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# RAC Medical Necessity Audits Accelerate, But Hospitals Say Some Miss the Boat

As recovery audit contractors (RACs) move full speed ahead with medical-necessity reviews, they may deny claims without a full picture of the patient's care, compliance experts say. RACs may deny admissions because a diagnosis or procedure is ripe for outpatient treatment, but patients don't always progress predictably. In some cases, RACs deny claims for inpatient admissions because patients could have been treated in observation, disregarding the documentation that shows the patients were, in fact, treated in observation before they were bumped up to an inpatient bed, some experts say.

The tension between hospitals and RACs may intensify now that the number of medical-necessity audits is increasing. The percentage of hospitals experiencing RAC medical-necessity overpayment determinations rose from 84% to 93% between the first and second quarters of 2011, the American Hospital Assn. (AHA) says in an August report. CMS expects hospitals to place patients in observation unless they meet inpatient criteria as described in the *Medicare Benefit Policy Manual*. According to the manual, physicians should consider ordering inpatient care if a patient is expected to require hospital care for at least 24 hours, but "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," including the risk of something bad happening to the patient if he or she is sent home.

Hospitals are worried they won't get a fair shake from RACs when admission is warranted, especially if RAC reviewers don't consider the entirety of the medical record during admission-necessity audits. "They are not looking at the full admission on the patient," says Colleen Dailey, clinical coordinator of defense audits for WellSpan Health in York, Pa. "They are just looking at the history and physical." The H&P — the heart and soul of a chart — includes the review of systems, chief complaint, past family and social history, and medical decision making. But the H&P doesn't typically contain physician orders, which can make or break a medical-necessity case, so RACs shouldn't limit the scope of their reviews to only the H&P, she says.

### Renal Case Shows Observation Snafu

For example, the Region A RAC recently recouped an MS-DRG payment that WellSpan received for treating an 80-year-old woman with altered mental status. Her daughter brought her to the emergency department after noticing reduced oral intake and greater confusion during the previous four days. The patient was diagnosed with a urinary tract infection, given IV antibiotics and placed in observation on May 15, 2010, pursuant to the physician's order. Ultimately, physicians diagnosed acute renal failure and upgraded her to an inpatient on May 16. The RAC, Diversified Collection Services, concluded that the patient did not qualify for admission and should have been treated in observation.

This felt Kafkaesque to Dailey because the patient was, in fact, treated in observation. Dailey pointed this out to the RAC when she submitted the medical records for review. Even if the RAC never looked beyond the H&P, it dated back to May 15, a day before the admission, so the patient's observation stay should have been clear to the RAC, and the hospital should not have been dinged for a short stay, she says. Instead, WellSpan has to invest in an appeal. Dailey says WellSpan makes its share of mistakes and accepts the RAC recoupment for them. But there are also plenty of unwarranted overpayment determinations, she says, and dealing with them eats up a lot of time.

Michael Taylor, M.D., vice president of clinical operations for Executive Health Resources in Philadelphia, has seen the observation problem elsewhere. "Unfortunately, when such denials are issued inappropriately, they may perversely penalize hospitals that are trying to do the right thing and appropriately use observation. When a patient is admitted to the hospital after failing to improve after a day or two in observation, the resulting stay may technically be considered a short stay, even though the patient has been hospitalized for

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several days," Taylor says. These denials are troubling if documentation shows that the patient failed to improve in observation and needed prolonged or intensive medical care. Taylor thinks hospitals should be prepared to appeal cases if they believe that the RAC denied a medically necessary admission after documented failure of an appropriate period of observation services.

Connie Leonard, the director of the Division of Recovery Audit Operations at CMS, confirms that "one of the prevailing reasons for denial [of inpatient claims] is the incorrect place of service. This usually means the patient was admitted inpatient when it could have been outpatient or observation." However, she hasn't heard of RACs denying inpatient claims in favor of observation when the medical records showed patients were first treated in observation. If provided with examples, Leonard says CMS "would absolutely look into the issue to determine if it needed to be addressed."

### RACs Are Skeptical of Syncope Admissions

The bulk of RAC admission-necessity denials stem from short stays (one or two days), AHA says. RACs now are reviewing short stays for medical DRGs, such as syncope, transient ischemic attack and chest pain, and surgical DRGs, including urological and gynecological procedures, Taylor says. RACs continue to add MS-DRG targets that will be evaluated through the lens of admission necessity.

Hospitals tend to appeal overpayment determinations when they believe they have complied with Medicare medical-necessity guidelines. For example, RACs have denied a lot of syncope cases (MS-DRG 312) based on the premise it can be treated in 24 hours or less, the litmus test for observation.

"But they are not taking into account the comorbidities of the patient," Dailey says.

If patients have a syncopal episode (faint) and there's a history of cerebrovascular disease, prior heart attack or coronary artery disease, the hospitalist (with the ED physician's concurrence) may order inpatient admission. They often are supported by InterQual admission-screening criteria, especially because it takes some medical detective work to determine the cause of sudden unconsciousness, Dailey says.

Though CMS announced in January that InterQual criteria are no guarantee that auditors will green-light an admission *(RMC 1/31/11, p. 1)*, Dailey says that "we are going with the premise that we are complying with the Medicare conditions of participation." That means WellSpan has a utilization review committee to review physician admission decisions and case managers who screen a majority of admissions pursuant to InterQual. All this is explained to the RAC when it requests medical records. But the RACs give so little in return, Dailey says. In their letters, RACs state their denials are based on whether the "specific plan of care can be implemented and completed within 24 hours.…Even if the expected outcome were not reached within that time frame, the patient could have been safely admitted to inpatient status within 24 hours."

### Renal, Urological Admits Can Be Problematic

The RACs also are denying admissions for renal or urological procedures. While on their face, certain renal procedures, such as cystoscopies, should be billed as outpatient services, there are always exceptions — and RACs are required to read medical records closely enough to recognize this, Dailey says.

But that was not the case in a recent overpayment determination of an MS-DRG payment for a patient who came to a WellSpan hospital ED with left-flank pain, nausea, vomiting, shakes and chills. The patient was rushed to the operating room, where a nephrologist performed a cystoscopy (which allows a peek inside the bladder and urethra) and inserted a double J stent to relieve kidney stones. Though the surgeon said the patient probably could be discharged home later that day, the surgeon wrote an order for admission instead of observation because of fears the patient would become septic. "He had a UTI and some signs of sepsis and an obstruction," Dailey says. In denying the claim, the RAC says the patient's condition did not necessitate admission; cystoscopies can be rendered on an outpatient basis. That's generally true, she says, but not in this kind of scenario.

WellSpan is appealing the renal-procedure case, but it has dispensed with the discussion period altogether. The CMS-mandated discussion period — the chance for hospitals to change the RAC's mind before starting a formal appeal — may be futile for medical-necessity denials because RACs don't seem to hear them out, Dailey and Taylor say.

### Discussion Period Is Source of Confusion

Taylor said the discussion period worked better when hospitals were disputing coding denials. "The discussion period has not been as successful as providers hoped" for medical-necessity overpayment determinations. Unlike coding, medical necessity involves discussions about medical decision making and physician insight. "Since providers are no longer assured direct access to the RAC medical director, they do not have the opportunity to make the case as effectively," Taylor says.

Leonard said she's unaware of any complaints about the discussion period. But she notes this option is available only when new information is presented. "Sometimes providers send in a discussion request without any additional information," Leonard says.

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Appeals are a mixed bag. Hospitals aren't faring well on the first few levels (e.g., redeterminations).

But hospitals shouldn't give up when they believe their claims are correct, Taylor says. "Hospitals are still frequently failing to appeal or meet appeal time frames," he says. "They are sometimes giving up early in frustration if they lose the first round of appeals." He encourages hospitals to press on if their appeals have merit because eventually they will hit administrative law judges (ALJs). "You may find the ALJ hearing to be a more conducive forum for having your voice heard. ALJs take more time on the case, and they don't use commercial admission screening standards as the only standard. They look at all the evidence."

Across the country in Washington state, Olympic Medical Center just got word that its RAC, HealthDataInsights, Inc., denied 19 inpatient stays for lack of medical necessity. Compliance officer Mic Sager says the hospital is appealing eight of them. In response to the denials, the hospital has beefed up its admission screening process. Case managers will do utilization review seven days a week, up from five. They work 6 a.m. to 8 p.m., so a big chunk of the day is covered, he says. Before, if a patient was admitted Friday and discharged Saturday, no case manager was around to screen the admission up front or in time to recommend a change in status using condition code 44.

This is a challenging area for hospitals, Sager notes. "Inpatient medical necessity is really soft," unlike medical necessity for outpatient lab tests, for example, which requires specific diagnoses to ensure Medicare coverage. Determining inpatient versus observation status "is so subjective," he says. "There is no objective legal standard." The appeals will be based on the fact that Olympic's admissions met InterQual criteria.

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