RAC Forensics 101: Part 2: The Results Letter and the Discussion Call

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Healthcare organizations are still struggling to manage the Recovery Audit Contractor (RAC) process implemented last year. This article is the second in a series that discusses the provider portal, the discussion period, and the review results letter. Part 1, published in the January issue, discussed the RAC process from requests to appeals.

Using the Provider Portal

After an organization submits medical records to the RAC, it should confirm that the RAC received them. Some organizations have had problems with RACs receiving records, so it is important to follow up with the RAC on this step and update the organization's RAC tracking system as necessary.

Organizations can use the RAC's provider portal to monitor and track their RAC activity. The portal lists automated and complex reviews and the current status of each. The information in the portals can and should be saved by providers on a regular basis to effectively monitor the status of their claim.

As accounts move through the audit process the RAC will post various action statements. There are no formal published definitions of the statements within the portal, so organizations should question those statements they do not understand to identify what actions the provider needs to take.

Common action statements include:

- Awaiting medical record
- Recovery
- Review results letter sent
- Claim sent to payer
- Overturned in discussion
- Additional information received after claim sent to payer
- Under review by medical director
- Claim excluded

Each RAC may perform the records reconciliation process differently. RACs may reconcile records all at once or separately. Providers can ask their RAC how this is performed and the best way to monitor this process.

In the event the data in the portal are incorrect, organizations should follow up with the RAC as necessary for resolution. It is important to remember that the information from the organization's record request letter will be necessary for resolution. It may be beneficial to have a paper trail to track correspondence on a particular issue, and e-mail may prove to be a better choice for follow up.

Review Results Letter

The review results letter should arrive within 60 days of receipt of the medical record documentation. Each letter must provide a rationale for the determination, such as violation of Medicare policy or rule, and if improper payment (under or over) was made based on that.

Organizations should review the letter carefully to determine next steps. The rationale should be compared with the medical record documentation to identify the facility staff needed to process the results.

For coding-related issues, the RAC program's statement of work requires RACs employ credentialed coders; however, it does not specify the required credentials. RACs may employ coding professionals without inpatient experience to review complex inpatient cases. Situations such as this may prove problematic and require additional work from the provider to overturn an incorrect coding decision. Providers should ensure they have appropriate staff reviewing denials and discussing cases.

Reviewing a Denial for Excisional Debridement

A healthcare organization admits a 50-year-old female following a motor vehicle accident, and the physician documents debridement. The coder assigns procedure code 86.22. However, the RAC review finds that the medical record documentation does not support the assignment because there was no physician documentation of excisional debridement.

The RAC states the coding denial is supported by the 2004 second quarter issue of Coding Clinic, which states, "The use of a sharp instrument does not always indicate that an excisional debridement was performed. Unless the documentation describes sharp debridement as a definite cutting away of tissue and not the minor removal of loose fragments with scissors or scraping away tissue with sharp instrument, assign code 86.28."

Coding staff need to evaluate the operative report and coding rules to determine next steps.

The organization reviews relevant Coding Clinic issues before deciding to discuss the case with the RAC. It then verifies whether the operative report for the debridement included the following documentation:

- Size
- Depth
- Removal of devitalized tissue
- Instruments used
- Definite cutting away of tissue (not the minor removal of loose fragments)

The Discussion Period

The discussion period is an added feature to the Medicare appeals process. It allows providers time to discuss the denial with the RAC and work to overturn the denial or make recommendations for a DRG change that may have been overlooked by the RAC. The discussion period begins with the receipt of the demand letter for automated reviews and with receipt of the review results letter for complex reviews.

There is still some confusion on how long the discussion period lasts. According to the Centers for Medicare and Medicaid Services' "Provider Options" chart (available online at www.cms.gov/RAC/Downloads/ProviderOptionsChart.pdf), the period lasts from the date of the review results letter up until the fortieth day.

Organizations can use this chart for additional time to present the case for denial reversal. However, setting an internal goal of 15 days for the discussion period will help the organization meet the RAC deadlines.

Outlining the process, beginning with the discussion period, will ensure that all stakeholders are engaged and ready to assist in this process. Key individuals are needed throughout the process, and it is important that they are accessible to meet all deadlines. This includes a representative from the coding staff to review any specific coding-related issues and a case manager to assess medical necessity denial issues.

The Decision to Discuss

Developing a matrix tool can help organizations decide whether to discuss a case for coding or medical necessity with the RAC. Organizations should note those areas that should work in their favor when making this decision, starting with the medical record documentation. They can also include references from the ICD-9-CM coding book (including the index and

tabular), CPT 4, the "Official Coding and Reporting Guidelines," *Coding Clinic*, federal and regulatory guidance, national coverage determinations, and local coverage determinations.

Organizations also must determine whether an individual or a team will decide whether to discuss the denial with the RAC. It is a significant decision for one individual to make. If the decision is left up to one individual, it could put a facility at financial risk. If the rules are misunderstood or misinterpreted, an issue that may warrant appeal could be closed, which can be detrimental to a provider.

Organizations should develop a process for making these decisions. Including an open dialogue on the issue will benefit an organization as it moves through the appeal process.

Key Elements to a Discussion Call

It is important to be factual and provide the appropriate evidentiary support in the discussion process. This includes the medical record documentation, coding instruction from ICD-9-CM, CPT 4, Coding Clinic, or state or federal coverage determinations. In some cases, it may be necessary to provide clinical support or explanation of the disease process and associated manifestations.

Organizations should provide the RAC with a copy of references being used in the discussion process to improve understanding during the call. Keep in mind that each RAC reviewer is different, and thus cases will be handled differently. Organizations should keep track of the reviewers and become familiar with the items they require for the discussion process in order to streamline this procedure.

The discussion call should be scheduled with the reviewer when all essential personnel are available with the necessary documentation. Reviewers are available to discuss the case at the time of the initial call, but oftentimes they allow providers to schedule an appointment to discuss the case. The decision to schedule an appointment is up to the provider. Many providers have also found success in submitting a letter with explanation and support.

It is important to be prepared with the appropriate documentation and the necessary staff to successfully discuss the issues. During the call, appropriate and professional behavior is essential. It is important to stay on task, stress specific points related to the potential denial, and provide clarification where needed.

Each organization will identify the appropriate staff for this process. Organizations may find that the most experienced coder is not the best person to participate in the call if he or she is not adept at relaying facts or setting emotions aside.

The RAC process takes considerable time and effort for organizations. Outlining the RAC review process and monitoring all activity will help organizations successfully navigate the multiple steps involved.

Part 1 in this series, "Medical Record Requests and the Discussion Period," appeared in the January 2011 issue. Part 3, covering the appeals process, will appear in March.

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