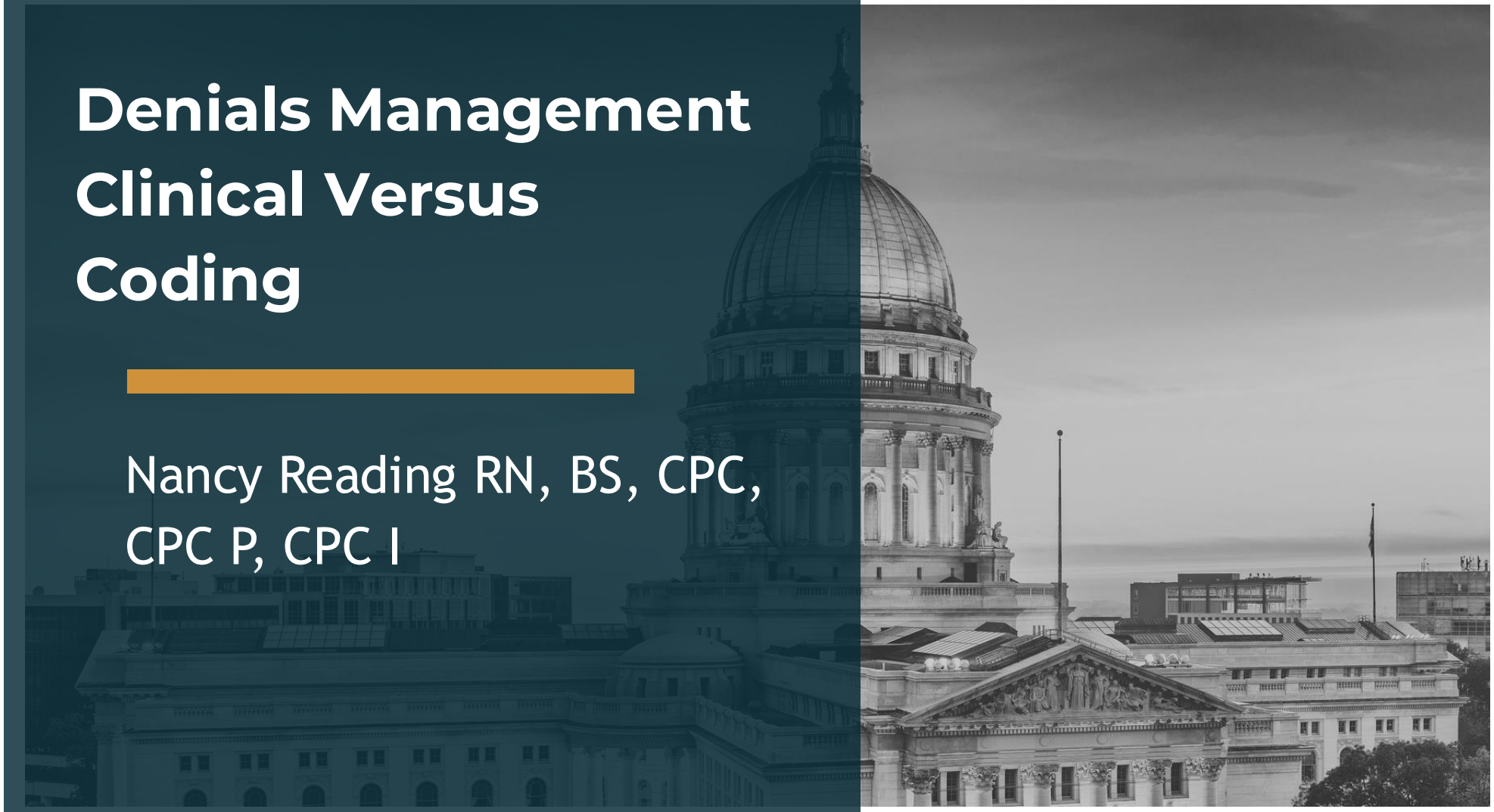
Denials Management Clinical Versus Coding



Nancy Reading RN, BS, CPC, CPC P, CPC I

January 14, 2025

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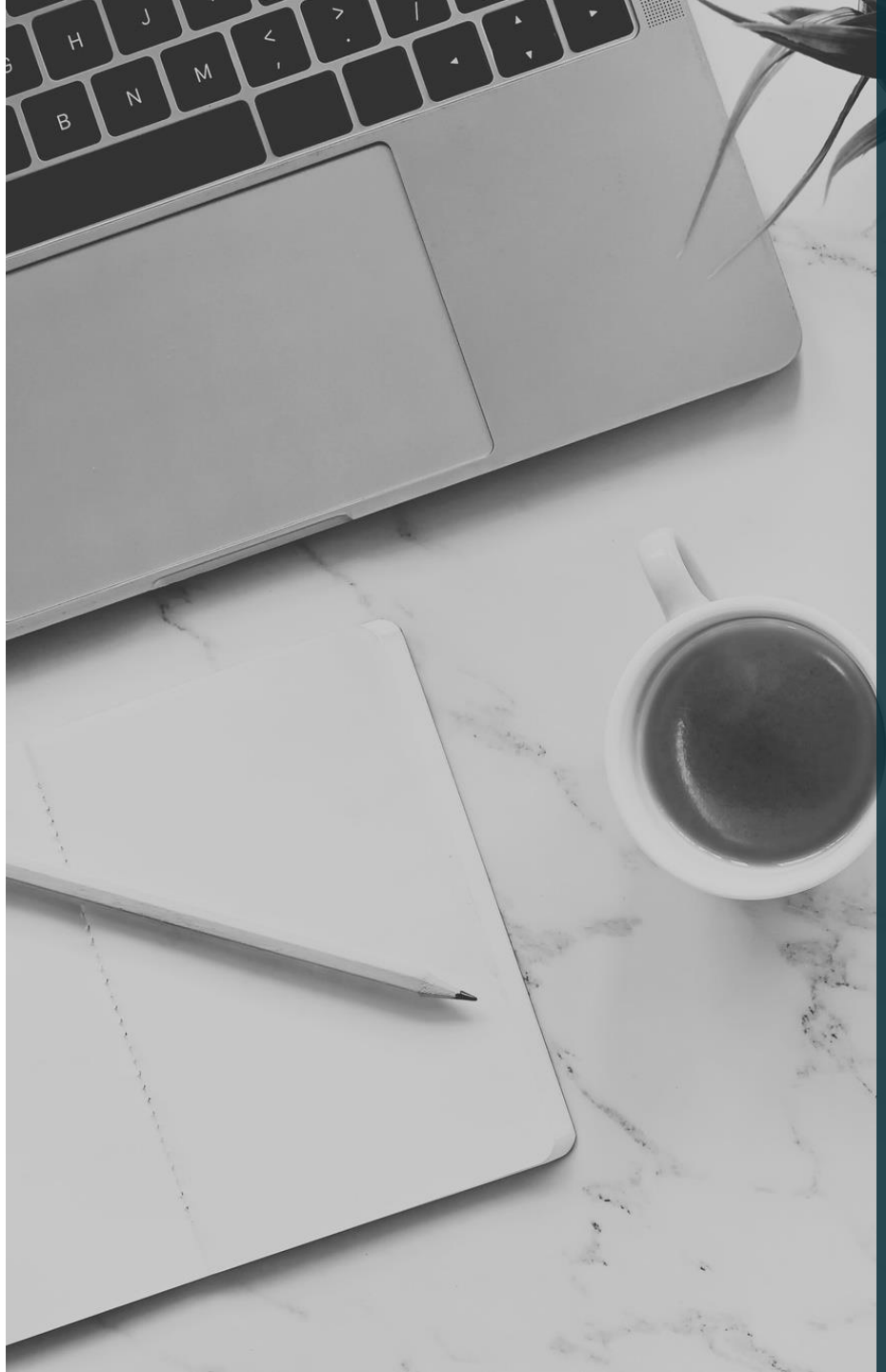
CORE VALUES

Elevate Medical Solutions has five core values: Integrity, Humility, Knowledgeable, Solutions Focused, and Team Player. Our focus from day one has been on our people. While everyone's walk of life is unique, we see a common theme in the professional journey of our people. Everyone on our team has a passion for what they do. They care about it, they get excited about it, and they love to watch their skills tackle the challenges their team is setting out to resolve.



OBJECTIVES

Identify Coding Versus Clinical Audit Nuances

Best Strategies to Bridge the Gap Coding vs Clinical

RCM and Denials - Best Tactics for Success

Root Cause Analysis

What are the Roadblocks to Success?

Coding is Driven by Clinical Documentation

- Coder's code based on information extracted from the clinical record
- Providers diagnose and document the information used to drive the codes.

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What are the REAL Issues? #1

- Official Coding Guidelines maintain the following:
- “Code assignment is based on the documentation by the patient's provider (i.e., physician or other qualified healthcare practitioner legally accountable for establishing the patient's diagnosis).”

What are the REAL Issues? #2

- Provider Documentation is not
  - Consistent through the hospital stay
  - Consistent across providers
  - There are many hands in the chart not always noting what the other hands are doing.

What are the REAL Issues?

- Provider Documentation is not always clear
  - In teaching environments, the attestation may or may not support the flow of diagnostic clinical events, diagnosis assignment, and evolution of a diagnosis.
  - Diagnoses that evolve throughout the hospital stay are not sufficiently addressed at discharge to determine whether the diagnosis was in fact a true problem.

What are the REAL Issues? #3

- Provider Documentation is not supported by clinical data
  - Clinical Diagnostic Data is not in evidence to support the documented diagnosis.
  - Quality measurement requirements for diagnoses like Sepsis create a plethora of denials based on initiation of the “Sepsis Bundle” in the absence of a true diagnosis of Sepsis.

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What are the REAL Issues? #4

- The thrust by hospitals to capture all the buzz words to identify MCCs and CCs has not addressed clinical parameters.
- Provider coaching over time to use key terms and assign high value diagnoses leads to coders identifying them and coding them with or without clinical support.
- This results in denials by third party payers costing the hospitals to lose more than they gain.

What are the REAL Issues? #5

- Diagnoses are assigned without explanation around missing clinical support see…..
- Case 1 Patient came in with hypotension, AKI, and elevated total bilirubin of 3.4 and severe metabolic encephalopathy. Lactate 1.1
  - Diagnosed with and treated for Sepsis. Fluids, IV Antibiotics and Pressors
  - No GCS, ED noted as unresponsive on admit
  - Borderline UA. Diagnosis was UTI
  - Cultures negative.
  - Stranding around gallbladder on US with Cholecystostomy tube in place from prior admission for cholecystitis and discharge 2 days prior.
  - Discharged on continuous antibiotics for 7 days, on antibiotics at time of re-admission and cultures collected.
  - Patient Expired hospital day 4
  - Provider notes did not reconcile any of the

What are the REAL Issues? #5

- Case 1 continued
  - Discharged on continuous antibiotics for 7 days from prior admission 2 days before presenting for the admission under review,
  - On antibiotics at time of re-admission and when cultures collected.
  - Denial letter noted the patient had no symptoms of UTI and therefore considering the negative culture and no symptoms, UTI was not allowed
  - They recoded Encephalopathy as the PDX
  - This was without regard for the notion the patient was unresponsive on admit and most likely could not verbalize symptoms.
  - Additionally, now based on the denial there was no identified diagnosis to support the shock and refractory hypotension.
  - Patient Expired hospital day 4
  - Provider notes did not reconcile any of the above. This made an appeal a challenge!

Was this Patient Septic?

- Claim Denied, DRG down graded.
- Appealed based on fact the patient had been on antibiotics as an outpatient
- Physician reviewer for insurance also denied UTI diagnosis based on lack of symptoms.
  - Patient was non-verbal on admission with acute metabolic encephalopathy.
- Providers caring for the patient discontinued antibiotics based on cultures without mention of or consideration for ongoing antimicrobial therapy.

What is the Bottom Line ?

1. Coders code appropriately from the medical record
2. The medical record **is not** clinically clear and consistent
3. **Data** required to support a diagnoses is **not** always **in evidence**
4. An absence of supporting diagnostic data is not adequately explained in reference to the diagnostic statement.

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Is There a Line in the Sand?

- Healthcare is ensnared between conflicting requirements from CMS for clinically compliant claims submission and the Official Guidelines for Coding and Reporting

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CODING ISSUES

Identify and Correct!

DRG Validation Audit

- The Centers for Medicare and Medicaid Services (CMS) defines the purpose of DRG validation as
  - “ensuring the medical record supports coded diagnostic and procedural information. [2]”

DRG Validation Audit

- DRG audits are performed by coding professionals who follow official coding guidelines as they evaluate the hospital claim against the patient's clinical record to substantiate coded elements.

DRG Validation Audit

- DRG audits evaluate coded elements such as:
  - principal diagnosis
    - Admitting Diagnosis
  - secondary diagnoses,
  - surgical procedures,
  - present on admission indicators and
  - discharge disposition as **documented by the physician.**

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DRG Validation Audit

- DRG audits can be performed concurrently and retrospectively.
- Working DRGs are often established shortly after admission, modified during the patient's hospitalization, and finalized upon discharge.

Role of the Discharge Summary

- The discharge summary is designed to be an overview of the hospital stay noting the all the key events driving a final diagnosis.
- There should be a designated primary provider overseeing the hospital stay who is responsible for following the patient from admission to discharge and performing this summary.
- When this information is missing, and the intel needed to support or refute a diagnosis along the way is not in evidence this is a roadblock to success.

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Role of the Discharge Summary

- There are strong opinions regarding whether a diagnosis can or can’t be coded if it is not listed in the discharge diagnosis and
- The list of discharge diagnoses is not always the same as the admission diagnoses.
- By definition the PDX is that diagnosis that after study was the reason for admission.
- What happens when the diagnosis listed as the principal diagnosis in the discharge summary was not mentioned through the hospital stay but is the result of a query?

Medical Coding Accuracy

- In general coders aim for a 95% or higher, accuracy rate
- Coding accuracy is critical for appropriate billing and reimbursement
- Coding accuracy is critical for compliant audit results
- Accurate coding results in a high first-pass resolution rate (this is the percentage of claims paid on first submission, indicating overall RCM effectiveness.)

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Medical Coding Accuracy – Missed/Lost Charges

- Repeatedly missed charges and possible reasons:
  - Non-billed charges resulting from human error,
  - Inadequate charge capture methodologies
  - Technology issues,
  - Non-covered services without an Advanced Beneficiary Notice (ABN)
  - Constant and undisputed insurer denials.

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Coding Errors Represent the Second Highest Reason for Denials

- Coding Errors Vary by Provider Type (Inpatient, Professional and Outpatient Hospital)
- Under coding, e.g. missing bilateral procedures, coding lower than documented Evaluation and Management Service, Not capturing timed services correctly or missing add on service codes.
- Missing modifiers
- Unbundling services
- Missing payable implant/supply
- Not coding the correct surgical approach in PCS or CPT
- Sequencing errors for Principal Diagnosis

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Coding Accuracy Interdependencies

- Coding depends on complete documentation,
  - Initial transport records should be scanned
  - Facility to Facility Transfer documentation should be scanned.
  - Reports generated outside the hospital EMR must then be scanned in.
- Coding depends on timely documentation
  - Pathology reports
  - Radiology reports
  - Implant details
  - Operative notes
  - Special Procedures reports

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Coders Require the Right Tools

- Coding depends on an **up-to-date** coding and billing system
- Accurate and complete coding depends on a trained and **continuously educated** coding workforce
- Access to **Authoritative References** for Coding is integral to success.
- Access to a CDI Partner /the Provider is best practice.

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Clinical Validation

Who’s on First?

Pinson and Tang December 9, 2021

- “Clinical validation is the process of validating each diagnosis or procedure documented within the health record, ensuring it is supported by clinical evidence in the medical record. Based on the False Claims Act of 1863, CMS does not permit providers to submit claims with codes for conditions that cannot be clinically validated based on authoritative and/or widely accepted diagnostic standards if it results in an “overpayment.”

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CMS RAC Statement of Work	CMS Medicare Program Integrity Manual	False Claims Act of 1863
"Clinical validation involves a clinical review of the case to see whether or not the patient truly possesses the conditions that were documented in the medical record."	"The purpose of DRG validation is to ensure that diagnostic and procedural information…coded and reported by the hospital on its claims matches the attending physician's description and the information contained in the medical record."	Imposes civil liability on any person (or organizations) who **knowingly** submits, or causes the submission of, a false or fraudulent claim to the Federal government. "Knowingly" is actual knowledge, deliberate ignorance, or reckless disregard. Includes submitting a claim with a higher weighted DRG than supported by the medical record.

Pinson and Tang December 9, 2021

- “The consequences of submitting clinically invalid diagnoses are numerous:
- Improper DRG reimbursement,
- Excessive denials,
- Unnecessary appeals,
- Risk of regulatory audits and penalties. “

Pinson and Tang December 9, 2021

- “Over-coding leads to MCC/CC classification downgrades, as have occurred with AKI and encephalopathy.”
- “To add insult to injury, denials and appeals mostly serve to enrich audit contractors at the expense of the Medicare trust fund.”

Clinical Validation

- Clinical validation must be performed by a licensed clinician and requires an in-depth review of the medical record to validate the medical diagnoses coded.
- Some of the common diagnoses that are a focus of clinical validation audit programs include **sepsis**, **renal failure**, **malnutrition**, and **encephalopathy** because of their frequent abuse.

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CMS Set the Stage at ICD 10 CM Implementation

- In a workbook for ICD 10 CM implementation for large practices CMS cited the following:
- “Emphasize the critical importance of proper clinician documentation and periodically audit sample records for completeness, accuracy, and consistency”
- “Emphasize in staff training and to external vendors the importance of ensuring that all coding is consistent with the clinical record and the risks to your practice if team members fail to code accurately”

https://www.cms.gov/files/document/icd10largepracticehandbook06044131pdf

Are Coders Asked to Perform Outside of Their Scope?

- ICD-10-CM Official Coding Guideline I.A.19 “Code Assignment and Clinical Criteria” caused further confusion by stating code assignment is not based on clinical criteria but rather the provider’s diagnostic statement.
- Coding Clinic Fourth Quarter 2016 pages 147-149 effective with discharges October 1, 2016, provided clarification by confirming clinical validation is not a coding review but rather a clinical review that must be performed by a clinician (RN, CMD, or therapist).

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Clinical Documentation Integrity

Bridge the GAP!!

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Clinical Documentation Integrity (CDI)

- The clinical documentation integrity (CDI) process identifies diagnoses and procedures in the medical record, supported by precise and appropriate clinical indicators, supporting stated diagnoses and then the appropriate ICD-10-CM and ICD-10-PCS codes can be assigned.

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Lost Opportunities and Queries

- An essential responsibility for CDI teams is to closely evaluate patient medical records and search for opportunities to further clarify documentation.
- When an opportunity is identified, a query is then presented to the provider to ensure that the patient's severity of illness and risk of mortality is reflected in the medical record.
- From these conversations, the most accurate codes are then conveyed to the appropriate audience.

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Proactive Provider Education

- In addition to reviewing records, CDI teams craft and facilitate education to broaden the foundational knowledge for providers in all service lines.
- Codes and subsequent coding guidance from CMS and AMA will change from year to year, CDI teams stay on top of changes and educate to them.

Ensure Accurate Representation

- CDI specialists closely interpret patient medical records to validate that the documentation is both accurate and complete.
- CDI specialists perform comprehensive analyses and verification of corresponding codes, ensuring that health systems are afforded the largest and most accurate reimbursements.
- The CDI specialist has a responsibility to identify the instances where the documentation is not supported by clinical evidence and query the provider for rationale.
  - In situations where this is an ongoing concern a physician champion may be necessary to intervene and educate.

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Additional Findings in Clinical Records

- CDI specialists understand that clinical documentation from the medical record is the foundation for data capture and ultimately used in reporting for
- Patient safety indicators (PSI),
- Hospital acquired conditions (HAC),
- Hierarchical conditions (HCC),
- Quality measures (QM),
- Hospital mortality ratios (observed and expected mortality calculations),
- Accurate lengths of stay (LOS),
- Diagnosis related grouper (DRG) assignments

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CDI Reviews

- Can be done concurrently
- Can be performed retrospectively
- Queries can be initiated concurrently or retrospectively
- There is no formal cut off for time elapsed from discharge to query, however it should be reasonable e.g. 30 days.

Third Party Payors Employ Clinical Audits

- Identify your stake holders and create a collaborative environment to work through these on appeal
  - clinical operations,
  - billing, follow-up,
  - denials,
  - coding teams,
  - clinical documentation improvement (CDI),
  - health information management (HIM),
  - business office, and compliance and
  - internal audit.

Queries

Compliance Counts!

Queries

- A “query” is a tool used to request provider communication concurrently or retrospectively to obtain documentation clarification.
- Who can query?
  - Query professionals (QP) include coding professionals, CDI professionals, physician/provider advisors, and all professionals who initiate communication that meets the definition of a query to clarify clinical documentation.
- Are your queries templated
- Does the provider answer the query in the query form only? OR
  - Do they then make a chart note to update the clinical record?
- See cdi-toolkit-for-beginners_final.pdf for full discussion of the

Which Provider do You Routinely Query?

- Queries should be sent to and responded to by provider(s) that are delivering direct care to the patient during the specific encounter.
- When multiple providers, from different specialties, are involved in the patient's care, the most appropriate provider related to the query subject should be queried.
- When conflicting documentation is present, the attending provider should be queried to resolve any discrepancies.

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Do You Query Non-provider Clinicians?

- It is up to the individual organization to determine in their policies and procedures if they will query clinicians who are not classified as a provider. For example:
  - Nurse administering infusions
  - Clinicians providing wound care
  - Respiratory therapist for mechanical ventilation
  - Nurse administering medication that has been ordered by the provider
  - Dietitian to provide body mass index (BMI)
  - Social worker, community health workers, case managers, or nurses for any clarification for Social Determinants of Health (SDOH)
- All individuals who are likely to receive a query should be educated about the reason(s) for the query, the process, and the expectations for completion and documentation.

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Compliant Queries

- Open ended or Multiple choice
- Clinical indicators driving the query must be included with directions as to where to find them.
- Not leading
- Must be specific to the current episode of care
- Pre-existing conditions can only be noted if they impact the current course of care.

Source of Clinical Indicators

- Clinical indicator(s) may be sourced from the entirety of the patient's health record to include but are not limited to:
  - Emergency services documentation (e.g., emergency service transport, ED provider, ED nursing)
  - Diagnostic findings (e.g., laboratory, imaging)
  - Provider impressions (e.g. history and physical, progress notes, consultations)
  - Relevant prior visits (if the documentation is clinically pertinent to present encounter)
  - Ancillary professional documentation and assessments (e.g., nursing, nutritionist, wound care, physical, occupational, speech, and respiratory therapist)
  - Procedure/Operative Notes
  - Care management/social services

20221212_acdis_practice-brief.pdf

Revenue Cycle Management (RCM) Denials and Appeals

Bringing it all Together!

Provider Fairytales About (RCM)

- Once bills are sent, payments magically appear.
- The insurers automatically receive every submitted claim. (Sadly, they do not: a claim may well be marked “not received,” “pending,” or even “missing”).
- “RCM is the biller’s/coder’s/administrator’s job, not mine!”
- Clinical productivity generates bills. Money simply follows.
- Denials are an unavoidable part of clinical practice. Accept them.

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Provider Fairytales About (RCM)

- Small losses are insignificant—do not pursue them.
- RCM is a linear process that guarantees payment.
- Once purchased, RCM software need not be reviewed. Do not ask: “What can improve the process?”
- Delayed payments are OK. Line of credit will cover the loss.

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CDI and Coding Concurrent Review

- How are charts selected
- How are coding issues moved to CDI for clinical confirmation
  - Who has the final say?
- Where are the initial codes and CDI notes logged?
- When diagnosis/procedures change and/or evolve is it captured?
- When PDX changes how is that explained and where?
- Are queries and results a part of the permanent record?
  - Are the outcomes of queries then integrated into the progress notes going forward?

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Post Discharge Coding and Chart Closure

- Coders versus CDI, who has the final say?
- What is the routing if there are discrepancies
- Timely post discharge queries
- Documentation Addendums
- Pathology/ Genetic / Molecular Biology Tests results in process
- Discharge Summary/ Procedure report not dictated
- What are the productivity Benchmarks
- Is there an internal auditing team/process?
- Coordination between providers for Co-surgery in Profee setting
- Documentation for Unlisted procedures in Profee Setting

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Coding From The Discharge Summary from ACDIS

- There is no language in the Official Guidelines for Coding and Reporting that specifies that the diagnoses must be present within the discharge summary.
- A medical record must stand on its own and in its entirety, not subject to any single page or document or obvious typo being an exculpatory issue (although that is exactly what the auditors will argue).
- The record stands as a unified body of documentation and it isn't always expected that every single note will have every single diagnosis.
  - AND, THIS INCLUDES THE DISCHARGE SUMMARY.

Q&A: Coding diagnoses left out of the discharge summary, January 11, 2018, CDI Strategies - Volume 12, Issue 2 Q&A: Coding diagnoses left out of the discharge summary | ACDIS

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Coding From The Discharge Summary from ACDIS

- It has always been the position of the American Hospital Association (AHA), CMS, and the National Center for Health Statistics (NCHS) that the coder should review and code the ENTIRE medical record, not just the discharge summary.
- Discharge summaries are notorious for being incomplete, inaccurate, and quite frequently missing at the time coding is done.
- In the past, up to 80% of records were coded without a discharge summary even being present.
- In current times, that number is much lower, but it still happens.

Q&A: Coding diagnoses left out of the discharge summary, January 11, 2018, CDI Strategies - Volume 12, Issue 2 Q&A: Coding diagnoses left out of the discharge summary | ACDIS

Barriers to the Number of Days to Bill/Charge

- Benchmark should be **2 days or less**, for **a professional** provider practice and **less than 30 days** for **inpatient** claims.
- Late or missing dictation/documentation/reports (op notes, pathology/radiology reports, implant information).
- Unaddressed coding queries, co-signatures, or edits.
- Overwhelmed or undertrained billing personnel.
- Clerical delays.
- Software issues

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Identify Blockage to Generating a Claim

- Late documentation
  - Provider does not document or dictate timely
  - Transcription company is behind
  - Data needed to establish final diagnosis is pending
- Missing documents.
- Low billing/coding team productivity,
- Claim scrubber edits to clear,
- Encounters without documentation, face sheet, attestation sheet, superbill or up to date demographics and insurance information.
- Poor charge entry accuracy

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Days in Receivables Outstanding

- Days in receivables outstanding tracks the average number of days it takes to collect payments.
  - **Aim for a days in receivables outstanding of 30 days or less to collect all payments due.**
- Underpayment Recoveries
  - **Providers fail to collect 2%–5% of net patient revenue**, due in part to inefficient RCM, or the frustration of disputing the claims.
  - Certain insurers are so notorious for attempts to wear down claimants that many practices and hospitals have stopped accepting them.

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Clean Claims Ratio

- Clean claim rate is the proportion of claims that do not require edits before submission
- Identify trends in denials and build an action plan with measurable outcomes
  - Mitigate denials by solving the problems up stream
    - Audit and Educate internally before the payor denies reimbursement
    - Provider Champion to work with providers as needed
    - Provider Champion to weigh in on appeal letters requiring provider level of expertise
    - Coder education and remediation plan to require progress.

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Clearing House Holdups

- Claim files are sent to the clearinghouse, and edited
- An edit report is sent back to the practice, indicating claims and charge lines rejected with various edit problems.
- If the details in these edit reports are not attended to, the claims and charges will never make it to the payer and be processed for payment.
- Uncorrected, these claims fall into a “black hole” and will remain on the practice’s accounts receivable forever and will exceed the timely filing limits set by the payer.
- Edits can be received from a clearinghouse at multiple levels
  - There are clearinghouse edits, where the clearinghouse scrubs the claims for errors in the submittals and
  - A second level occurs when the payer rejects the claim, as the beneficiary is not on file or an incorrect beneficiary ID number, etc.

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Denials Management From HFMA

- “ shows that organizations have seen an increase of more than 58% in payer integrity audits over the past several years, even with COVID-19.[d]
- There’s also been up to a 34% bump in medical record exchange and a 21% increase in the cost involved in mitigating compliance risk in the exchange of information.
- In October 2022, a survey by Kaufman, Hall & Associates, LLC: Of 86 hospital and health system leaders, 67% reported an increased rate of claim denials.
- That is more than double the 33% who reported increased denials in 2021.
- In addition, 51% said they experienced an unfavorable change in payer mix, with a lower percentage of commercially insured patients.
- Another 41% reported an increase in bad debt or uncompensated care.”

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Denial Volume to Denial Appeal Rate From HFMA

- “Claim denial costs hospitals roughly $262 billion per year, creating significant cash-flow issues.
- To avoid lost revenue, analysts look at denial percentages and the dollar amounts from denied claims.
- Denial rates are typically 5%–10%, which can improve after automating workflows.
- The denial appeal rate is the ratio of total number of denials appealed to the total volume of denials.
  - A high ratio is ideal: a low ratio suggests opportunities for automatic write-offs or adjustments.”

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Identify Key Personnel

- Payment Posting
  - Who is responsible to identify trends in denials?
  - Who monitors accounts receivable?
- Internal Compliance Auditors Identify coding issues
- Close the RCM loop with front end coders
  - What is the flow in your business to close the loop between claims denials and front-end coders?

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Appeal Denials When Appropriate!

- Appeal denials where possible!
- DO NOT leave money on the table
- Look for Denial Trends
- Clinical versus Coding Denials should be routed to the best professional to do the appeal
- Track responses

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Challenges for Appeal

- Specialty service lines often carry special documentation, coding and billing requirements.
- There are also nuanced rules for managing and appealing cases within specialties. Psychiatry, for instance, requires extra security measures for releasing behavioral health information.
- Rehab, home health, psychiatry and infusion therapy are common culprits for payer denials and audits.

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Close The Loop in RCM

Beginning to End Processes to Facilitate Success

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Administrative Tasks

- Insurance Verification
- Demographic Verification
- Collect Co-Payment
- Sign an ABN before services are rendered
- Charge Capture Analysis
- Charge Description Master Audit
- Itemized bill to clinical record review
- Keep Invoices Accessible
- Ensure Medical Necessity requirements are met and documented

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Integration of Outside Records

- Transfers from other facilities
- EMS transport
- Diagnostic tests recorded in unintegrated systems
- Pertinent Pathology Reports sent out for read or consultation
- Office notes done just prior to admission or for pre-operative History and Physical done within 30 days
- Copies of laboratory or radiology reports performed at an outside facility and identified as the reason for admission.

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Regulatory Compliance

- A written compliance plan that is in use is key per the 2023 DOJ and Sentencing Commission Guideline update.
- “If it is determined that there was an effective compliance program and the wrongdoing was by a “rogue” employee, then this would lead to mitigation of penalties. On the other hand, failure to evidence a commitment of compliance, would be an aggravating factors in assigning penalties.”
- “While the USSC recognized that compliance programs could not eliminate all offenses, they could identify when and how the organization went “off course.””
- “This evidences compliance program effectiveness; a program that fosters prompt reporting to law enforcement as appropriate along with mitigation and corrective action to reduce the likelihood of the offense re-occurring. In fact, Chapter 8 states “The failure to prevent or detect the instant offense does not necessarily mean that the program is not generally effective in preventing and detecting criminal conduct.””

https://www.compliance.com/wp-content/uploads/2023/04/JHCC_0102_23_Watnik.pdf

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Regulatory Compliance

- Audit
- Educate
- Re-Audit
- Track Trends
- Engage a physician partner/champion to help with provider training
- Compliance plan can have incentives and penalties, doled out by other physicians/providers
- Stay Current on Code Changes
- Implement Policies where needed
- Get Stakeholder Buy In!

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Health Information Management (HIM)

- How are coding and health records activities related in your facility?
- How long from discharge to charges dropping per policy
- How long for a provider to reply to a query?
- Are there incentives or penalties for missing deadlines?
- How are codes reconciled between Coder and CDI
  - Who is the tie breaker?
  - Do you have a Physician Advisor
- What is the educational model for Coders, CDI and Providers?
- What are your productivity standards?

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Identify Leadership/Oversight Individuals and Processes

- Keep all processes functioning
- Accountable to Outcomes
  - Accountable for fiscal health of the entity
- Install a board or committee to weigh in on key decisions
  - Link coders, CDI, providers, compliance and business stakeholders

Questions

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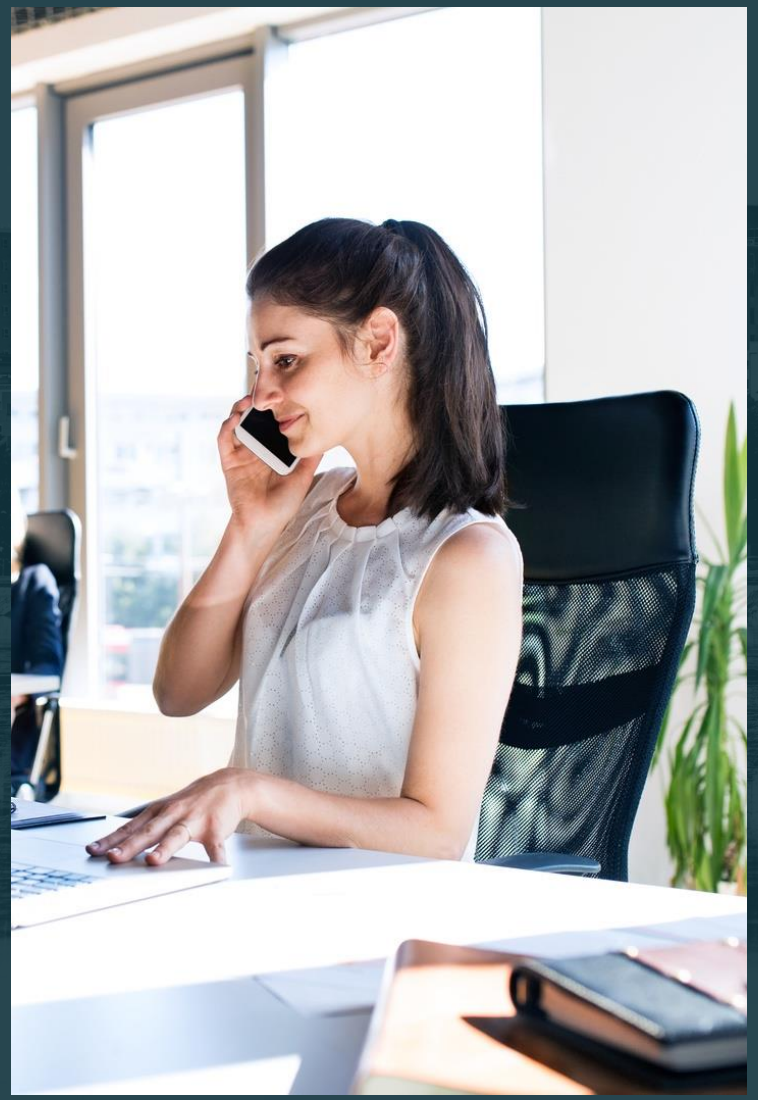

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