



How to Prepare a Winning RAC Appeal

Craneware InSight Consulting

Introduction

● Introductions

- Karen Bowden, RHIA, Senior VP of Craneware InSight Consulting
- Managed demo phase RAC appeals for nine hospitals in Massachusetts, totaling 340 appeals valued at \$7.2 million.
- Only 1 in every 3 appeals were successful in RAC demo phase according to CMS*, but Craneware InSight won 90 % of our appeals to date, with 11 still in play.



* The Medicare Recovery Audit Contractor (RAC) Program: An Evaluation of the 3-Year Demonstration, CMS (June 2008)

Outline of Webinar

1. **RAC Impact**
2. **Three Fundamental Rules**
3. **Coding Related Denials**
4. **Medical Necessity Denials**
5. **Appeal Letter Format**
6. **What to expect at FI, QIC, and ALJ levels**

Impact: RAC Demonstration Phase

- Overpayments collected from providers – **\$993M**
- Underpayments paid back to providers – **\$38M**
- Auditors are paid commissions up to 9-13%.

Three Fundamental Rules

Rule #1: Don't assume the RAC denial is accurate

If you believe you can defend how you billed a claim, defend it by writing an appeal.

Three Fundamental Rules

Rule #2: Stop automatic recoupment of payment

Always meet appeal deadlines at the 1st and 2nd levels of appeal that stop an automatic recoupment of payment. Any appeal that is received after the 30th day at the 1st level of appeal or the 60th day at the 2nd level of appeal will result in recoupment of your original Medicare payment.

Three Fundamental Rules

Rule #3: First do your homework, then write your appeal

Write your 1st level of appeal to win at an ALJ level of appeal. New evidence can not be presented at the ALJ level, therefore, you should take the time and resources necessary to defend your position fully at the first level of appeal.

Coding Related Denials

- **Root causes are usually:**
 - documentation that does not support the coding [e.g., MCC/CC not documented; coded procedure not supported] or
 - coding errors [e.g., incorrect principal diagnosis sequencing, incorrect discharge disposition, incorrect code selection].

Coding Related Denials

- **Coding denials are typically partial claim denials where the RAC recommends coding changes that result in a lower paying DRG as a result of changing the principal diagnosis or disqualifying the MCC/CC.**
- **RAC is targeting DRGs with only one MCC/CC which logically may be easier to disqualify rather than claims that group to a DRG with multiple MCC/CCs coded. They are also targeting easy calculations prone to error such as DRGs with 96+ hours of intubation.**

Appealing Coding Related Denials

- **The medical record should be reviewed to determine if the reviewer agrees or disagrees with the RAC determination. Don't assume the RAC denial is accurate.**
 - If the reviewer agrees with the 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.
 - If the reviewer disagrees with the RAC determination, the reason for the disagreement will lead to the next action.

Appealing Coding Related Denials

- **If supporting documentation is missing, a request for a discussion period should be initiated and documentation to support the coding should be submitted to the RAC.**
 - Please note, the discussion period is not an appeal and the clock is still ticking on the 30 day appeal response period. However, the RAC will accept missing documentation during a discussion period and it may be a step that successfully resolves the RAC denial. Timely follow-up with the RAC during the discussion period will be necessary to determine the outcome of the “discussion”.
 - If by day 20 there is no resolution of the denial with the RAC, an official 1st level appeal should be written to stop automatic recoupment of payment. Use the missing documentation to respond to the denial.

Appealing Coding Related Denials

- For all other reasons, Craneware InSight Consulting believes an appeal will be necessary for denial resolution.

Developing Arguments for Coding Appeals

- **Arguments to support your appeal must be based on evidence, either medical record documentation or other official coding rules.**
- **You must fully develop your arguments in a well written, clearly understood appeal letter.**
- **Simply filling out a form that states you disagree or a one-line statement may not bring the result you hope.**
- **Complex denials typically put significant revenue at risk for loss. Writing a comprehensive appeal with appeal arguments that support your position is the best chance of winning an appeal. Do your homework.**

Developing Arguments for Coding Appeals

- **Develop coding arguments based on evidence:**
 - Research official coding rules in ICD9 Coding Rules and Regulations.
 - Research updates to coding rules in the AHA Coding Clinic – cite references.
 - Request letters of clarification from physicians or surgeons and file these as late entries to the medical record.
 - Research other rules or definitions – we had an experience where ALJs supplied numerous definitions for surgical debridement that they accepted in addition to the Coding Clinic definition.

Medical Necessity Denials

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

Preparing a Medical Necessity Appeal

- **The reviewer working medical necessity denials should be well versed in Medicare definitions of an inpatient and the criteria used to meet medical necessity.**
 - Definitions can be found in the MBPM Chapter 1, section 10
- **Additionally, the reviewer should be familiar with the Limitation of Liability in the SSA, section 1879.**
 - The language in this act defines the criteria for holding a provider liable in that they knew or should have known that the admission would not be covered by Medicare.
- **Review the RAC denial and the medical record to abstract clinical information that meets Medicare inpatient status criteria**

Preparing a Medical Necessity Appeal

- **Develop a template to abstract information from the medical record as it is reviewed. Information that should be collected to formulate the appeal includes:**
 - 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, document that fact.
 - Physician order for inpatient admission
 - Presenting signs and symptoms that necessitated inpatient care
 - All significant co-morbidities
 - Significant interventions and/or monitoring that is typically performed on an inpatient basis
 - Patient condition or presence of co-morbidities that increase risk of procedure performed (i.e. chronic kidney disease in patients having a procedure with significant contrast load)
 - Did something occur that made the procedure complex (e.g., 3 coronary stents were placed)
 - Any complications that developed as a result of the procedure or after admission

Preparing a Medical Necessity Appeal

- **Additionally, the reviewer should research and document findings related to:**
 - Clinical evidence published in professional journals that supports the level of care billed and/or rates of complications with certain co-morbidities 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 the procedure as an inpatient utilizing concurrent authorization procedures.
 - This 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 which set a community standard of care, how could you have known Medicare would not cover this procedure as an inpatient service?

Decision to Appeal?

- **After all this information is assembled, the reviewer must determine if he agrees or disagrees with the RAC determination of non-coverage.**
 - Just as described in the coding section, if a case can not 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.

The Appeal Letter Format

- **The appeal letter format our Consulting team uses is as follows:**
 - Recap of denial, date of the letter and issues the RAC identified
 - Clear statement of disagreement with the RAC findings
 - Clear, concise arguments that support your position – use as many as possible
 - Use Medicare definition of an inpatient and describe how the case at hand meets those criteria
 - Reference sections of the medical record and cite the page (highlight entries and attach to appeal)
 - If Utilization Management Plan addresses complex patient and/or complex procedures that support position, supply specific guidelines and described approval process at the hospital.
 - Cite commercial payer experience during the timeframe of the review to support community standard of care.
 - If coding issue, attach all supporting documentation to defend coded claim.

Our Experience - FI Level Appeals

- **The FI appeal experience was not very revealing**
 - The same argument was made for similar cases, some won – some lost. No discernable differences could be identified
 - The FI did not send letters when denials were overturned, just payments on remittance advice – so we did not know why we won
 - Cases where denials were upheld, seemed to be rubber stamped with language identical to the RAC
 - Many denial letters had cut and paste errors, referencing wrong hospitals, patients, procedures.

Our Experience - QIC Level Appeals

- **Invalid Admission Orders**
 - Did not recognize electronic orders
 - Did not recognize orders written as “admit to MD, floor”
 - Denied entire claims for missing admission order dates and signatures
 - RAC could not deny for these reasons but QIC did
- **Basis for Appeal to ALJ**
 - HPMP training document on writing Observation orders states an order written as, “Admit to Dr. Smith” or “Admit to 7 North” is considered an inpatient order.
- **No informed consent**
 - Bedside procedures – debridement – not appealed
 - Corrective action plan required.

Our Experience - ALJ Level Appeals

- **You probably don't need an attorney**
 - CMS had an attorney present during two ALJ hearing where more than 20 cases were being heard. CMS never involved a medical expert in a hearing. CMS attorneys never asked a single question nor did he present additional documentation supporting their decision.
 - The judge swore us in over the phone and verified that we waived our right to an attorney.
- **The ALJ level is the first real voice you will have to defend your position.**
 - The data shows that the ALJ has been fair and reasonable in making decisions.
 - The outline followed for the first level of appeal will be the defining arguments presented at ALJ.

Our Experience - ALJ Level Appeals

- **You do not learn the outcome of a hearing until you get the written decision.**
- **Each response provided valuable arguments for future appeals.**
 - Craneware InSight has catalogued these ALJ opinions for reference in future appeals for InSight Audit.
- **Decision can depend on your judge**
 - All 11 cases lost at ALJ were decided by one judge who made a different decision than many others on similar cases.
- **Cases won at ALJ level or higher are eligible for interest payments.**
 - Interest was not paid to our clients and required follow-up.

Stand By Your Claim!

- **Be persistent if you believe you are right. Continue to escalate your appeal to higher levels if not successful.**