Weathering a Medicare Audit: Overview of the Medicare Appeals Process

Chances are if you are involved with a physician practice, you have personally experienced the effects of a Medicare audit or know a colleague who has. This article breaks down the Medicare appeals process into a step-by-step explanation to prepare physician practices and other health-care providers for what to expect when weathering a Medicare audit appeal.

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THE MEDICARE APPEALS PROCESS

The five step appeals process is uniform for all Medicare contractors and both Medicare Part A and Part B appeals. CMS contracts with a variety of audit Medicare contractors including Recovery Audit Contractors (RACs), Medicare Administrative Contractors (MACs), Program Safeguard Integrity Contractors (PSCs), and Zone Program Integrity Contractors (ZPICs).

Providers are typically notified of the audit findings by way of an audit results letter and overpayment demand letter issued by the Medicare contractor. This correspondence provides information regarding the reviewer's findings and the claim determinations, as well as the alleged overpayment to be returned to Medicare. Providers should note that receipt of the overpayment demand letter triggers the timeframes for appeal.

STEP 1: REDETERMINATION

The first level of appeal is redetermination. Providers who are dissatisfied with the contractor's initial determination must file a request for redetermination within 120 calendar days from the date the provider received notice of the initial determination.[1]

However, in order to prevent recoupment of the alleged overpayment against the provider's current Medicare payments, the request for redetermination must be filed within 30 days of the date of the first demand letter. Otherwise, recoupment will begin on the 41st day after the date of the first demand letter.

Given this short timeframe, it is important for providers to act quickly in order to meet the appeal deadlines and prevent the withholding of current Medicare payments, which can create a significant financial hardship on a

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physician practice. Although redetermination is the first stage of appeal, it is important to include legal counsel in the appeals process. Healthcare attorneys specialize in developing the most effective appeal at the earliest stages. The early involvement of counsel may help physician practices receive favorable appeal determinations earlier in the appeals process.

STEP 2: RECONSIDERATION

A provider who is dissatisfied with the redetermination decision may file a request for reconsideration with a Qualified Independent Contractor (QIC). A request for reconsideration must be filed within 180 calendar days from the date the provider received notice of the redetermination decision.[2] However, in order to prevent a withholding of current Medicare payments at this stage, the request for reconsideration must be filed within 60 days of the date of the redetermination decision.[3]

Reconsideration is an independent review of the initial determination, redetermination and other issues related to payment of the appealed claim.[4] The reconsideration decision is based on a review of the findings and evidence submitted at the initial determination and redetermination levels. However, providers must also submit any additional evidence or missing documentation at this level of appeal. Failure to submit all evidence prior to the issuance of the reconsideration decision will prevent the future consideration of that evidence absent a showing of good cause.[5] The QIC must notify all parties of the reconsideration decision within 60 days of the request, unless additional evidence has been submitted, which extends the QIC's deadline. Once a reconsideration decision has been rendered, providers cannot stop the withholding of current Medicare billings and the Centers for Medicare and Medicaid (CMS) may begin recoupment of the alleged overpayment.

STEP 3: ADMINISTRATIVE LAW JUDGE HEARING

The third level of appeal involves an administrative law judge (ALJ) hearing. To preserve the right to an ALJ hearing, a provider must file a written request within 60 days of the date that the provider received notice of the reconsideration decision.[6] Unlike the first two levels of appeal, there is an amount in controversy requirement in order to proceed to an ALJ hearing; this is currently $130.[7]

ALJ hearings may be conducted in-person, by video-teleconference (VTC) or by telephone. At the hearing, parties have an opportunity to present documentary evidence, legal arguments and witness testimony, which may include internal clinicians and experts. The ALJ examines the issues, questions the parties and other witnesses, and review documents material to the issues. An ALJ's decision is based on the hearing record and is required to be made within 90 days from the date it received the request for hearing, unless the time period has been extended or waived.

STEP 4: MEDICARE APPEALS COUNCIL

The fourth level of appeal is Medicare Appeals Council (MAC) review. To request a MAC review, a party must file a written request within 60 days of receiving the ALJ decision or dismissal.[8] A party's request for MAC review must identify the parts of the ALJ action with which it disagrees and explain the reasons for the disagreement.

An appeal to the MAC does not involve a hearing. Instead, upon request, the MAC will give the parties an opportunity to file written statements. The MAC may also request that CMS or its contractor file a brief.

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The MAC may grant a party's request to appear and present oral argument if the case raises an important question of law, policy or fact that cannot be decided based on written submissions alone. Unless extended due to the filing of a written brief, the MAC must issue a final action or remand within 90 days of receiving the appellant's request for review. The MAC may remand the case if additional evidence is needed or if additional action by the ALJ is required to make a decision. The MAC's decision binds all parties unless the decision is later modified by a federal district court. If the MAC does not issue a decision, dismissal or remand within the required time frame, the provider may request that the case be accelerated to federal district court.

STEP 5: JUDICIAL REVIEW IN FEDERAL DISTRICT COURT

A party to a MAC decision or a party requesting escalation from the MAC may proceed to a fifth level of appeal in federal district court. In order to file an action for judicial review, the amount in controversy requirement must be met (currently set at $1,300), and the party must file in federal district court within 60 days of receipt of the MAC's decision.

CONCLUSION

It is important for healthcare providers and their staff members to understand the Medicare appeals process and the key timeframes for appealing an unfavorable Medicare audit determination. While the Medicare appeals process can appear daunting, providers armed with an understanding of the process are better prepared to jump into action if and when they are faced with a MAC, RAC, or ZPIC audit of their Medicare claims. ■

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[1] 42 C.F.R. § 405.942 (2009).
[2] 42 C.F.R. § 405.962 (2009).
[3] Limitation on Recoupment (935) for Providers, Physicians and Suppliers Overpayments," MLN Matters, Number MM6183 Revised, September 29, 2008, http://www.cms.gov/MLNMattersArticles/downloads/MM6183.pdf
[4] 42 C.F.R. § 405.968 (2009).
[5] 42 C.F.R. § 405.966 (2009).
[6] 42 C.F.R. § 405.1002 (2009).
[7] 42 C.F.R. § 405.1006 (2009). The specific amount in controversy is governed by the regulations set forth in 42 C.F.R. § 405.1006. At the time of this writing, the amount in controversy requirement for an ALJ hearing is $130, pursuant to Adjustment to the Amount in Controversy Threshold Amounts for Calendar Year 2011, 75 Fed. Reg. 58,408 (Sept. 24, 2010).