, **no interest will accrue** and the provider will have 120 days within which to file its 1st level appeal.

   (b) The provider may also enter into an ERP for up to 60 months from the date of the Demand Letter. Due to an increasing overturn rate at the second level, most providers do not enter into the ERP until they receive appeal results at the second level; however, an ERP approved later in the process will still be based on a maximum repayment period of 60 months from the original Demand Letter. Interest will accrue during the ERP.
(3) **Allow the Alleged Overpayment to be Recouped & Appeal:** A third option is for providers to permit the alleged overpayment to be recouped through the immediate offset of the overpayment from current Medicare payments. While this option has the benefit of avoiding interest charges, it also has an added benefit. The provider will receive interest from CMS on any funds recouped that are associated with claims the provider successfully appeals. The provider must notify the A/B MAC in writing that it wants to choose this option if the provider appeals the denials before the full amount is recouped.

IV. **Redetermination Decision – First Level Appeal Decision – No Deadline.**

There is no specific deadline under the Medicare appeal regulations for the Auditor to issue its first level, Redetermination Decision. Generally, this is intended to take 60 – 90 days, but frequently takes longer.

V. **Reconsideration Appeal – Second Level Appeal – 60 Day/180 Day Deadline.**

Once the Redetermination Decision has been issued, the provider will essentially have the same three options as indicated above, with different deadlines. At the second level, the provider has **180 days** from receiving the Decision to file a second level appeal (Request for Reconsideration). However, in order to stop recoupment, the provider must file its appeal within **60 days** from the date of that Decision. If the appeal is filed more than 60 days after the Redetermination Decision, and not all monies have been recouped, the MAC must stop recouping upon notification of the provider’s Reconsideration appeal.

The Request for Reconsideration is filed with the appropriate Qualified Independent Contractor (“QIC”) for the provider’s jurisdiction.

Thorough preparation of the appeal package(s) and compilation of evidence is critical at this level. If any crucial evidence is not submitted with this appeal and the provider appeals further to an Administrative Law Judge (3rd Level), it will be required to show “good cause” why the evidence was not submitted before the Reconsideration Decision was issued.

If the alleged overpayment was statistically extrapolated by the Auditor, the provider will need to retain a statistical expert to effectively refute the Auditor’s use of extrapolation. The provider may also want to consider retaining a medical expert who may provide additional support any claims denied for lack of “medical necessity.”

V. **Reconsideration Decision – Second Level Appeal Decision – 60 Days Deadline.**

Theoretically, the QIC is required to issue the Reconsideration (2nd Level) Decision within sixty (60) days from its receipt of the appeal. Unfortunately, the QIC almost always takes longer than the 60 days (frequently several months). If it does, however, the provider has the option to escalate the appeal to an Administrative Law Judge (“ALJ”) by
filing a written request with the QIC. The QIC will then have five (5) days from receiving the request to either render its Reconsideration Decision or escalate the appeal to the Office of Medicare Hearings & Appeals (“OMHA”) for hearing before an ALJ.

The advantage of not escalating and waiting for the QIC to issue its decision on its own time is that recoupment cannot begin while the 2nd Level Appeal is pending, assuming the 1st Level Appeal was filed within 30 days, or recoupment was stopped at some point previously.

After the Reconsideration Decision is issued by the QIC, recoupment will be initiated regardless of whether the provider files a 3rd level appeal to the Administrative Law Judge (Request for Administrative Law Judge Hearing). With the hopes that the QIC will overturn a significant number of the claim denials (resulting in a significantly lower overpayment demand), most providers will wait until this point to enter into an ERP. CMS has the discretion to grant repayment periods for up to 60 months; however, that repayment period will begin on the date of the original demand. If the first and second level appeal process takes ten (10) months, the provider would only have a maximum repayment period of 50 months, thereby increasing the monthly payments.

VI. REQUEST FOR ALJ HEARING – THIRD LEVEL APPEAL – 60 DAYS DEADLINE.

The Request for ALJ Hearing (3rd level) appeal must be filed within 60 days from the date of the Reconsideration Decision. In February, 2014, however, OMHA announced that no new ALJ assignments will be made until OMHA has caught up with its huge backlog of cases. At the time, OMHA estimated that delays could last up to 28 months. However, due to intense pressure, CMS has opened two additional ALJ offices and offered providers flat settlement programs in an effort to alleviate the immense backlog of appeals at the ALJ. While these efforts have helped, providers should still expect significant delays while waiting for their appeals to be heard by an ALJ.

Once an ALJ has been assigned, the ALJ will schedule a hearing. Hearings are usually held by telephone, but the provider may request an in-person hearing which is subject to the ALJ’s approval.

At the hearing, the provider can present its case by oral arguments, and presenting testimony of witnesses – treating physician, medical expert, other healthcare professionals, statistical expert, etc. CMS and the Medicare Contractor/Auditor have the option to participate in the hearing as “parties,” but more often than not, they do not and will only have a representative(s) present to answer questions from the ALJ.

VII. ALJ DECISION – THIRD LEVEL APPEAL – 90 DAYS DEADLINE.

The Medicare Appeal regulations require that the ALJ render a decision within 90 days of the hearing. In our experience, the ALJ usually takes much longer than 90 days, and it could take months after the hearing. Moreover, given the current backlog at OMHA and the moratorium on ALJ assignments, we cannot say how long it may take to receive an ALJ Decision.
VIII. REQUEST FOR MEDICARE APPEALS COUNCIL REVIEW – FOURTH LEVEL APPEAL – 60 DAY DEADLINE.

The ALJ Appeal is usually where most claim denials and statistical extrapolations get overturned. There are, however, two more appeal levels. The 4th Level is called a Request for Medicare Appeals Council Review. This review may be requested by the provider or by CMS through its Medicare Contractor within 60 days after receipt of the ALJ Decision.

Even if CMS or its Contractor did not participate in the ALJ Hearing as a party, they may request review if, in its view, the Decision contains an error of law that could affect the outcome or presents a broad policy or procedural issue that may affect the public interest.

Additionally, the Council may rehear a case “on its own motion.” It may decide to review an ALJ’s Decision if, in the Council’s view, (1) the ALJ’s Decision was not supported by sufficient evidence or (2) the ALJ abused his discretion.

There is usually no hearing at the 4th level of appeal. If neither the provider nor CMS/Contractor requests review within 60 days, the ALJ’s Decision becomes final and no further appeals may be taken.

IX. MEDICARE APPEALS COUNCIL DECISION – FOURTH LEVEL APPEAL – 90 DAYS DEADLINE.

The Council has 90 days within which to issue a Decision unless that time frame is extended. The Council’s Decision may (1) revise the ALJ’s Decision or (2) the Council may remand the case back to the ALJ for certain specific action and, possibly, rehearing.

X. U.S. DISTRICT COURT REVIEW – FIFTH LEVEL APPEAL – 60 DAYS DEADLINE.

The last appeal level is a Request for Judicial Review. This Request must be filed with the U.S. District Court within 60 days of receiving the Medicare Appeals Council Decision.

The Court’s review is “on the record” only, i.e., there is no hearing – only briefs and evidence already in the record. The Court will review the evidence and the parties’ briefs and make its decision based on that information. Unless there is evidence of clear error, this option is not usually recommended as the Court defers to the ALJ or Council.

XI. ACCRUAL OF INTEREST FOLLOWING AN OVERPAYMENT DETERMINATION.

When an overpayment has been appealed initially, interest will begin to accrue on Day 31 following the date of the MAC’s first demand letter (“Initial Demand”). The interest rate changes from year to year and is published in the Federal Register. Interest is “simple interest,” starting on Day 31 from the date of the Initial Demand and is calculated in 30-day periods. There are no partial or pro rata 30-day periods. If, for instance, the
overpayment is reversed at subsequent appeal and the decision was issued 45 days after issuance of the Redetermination Decision, interest on the overpayment would be for two 30-day periods of time.

If the Medicare contractor wins on appeal (at whatever level the provider stops appealing without winning), the provider will then have to start repaying the overpayment plus any interest accrued. If, however, the provider wins on final appeal, and if recoupment has taken place at some point during the appeals process, Medicare must pay the provider interest from the date on which the recoupment of funds was first initiated. It will only be simple interest and only on the amount of money that was actually recouped. There would not be any “interest on interest,” and no interest will be paid on any period of time less than 30 days. That is, if the total amount of time between the date recoupment was initiated and the date the overpayment decision was reversed is, e.g., 95 days, the provider would only receive interest for 90 days, i.e., 3 full 30-day periods.

If you would like to review the CMS Manual provisions on filing an appeal, see the following link:

Below is a table copied from the Medicare Financial Management Manual, Chapter 3, § 200.2.2 – Recoupment After the First Demand: When Does it Begin?

### 200.2.2 - Recoupment After the First Demand: When Does it Begin?
*(Rev. 141, Issued: 09-12-08, Effective: 09-29-08, Implementation: 09-29-08)*

<table>
<thead>
<tr>
<th>Timeframe</th>
<th>Medicare Contractor</th>
<th>Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Day 1</strong></td>
<td>Date of Demand Letter (Date demand letter mailed)</td>
<td>Provider receives notification by first class mail of overpayment determination</td>
</tr>
<tr>
<td><strong>Day 1-15</strong></td>
<td>Day 15 deadline for Rebuttal request. No recoupment occurs</td>
<td>Provider must submit a statement within 15 days from the date of demand letter.</td>
</tr>
<tr>
<td><strong>Day 1-40</strong></td>
<td>No recoupment occurs</td>
<td>Provider can appeal and potentially limit recoupment from occurring</td>
</tr>
<tr>
<td><strong>Day 41</strong></td>
<td>Recoupment begins</td>
<td>Provider can appeal and potentially stop recoupment</td>
</tr>
</tbody>
</table>

### 200.3 - What to Do When a Valid Request for Redetermination for Appeal is Received
*(Rev. 141, Issued: 09-12-08, Effective: 09-29-08, Implementation: 09-29-08)*

**Action to take:**
1. Upon receipt of a timely and valid request for a redetermination of an overpayment, Medicare contractors shall cease recoupment of the overpayment that is the subject of the appeal.

2. If the recoupment has not yet gone into effect, Medicare contractors shall not initiate recoupment.

3. If the Medicare contractor recouped funds before a timely and valid request for a redetermination was received; the amount recouped shall be retained and applied first to interest and then to principal.

4. If an overpayment is appealed and recoupment stopped, the Medicare contractor shall continue to collect other debts owed by the providers, physicians and suppliers but may not withhold or place in suspense, any monies related to this debt, while it is in the appeal status.

5. The debt shall be reported in Appeal status and shall continue to be aged and interest continues to accrue.

6. The Contractor shall send a notice to the provider that briefly states you received the valid and timely request and recoupment has stopped. Construct a short paragraph such as the following:

§ 200.3.F. When does Recoupment Begin or Resume after the redetermination?

<table>
<thead>
<tr>
<th>Timeframe</th>
<th>Medicare Contractor</th>
<th>Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>Day 60 following revised notice of overpayment following redetermination</td>
<td>Date Reconsideration request is Stamped in Mailroom, or Payment Received from the revised overpayment notice</td>
<td>Provider Must Pay Overpayment or Must have submitted request for 2nd level appeal</td>
</tr>
<tr>
<td>Day 61- 75</td>
<td>No Recoupment Occurs</td>
<td>Provider appeals or pays</td>
</tr>
<tr>
<td>Day 76</td>
<td>Recoupment Begins or Resumes</td>
<td>Provider Can Still Appeal. Recoupment stops on date receipt of appeal</td>
</tr>
</tbody>
</table>

200.3.1 - What To Do When a Valid and Timely Request for a Reconsideration is Received  
(Rev. 141, Issued: 09-12-08, Effective: 09-29-08, Implementation: 09-29-08)

The QIC determines the validity and timeliness of a request for a reconsideration. However, to limit recoupment of the overpayment a provider must request a reconsideration and have
it postmarked by the 60th day. Refer to § 200.3 (E) of this section for additional information regarding QIC contractor communication regarding the filing of a request for reconsideration.

A. Actions to take:

1. Upon receiving notification from the QIC of a valid and timely request for a Reconsideration. The Medicare Contractor shall cease recoupment of the overpayment.

2. If the recoupment has not yet gone into effect, the contractor shall not initiate recoupment.

3. If the Medicare contractor recouped funds before a timely and valid request for a reconsideration was received; the amount recouped shall be retained and applied first to interest and then to principal.

4. If an overpayment is appealed and recoupment stopped, the Medicare contractor should continue to collect other debts owed by the providers, physicians and suppliers but may not withhold or place in suspense, any monies related to this debt, while it is in the appeal status.

5. The debt shall be reported in Appeal status and shall continue to be aged and interest continues to accrue.

6. The Contractor shall send a notice to the provider that briefly states you received the valid and timely request and recoupment has stopped.

E. Initiating or resuming recoupment after a reconsideration decision in the following circumstances:

Following final decision or dismissal by the QIC, recoupment can be initiated or resumed whether or not the provider, physician or other suppliers subsequently appeals to the ALJ (third appeal level) and all further levels of appeal.

1. The contractor shall initiate or resume recoupment no earlier than the 30th calendar day after the date of the written notice to the provider, physician or other suppliers of the revised overpayment amount if the reconsideration decision is partially favorable (partial reversal).

2. The contractor shall initiate or resume recoupment no earlier than the 30th calendar day on the remaining unpaid principal balance and interest if it has not been satisfied in full and the provider, physician or other suppliers has been afforded the opportunity for rebuttal in accordance with requirements of CFR 42 §405.373 through §405.375.