Learning Objectives

• Explain the scope and objectives of the Recovery Auditor program
• Develop an appeals strategy based on examples of successfully defended cases
• Describe best practices for drafting appeals letters

Mission of RAC Program

• Detect and correct past improper payments in the Medicare fee-for-service (FFS) program
• Expands to all 50 states
• Protecting the Medicare trust fund
• A tool for preventing future inappropriate payments

Successful Strategies to Avoid RAC Denials and DRG Downgrades

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Who Performs the Reviews

- CMS has divided the country into four geographic locations
- Each location has different organizations conducting these reviews
  - Region A: Performant Recovery
  - Region B: CGI
  - Region C: Connolly
  - Region D: HealthDataInsights
- Staff consists of nurses, therapists, certified coders, and a physician CMD

Who Will RAC Target?

- Physicians
- Providers
- Facilities
- Suppliers

RAC Audits – Statement of Work

- DRG validation vs. clinical validation
  - "DRG validation is the process of reviewing physician documentation and determining whether the correct codes and sequencing were applied to the billing of the claim."
  - "Clinical validation is a separate process, which involves a clinical review of the case to see whether or not the patient truly possesses the conditions that were documented."

RAC Audits – Statement of Work (cont.)

- Rationale for determinations
  - "The Recovery Auditors shall clearly document the rationale for determination."
  - "...including a detailed description of the Medicare policy or rule that was violated and a statement as to whether the violation resulted in an improper payment."
  - "Recovery auditors shall ensure they are identifying pertinent facts contained in the medical record to support the review determination"
  - Each rationale shall be specific to the individual claim under review."
Prepayment Review Demonstration

- Demonstration began September 2012
- Prior to payment chart requested for review
- Specific claims with a history of high rates of improper payments

Prepayment Review Demonstration (cont.)

List of MS-DRG and Month to Start for Prepayment Review:

- September 2012
  - MS-DRG 312
  - Syncope & Collapse

- January 2013
  - MS-DRG 069
  - Transient ischemia

TBD
- MS-DRGs 377–379
  - G.I. Hemorrhage

TBD
- MS-DRGs 637–639
  - Diabetes

Type of Audits

- Automated reviews – Claims review
- Complex reviews – Record review

Audit Timelines

- Please review “The Medicare Appeals Process” provided by the Medicare Learning Network available at CMS.gov as well as shown in your handouts (Exhibit A)
CDI Program's Role

- “RAC Proof”
- “RAC Them Back”

“RAC Proof”

- Clinical indicators are part of the physician's/MLP’s note to support diagnosis being documented

“RAC Proof” (cont.)

- Excisional debridement
  - 100% review by CDI prior to claim submission
  - Size
  - Depth
  - Removal of devitalized tissue
  - Instrument(s) used
  - Definite cutting away of tissue

Developing Your Appeals

- Enlist the help of your physicians in writing the appeals
- Recognized resources
- Utilize prior denials with successful wins
Acute renal failure

RAC’s review

The patient is a 76-year-old male admitted with coronary atherosclerosis of native coronary artery. The provider assigned 584.9 (Acute renal failure, unspecified) as a secondary diagnosis. The documentation in the medical record does not support the assignment of 584.9 as a secondary diagnosis. Although the attending physician does document acute renal failure in the discharge summary, code 584.9 has been removed from the claim due to a lack of supporting clinical evidence. This review was performed by a certified coder and a clinician.

Hospital’s response to RAC’s finding (discussion period)

I do not agree with the RAC’s decision for the following reason(s): The DCS’ audit determination rationale states “the documentation in the medical record does not support the assignment of 584.9 (Acute renal failure, unspecified) as a secondary diagnosis.” However “acute renal failure” is documented many times throughout the progress notes and it is validated by the clinical evidence in the record.

This 76-year-old male with a past medical history of hypertension, hypercholesterolemia, peripheral vascular disease, and coronary artery disease was electively admitted for coronary artery bypass grafting on 7/29/09. Postoperatively, he became hypovolemic and hypotensive with decreased urine output. His BUN and creatinine abruptly rose from 18 and 1.1 to 30 and 1.8, respectively. He was treated with IV albumin and packed red blood cell transfusions. Blood work and fluid and electrolyte balance continued to be closely monitored. The cardiology notes 7/31/09 document “acute kidney injury ... likely secondary to hypovolemia.” “ARF” and “acute renal failure” continue to be documented throughout the progress notes.

The Acute Kidney Injury Network (AKIN) criteria for acute renal failure is “an abrupt absolute increase in the serum creatinine concentration of ≥ 0.3 mg/dl from baseline, a percentage increase in the serum creatinine concentration of > 50%, or oliguria of less than 0.5 mL/kg per hour for more than six hours … The addition of an absolute change in serum creatinine of ≥ 0.3 mg/dl is based on epidemiological data that have demonstrated an increase in mortality risk associated with changes in serum creatinine concentration as little as 0.3 to 0.5 mg/dL.”
“RAC Them Back” (cont.)

This patient’s abrupt rise in creatinine from 1.2 to 1.8 clearly meets the AKIN criteria for acute renal failure described above. The diagnosis of acute renal failure also meets the UHDDS definition of “other diagnoses”: “all conditions that coexist at the time of admission, that develop subsequently, or that affect the treatment received and/or the length of stay.”

It is for the above stated reasons that we hold firm in our belief that 584.9 (Acute renal failure, unspecified) was correctly reported as a secondary diagnosis.

Response from RAC:

Dear Medicare Provider,

This letter is to notify you of a decision to overturn our original improper payment determination. This decision was based on the additional information provided.

Take-Home Message

- Exhibit B
- Exhibit C
- Exhibit D
- RAC Proof
- RAC Them Back
RAC Auditors’ Contact Information

Region A: Performant Recovery
- States: CT, DE, DC, ME, MD, MA, NH, NJ, NY, PA, RI, and VT
  www.dcsrac.com, info@dcsrac.com, 866-201-0580

Region B: CGI
- States: IL, IN, KY, MI, MN, OH, and WI
  http://racb.cgi.com, racb@cgi.com, 877-316-7222

Region C: Connolly, Inc.
- States: AL, AR, CO, FL, GA, LA, MS, NM, NC, OK, SC, TN, TX, VA, WV, Puerto Rico, and U.S. Virgin Islands
  www.connollyhealthcare.com/RAC, RACinfo@connollyhealthcare.com, 866-360-2507

Region D: HealthDataInsights
- States: AK, AZ, CA, HI, ID, IA, KS, MO, MT, ND, NE, NV, OR, SD, UT, WA, WV, Guam, American Samoa, and Northern Marianas

Example of Region A Reviews

- A000922010 MS-DRG Validation and Medical Necessity Review: Nervous System Disorders (At this time, Medical Necessity Review limited to MS-DRGs 056 and 057) Complex Inpatient Hospitals CT, DC, DE, MA, ME, NH, NJ, NY, PA, RI, VT 9/9/2010 Details
- A000932010 MS-DRG Validation and Medical Necessity Review: Musculoskeletal Disorders (At this time, Medical Necessity Review limited to MS-DRGs 551 and 552) Complex Inpatient Hospitals DC, CT, MA, ME, DE, NJ, NY, PA, RI, VT 9/9/2010 Details
- A001022010 MS-DRG Validation and Medical Necessity Review: Respiratory (At this time, Medical Necessity Review limited to MS-DRG 190, 191, and 192) Complex Inpatient Hospitals CT, DC, DE, MA, ME, NH, NJ, NY, PA, RI, VT 9/9/2010 Details

Thank you. Questions?

In order to receive your continuing education certificate(s) for this program, you must complete the online evaluation. The link can be found in the continuing education section at the front of the workbook.