Hospitals are hitting more bumps in the road as they navigate recovery audits. Some say they lose time to glitches in the appeal process and the “he said, she said” between recovery audit contractors (RACs) and Medicare administrative contractors (MACs).

At the same time, hospitals continue to enlist the help of physicians in RAC denial management, with mixed results.

“I think the volume is so heavy that mistakes can potentially arise,” says Evan Pollack, M.D., senior medical director of Medicare appeals for Executive Health Resources in Newtown Square, Pa.

One problem stems from a change in the way appeal-filing deadlines are calculated. At least one MAC starts the countdown from the date on Medicare remittance advices, not demand letters. That cuts short the time hospitals have to prepare appeals, says Colleen Dailey, clinical coordinator of defense audits for WellSpan Health in York, Pa. Remittance advices and demand letters both state the fate of claims — whether there is a partial or full denial and the reason why — but remittance advices are sent to hospitals electronically, which means they have an earlier date than demand letters and arrive faster. As a result, MACs are rejecting some appeals on the grounds that they missed the 120-day filing deadline based on receipt of the remittance advice, not the demand letter, she says.

But it gets wackier from there. In December, WellSpan appealed four RAC claims denials to its MAC, Highmark Medicare Services. The appeals were filed within 120 days of the date on the demand letters, as required. Dailey was surprised when the appeals were dismissed out of hand, and not for any substantive reason. Highmark said WellSpan missed the filing deadline because the clock started ticking the day it sent the remittance advice, not the demand letter.

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That was “out of the blue,” she says. WellSpan was in jeopardy of losing appeal rights based on the MAC saying that the clock on the filing deadline starts ticking when the remittance advice is issued. But that wasn’t all.

The MAC’s dismissal made no sense because it was based on December appeals. “We showed them the demand letter, where it stated that the appeal was due within 120 days of receipt,” Dailey says. The MAC agreed it made a mistake, Dailey said, but it needed time to change its processes “because the deadlines in their software are based on transmission of the remittance advice, not the date on the demand letter.” Instead of a happy ending, however, the MAC rejected four more WellSpan appeals based on the date of the remittance advice. “The demand letter is a pivotal document,” she says. “Everything in the RAC program says the demand letter starts the timeline.”

MACs, Hospitals May Use Different Clocks

A CMS spokesman says the clock for filing appeals starts running the day the demand letter or Medicare remittance advice goes out. “In fact, CMS adds five days mailing time to the appeal timeframe to account for the receipt of the demand letter,” he says.

But Dailey says there’s a distinction. Not only are remittance advices sent earlier than demand letters, they are sent to different people. To cope, WellSpan will reset all the timelines in its defense-audit software. WellSpan now has to appeal the cases to the qualified independent contractor, arguing the cases were dismissed in error. If the hospital wins, then it can appeal the denials based on the reason for their denials. “None of this has to do with the substance of the cases,” she says.

Other problems are cropping up. Some relate to MACs assuming responsibility for demand letters from the RACs in January.

An apparent delay in getting demand letters out is wasting precious appeals time, says Vera Phillips, compliance specialist at Olympic Medical Center in Port Angeles, Wash. Its RAC, HealthDataInsights (HDI), sends overpayment determinations electronically to the MAC, Noridian Administrative Services. Phillips figures it’s taking 10 to 14 days for demand letters to reach the hospital. Because the deadline for preventing recoupment pending appeals is 41 days from the date
on the demand letters, hospitals lose the time that they seem to be languishing in a Noridian warehouse, she says. “I believe they are postmarked and run through the meter but not mailed because it doesn’t take 10 to 14 days to get to us.” Even worse, the hospital is experiencing recoupment with little warning. The RAC sends the MAC audit results electronically, but the RAC sends the hospital audit results by mail. Because Noridian receives the overpayment determinations before the hospital —and is efficient in this respect — the demand letters hit the hospital within a day or two of the RAC’s findings. “It gives us no time to even review to see if we care to disagree,” she says.

The RAC has thrown obstacles in her path as well. HDI informed Olympic Medical Center of numerous underpayments last year, but it hasn’t paid the hospital back yet and now Phillips is getting the runaround. Noridian said the claims were closed but HDI said they weren’t. “I was told they reversed the findings, but I haven’t seen any documentation to support that,” she says. In other words, sometimes hospitals get letters notifying them of underpayments, but then the RAC changes its mind and the MAC takes back the money.

Frustration, Confusion Are the Norm

Frustrated with all the confusion, on March 7 Phillips sent both the RAC and MAC 28 pages worth of paperwork documenting the unreturned overpayments, demand letters that were never received and “claims we have had no response on whatsoever” after sending in medical records. Hopefully, there will be some response, though it may take months. That’s how long it took the hospital to get interest back on 21 claims it was wrongly charged on demand letters that were never sent.

To survive defense audits, you have to be “tenacious,” Phillips says. It takes persistence and patience to track the requests, denials, appeal deadlines and results, and identify and resolve the snafus. A certain amount is out of a hospital’s control. HDI insists submissions were forwarded to Noridian, which denies having them, so Phillips keeps calling.

In a similar vein, while RACs allowed hospitals to specify the person who should receive demand letters, MACs don’t always extend the same courtesy, says Steven Greenspan, vice president of government appeals and regulatory affairs at Executive Health Resources. “It’s a game-changing event for providers because now they have to worry whether they got the demand letter,” he says. “There is a lot of follow-up for providers. Some MACs accept requests to send demand letters to a designated person at the hospital, Greenspan says, but they are not obligated to do this.

In addition to MAC and RAC snafus, some hospitals say it is an uphill battle to engage physicians in documentation improvement and denials management. But that picture is ambiguous. Some experts say physicians are frustrated when auditors declare their admissions medically unnecessary and willingly engage in appeals and compliance initiatives. Others say physicians are tired of all the regulatory and compliance demands, and focus only on what they perceive is important to patient care and their own reimbursement, which is not yet affected, for the most part, by hospital claims denials.

Dailey has found some physicians more responsive than others. For example, after WellSpan got a number of RAC denials for urinary and renal procedures, which is a big admission necessity issue (RMC 3/5/12, p. 1), she met with the physician who managed the practice responsible for some of the denied procedures. They talked about the relative invasiveness of the procedures and complication rates. “He liked that we went over and talked to him about it,” Dailey says. As it turned out, the physicians had already changed their habit of admitting inpatients for urinary and renal disorder procedures. Instead, the physicians were now performing the surgeries on an outpatient basis with observation. Her interaction with this practice manager was a positive experience. And it was interesting because these physicians were not employees of WellSpan.

But that hasn’t always been Dailey’s experience. WellSpan decided to appeal one of the urinary-procedure admission denials to an administrative law judge. She asked the physician to attend the ALJ hearing to explain why he admitted the patient, but he got huffy. “The doctor wasn’t willing to help me appeal it,” she says. “He said, ‘who is Medicare to say I can’t do this in the hospital?’” The ALJ told WellSpan to be there on a Thursday, but the physician refused, saying he had procedures to perform. He never showed, but the end result was favorable for WellSpan anyway.

Sharing Data With Physicians Can Help

Sharing data with physicians may change their behavior. Show them how many cases were denied because of their missing or erroneous documentation and how much money was lost, she says. “It means something to them. It makes it more possible to get their buy-in,” she says. “It has to be concrete for them.”

It helps to say, for example, that “we had 487 medical records audited by the RAC and so many were denied and that means $2 million had to be given back,” Dailey says. That’s $2 million less for equipment that physicians want to buy.
But Pollack predicts it will always be an uphill battle, especially until physicians have a financial stake in denials. “The government would like nothing more than for hospitals and physicians to work closer and better and to support each other. That’s the logic behind ACOs. But there is a certain amount of mistrust,” he says. “Physicians may be less inclined to get involved because [denials of hospital claims] do not directly affect a patient’s care. They may view this more as a financial issue for hospitals.”

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