RAC Forensics 101

Part 3: Denials Management

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The denials management process is the final step in the RAC process and can be the most time-consuming portion, depending on the circumstances of each case. Providers may appeal a RAC decision either through the discussion period or the formal Medicare Appeals Process.

Becoming knowledgeable about all appeal levels helps providers meet deadlines, prepare supporting documentation, customize appeal letters, and enter new evidence in support of their cases.

This article is the final installment in the series and reviews the denials management process for RACs. Part 1, published in the January issue, discussed requests and appeals. Part 2, published in the February issue, examined the results letter and discussion call.

Discussion Period

The discussion period is the first avenue for providers to overturn a denial well before refunding or recouping any monies (see part 2 in this series). A provider who is clear, factual, and has documented evidence supporting its original claim can often use this period to its benefit. Providers should use this period to have formal discussions with the RAC or submit their case via fax.

Even with the best documentation, a provider cannot be assured of overturning denials during the discussion period. However, providers should put in the necessary effort to try to overturn any denials before submitting to the Medicare Appeals Process.

Medicare Appeals Process Deadlines

The Medicare Appeals Process is the next step in contesting denials. It consists of five levels.

Level I: Redetermination through the fiscal intermediary or Medical Administrative Contractor. Providers have 120 days from the date of receipt of the initial claim determination to file a request for redetermination. They must file the request by day 30 of the demand letter to avoid recoupment of the denial amount on day 41.

Level II: Reconsideration through a qualified independent contractor (QIC). Providers have 180 days from the date of receipt of the redetermination decision to file a request for reconsideration by a qualified independent contractor. They must file the request by day 60 of receipt of the redetermination to avoid recoupment. Level II is the last appeal stage in which providers can submit additional information. The QIC should return a decision to the provider within 60 days of receipt of the reconsideration request.

Level III: Administrative law judge hearing. To present a case to the administrative law judge, the amount in contoversy (denial amount) must be at least $130. Providers have 60 days from receipt of the reconsideration decision to file a request for a hearing. A decision will be provided within 90 days of receipt by the administrative law judge hearing office. At this point, the Centers for Medicare and Medicaid Services will recoup the overpayment plus interest.

Level IV: Medicare Appeals Council. Providers have 60 days from the receipt of the administrative law judge decision to file an appeal to the Medicare Appeals Council.

Level V: Federal district court. Providers have 60 days from the Medicare Appeals Council decision to file an appeal to the federal district court. The overpayment must be paid at the administrative law judge hearing and the federal district court stages.

Automated Denials versus Complex Denials

Before moving forward with the appeals process, organizations should understand the difference between automated and complex denials.

Automated denials offer a limited opportunity to appeal and are based off very specific guidelines, most often related to a billing guideline, coding rule, or other regulation (e.g., CPT description). These denials are often related to a rule or guideline change.

Complex denials offer increased opportunity to appeal and may require more legal expertise and increased physician involvement.

Navigating the Appeals Process

Providers should take the following steps before submitting any claim to the appeals process:

- Validate that all available documentation has been submitted.
- Review the content of the documentation related to the denial and determine if additional documentation or clarification is needed (e.g., queries, updates, missing documentation).
- Include documentation (e.g., physician letter) from experts immediately involved in the case to provide additional clarification or insight.
- Review regulatory guidance (e.g., *Coding Clinic*, ICD-9-CM Official Guidelines for Coding and Reporting, local and national coverage determinations, fiscal intermediary/CMS billing guidance) with regard to the date of the account in question.
- Determine whether there were any changes in regulatory guidance that would support or deny an appeal on the case in question. If there is, note the guidance changes and decide if next steps are needed from an appeals standpoint. If it is fewer than 15 days from the receipt of denial, call the RAC for a discussion period review. If it is more than 15 days, appeal the denial. If no other cause for appeal is found, consider accepting the denial and allowing recoupment.

After following these steps, organizations may need to move to the first level of appeals. The RAC should forward the record to the fiscal intermediary for the first level of appeal. The fiscal intermediary may prefer to receive the record with the redetermination form to ensure the record is detailed in a format that is logical and easy to follow. Organizations should communicate with their fiscal intermediary to determine what it needs and its capabilities to receive electronic records.

It is up to the provider to ensure all deadlines are met and the proper forms are submitted in a timely fashion for each appeal level. Keep in mind, level II is the last level that allows organizations to enter new evidentiary support. Organizations should put their best foot forward at this level.

It is possible to aggregate denials and present them in groups that have related denial reasons for appeal decisions. Writing appeal letters can be time consuming and take internal staff away from their primary duties. Providers should identify the key staff who will participate in the appeals process. In some situations, it may be necessary or more beneficial to enlist the help of an external contractor to manage the appeals process.

Regardless of whether appeals are managed internally or externally, providers should follow these steps when navigating the appeals process:

- Include all related components specific to the denial (e.g., request form, medical record, supporting documentation).
- Complete all necessary forms required for each level of appeal.

- Adhere to the time frames for each level, including the time frames for recoupment.
- Confer with the attending physician to obtain any additional insight on the case. The physician can be involved in helping ensure the letter accurately reflects the points of the case and as a witness in a hearing such as the administrative law judge hearing.
- Use terminology associated with the denial in the appeal letter (e.g., "*Coding Clinic*, first quarter, 2003, pg. 6, states…").
- Include clinical support from the health record in the appeal letter.
- Add appropriate interdisciplinary team notes for additional documentation support in the letter.
- Include references to medications as well as ancillary tests in the letter.
- Appropriately summarize the case, including documentation extracts in the letter.
- Provide a chronological sequence of events and add clinical justification as appropriate in the letter.
- Validate all evidence-based references or those related to anatomy, physiology, or the disease process.
- Include formal references to supporting materials in the letter (e.g., *Coding Clinic, CPT Assistant*, and *Federal Register*).

Providers can consider the following sample language when writing appeal letters:

> As stated in the Uniform Hospital Discharge Data Set (UHDDS) rules for coding and reporting of diagnoses, conditions that are documented by the physician that are clinically evaluated, diagnostically tested, and/or therapeutically treated should be coded as secondary diagnoses. In this instance, _____ should be reported as a secondary diagnosis due to the following documentation: _____.

Or

> As stated in the Official Guidelines for Coding and Reporting, "Any documented significant condition that impacts care and is treated should be coded. A condition is clinically significant when it has implications for the patient's future health care and/or requires any of the following:
>
> a. Clinical evaluation; or
>
> b. Therapeutic treatment; or
>
> c. Diagnostic treatment; or
>
> d. Extended length of stay; or
>
> e. Increased nursing care and/or monitoring; or
>
> f. Has implications for future health needs"
>
> _____ was documented in _____and treatment administered in the form of _____.
>
> Please accept the above guideline information as well as documentation from the health record for reconsideration. We look forward to hearing from you.

The decision to appeal can be complex, and organizations must ensure that the documentation contains solid evidence and support for their appeal. There may be cases where the internal impact of the appeal process outweighs the appeal itself. For example, organizations must determine if they want to use time and staff to argue a random denial of $100 when it could take hundreds of dollars in staff and legal resources to defend it. At times, it can be a matter of principle. Organizations may find that the decision to appeal a denial may need to be made on a case-by-case basis.

During the RAC's short history, providers have had success in overturning denials during the administrative law judge stage. Providers should not rely on this stage solely, but it does offer some optimism for a nonbiased judgment. Providers may need the expertise of an attorney to handle the motions at this appeal level.

Discussing and outlining the RAC process helps organizations remain on their toes in this time of increased scrutiny. It is crucial that providers stay abreast of regulatory issues as they will continue to increase in the coming years. Medicaid RAC is just around the corner.

References

Centers for Medicare and Medicaid Services (CMS). "Medicare Reconsideration Request Form." Form CMS 20033. Available online at https://www.cms.gov/cmsforms/downloads/cms20033.pdf.

CMS. "Medicare Redetermination Request Form." Form CMS 20027. Available online at https://www.cms.gov/cmsforms/downloads/cms20027.pdf.

CMS. "Request for Medicare Hearing by Administrative Law Judge." Form CMS 20034AB. Available online at https://www.cms.gov/cmsforms/downloads/cms5011a-b.pdf.

CMS. "Statement of Work for the Recovery Audit Contractor Program." Available online at https://www.cms.gov/RAC/downloads/Final%20RAC%20SOW.pdf.

For the preceding articles in this series, see "RAC Forensics 101: Part 1: Medical Record Requests and the Discussion Period" in the January 2011 issue and "RAC Forensics 101: Part 2: The Results Letter and the Discussion Call" in the February 2011 issue.

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Article citation:
Easterling, Sharon. "RAC Forensics 101

Part 3: Denials Management" *Journal of AHIMA* 82, no.3 (March 2011): 56-58.