



# RAC AUDITS: BETTER GOOD THAN LUCKY.

New clarifications to Medicare guidelines are blurring the lines for some hospitals when it comes to Recovery Audit Contractor (RAC) audit appeals. The “Two Midnight” rule as well as backlogs in appeals may impact the Medicare Claim Audit environment over the next year. With these factors at play, now is the time for providers to review their patient admission process; as strong policies and procedures can prevent inpatient claim denials.

## THE BOTTOM LINE

The best way to avoid gambling on RAC audit appeals is to have a strong front-end process to support and document the decision to admit.

While no specific form is dictated or required by Medicare, now is a good time to formalize the process.

## THE “TWO MIDNIGHT” RULE

The 2014 Inpatient Prospective Payment System (IPPS) Update included clarifications to the Medicare guidelines as to when inpatient care is appropriate. The new guidelines have a two midnight benchmark: if the patient is expected to require care spanning over two midnights, then inpatient admission is appropriate.

The new guidelines also grant a “presumption” that an inpatient stay crossing two midnights is appropriate, and generally excludes these claims from audit review. Going forward, administrative contractors have been ordered to perform “probe” samples of inpatient stays not qualifying for the presumption (less than two midnights) to review compliance.

In the meantime, RACs cannot request records for medical necessity review during the phase-in period, which may translate into fewer record requests for some providers. Centers for Medicare & Medicaid Services (CMS) has issued a halt on the audit of claims with dates of service from Oct. 1, 2013 - September 30, 2014, by RAC auditors. However, RAC can continue to review medical necessity on claims prior to October 1, 2013, and they can also continue coding reviews on all claims, so they won’t go away entirely.

When does the “Two Midnight” rule get tricky? One example is when a patient comes into the hospital in critical condition, is treated in the ICU, but recovers quickly and is ready for discharge the next day. While the stay is less than two midnights, the patient was admitted as inpatient due to medical necessity. Claim denials when patients meet clinical criteria for admission at arrival, and improve to the point they are ready for discharge prior to the passing of two midnights may be difficult to appeal on the clinical case merits under these new guidelines.

While the two midnight presumption may reduce the number of claims audited by RAC, it is generally disliked in the provider community as it reduces emphasis on the clinical picture of the patient and heavily relies on length of stay.

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**PROVIDERS SHOULD PICK STRONG CASES TO FIGHT ON CLINICAL NECESSITY, BUT WEIGH WHETHER A MULTI-YEAR APPEAL FIGHT IS WORTH FORGOING THE PART B REIMBURSEMENT IN THE SHORT TERM.**

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### **APPEALS BACKLOGS AND REBILLING GUIDELINES**

One unintended consequence of the RAC program has been a huge volume of appeals working through the system. Most appeals, particularly medical necessity appeals, have to reach the third level of appeal before an Administrative Law Judge (ALJ) to have a good chance of success. Due to the overwhelming appeal volume associated with the RAC audits, ALJ hearings are backlogged by a year, and according to some anecdotal reports, as far as 28 months out from the appeal request. The “Two Midnight” rule could increase the number of appeals filed because it does not take medical necessity into consideration. Additional appeals will create longer backlogs.

Extremely long appeal timeframes, along with Part B rebilling guidelines associated with ruling CMS-1599-F, will put pressure on providers regarding their decision to appeal denied inpatient claims. The interim ruling CMS-1455-R opened a window for providers to drop pending appeals for claims currently in process, or still in the window to file an initial appeal, to be able to file for Part B reimbursement without regard to timely filing rules. This was a temporary carrot dangled in front of providers to try and reduce appeal backlogs. The final ruling CMS-1599-F reinstates the timely filing rules for Part B claims associated with denied inpatient claims with dates of service October 1, 2013, forward.

Denied inpatient claims commonly run from \$3,500 to \$5,500, while the Part B reimbursements may net \$500 to \$1,500. It becomes a gamble to lose a sure, but smaller, reimbursement for the hope of retaining all of the inpatient stay at some point in the future, maybe two years out. And the new “Two Midnight” rule clarifications may make it more difficult to appeal on the clinical merits of a claim if it did not span the requisite two midnights. So with all these factors in play, appeal decision makers may have to ask themselves, “Do you feel lucky?”

The “Two Midnight” rule audit moratorium will limit the number of denials at least until September 30, 2014. Providers should pick strong cases to fight on clinical necessity, but weigh whether a multi-year appeal fight is worth forgoing the Part B reimbursement in the short term.

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**CONTACT US.**

For more information about how HORNE can help you avoid a RAC audit gamble, contact Ken Miller, CPA, CIA, CRMA, CHC, at [ken.miller@horne-llp.com](mailto:ken.miller@horne-llp.com).

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**BETTER GOOD THAN LUCKY**

The best way to avoid gambling on appeals is with strong front-end process to ensure level of care decisions are well supported and all documentation supports the decision to admit. CMS has re-emphasized expectations of a “certification” of inpatient admissions. While no specific form is dictated or required, now is a good time for providers to formalize the process.

At the time of admission there should be an expectation that the patient will require care spanning two midnights. Care managers often have to use the physician order, history and physical and progress notes to support the admission. A certification document done at the time of admission that shows the clinical case that supports the expectation of the two midnight length of stay may be crucial for the best odds of supporting an admission where the patient improves quickly and is discharged earlier than expected.

Providers should have their existing RAC management processes reviewed by knowledgeable health care consultants to ensure they are functioning as management expects, and that accurate information is being provided to decision makers. RAC error trends should also be reviewed and assessed if corrective actions are working. If you have multiple years of the same level of errors, there may be processes not functioning properly that need to be studied and addressed.

The bottom line is this: providers should take smart and effective actions to prevent denied inpatient claims on the front-end. With the uncertainty created by the “Two Midnight” rule and appeals backlogs, preventing inpatient claim denials is one factor that providers can control with strong policies and procedures.