RAC Inpatient Coding Denials: Key Areas of Improper Payment in permanent program

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The Recovery Audit Contractor (RAC) demonstration program found that "most of the overpayment amounts collected by the RACs (about 85 percent) were from inpatient hospital providers," and "almost half of the improper payments were the result of incorrect coding."[1] Things have changed with the permanent RAC program.

According to the Centers for Medicare and Medicaid Services' most recent RAC update for fiscal year 2011, the top issue in each of the four RAC regions was medical necessity.[2] Seasoned coders should not be surprised by this switch in focus, because RACs stand to recoup the entire DRG payment with a medical necessity denial versus a DRG payment difference for a coding denial. It appears the RACs will continue to review inpatient cases for coding accuracy as this is still a lucrative target for recoupment of Medicare overpayments.

This article examines five areas of improper payments due to incorrect inpatient coding identified during the RAC permanent program and references the AHA *Coding Clinic* guidance applicable for each.

Excisional Debridement

Excisional debridement remains one of the top reasons for RAC inpatient coding denials. According to the 1991 third quarter issue of AHA *Coding Clinic*, documentation for excisional debridement must include the following components:

- Size
- Depth
- Removal of devitalized tissue
- Instruments used
- Definite cutting away of tissue (not the minor removal of loose fragments)[3]

When a coder is uncertain as to the extent of debridement, the physician should be queried. Helpful AHA *Coding Clinics* to reference include:

- 2008 First Quarter, volume 25, page 3
- 2004 Fourth Quarter, volume 21, page 137
- 2004 Second Quarter, volume 21
- 2000 Second Quarter, volume 17, page 9
- 1991 Third Quarter, volume 8
- 1988 Fourth Quarter, volume 5

One of the most common RAC debridement denials occurs in conjunction with procedures where the debridement is an integral part of the procedure. Coding professionals should be cautious of these operations and reference the AHA *Coding Clinics* when in doubt.

Coders also should consider posting flyers, developing online tutorials, or conducting brief educational sessions to teach providers how to document excisional debridement. Some have even developed template-transcribed operative notes to include the components.

Sequencing Principal Diagnosis

Under the demonstration program RACs cited the selection of principal diagnosis as one of the leading areas of concern. Unfortunately, this still holds true under the permanent program.

Many of the current RAC inpatient coding denials regarding the sequencing of principal diagnosis refer to the treatment as not equal. For example, one RAC noted, "Although hypotension and other conditions coexisted with dehydration at the time of admission treatment was not equal."[4]

The 1990 second quarter AHA *Coding Clinic* notes under "Guidelines for Selection of Principal Diagnosis PD#5-Two or more diagnoses that equally meet the definition for principal diagnosis":

> In the unusual instance when two or more diagnoses equally meet the criteria for principal diagnosis as determined by the circumstances of admission, diagnostic workup and/or therapy provided, and the Alphabetic Index, Tabular List, or another coding guideline does not provide sequencing direction, any one of the diagnosis may be sequenced first.[5]

A question was posed to the 1994 second quarter AHA *Coding Clinic* peer review organization transmittals regarding the selection of principal diagnosis based on the definitive surgical or nonsurgical procedure.[6] The AHA *Coding Clinic* responded by referring to the previously referenced 1990 second quarter AHA *Coding Clinic's* "Guidelines for Selection of Principal Diagnosis," stating, "It is unclear what constitutes a 'definitive' procedure..." and noting that the publication cited in the question, the 1984 book *Coding for Prospective Payment*, should not be considered to be official coding advice.

Based on this guidance, it would behoove providers to appeal RAC or any other payer coding denials that reference treatment as the reason for the selection of a principal diagnosis.

Dehydration versus Acute Renal Failure

The third quarter 2002 AHA *Coding Clinic* gives a good example of a case where a patient is admitted with acute renal failure due to severe dehydration.[7] The patient is treated with IV fluids, and renal function improves. The acute renal failure is sequenced as the principal diagnosis.

However, each record stands alone, and a thorough review of the medical record will determine the correct principal diagnosis for each case.

Foot Ulcers versus Diabetic Condition

Another common area of confusion in selecting the correct principal diagnosis occurs in patients who are admitted with foot ulcers due to a diabetic condition. A good reference to alleviate confusion is the 1991 third quarter AHA *Coding Clinic*, which states that the underlying cause of foot ulcers in a diabetic patient may be due to neuropathy or peripheral vascular disease. It notes that sequencing depends on the circumstances of the admission.

However, it also states, "Diabetic foot ulcers resulting from diabetic neuropathy with insults to the feet due to loss of sensation and those resulting from peripheral vascular disease are coded first to the appropriate diabetes code (250.6X or 250.7X, respectively) and second to the code for ulcer of the lower extremity, 707.1, followed by the code for gangrene (if present), 785.4."[8]

Using clinical documentation specialists to help query and educate physicians regarding the cause and effect of diabetic conditions may lessen the number of RAC coding denials.

Alcoholic Liver Cirrhosis versus Hepatic Encephalopathy

When it comes to alcoholic liver cirrhosis versus hepatic encephalopathy, the 2002 first quarter AHA *Coding Clinic* clearly advises coders to assign hepatic encephalopathy as the principal diagnosis, noting that hepatic encephalopathy is a life-threatening event that may require immediate treatment.[9]

Coders should ask themselves whether they could stay home watching TV with alcoholic liver cirrhosis. The answer is probably yes. However, with hepatic encephalopathy doing so would be virtually impossible.

Notes

1. Centers for Medicare and Medicaid Services. "CMS RAC Status Document, FY 2007: Status Report on the Use of Recovery Audit Contractors (RACs) in the Medicare Program." February 2008.
2. Centers for Medicare and Medicaid Services. "FY 2011: 4th Quarter Report." November 23, 2011. https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Recovery-Audit-Program/Recent_Updates.html.
3. American Hospital Association (AHA). *Coding Clinic*. Third Quarter 1991.
4. Health Data Insights. CHDD RAC coding/DRG denial letter.
5. AHA. *Coding Clinic*. Second Quarter 1990.
6. AHA. *Coding Clinic*. Second Quarter 1994.
7. AHA. *Coding Clinic*. Third Quarter 2002.
8. AHA. *Coding Clinic*. Third Quarter 1991.
9. AHA. *Coding Clinic*. First Quarter 2002

References

Centers for Medicare and Medicaid Services. RAC Overview. https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Recovery-Audit-Program/.

Wilson, Donna. "Coding for Excisional vs. Non-Excisional Debridement." Audio seminar. March 4, 2010.

More RAC Resources

Members can also log on to AHIMA's Recovery Audity Contractor Community of Practice for the latest news and discussions on the RAC program. Visit www.ahima.org and click on "Communities of Practice" in the top left toolbar. [Communities site no longer available]

CMS also offers RAC program information and updates at https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Recovery-Audit-Program/.

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