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Flipping Coding Denials to Medical Necessity Complicates Appeals

The volume of medical-necessity appeals may keep growing partly because some coding denials are being flipped to admission denials in the midst of the appeals process.

Medicare administrative contractors (MACs), which administer the first level of appeals, and qualified independent contractors (QICs), which do the second level, sometimes flip coding denials to medical necessity denials. Apparently CMS permits claims denials to be flipped midstream, but it's another wrench in a hospital's defense audit process.

"You have to be prepared to defend MS-DRGs and the medical necessity of the admission. You never know what will happen," says Colleen Dailey, clinical coordinator of defense audits for WellSpan Health in York, Pa. In fact, WellSpan had 100 appeals of RAC coding denials pending as of mid-March, and half were flipped by the QIC to medical necessity cases. The reason isn't a mystery, she says, since Medicare recoups far more money if it voids an inpatient admission than if it recodes an MS-DRG. However, that will change somewhat under the new CMS rebilling rule and proposed regulation because hospitals have the opportunity to recover payments for Part B services after Part A denials *(RMC 3/18/13, p. 1)*. Part B pays less than an inpatient admission but far more than the few ancillaries hospitals recovered until now.

Flipping has its surreal moments. At a March 5 hearing with an administrative law judge (ALJ), Dailey came prepared to argue that a patient's admission for a laminectomy and foraminotomy was medically necessary. But the two RAC representatives — a physician-attorney and a nurse — expected to advocate for their coding denial. The RAC had no idea that its coding denial was flipped, and the ALJ was unsure what to do, Dailey says. "There is a lack of communication," she contends.

Communications Are Not Always Effective

The RAC had denied the claim in July 2011 on the grounds that secondary diagnoses of acute blood loss anemia and acute renal failure were not supported. WellSpan tried to change the RAC's mind during the discussion period, and when that failed, WellSpan appealed to the MAC in November 2012. That's when the infamous flipping occurred. All of a sudden the MS-DRG coding was moot, and the denial was about the medical necessity of the setting. Accordingly, WellSpan changed course with its QIC appeal in January 2012 but lost again, so the next step was the ALJ. Finally, the hearing came, and everyone scrambled.

The ALJ offered a compromise: Either he could postpone the hearing pending advice from CMS, or the two sides could argue both the coding and medical necessity issues. Dailey feared a delay would drag out the appeal another year or two — and it took 2 1/2 years to get the ALJ hearing — so she forged ahead with the RAC's concurrence. "I was unprepared to defend the DRG, but I had the appeal the coders prepared for the discussion period and the MAC appeal, so I read that," she says.

Another twist: Even though the RAC argued the coding case at the ALJ's insistence, neither was familiar with *Coding Clinic* or whether it was approved by CMS, Dailey says. She recommends that all hospitals include standard language in their appeals explaining the role of the quarterly guidance and its CMS imprimatur. The American Hospital Association, which publishes *Coding Clinic*, says on its website that "coding advice [in *Coding Clinic*] is approved by CMS for Medicare reimbursement and accepted by many other health care plans, Medicaid programs and state data sets."

There's no word yet on the outcome of the strange hearing. The ALJ could agree the admission was medically necessary but downcode the MS-DRG or vice versa. "It's just crazy," Dailey says.

The rationale for flipping is the appeals contractors' *"de novo"* authority, which means they can look at each claim anew, says attorney Andrew Wachler of Wachler & Associates in Royal Oak, Mich. "If you go from the Medicare Appeals Council to federal court, it is not *de novo*. They will only look at whether something is arbitrary or capricious or isn't supported by facts," he says. "But at the levels below, everyone looks at claims fresh. You don't have to show the RAC is wrong or the QIC is wrong." *De novo* is how flipping happens, Wachler says. "Therefore you have to support your coding and your medical necessity," he says.

Flipping is another twist in the appeals doors that opened and closed with the CMS ruling and proposed

regulation, which were announced March 13. The ruling and the regulation both allow hospitals to seek Part B payment when their Part A inpatient claims are denied for lack of medical necessity based on the setting. But the appeals picture is different. Under the ruling, which is now in effect, hospitals may appeal Part A admission denials and, if they lose, they have 180 days to refile the claims for Part B payments. The proposed regulation, which will supersede the ruling when finalized, does the same thing, but it imposed the one-year Medicare timely claims-filing deadline. This controversial provision requires hospitals to rebill Part B claims within a year of the date of service. Lawyers say it's almost impossible for hospitals to pursue appeals of the Part A medical necessity denials and then seek Part B payment if they lose within a year. In essence, the proposed regulation requires hospitals to choose between appealing Part A medical necessity denials and collecting Part B payment, according to attorneys.

Strong Cases Should Still Be Appealed

In light of this landmark change in payment policy, hospitals should continue to appeal strong medical-necessity cases, lawyers say, but perhaps not the weaker ones in favor of seeking Part B payment. "If the hospital is confident that its Part A stay was justified, they should strongly consider sticking with the appeal. Dropping out just to rely on the ruling and get the Part B payments would be less than a Pyrrhic victory," says Boston attorney Larry Vernaglia, with Foley & Lardner LLP. "On the other hand, if the appeal was a stretch, so there is a real litigation risk, I might take the Part B payments and go home." Minneapolis attorney David Glaser, with Fredrikson & Byron, agrees. "If it's a weak case, you may want to just take the outpatient payment. But for strong cases, my advice is fight," he says.

In terms of flipping, hospitals should keep in mind that appeals are an invitation for contractors to look at all aspects of their documentation, another reason to consider seeking Part B inpatient instead. "One of the checklists of an appeal is to ask if there is any reason we don't want someone looking at this chart," he says. "Can they switch or identify another problem?" If that's the case, maybe forget the appeal. "Under the new ruling, you can still bill Part B," Glaser says.

Dailey doubts that WellSpan will change its approach to appeals. If an admission was medically necessary, she will fight for it. Like other hospitals, it recovered Part B payments before the CMS ruling, which is what prompted it. At least the CMS ruling frees hospitals from having to appeal to get the Part B payment. "But it will be an increase in the burden for people in the coding and billing departments," Dailey notes, because there will be a shift from ICD to CPT codes for some claims, which also can now include services that were once bundled because of the DRG window payment policy.

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