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Association of Clinical Documentation Improvement Specialists

DENIALS MANAGEMENT: LEVERAGING CDI EXPERTISE TO PROTECT REVENUE

Leadership research survey indicates growing role of CDI professionals in clinical validation, denials prevention, and clinical appeals

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Hospital audits and insurance claims denials are becoming increasingly common and increasingly high-profile. Some auditors have resorted to questionable or opaque tactics, including the use of Sepsis-3 criteria prior to their widespread adoption, or denying malnutrition claims despite clear documentation of ASPEN criteria. That makes the job of a CDI specialist all the more difficult. It's no longer enough to obtain physician documentation of a diagnosis; the diagnosis must also be clinically validated in the chart.

However, denials have also opened a new opportunity for CDI specialists to demonstrate their value, as they can apply their clinical acumen and knowledge of documentation and coding guidelines to issue clinical validation queries, engage in preemptive denials protection, and get involved in appeals.

We asked eight CDI leaders to evaluate the results of a nationwide survey on clinical denials and discuss their organizational strategies for denials prevention, appeals, and management. Following is a review of the survey results and a summary of that discussion.

Clinical validation

Approximately 85% of respondents to ACDIS' CDI Research Series survey—a group of 118 CDI professionals from across the country, with more than 80% possessing CDI supervisor, manager, or director titles—reported that clinical validation is a core function of their CDI review staff. Clinical validation is defined as clarifying diagnoses in the health record that may lack clinical support, including clinical indicators such as lab tests, associated treatments, or diagnostic studies. Only about 3% of respondents indicated that they perform no type of clinical validation (see Figure 1).

Figure 1. Is clinical validation (i.e., clarification of diagnoses that may lack documented clinical support) a function of your CDI department?

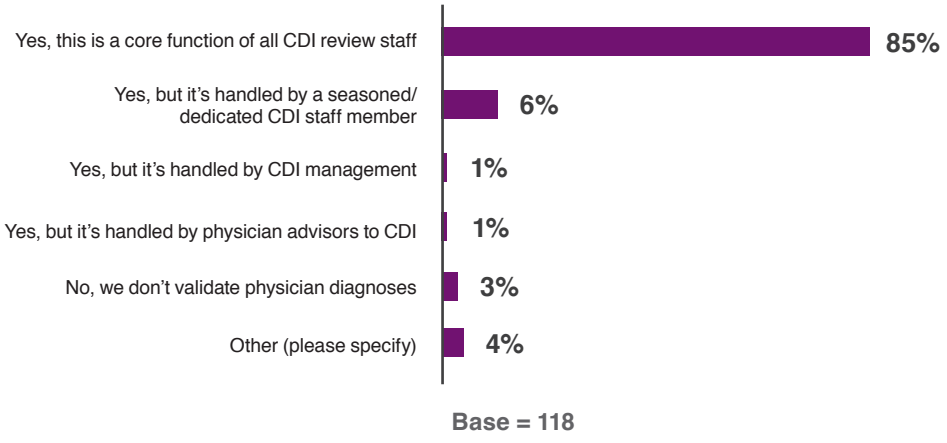
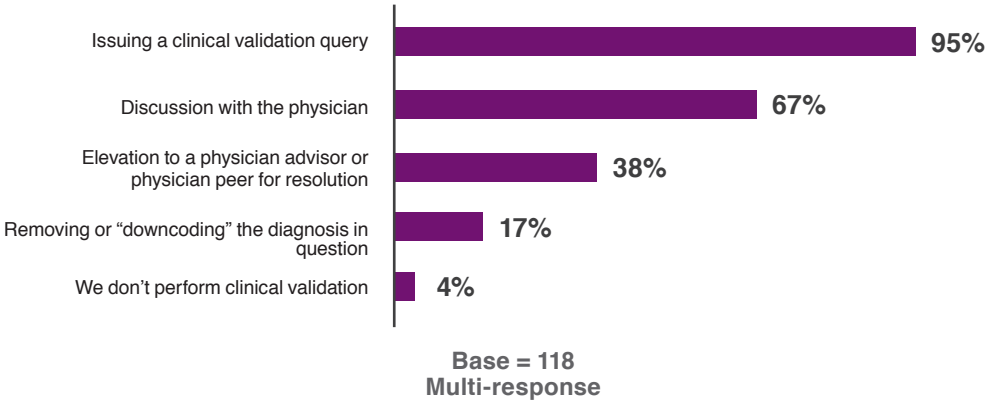


Figure 2. What does your process of clinical validation entail? Select all that apply.



Base = 118
Multi-response

But the form and format of clinical validation can vary significantly. While most respondents (approximately 95%) issue clinical validation queries, about two-thirds engage in discussion with the physician of record, 38% elevate clinical validation concerns to a physician advisor, and approximately 17% will ultimately remove or downcode a non-validated diagnosis (see figure 2).

CDI staff at Yale New Haven System perform clinical validation of all diagnoses that lack support, regardless of whether they impact the principal diagnosis, says Tonia Catapano, RN, BSN, CCDS, CCS, RHIA, director of coding and CDI for the organization. "This is a core function of the CDI role. But we are noticing that with the high-risk diagnosis we are still seeing denials, even if the clinical indicators are there," she says. "We fight back, and some we might win, but some—50% of the commercial payers—we might lose."

A common obstacle in obtaining documentation to support clinical validation is a lack of physician buy-in. Charrington "Charlie" Morell, RN, CCDS, division director of CDI for HCA West Florida Division in Tampa, has found success by turning the physician's focus back to the care of the patient. A recent query to clarify conflicting smoking status in a patient met with initial skepticism, but physicians complied when Morell explained that a documented smoker pays more for insurance and may be rejected by a plastic surgeon as a poor candidate for elective surgery due to the increased likelihood of poor outcomes. She had also heard of a case in which a spouse was denied life insurance benefits because the patient had declared he was a nonsmoker, but his medical record had him documented as a smoker. Fixing this discrepancy led to a long fight with

the insurance company. Armed with these examples, clarifying smoking status is now a lot more important to the physician involved.

"A good rule of thumb to consider when performing clinical validation is, if you had to write a letter today to support that diagnosis, what portions would you print, and what clinical indicators would you include to justify that it was appropriate for the physician to report that diagnosis?" says Adelaide M. La Rosa, RN, BSN, CCDS, assistant vice president of HIM/CDI/EMPI/DRG appeals for Catholic Health Services of Long Island in New York City. "We want to denial-proof these cases, and once we get the denials back, we want to fight back with recognized resources, clinical indicators, and get the physician of record to also write the letter. At the end of the day, they need to know it's about their [physician's] profile, and it also contributes to their risk-adjusted payments."

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>
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Removing or downcoding diagnoses that lack clinical support is seen as a slippery slope by some. "We're not the physician, we just can't arbitrarily decide not to code that diagnosis," said one participant. But others believe that coding a documented diagnosis without clinical support can be seen as failing to meet UHDDS criteria of a secondary diagnosis. Moreover, coding an unsupported diagnosis can put an organization at high risk for denial and additional scrutiny.

Having a written escalation process and policy can serve as protection in these instances. Asking physicians to attend Targeted Probe and Educate (TPE) sessions hosted by CMS is another powerful educational tool. "We will not code something if the clinical indicators are not there," La Rosa says. "You are held accountable as a facility for reporting something when it's not appropriate. It's a potential quality issue, and that case will be elevated to the CMO."

Denials prevention

CDI specialists are doing more to prevent denials than just issuing concurrent clinical validation queries. They are also reviewing for additional CCs and MCCs to "protect" cases (53% of respondents), focusing on high-risk DRGs and diagnoses (36%), and working with

payers and/or stakeholders in their organization to establish criteria for diagnoses (22%) (see figure 3).

Rachel Roeber, RN, BSN, CCDS, CCS, CPHQ, director of coding and clinical documentation for Greater Hudson Valley Health System in Middletown, New York, is involved in all her organization's managed care contracts, sitting at the negotiating table to work out administrative burden and reimbursement rates, audit rates, diagnosis definitions, and clinical criteria. "We have gotten payers to agree to only use one vendor to audit, and to audit quarterly, which helps with our audit workload," she says. "I might not get exactly what I want, but it's always a win for our organization to be there."

Participants in the survey review group also recommend participating in your state hospital associations, which can lend support for the use of clinical criteria. The Greater New York Hospital Association, for example, recently got the giant healthcare insurer United to back down from its intention to adopt Sepsis-3 criteria for auditing claims on January 1. Other states, including Connecticut, are taking similar action.

User-friendly improvements to the EHR, including improved workflows and the use of documentation templates, can also help prevent denials. Lee Anne Landon, BSN, CCMC, CCDS, manager of the clinical documentation program at HonorHealth in Scottsdale, Arizona, has had success bringing dietitians' consults and ASPEN criteria screenings into the summary page that greets physicians when they log into Epic. If a physician agrees that a patient has malnutrition, he or she can quickly add the information to the patient's progress note.

Figure 3. Do you or your CDI staff perform denials prevention? Select all that apply.

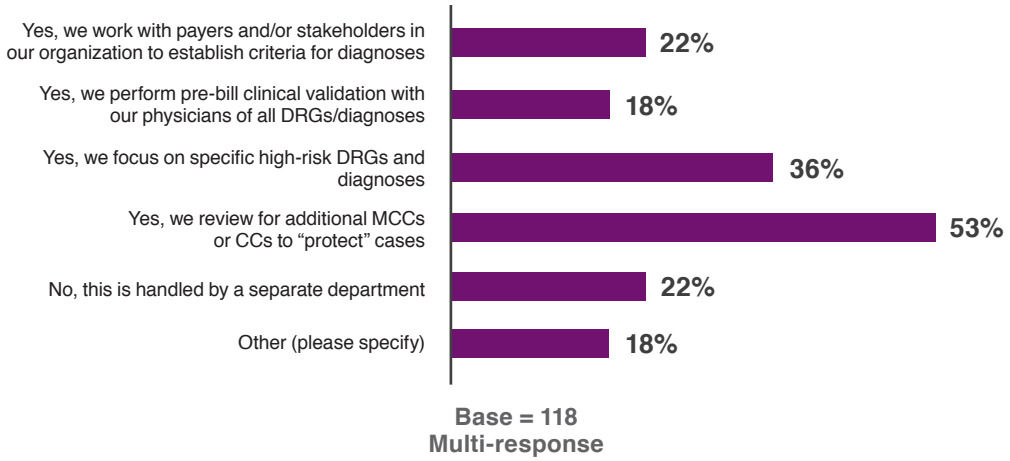
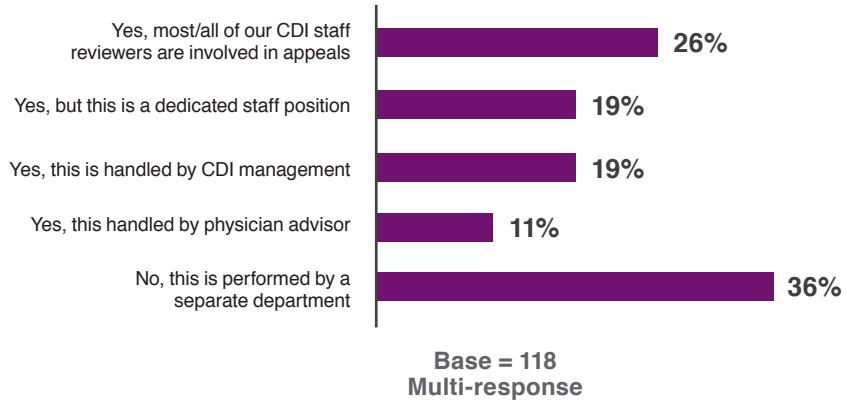


Figure 4. Do you or your CDI staff manage or assist in the appeals process for clinical denials? Select all that apply.



Catholic Health Services of Long Island recently developed and deployed an ICD-10 documentation app for its physicians. The early returns look good, as physicians can quickly look up common high-risk diagnoses and supporting clinical indicators on their mobile devices while documenting in the chart. "It seems to be really working nicely," La Rosa says. "Even when the CDI team meets with a doctor on the floor, they'll say, 'Let's take a look at your app and go over [the chart].'"

Kelly Skorepa, BSN, RN, CCDS, director of CDI with University Hospitals Health System in Cleveland, leverages the system's high-reliability, specialty-focus medicine teams to develop systemwide clinical criteria for sepsis and acute respiratory failure. The organization is now planning to expand to additional diagnoses. "We don't have a clinical indicators committee, but [CDI] does work with the leaders of those teams to develop diagnosis-specific clinical indicators and best-practice documentation examples, so that way these guidelines have some clout and approval before we send them out across the organization," she says.

Clinical appeals

As noted above, the vast majority of CDI professionals are involved in some form of denials prevention and protection. But fewer are engaged in the appeals process post-denial. Some 26% of respondents to the CDI Research Series survey indicated that most or all of their CDI staff reviewers are involved in appeals. Another 19% indicated that a dedicated staffer handles appeals. Others indicated that appeals are handled by CDI management (19%) or a physician advisor (11%), while 36% stated that appeals are performed by a separate department altogether (see figure 4).

Greater Hudson Valley Health System's appeal analysts send the denial back to the CDI and coder who worked the case, asking whether they agree or disagree with the payer and prompting them for a brief rationale. "We try to incorporate that rationale into our appeal letters," Roeber says. "If nothing else, it's a learning opportunity for what the payers are looking for, so we can be more proactive in the future."

Beth Wolf, MD, CCDS, CPC, physician consultant for 3M Health Information Systems and a physician advisor for Roper St. Francis in Charleston, South Carolina, says that she always involves the attending physician when a DRG denial comes in, even if a successful appeal is unlikely. "I do not let it go without sending them the letter; I give them the opportunity to participate," she says. This step raises awareness, allowing physicians to see how their documentation is being interpreted.

Wolf also notes that taking legitimate appeals all the way to peer-to-peer (i.e., physician-to-physician) reviews with insurers can result in an overall lower denial rate. "They don't want to pay their expensive people to talk to me if they know I will win," she says.

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HonorHealth uses a denials workgroup to manage its appeals. Team members analyze the denial to determine if it warrants appeal, then gather resources to support the appeal letter. The team shares denial results with other hospitals throughout the organization and presents findings at meetings. "The reason I don't have everyone doing [appeals] is it's so labor-intensive," Landon says. "The time factor is a big issue, and it would impact all the other work they have to do."

Mary Bourland, MD, vice president of medical documentation with Mercy in Chesterfield, Missouri, says her organization uses a select team of experienced CDI professionals and coders to perform appeals. "We take the data back to the CDI and the coding teams for education, and we look at targeted issues and problems with queries, etc., and go back and do targeted education with that individual."

Some organizations use outsourced companies to perform their appeals, with mixed results. While outsourcing frees up time for CDI and coding professionals to perform a full review caseload, the quality of the work is not always great—and it can be costly.

Bringing DRG appeals back in-house can open up promotion opportunities for experienced staff. After scaling back its outsourced appeals, Catholic Health Services of Long Island hired a director and four staff from its CDI ranks to track denials, write appeals letters, and manage the overall process. The system now has four years' worth of reliable data on denials to trend. La Rosa was also able to show the denials data from one facility over a year related to diagnoses not clinically supported; she then leveraged that loss into approval to hire a new CDI staff member.

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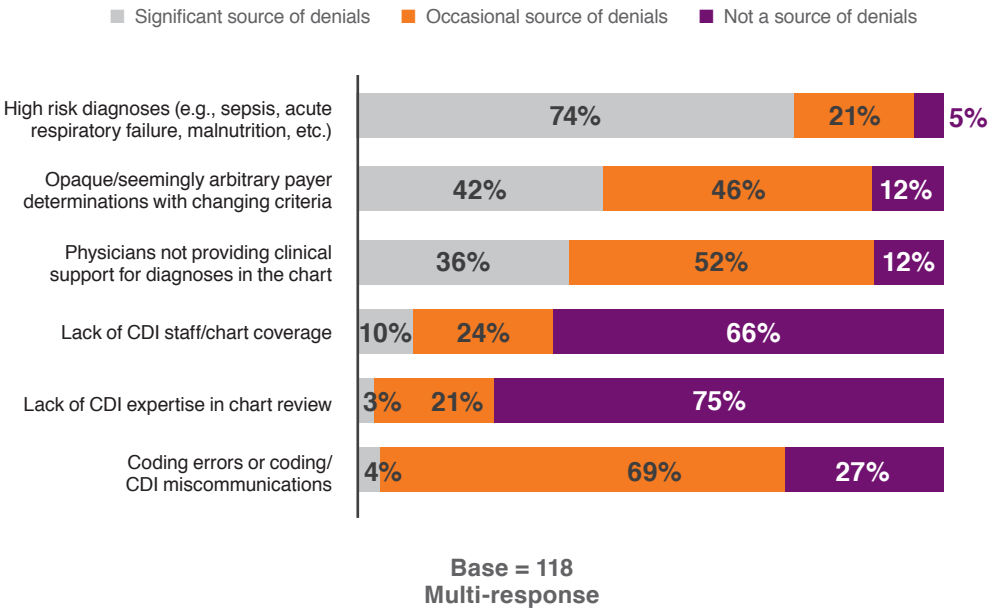
"Speaking of these outsourced companies, they don't always do as good a job as they could; it's very cookie-cutter," La Rosa says. "Don't get discouraged if your appeals are not upheld. I think it's the way they're writing their letters."

Of the 36% of survey respondents who said that appeals fall to another department, Wolf remarks that in her experience, this typically means HIM/coding. She notes that moving appeals into CDI requires developing new skill sets that aren't always part of the typical CDI workflow. "These include writing the appeal and looking for clinical indicators that may be in the nursing notes, not just the physician's notes," she says.

Sources of denial

Survey respondents were also asked to identify the most significant sources of denial in their organization. Not surprisingly, the majority identified high-risk diagnoses (e.g., sepsis, acute respiratory failure, malnutrition) as a significant source of denials (74%), followed by opaque or seemingly arbitrary payer determinations with changing clinical criteria. Some 42% indicated the latter to be a significant source of denials, and 46% an occasional source of denials.

Figure 5. Of the below sources of denied claims, please indicate whether these are significant sources of denials, occasional sources of denials, or not a source of denials.



Base = 118
Multi-response

A bit surprising to panelists was the high degree of coding errors and coding/CDI miscommunications as denial sources. Although just 4% of survey respondents described these slipups as a significant source of denials, nearly 69% listed them as an occasional source of denials. This data indicates there is more work to be done in the chain of communication between CDI and HIM/coding departments. One suggestion from survey participants was to build multidisciplinary CDI teams that include professionals with strong clinical backgrounds (registered nurses, for example) and coding/HIM professionals (see Figure 5).

"This is the reason that my team is made up of coding and CDI experts," Skorepa says. "We see missed query opportunities where the CDI might not have seen the last few days of the stay and the coder added a diagnosis that wasn't clearly supported. We provide internal education back to our coding team to say, 'When you see this documented and you're questioning whether there is clinical support, you need to kick this back to the CDI for that collaboration before we drop the bill.'"

Mercy strives to maintain its uncoded days at two or less to help keep its discharged not final billed (DNFB) low. "That poses a challenge as we do put a stop on all PSIs, HACs, quality indicators, and clinically

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unsupported, which goes to a special team," Bourland says. If the final DRG assigned by coding does not match CDI's working DRGs, the coders must assign a reason why (progression of the chart, procedure done post-discharge, etc.).

Catholic Health Services of Long Island has changed the traditional last touch point of the claim, assigning ultimate responsibility for bill drop to its CDI professionals. The organization uses Epic, which is programmed to hold the coders' work in a queue for CDI review. "The CDI being clinically savvy, knowing clinical validation, and being coding savvy, performs their coding validation," La Rosa says. "It is now up to CDI to determine what is the appropriate principal diagnosis; are the secondary diagnoses coded appropriately with clinical indicators; and procedures. CDI also completes the coding and drops the claim."

Figure 6. Do you track the impact of denied claims on your CDI department? Select all that apply.