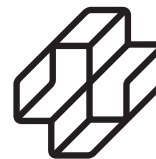


Revenue Cycle Strategist



hfma[™]

healthcare financial management association

www.hfma.org/rcs

How to Write a RAC Appeal Letter

By Karen Bowden

A well-written RAC appeal letter can help you win your case and ease the administrative burden of audits.

Published statistics on RAC appeals led providers to believe that only one out of every three appeals were successfully decided in the provider's favor. The low rate of success and prohibitive costs of appealing may have led hospitals to choose not to appeal even when they disagreed with the auditor's findings. However, the June 2010 update to the evaluation of the three-year RAC demonstration program reported that providers were actually winning nearly double the amount of appeals that was previously reported. The reason behind the reversal is that in previous reports, CMS was counting each appeal level as a separate appeal. In fact, 64.4 percent of all appeals were decided in the provider's favor.

Often, the content of your appeal letters will determine whether you will win your case.

Writing a comprehensive appeal letter with well-developed arguments may seem like a burden so early in the process, but taking the time to research and write your letter has significant long-term benefits over the course of your appeal. A well-written appeal can eliminate the need for hiring attorney representation at the administrative law judge (ALJ) level and beyond. Also, these audit appeals not only are about recouping the dollar value of this and other comparable claims, but also affect your facility's risk of further audits if these

INSIDE THIS ISSUE

Coding Q&A: Late Hours Coding	4
Reprocessing Claims Affected by ACA and 2010 MPFS Changes	5
Case Study: Working with Medicaid to Benefit Your Bottom Line	6
Medicaid Spending on Dual Eligibles, FFY07	8

WEB EXTRAS!

See an example of a RAC appeal letter at www.hfma.org/rcs

Coming Soon: Medicaid Recovery Audit Contractors
www.hfma.org/rcs

kinds of appeals are lost. Ask yourself: Is this a fight we need to win to stay in business?

Getting Started with an Appeal

The fundamental rules of the appeal process are:

- > Never assume that a RAC denial is accurate. If you believe you can defend how you billed a claim, then defend it by writing an appeal.
- > Always meet appeal deadlines at the first and second levels of appeal that stop an automatic recoupment of payment. Any appeal that is received after the 30th day at the first level of appeal or the 60th day at the second level of appeal will result in recoupment of the original Medicare payment.
- > Write the first level of appeal to win at an ALJ level of appeal. New evidence cannot be presented at the ALJ level, so you should use the time and resources necessary to defend your position fully at the first level of appeal.

Robert Fromberg
Editor-in-Chief

Carole Bolster
Senior Editor

Amy D. Larsen
Production

Revenue Cycle Strategist is published 10 times a year by the Healthcare Financial Management Association, Two Westbrook Corporate Center, Suite 700, Westchester, IL 60154.

Presorted nonprofit postage paid in Chicago, IL 60607.
©2011 Healthcare Financial Management Association.

Volume 8, Number 2

Subscriptions are \$110 for HFMA members and \$165 for other individuals and organizations. Subscribe online at www.hfma.org/rcs or call 1-800-252-HFMA, ext 2. To order reprints, call 1-800-252-HFMA, ext. 387.

To submit an article, contact Carole Bolster at cbolster@hfma.org.

Revenue Cycle Strategist is indexed with Hospital and Health Administration Index and the HealthSTAR database.

Material published in **Revenue Cycle Strategist** is provided solely for the information and education of its readers. HFMA does not endorse the published material or warrant or guarantee its accuracy. The statements and opinions in **Revenue Cycle Strategist** articles and columns are those of the authors and not those of HFMA. References to commercial manufacturers, vendors, products, or services that may appear in such articles or columns do not constitute endorsements by HFMA.

ISSN 1549-0858

Writing the Appeal Letter

A successful appeal letter should do the following:

- > Recap denial, date of the letter, and issues the RAC identified.
- > State clearly your disagreement with the RAC findings.
- > Present clear and concise arguments that support your position. Use as many as possible.
- > Use Medicare's definition of an inpatient, and describe how the case at hand meets those criteria.
- > Reference relevant sections of the medical record, and cite the page (highlight entries and attach to appeal).
- > If your hospital's utilization management plan addresses complex patients and/or complex procedures that support your position, supply specific guidelines and describe the hospital's approval process.
- > Cite commercial payer experience during the timeframe of the review to support community standard of care.
- > If the appeal relates to a coding issue, attach all supporting documentation to defend the coded claim.

When filing a RAC appeal, you should be persistent. If you believe you are right and have the evidence to support your argument, continue to escalate your appeal to higher levels if you are not initially successful. Experience has shown that the ALJ level is the first real voice you will have to defend your position. The data show that the ALJs have been fair and reasonable in making decisions. The outline followed for the first level of appeal will be the defining argument presented to the ALJ.

Keep in mind that the content and arguments the appeal letter contains will vary based on whether the appeal deals with coding or medical necessity.

Coding Appeals

The root cause of coding-related denials is usually related to documentation that does not support the coding (e.g., major complication and comorbidity/complication and comorbidity [MCC/CC] not documented; coded procedure not supported) or coding errors (e.g., incorrect principal diagnosis sequencing, incorrect discharge disposition, or incorrect code selection). Coding denials are typically partial claim denials where the RAC recommends coding changes that result in a lower paying diagnosis-related group (DRG) as a result of changing the principal diagnosis or disqualifying the MCC/CC. The RACs are targeting DRGs with only one MCC/CC, which logically may be easier to disqualify than claims that group to a DRG with multiple MCC/CCs coded.

The first step in responding to a coding-related RAC denial is to review the medical record. If the reviewer agrees with the RAC determination, the case should *not* be appealed. Management should determine if a pattern of errors can be identified so a corrective action plan can be developed to correct the underlying issue. On the other hand, if the reviewer disagrees with the RAC determination, the reason for the disagreement will lead to the next action.

If supporting documentation is missing, you should initiate a discussion period and submit the missing documentation to support the coding to the RAC. Keep in mind that the discussion period is not an appeal and that the clock is still ticking on the 30-day appeal response deadline. The RAC will accept missing documentation during a discussion period, and this step could successfully resolve the RAC denial. Timely follow-up with the RAC during the discussion period will be necessary to determine the outcome of the "discussion." If there is no resolution of

the denial with the RAC by day 20, then you must write an official first-level appeal and use the missing documentation to respond to the denial.

For all other reasons, an appeal will be necessary to resolve coding-related denials.

Arguments to support your appeal should be based on evidence—either medical record documentation or other official coding rules. You should fully develop your arguments in a well-written, clearly understood appeal letter, as previously mentioned. Simply filling out a form that states that you disagree with the RAC or writing an undeveloped one-line statement will not bring the result you hope. Complex denials typically put significant revenue at risk for loss.

You should always develop coding arguments based on evidence:

- > Research official coding rules in ICD-9 Coding Rules and Regulations.
- > Research updates to coding rules in the *AHA Coding Clinic* and cite references.
- > Request letters of clarification from physicians, and file these as late entries to the medical record.
- > Research other rules or definitions. In one organization's experience, ALJs supplied numerous definitions for surgical debridement that they accepted in addition to the *Coding Clinic* definition.

Medical Necessity Appeals

Medical necessity denials are typically focused on short stays and are defined by the RAC as either procedure not an inpatient procedure or admission does not meet inpatient level of service. Both issues result in full claim denials because a medically necessary admission is required for Medicare coverage to apply.

The reviewer who works your facility's medical necessity denials should be well

Five Levels in the RAC Appeals Process

Medicare offers five levels in the Part A and Part B appeals process. The levels, listed in order, are:

- > Redetermination by a fiscal intermediary, carrier, or Medicare Administrative Contractor
- > Reconsideration by a Qualified Independent Contractor
- > Hearing by an Administrative Law Judge
- > Review by the Medicare Appeals Council within the Departmental Appeals Board
- > Judicial review in U.S. District Court

Source: Centers for Medicare & Medicaid Services.

versed in Medicare's definitions of an inpatient and the criteria used to meet medical necessity, which can be found in the *Medicare Benefit Policy Manual*, Chapter 1, Section 10:

An *inpatient* is a person who has been admitted to a hospital for bed occupancy for purposes of receiving inpatient hospital services. Generally, a patient is considered an inpatient if formally admitted as inpatient with the expectation that he or she will remain at least overnight and occupy a bed even though it later develops that the patient can be discharged or transferred to another hospital and not actually use a hospital bed overnight.

Additionally, the reviewer should be familiar with the limitation of liability provision of the Social Security Act. The language in this act defines the criteria for holding providers liable in that they knew or should have known that the admission would not be covered by Medicare:

...no provider shall be civilly liable for action taken in compliance with professionally developed norms of care and treatment operating in the area where such doctor took such action...

As with coding appeals, the first step for medical necessity appeals is a thorough review of the RAC denial and the medical record in question. To speed this process, the reviewer should develop a template to abstract information from the medical record as it is reviewed. The

template should include all information that needs to be collected to formulate the appeal:

- > Admission review notes written by the case manager who approved the case for meeting inpatient level of care (If the patient met InterQual or Milliman criteria for admission, the reviewer should document that fact.)
- > Physician order for inpatient admission
- > Presenting signs and symptoms that necessitated inpatient care
- > All significant comorbidities
- > Significant interventions and/or monitoring that is typically performed on an inpatient basis
- > Patient condition or presence of comorbidities that increase risk of procedure performed (e.g., chronic kidney disease in patients having a procedure with significant contrast load)
- > Whether something occurred that made the procedure complex (e.g., three coronary stents were placed)
- > Any complications that developed as a result of the procedure or after admission

Additionally, the reviewer should research and document other findings related to the case:

- > Any clinical evidence published in professional journals that supports the level of care billed and/or rates of complications with certain comorbidities that may be applicable
- > Hospital-specific guidelines that have been approved by the utilization

management committee and adopted as admission guidelines

> Information related to the rate non-government payers approved for the procedure as an inpatient utilizing concurrent authorization procedures (This information may be a key data point when testing the limitation of liability. If all other payers approve a procedure as inpatient and those payers use a real-time authorization process that has set a community standard of care, how could you have known Medicare would not cover this procedure as an inpatient service?)

After all this information is assembled, the reviewer must determine whether he or she agrees or disagrees with the RAC determination of noncoverage. Just as described in the coding section, if a case cannot be defended in appeal,

management should determine if a pattern of errors can be identified so a corrective action plan can be developed to correct the underlying issue. If the reviewer disagrees with the RAC determination, the reason for the disagreement will be well defined from the abstract created during record review. Use the abstract to help recap the denial and the issues the RAC identified, and write a clear statement of disagreement with the RAC findings in your appeal letter.

Assessing Resources and Skills

The person or team assigned to reviewing and appealing RAC audit denials via appeal letters should be able to wear many hats during the appeals process. When assembling a team or choosing your facility's RAC coordinator, look for the following skills: legal knowledge;

billing knowledge; analytic writing capability; project management skills; accounting skills; and time, availability, and priority to complete the process.

Preparing and responding to RAC audits can be a daunting task, requiring cross-departmental coordination under tight deadlines. Repeated automatic recoups from missed deadlines can play havoc on cash flow, so take the time to prepare a template for writing appeal letters. You will win more cases, get your appeals out the door on time, and help ease the administrative burden that RAC and the alphabet soup of other audits have placed on providers. ☞

Karen Bowden is Senior VP of Consulting, Craneware InSight, Needham, Mass., and a member of HFMA's Massachusetts-Rhode Island Chapter (kbowden@claimtrust.com).



May 5, 2010

Hospital Name: General Medical Center
HIC #999999999A
MRN # 1234567
Patient Name: Doe, John
Dates of Service: 2/6/2006-2/7/2006
RAC reference ID: 12345678901

To Whom It May Concern:

General Medical Center was notified by the RAC that it received Medicare payment in error for the above referenced claim. We are writing to request redetermination of the RAC Decision which states "the procedures performed (CPT 35473, 35474 and 75635) are on the CMS Hospital Based Outpatient Prospective Payment System/APC list for 2006 and therefore this claim should be billed at the appropriate outpatient level of care." General Medical Center has developed process and procedures for determining the clinically appropriate level of care. The process is based upon established clinical criteria, community standards of care, payer-specific guidelines and an internal clinical review process. A rigorous utilization assessment is conducted on all admissions and each case is validated for the appropriateness of the level of care assigned. General Medical Center is confident that we have billed this procedure correctly and in compliance with Medicare and other Federal laws which are presented in this appeal.

The admitting attending physician documented his intent for providing inpatient level of care at the time of admission by writing an inpatient admission order. Attached is a signed, dated and timed physician admission order to the Intensive Coronary Care Unit (ICCU). In summary, Mr. Doe is a 75 year old man with a past medical history of Peripheral Vascular Disease, Diabetes and Renal Insufficiency with an admission Creatinine of 1.9, who underwent angioplasty of his right common iliac artery and right superficial femoral artery with stent placement. His postoperative course was complicated by hypertension with BP's 180-210/70-80s which was treated with Hydralazine IV and HCTZ. He was monitored with intensive vital signs throughout his inpatient stay. He received pre and post intravenous bicarbonate and Mucomyst for protection against Contrast Nephropathy and continued on 100cc/h of IVF. The following day, he was discharged after careful monitoring of lab values specifically his Creatinine to ensure his renal status was stable. The utilization management protocol at the medical center leveled this case as inpatient. Based upon the physician intent and the clinical justification presented here, Medicare rules and regulations for establishing inpatient level of care have been met. The inpatient admission was reasonable and medically justified.

General Medical Center also requests redetermination of the decision that was based solely on the fact that a peripheral angioplasty is not on the Medicare Inpatient Only list. The Recovery Audit Contractor has misinterpreted the intent of the Medicare Inpatient Only list. The Medicare Inpatient Only list was created to identify the procedures that can only be safely done as an inpatient. It identified and excluded cases that could not be performed as an outpatient. Under the hospital Outpatient Prospective Payment

In the introduction, you should recap the denial, the date of the letter and issues the RAC identified. List the claim in question and the reason why it was denied.

Clear statement of disagreement with the RAC findings.

In this example, the RAC has denied inpatient level of care as not medically necessary. We begin building our argument by referencing the attached inpatient admission order from the attending physician. You should list as many clinical justifications as possible. For example, if your Utilization Management Plan addresses complex patient or complex procedures that support your position, then supply the specific guidelines and the described approval process at your hospital. Use Medicare's definition of an inpatient and describe how the case at hand meets those criteria.

System (OPPS) regulations, CMS has broad latitude to characterize a particular service as appropriate for outpatient care. Certain surgical procedures, radiologic procedures (including radiation therapy), clinic visits, partial hospitalization for the mentally ill, surgical pathologic evaluations, and cancer chemotherapy are listed by the agency as types of care that are probably appropriately performed on an outpatient basis. CMS has given some indication of the guidelines it uses in determining the appropriate setting for a medical procedure. An invasive procedure that requires at least 24 hours of recovery or observation before a patient can be safely discharged was cited as an example of a service that should be performed on an inpatient basis. See 65 Federal Register 18434-18820 (April 7, 2000). The placement of a procedure in the outpatient category does not mandate that it be performed in that setting, with the final determination ultimately dependent on patient-specific factors as determined by his or her physician. For instance, should a patient's underlying medical condition necessitate at least 24 hours of recovery or observation following what is normally considered an outpatient procedure, a hospital may perform that procedure in the inpatient setting.

Here, although certain of the Beneficiary's procedures were included in OPPS and assigned to an ambulatory payment classification (APC) as being "outpatient," Medicare coverage of resulting hospital admission is not precluded. According to the Medicare Benefit Policy Manual, factors to be considered when making the decision to admit include such things as the severity of the signs and symptoms exhibited by the patient; the medical predictability of something adverse happening to the patient; the need for diagnostic studies that appropriately are outpatient services (i.e., their performance does not ordinarily require the patient to remain at the hospital for 24 hours or more) to assist in assessing whether the patient should be admitted; and the availability of diagnostic procedures at the time when and at the location where the patient presents.

In this case, there is no evidence to demonstrate that the physician's judgment to admit the Beneficiary as an inpatient was unnecessary or inappropriate. The decision to admit the Beneficiary was the result of a complex medical judgment that was only made after the physician considered the Beneficiary's complex medical history (including peripheral vascular disease status, diabetes, and renal insufficiency) and current needs. The Beneficiary presented for the surgery and, after the surgery was completed, time was needed in order to ensure that the Beneficiary did not experience complications based upon his co-morbidities. Given the Beneficiary's age, medical history, and presenting status, an overnight inpatient admission was both medically reasonable and necessary.

Accordingly, the hospital admission furnished to the Beneficiary meets Medicare coverage requirements. Therefore, the hospital admission at issue should be covered under Medicare.

Sincerely,

Mary Smith, RN, BSN
Appeal Specialist
General Medical Center

To conclude this example, we provide a comprehensive argument that the RAC has misinterpreted the the intent of the Medicare Inpatient Only list.

After your clinical arguments, your letter can be modified with different ALJ references that can be added to the letter to support the appeal. Cite commercial payer experience during the timeframe of the review to support community standard of care.

Always attach all supporting documentation. This is especially important for coding-relating denials in order to defend the coded claim. Reference sections of the medical record and cite the page (highlight entries and attach to the appeal).