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Documentation of medical necessity drives successful RA appeals

Most hospitals have been overwhelmed by Recovery Auditor (RA) requests for documentation. So it's no surprise that the RAs themselves seem to be equally as burdened with the task of processing those records.

"There has been a great deal of overload and overburden on the system in general," says **Marilyn S. Palmer, DO,** vice president of audit, compliance, and education at Executive Health Resources in Newton Square, Pa. "This is part of the reason why CMS is addressing this Part A to B rebilling." (See p. 10 for an overview of the Administrative Ruling and proposed rule related to Part B rebilling.)

Qualified Independent Contractors (QIC)—the entities responsible for processing level two appeals—have 60 days to make a determination. If they're unable to do this, they must provide hospitals with a process to escalate the denial directly to the Administrative Law Judge (ALJ)—the third level of appeals.

Palmer says the ALJ is increasingly remanding cases back to the QIC, which only increases the burden placed on it. Executive Health Resources, which assists hospitals in the appeals process, receives approximately 2,500 escalation notices per week, she adds.

Medical necessity is a top target

What are some of the most common RA denials to date?

"Cardiovascular procedures have been looked at since the RA demonstration project began, and they continue to be looked at going forward mainly because of the dollar amounts of these procedures," says Palmer. "Screening doesn't normally cover these cases very well, and physician review is often needed."

Three out of four RAs list medical necessity of cardiovascular procedures as their top issue, according to CMS data published in May 2012. Medical necessity of minor surgery or other treatment billed as an inpatient stay is the top issue for the fourth RA.

This data doesn't surprise **Jonathan G. Wiik, MSHA, MBA,** chief revenue officer at Boulder (Colo.) Community Hospital. Forty-three percent of the hospital's RA audits pertain to cardiovascular cases. Gastrointestinal and musculoskeletal cases rank second and third at 24% and 21% respectively. The remaining 12% fall under the "other" category.

Boulder Community Hospital, a 265-bed acute care facility, began experiencing RA audits in 2010. The audits focused largely on DRG code validations. However, throughout 2011 and 2012, Wiik says the

audits have shifted in focus exclusively to medical necessity.

"We've got several million dollars held up in appeal right now," says Wiik. "That [amount] is only going to get larger."

Part B rebilling provides another option

Wiik says hospitals essentially have two choices in light of CMS' recent Administrative Ruling and anticipated final rule on Part B rebilling:

- Defend the admission criterion and utilization review (UR) process in an appeal and wait for the reimbursement to which you're entitled
- Ignore the UR criterion and process and accept reimbursement at a lower rate now by rebilling the denied Part A claim to Part B

"We have taken the position at our hospital to appeal [cases] that have appropriate documentation and that are compliant," says Wiik. "The incremental financial reimbursement that we're getting is substantial. We need to continue to appeal and justify what we've done."

Hospitals must look at each case individually to determine the financial impact of rebilling to Part B, says Palmer. "If you're thinking about withdrawing cases that are in the process of appeal, you want to think carefully about the implications of your decision," she says. Not only could the financial reimbursement be significantly less, but it will also require hospitals to refund the Part A deductible to patients and rebill them for Part B. Communication with patients about this change in status and what it means for them is—and will continue to be—a challenge, she adds.

Concurrent reviews, strong RA process are key

"The best practice is to get it right from the start," says Palmer. "The best way to decrease denials or increase overturn rates begins with a compliant concurrent review of documentation."

Wiik says that Boulder Community Hospital has managed to overturn all of its denials at various stages of appeal—and most frequently at levels one and two. He attributes this success to staff members who are dedicated to the audit and appeals process. Wiik says 2.5 FTEs examine patient status seven days a week. The hospital's UR committee works in conjunction with Executive Health Resources to substantiate and defend/appeal inpatient determinations.

The hospital also has a clearly defined procedure for managing the appeals process. First, the patient financial services (PFS) department receives a denial/request notification. Next, a member of the PFS department sends the denial/request to a coder for review. The coder then sends the denial/request to the appropriate department for review. The hospital tracks each of these transfers using its homegrown tracker as well as Executive Health Resources' appeals portal.

Education and diligence play a large role in ensuring compliance going forward, says Wiik. For example, the hospital's chief medical officer leads education sessions for various specialties that are geared toward documentation compliance. The hospital also tracks metrics and audits of inpatient vs. observation determinations and then reports feedback to senior leadership. In addition, it publishes a medical staff newsletter. A Program for Evaluating Payment Patterns Electronic Report committee also reviews data quarterly to look for DRG outliers that could eventually become RA targets.

Physician education is crucial

Educating physicians about how to properly document medical necessity is an incredibly crucial part of ensuring success with RA audits and appeals, says Palmer. Documentation should include the following:

- Medical history (H&P)
- Current medical needs
- Severity of signs and symptoms
- Facilities available for adequate care
- Predictability of adverse outcomes

Predictability of adverse outcomes is the most challenging for physicians. "Physicians actually do this very well, but we do it in our heads," says Palmer. These questions can help get physicians thinking about articulating their thought processes:

- What's your impression of the patient?
- What are your concerns for this patient?
- Based on these concerns, what's the potential for a

poor outcome?

Discourage physicians from reporting a sign or symptom rather than a diagnosis. "This is a really hard habit to break," says Palmer. Many physicians say that they simply don't know what to document, she adds.

Encourage physicians to document what they think is the cause of a patient's chest pain, for example. Ask them to document their top few suspected diagnoses and concerns for those diagnoses, says Palmer. "If you expect the auditor to dig through and put two and two together and build a story themselves, you're kind of asking a lot of them," she adds.

EDITOR'S NOTE

This article is based on content originally presented during HCPro's audio conference "Medical Necessity 2013: Reduce Risk and Overturn Denials." For more information, visit *http://tinyurl.com/c8grjk9*.

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