
MEDICARE COMPLIANCE

RAC Denials for Unnecessary Admissions Are Overturned; Process Is Questioned

Hospitals may be able to fend off recovery audit contractor (RAC) claims denials for medically unnecessary admissions or services because some of them have been overturned, experts say. If RACs are too quick to reject admissions because they don't meet screening criteria (e.g., InterQual) without looking at the entire medical record, hospitals may be able to reverse them. Products like InterQual are just guidelines, experts say, and their use is not required by Medicare. The best approach, however, is to have an effective up-front process that provides ample documentation of the decision making behind an inpatient admission as described in the *Medicare Benefit Policy Manual*.

Meanwhile, there's evidence that RACs may rush to judgment about some inpatient admissions, says physician Robert Corrato, M.D., CEO of Executive Health Resources, a Philadelphia consulting firm. For example, CMS appeals contractors and administrative law judges overturned more than 1,000 RAC claims denials appealed by hospitals in four states toward the end of the RAC pilot, which wrapped up in March, says Corrato, whose organization helped the hospitals mount appeals. The hospitals were able to prove that the admissions and/or services were medically necessary, he says.

"We did more than 7,000 appeals. Of the 1,000 cases fully adjudicated so far, we were able to get all of them overturned," he says. He attributes many of the reversed denials to RACs' over-reliance on InterQual. "We often see the use of InterQual in a way that goes beyond the limitations of the tool," he contends.

However, CMS says that only 5% of RAC determinations were overturned on appeal from the beginning of the pilot through Oct. 31, 2007. "CMS does not expect this number to change significantly once the evaluation report of the three-year demonstration is released," a CMS official tells RMC. About 40% of the overpayments identified by RACs were based on their assertions that the services lacked medical necessity. But Corrato notes that "when the 5% figure was computed, very few cases had advanced to the third level of appeal (the ALJ)" and "CMS's own statistics... indicate that 44.2% of appealed cases were decided in favor of the provider."

If hospitals feel admissions are justified, they should appeal RAC denials that are based solely on InterQual or on superficial review of the medical records, experts say. "InterQual has never been published as the standard for hospitals to follow by Medicare," says Fort Lauderdale, Fla., attorney Lester Perling, who is with Broad and Cassel. "There are no published national criteria for [determining] inpatient admission versus observation."

RACs are Medicare's first contingency-fee contractors. They get paid only for identifying payment errors. In 2005, at Congress' direction, CMS launched RACs as a pilot in three states — Florida, New York and California. South Carolina and Massachusetts were added last year. And now, again under a congressional mandate, CMS is taking RACs national (though in stages). The first part of the rollout began in May. RACs will be operational in all states by early 2009 (*RMC 4/21/08, p. 3*).

RACs were encouraged to use InterQual or another screening tool during the pilot, CMS says, "to help them identify claims where the severity of the patient's illness and intensity of services provided by the hospital did not justify an inpatient hospital stay. The screening tool served only as a guideline to assist the clinician reviewer. In other words, failure to meet the standards of a particular screening tool does not necessarily warrant the denial of a claim."

Under the pilot, RACs got paid even when their overpayment determinations were reversed on appeal. But in the permanent program, RACs will lose their contingency fees if their findings are reversed on appeal. That should reduce the incidence of unfounded claims denials. But the whole medical-necessity picture can be murky.

"As much as we want medicine to be precise, you have patient variability," points out Marion Kruse, a director at FTI Consulting in Atlanta. Admission decisions are not always black and white (except for Medicare's list of inpatient-only procedures), she says.

The *Medicare Benefit Policy Manual* spells out what's required for admission, and that should be good enough to sustain a claim for inpatient care, regardless of whether InterQual agrees, she says (as long as a hospital complies with the Medicare conditions of participation and has a

utilization-review committee in place to monitor admission necessity and arbiter disputes). "Generally, a patient is considered an inpatient if formally admitted as an 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," according to Chapter 1, "Inpatient Hospital Services Covered Under Part A." "The decision to admit a patient is a complex medical judgment which can be made only after the physician has considered a number of factors."

For medical DRGs, Kruse says, the heart of documentation should be the physician's explanation of the risk the patient faces if discharged home. What is the physician worried about and why? Is it the way the patient reacted to treatment? Is it his or her history? Is the patient receiving medical care that can't be done in an

outpatient setting (e.g., pulse oximetry monitoring)? "If physician documentation focuses on that, hospitals could fight [RAC denials] and show they are meeting the Medicare manual," says Kruse.

Corrato says that high-dollar, short-length-of-stay diagnoses were closely scrutinized toward the end of the RAC demonstration, a trend he expects to continue. In particular, he saw a lot of RAC attention to orthopedic procedures (e.g., kyphoplasty, which involves rebuilding vertebrae) and interventional cardiology procedures (e.g., angioplasty, pacemaker implantation). With advances in technology, lengths of stay are shortening, he says, which made auditors think these procedures could be done on an outpatient basis.

"The problem is the evaluation of these cases is often incomplete," contends Corrato. "Just because you can take care of a very sick patient in one day doesn't mean they

Preventing, Overturning RAC Denials for Unnecessary Admissions

To defend against inappropriate recovery audit contractor (RAC) denials, Robert Corrato, M.D., recommends that hospitals have "a compliant daily process for review and certification of Medicare admission status." The goal is to achieve proper certification of claims as either inpatient or observation status, says Corrato, who is CEO of consulting firm Executive Health Resources (see story, p. 1).

Here are tips from Corrato on designing a compliant process:

- ◆ **Make sure your hospital has a strong utilization-review plan and committee** that are consistent with the standards of the Medicare Conditions of Participation (CoPs).
- ◆ **Enforce a two-level admission medical-necessity certification process**, as directed by the *Hospital Payment Monitoring Program Compliance Workbook*. This calls for strict application of inpatient screening criteria by case or utilization managers, followed by physician review of cases that don't meet the screening criteria, he says.
- ◆ **Check that case managers and utilization managers use updated inpatient screening criteria.**
- ◆ **Work closely with a physician-adviser team that is knowledgeable** in Medicare and Medicaid rules and regulations, is up-to-date on evidence-based care guidelines and algorithms, and has a track

record of experience in making consistent and valid medical-necessity determinations.

- ◆ **Provide ongoing training for — and inter-rater reliability testing of —** your case- or utilization-management and physician-adviser teams.
- ◆ **Create "an enduring and auditable document for each Medicare case** that provides permanent evidence of your compliant Medicare claim status certification process," and make it available for review, if necessary, by a RAC auditor, he says.
- ◆ **Educate treating physicians on the importance of complete documentation**, the need to work closely with case management and physician advisers, and the role they play in ensuring both hospitals and physicians practice regulatory compliance.
- ◆ **Develop processes to ensure communication among case managers**, physician advisers and the treating physicians, as required by the CoPs.
- ◆ **Conduct regular analysis of your Program for Evaluating Payment Patterns Electronic Report**, looking critically at observation and one-day stays, to identify areas that need improvement or more attention.
- ◆ **Ensure that the case management, health information management/coding, finance and compliance departments** are involved in the process of ensuring a compliant daily Medicare claim status certification program.

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don't qualify as an inpatient under regulatory guidelines." Conversely, he says, a patient who is in the hospital for three days may never meet Medicare admission criteria.

For example, patients at high risk of death from major blockages of their coronary artery may stay in the hospital only briefly because "we can fix [their problem] fast with clot-busting medicines or platelet-blocking medicines or angioplasty," he says. "It's not about the time the patient spent in the hospital. It's about the physician's evaluation of the probability of something bad happening to the patient if we don't manage them quickly and in the appropriate setting."

Patients with similar presenting symptoms but different histories and life circumstances may wind up in different settings, Corrato notes. He uses the example of a 17-year-old weightlifter and a 90-year-old woman who both present to the emergency department with chest pain. The teenager bench-pressed a lot of weight the night before, so the physician figures he probably pulled a muscle. But the patient's father had a heart

attack at age 40, so the teenager is placed in observation and given a stress test, echocardiogram, etc. The senior citizen has a history of coronary artery disease, takes heart medicine and also had severe chest pain six months earlier, so she's given the same tests, but admitted as an inpatient. "A lot of these cases might not meet screening criteria like InterQual but will meet Medicare definitions. The auditors are not really looking in depth," says Corrato.

However, he says, there are plenty of cases that are straightforward. Some patients don't belong in an inpatient setting. For these patients, hospitals will legitimately face RAC overpayment determinations if they're inappropriately admitted. The best protection against mistaken admissions is an effective process to ensure compliance with Medicare regulations on admission necessity (see tips, p. 2).

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