

# MEDICARE COMPLIANCE

## Hospitals Start Getting Medical-Necessity Denials From RACs

Recovery audit contractors (RACs) are beginning to deny Medicare claims on the grounds that they lack medical necessity.

“We are seeing a lot of medical necessity short-stay denials in surgical and medical target areas,” says Michael Taylor, M.D., vice president of clinical operations for Executive Health Resources in Philadelphia.

In the medical arena, hospital one-day stays have been denied for transient ischemic attack (TIA), syncope, chest pain, and patients with gastroenteritis, dehydration and diarrhea, he says.

In the surgical arena, hospital one-day stays have been denied for cardiac stents, orthopedic procedures (e.g., laminectomies), and some urological procedures (e.g., urethral swings for incontinence). And RACs have denied some dialysis access procedures performed in an inpatient setting, Taylor says.

What these site-of-service denials often have in common, Taylor says, is the discharge of inpatients before they stay overnight in the hospital. According to the Medicare Benefit Policy Manual, the rule of thumb for most inpatient admissions is that the physician expects the patient to stay in the hospital overnight and occupy a bed. Some of the claims denied by the RACs stem from services that could have been provided in observation or should have been outpatient procedures. “If the patient is at relatively low risk of short-term morbidity and/or death, and the doctor never has any expectation of keeping him overnight, outpatient care may usually be more appropriate,” Taylor says. In other cases, physicians may have hospitalized high-risk patients with the intent of keeping them overnight, but the patients fared well and could be sent home earlier. Denials in those circumstances may often be successfully appealed.

To prevent unwarranted admissions, Taylor suggests hospitals review admission necessity concurrently — while the patient is still in the hospital — and be very precise about it.

For example, with laminectomy, the details of the case may determine whether admission is necessary for this expensive procedure for a particular patient. A laminectomy is a spine operation in which a piece of bone is removed, usually to treat abnormal narrowing of the spinal column. In recent years, some types of laminectomies have become much less invasive. As a result, they may be performed in the outpatient setting. Because RACs are targeting inpatient laminectomies where the patient goes home the same day, hospitals should carefully screen them for medical necessity of the appropriate setting, Taylor says. “Not all laminectomies are the same,” he emphasizes. Laminectomies are defensible as an inpatient procedure, Taylor says, under certain circumstances:

- ◆ *Patients undergo more extensive procedures* (i.e., more bone is removed).
- ◆ *There is the potential for complications*, such as uncontrolled pain requiring higher frequency and doses of intravenous analgesic medications or greater than expected blood loss.
- ◆ *Patients have certain comorbidities*, such as uncontrolled diabetes, or in some cases ASA class IV patients with significant systemic diseases may need to be admitted.

But if an attending physician mistakenly believes that all laminectomies should always be performed in the inpatient setting, and the hospital case manager doesn't check to ensure that the procedure fulfills the Medicare medical necessity requirements, “an overpayment could occur,” Taylor says. Even if admission screening tools (e.g., InterQual, Milliman) give the green light for admission, that isn't a guarantee of Medicare coverage, a position CMS has made abundantly clear (*RMC 1/31/11*, p. 3).

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