1. Review the correspondence to determine if it is a Complex RAC Review or an Automated RAC Review.
   1.1. A **Complex RAC Review** will indicate that the claim is under review by the RAC and that specific and detailed additional information is being requested.
      1.1.1. For a Complex RAC Review, proceed to step 2
   1.2. An **Automated RAC Review** will indicate that the claim has been reviewed by the RAC and denied, and Medicare is recouping payment for the services provided.
      1.2.1. For an Automated RAC Review, proceed directly to Step 16
1. COMPLEX RAC Review

2. Collect Internal Documentation

3. Collect External Documentation from Other Allied Healthcare Providers

4. Create separate letter to document care provided

5. Submit package to RAC within 45 days of receipt

6. Receive Reply from RAC within 60 days

7. RAC Decides in favor of Supplier

8. RAC Determines Overpayment

9. DO NOT Refund Payment

10. RAC Letter offers optional “Discussion Period”

11. Submit additional information to RAC within 30 days

12. Receive Reply from RAC

13. RAC Decides in favor of Supplier

14. RAC Upholds Overpayment

15. Receive DME MAC Demand Letter

16. Proceed to Appeal Denial

Congratulations
2. Carefully review the RAC request
   2.1. Identify the specific information being requested by the RAC
   2.2. Review the Medicare LCD for the coverage guidelines for the services under review
   2.3. Review the “pull list” included with the RAC request. Collect the specific documents from the patient record that satisfy the requirements of the pull list, and that document the provision of, and medical necessity for, the service(s) under review.
   2.4. Note that more than one patient may be included on the RAC request
   2.5. For each patient, create a separate and individual RAC File with a copy of all the information received from and sent to Medicare. This can include but is not limited to:
      2.5.1. Signed and dated progress notes and measurement forms from the patient record related to the services provided (evaluation to delivery)
      2.5.2. Initial or dispensing order, and detailed written order
      2.5.3. Proof of Delivery
      2.5.4. CMN or Certifying Statement (if applicable)

3. For each patient and date of service, request the following documentation, as appropriate, from other healthcare providers involved in the patient’s care. Per Medicare regulations, this documentation must be included in the medical record; the "medical record" is defined as "The medical record is not limited to physician’s office records but may include records from hospitals, nursing facilities, home health agencies, other healthcare professionals, etc. (not all-inclusive)."

3.1. Supporting medical records could include:
   3.1.1. Clinical notes/medical records from the referring physician
   3.1.2. Operative reports
   3.1.3. Progress or clinical notes from surgeon or other healthcare providers
   3.1.4. Hospital records
   3.1.5. Therapy records
4. The clinician may write a separate statement or letter to clarify or support the documentation gathered above; this be helpful in explaining the progression of the patient’s care. However, this statement cannot take the place of this documentation or fill in missing details; the only valid documentation that will be considered is signed and dated documentation that was in the file on or before the date of service.

5. Submit all documentation.
   5.1. Bundle the documentation for each patient separately, and include a copy of the pull list provided with the original RAC request. The RAC request provides the address and/or fax number for records submission.
   5.2. All documentation must be submitted to the RAC within 45 days of the date of the RAC request.

6. The RAC may take up to 60 days to review your submission and make its determination.
   6.1. Once the RAC makes its determination, you will receive a RAC Review Results Letter.
   6.2. The letter will be labeled as such, and will be clearly be marked with the name of the RAC.

7. If the RAC decides in your favor, the process is complete. Congratulations.

8. If the RAC decides that all or part of the claim was paid incorrectly, it will refer the claim to your DME MAC for overpayment collection.

9. Do not refund based solely on the RAC’s Review Results Letter; the overpayment demand letter from the DME MAC will follow shortly and will contain further instructions.
10. The Review Results Letter will offer you the option of entering into an *optional* “Discussion Period” with the RAC. This is an opportunity to provide additional information to support the service billed.

10.1. Note that steps 10 and 11 are optional; you must also proceed immediately to step 14 to initiate an appeal.

10.2. Be advised that if you prepare and submit an appeal, and the RAC subsequently decides in your favor (step 13), then yes, you did all the appeal work for nothing.

10.3. On the contrary, if you did not start the appeal and the RAC decides it is an overpayment (step 14), you just lost valuable time in the process.

11. Your discussion request must be made in writing within 30 days of the results letter and must include evidence to support why you feel the services provided were properly coded and correctly billed and should be covered by Medicare.

11.1. The RAC Review Results Letter will provide you with instructions on where to request a discussion.

**11.2. The Discussion Period is not part of the appeals process; it is an independent opportunity to refute the RAC’s findings. If you receive an unfavorable response during the Discussion Period but fail to submit a timely Redetermination request (see below) you may not appeal the results of the Discussion Period.**

12. The RAC may take up to 60 days to review your discussion period submission and make its determination. Once the RAC makes its determination, you will receive a RAC Review Results Letter. The letter will be labeled as such, and will be clearly be marked with the name of the RAC.

13. The RAC decides in your favor, the process is complete. Congratulations.

14. If the RAC has identified an overpayment it will refer the claim to the DME MAC for adjustment. The DME MAC will subsequently issue an overpayment demand letter to you.
15. The DME MAC demand letter will list the specific claims and claim lines that the RAC has reported as overpaid.

15.1. Demand Letter will come in the form of an overpayment demand from the DME MAC. It may reach you before you receive notification of the RAC review. The demand letter and attached overpayment report may not mention or reference the RAC.

15.2. If you receive a RAC Review Results Letter that indicates you’ve been overpaid, and you do not receive an overpayment demand letter from the DME MAC within 5 business days, you should contact the DME MAC for further instructions.

15.3. Carefully review the overpayment demand letter and attached overpayment report to determine patients, codes and dates of service involved.

15.4. Note that more than one patient may be included on the overpayment report.

15.5. The only circumstances under which refunding should be your first option are:

15.5.1. If the overpayment determination is clearly correct and the services were billed erroneously, see step 17

15.5.2. If you are unable to submit a Redetermination Request within 30 days, see step 19
16. Review the file for each patient to assess the status of the review:
   16.1. Confirm the details related to the specific reason(s) for the denial
   16.2. Review documents from the patient record that specifically address the reason(s) for the denial
   16.3. If overpayment determination is clearly correct and the services were billed erroneously, refund as instructed.
   16.4. If the services were billed correctly, proceed to step 17.

17. Services were billed correctly.
   17.1. Refunds must be made within 30 days of the date of the overpayment demand letter, even if you do not agree with the RAC’s overpayment determination. If refunds are not made timely, Medicare will offset any claim payments associated with the Tax ID number under which your office operates. See step 20.
   17.2. Refunds/offsets may be delayed by submitting a Redetermination request with 30 days of the date of the overpayment demand letter. See step 18.

18. Based upon the documentation you have on hand, determine if you can submit a Redetermination request within 30 days.
   18.1. If a request CANNOT be submitted in 30 days, proceed to step 19
   18.2. If a request CAN be submitted in 30 days, proceed to step 19

19. Submit Redetermination Form to DME MAC within 30 days.
   19.1. If you do not agree with the RAC’s determination, in order to stop overpayment recoupment, you must submit a valid request for a Redetermination within 30 days from the date of the RAC letter.
   19.2. The clinician may write a separate statement or letter to clarify or support the documentation gathered above; this may be helpful in explaining the progression of the patient’s care.
   19.3. However, this note cannot take the place of this documentation or fill in missing details,
   19.4. The only valid documentation that will be considered is signed and dated documentation that was in the file on or before the date of service.
   19.5. The Redetermination request must be submitted to the DME MAC, using the address provided in the RAC letter or overpayment request.
19.6. Appealing within 30 days will put the overpayment on hold, although interest is charged unless the appeals outcome is in your favor. A failure to either appeal or refund within 30 days will cause the overpayment to be recouped through claim offsets ("take backs.")

19.7. In the event that the denial is based upon misapplication of the Medicare LCD, the reference document for the appeal should be copy of the Medicare LCD with specific reference to the clause or specifics of the regulation(s)

19.8. Note that more than one patient may be included on overpayment report.

19.9. For each patient, create a separate and individual RAC File with a copy of all the information received from and sent to Medicare. This can include but is not limited to:

19.9.1. Signed and dated progress notes and measurement forms in the patient record related to the services provided (evaluation to delivery)

19.9.2. Initial or dispensing order, and detailed written order

19.9.3. Proof of Delivery

19.9.4. CMN or Certifying Statement (if applicable)

19.10. If you have not already done so, collect the documentation described in Step 3, as appropriate.

20. If you do not submit your Redetermination request within 30 days, overpayment recoupment will begin on the 31st day.

20.1. Do not submit your appeal or refund to the RAC. You must follow the instructions included in the overpayment letter for both appeals and refunds.

21. If you miss the 30 day mark, you still have up to 120 days from the date of the RAC letter to submit your Redetermination; however, recoupment will occur on the 31st day from the date of the RAC letter.

21.1. Refer to details in step 19.2 to 19.4 with regard to submitting documentation.
22. Once the DME MAC makes its reviews your Redetermination and makes its decision, you will receive a letter that explains the outcome.

23. If the DME MAC decides in your favor, the process is complete. Congratulations.

24. If your Redetermination request is not decided in your favor, you may continue to appeal the RAC’s decision by submitting a Reconsideration request (second level of appeal.)
   24.1. The Redetermination letter will contain instructions on where and when to submit your Reconsideration request
   24.2. If you decide not to go to a second level appeal:
       24.2.1. If you requested the Redetermination within 30 days (step 19), submit a refund.
       24.2.2. If you already did a refund (Step 20 or 21) then no further action is necessary, the refund has already taken place.

25. Submit Reconsideration Form for second level appeal.
   25.1. Reconsideration must be submitted within 180 days of receiving the Redetermination denial
   25.2. It is important to clearly provide specific details or information to support your claim for payment.
   25.3. In some instances the reason for denial from Medicare may change or expand to deny additional codes. It is important to clearly document this change in the request for reconsideration.
   25.4. Complete the Reconsideration form, and submit it with supporting documentation to the QIC at the address indicated on the Redetermination letter.

26. Once the QIC makes its determination, you will receive a decision letter.

27. If the DME MAC decides in your favor, the process is complete. Congratulations.
28. If your Reconsideration request is not decided in your favor, you may continue to appeal the RAC’s decision by submitting an ALJ (third level of appeal.)

28.1. The Reconsideration letter will contain instructions on where and when to submit your ALJ request.

28.2. If you decide not to go to a third level appeal:

28.2.1. If you requested the Redetermination within 30 days (step 19), submit a refund.

28.2.2. If you already did a refund (Step 20 or 21) then no further action is necessary, the refund has already taken place.

29. If you wish to continue your appeal by requesting an Administrative Law Judge (ALJ) Hearing (third level of appeal.) The Reconsideration letter will contain instructions on where and when to submit your ALJ Hearing request:

29.1.1. ALJ request must be submitted within 60 days of receiving the Reconsideration denial.

29.1.2. Complete forms to request an ALJ

29.1.3. Provide basic ALJ steps

29.1.4. New information CANNOT be submitted, case must rest only on documentation already provided in 1st and 2nd level appeal.

29.1.5. Complete a simple overview and documentation support to submit for ALJ

30. ALJ Schedule and Attendance

30.1. A Federal Judge Clerk will contact you by fax or mail to inform you of the date and time of your ALJ.

30.2. You have 5 days to respond and confirm the ALJ date and time.

30.3. If you do not respond timely, the denial will be upheld.

30.4. The typical procedure is that on the scheduled time and date, the judge will call you and host a conference call to review the documentation and listen to your reasoning as to why the denial should be overturned.

30.5. The ALJ is a legal proceeding, each witness is sworn in and all testimony is recorded and on the record.
31. If you win the ALJ, congratulations, you have successfully supported your patient by having reasonable and necessary services properly reimbursed.

32. If you do not wish to appeal the ALJ’s decision, then the RAC process is now exhausted:
   32.1.1. If you requested Redetermination within 30 days (step 19), submit a refund.
   32.1.2. If you already did a refund (Step 20 or 21) then no further action is necessary, the refund has already taken place.

33. You may appeal an ALJ decision with the Medicare Appeals Council
   33.1. Proceeding to this level must be approved by Hanger Clinical Operations, Compliance and Legal Departments.
   33.2. Appeal to Medicare Appeals Council must be submitted within 60 days of receiving the unfavorable ALJ Ruling.
   33.3. This level of appeal is under a public forum, which means the final decision is published and can be used to set precedent for future cases.
   33.4. If you choose to appeal to the Appeals Council, the ALJ Denial letter will provide details as to the process to submit the appeal.
   33.5. To overturn an ALJ, you must provide evidence to clearly show that the ruling Judge made a mistake in applying the rule of law, simply disagreeing with the decision is not an acceptable reason to appeal.

34. If you win the appeal to the Medicare Appeals Council, congratulations; you have successfully supported your patient by having reasonable and necessary services properly reimbursed and have help set a precedent for future rulings.

35. If the ALJ Medicare Appeals Council appeal is not favorable, and you do not wish to appeal further, the process is now exhausted:
   35.1.1. If you requested redetermination within 30 days (step 19), submit a refund.
   35.1.2. If you already did a refund (Step 20 or 21) then no further action is necessary, the refund has already taken place.
36. If you wish to appeal an unfavorable decision by the Medicare Appeals Council, you may request a judicial review in Federal District Court:

36.1. The Appeals Council decision will contain instructions for filing this fifth and final level of appeal.

36.2. Amount in controversy must be at least $1400.

36.3. You must request this level of appeal within 60 days of the Appeals Council decision.

37. If you win the appeal in Federal District Court, congratulations; you have successfully supported your patient by having reasonable and necessary services properly reimbursed.

38. If your appeal in Federal District Court is not found in your favor, you have exhausted the Medicare Appeals process. If you have not already done so, you must submit a refund.