Denials Management: A CDI Approach to DRG Validations

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Disclaimer: The following presentation was prepared by Marilyn Sanchez and Sharra Way in their personal capacity. The opinions expressed herein are those of the authors and do not necessarily reflect the views of Orlando Health.

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Presented By

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Presented By

Sharra Way, RN, CCDS, is a CDI specialist at Orlando Health in Orlando, Florida. She has over 20 years' experience in emergency medicine, critical care, interventional radiology, and rapid response nursing. She works with the denials management team at Orlando Health, where she began her position in CDI performing concurrent reviews in 2019. In 2021, she transitioned to denials management, reviewing DRG audits and defending them based on evidence-based research and practice guidelines.

Learning Outcomes

- At the completion of this educational activity, the learner will be able to:
  - Identify 6 tools for DRG validation denials management
  - Identify at least 3 other departments for collaboration
  - Identify at least 3 benefits of data collection
  - Identify at least 3 steps in how to operationalize a denials management team in CDE
  - Identify 3 ways denial management impacts the organization

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Denials Management: A CDE Approach to DRG Validations

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Birth of the PDT (Payer Defense Team)

- CDE program was established in 2014
  - Concurrent reviews
  - Physician engagement
  - Reconciliation
  - Education

- DRG validations were sent to coding team

- 2020 COVID happened! The world shut down!
  - Opportunity!!!
  - April 2020 – PDT was born!
  - 2 CDE specialists built it from nothing
  - Primary focus: Clinical validation and DRG (coding) validation denials

- We did not have all these tools in place at first! It took time to develop, and we *CONTINUE* to grow and develop our program.

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Tools for Successful Denials Management

- Designated team members
- Diagnosis definitions
- Appeal letter templates
- Evidence-based references
- Data collection
- Collaboration
  - Physician advisors
  - CDE concurrent team
  - Ancillary departments
- JOC (Joint Operations Committee) meetings
- Managed Care contract negotiations

Dedicated Team

- Having dedicated CDE team members to review these accounts
- Benefit of CDE handling:
  - Coding and guidelines
  - Clinical
- Detail oriented individuals
- Self-starters
- Self-motivated

Ok A-Ok Woman - Free photo on Pixabhttps://pixabay.com/photos/ok-a-ok-woman-yes-positive-symbol-2385794/ay

Diagnosis Definitions

- Create *evidence-based* diagnosis definitions
- Committee evaluates need for definition and updating existing definitions annually and as evidence is updated
- Collaborate with physician specialists
- Utilized ***SYSTEM WIDE*** not just CDE!
  - Physicians recognize these definitions and utilize in their practice/documentation
  - Utilized in query templates
  - Utilized on DRG validation side – embedded in letter templates
- Include diagnoses that payers frequently target
  - Sepsis, AKI, respiratory failure, OB, and Neonatal issues

Appeal Letter Templates

- Begin with diagnosis definitions
  - Build a template using the references for the definition
  - Suggest having at least these 5:
    - Sepsis
    - Respiratory failure
    - Malnutrition
    - AKI
    - Generic template

- Work smarter, not harder!

Evidence-Based References

- Begin the diagnosis definitions
  - Should have references that helped to build the definition
- Keep a library of references as you find them
  - Function within Word
  - Keep a separate document
- Ensure they are credible references
  - PubMed
  - UpToDate
  - MedScape
  - KDIGO
  - ASPEN

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Data Collection

- Used for productivity of team members
- Identify trends:
  - Payer specific
  - Diagnosis
  - Volume
  - Types
  - Rationales
  - Self-denials
  - Overturn rates
- Track data
  - Utilize any means
    - Software to Spreadsheets
- 🔑Key Objectives
  - Collect the data
    - *VERY IMPORTANT* part of our role
  - Centralize location where all team members can access
  - SHARE the data you collect
    - Leadership
    - CDE department
    - Physician advisors

Collaboration With Physician Advisors

- Utilize their specialties
  - Adult
  - Obstetrics
  - Pediatric
- Assist with self-denials and appeal letters
- Assist with clinical language and diagnoses wanted within payer contracts
- Data trends (scheduled meetings)
- Education (reciprocal)
- Legal proceedings

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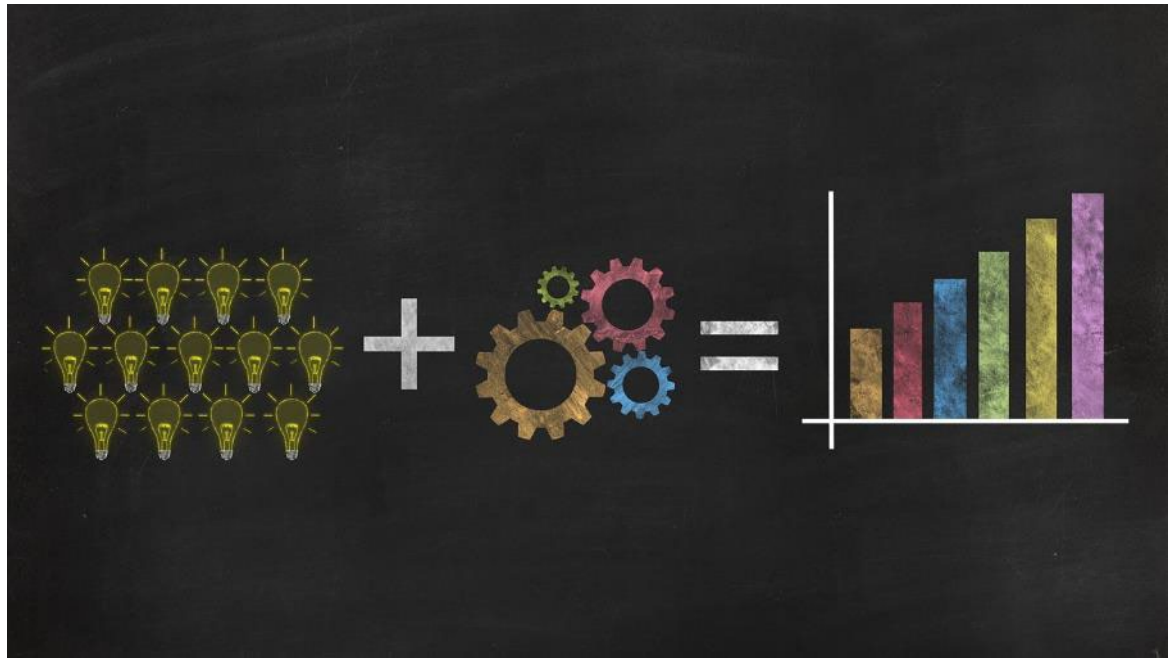
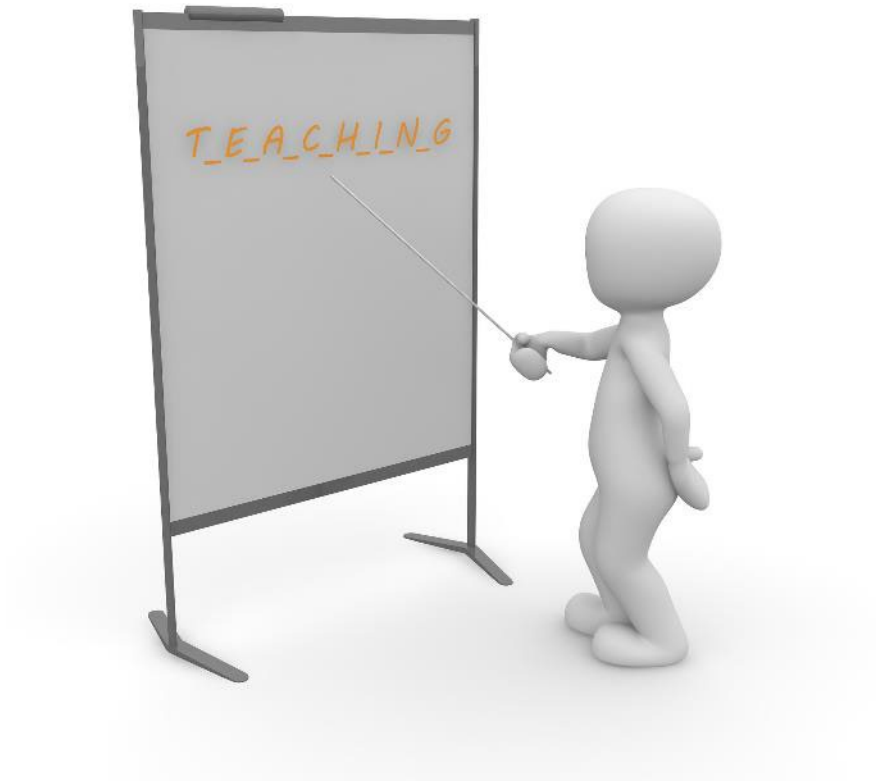
CDE Concurrent Team Collaboration

- Utilizing the diagnosis definitions in clarifications
  - Embedded in templates
- Provide data trends
  - How many cases reviewed, self-denied, appeal sent, appeals won
  - Associated dollar amount
  - Top diagnoses



CDE Concurrent Team Collaboration (cont.)



- Education based on monthly data
  - Frequent diagnoses payers target
    - Sepsis, AKI, respiratory failure
  - Case studies
  - Show the query opportunities
    - Validation, POA, conflicting documentation
  - Show associated dollar amounts
  - Opens communication
    - They feel comfortable asking questions

Concurrent Team Collaboration (cont.)

- Kudos when clarifications aid in appeal
  - Recognition well deserved
  - Key to our defense
  - Appreciation that comes full circle

Ancillary Department Collaboration

- Patient Accounting
  - Receive letters from them
  - Collaborate on account/ letter status
  - Submit appeal letters to them for processing
  - Submit self-denial spreadsheets for processing of refund
- Coding
  - Adjust final billing
    - Self-denials or modified results
  - Share data trends
- Health Information Management (HIM)
  - Review governmental release of information
  - Process improvement
  - Receive payer letters from them

JOC (Joint Operating Committee) Meeting

- Monthly meetings with payers and the organization
- Status of outstanding payer balances
- Shines light on opportunities regarding contract content, pre-approvals, denials
- Goals for denials management within these meetings
  - Discuss trends in denials
  - Discuss contractual discrepancies within the denials space
  - Reduce recurrent denials for frequently denied diagnoses per payer trends

Managed Care Contract Negotiations

- Addition of approved diagnosis definitions within contract
- Reduce denials going forward
- Increase provider wins
- Communication regarding trends in the denial space
  - Example: Pre-payment denials or payment retractions

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How to Operationalize DRG Validation Denials Management

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How to Operationalize

- **Get DRG validations routed to the dedicated team**
  - Collaboration with HIM / Mailroom / Patient Accounting
    - ALL sources that may receive the letters
  - Denials for medical necessity or overpayment are outside of CDI
  - As you grow your denials management team, you can incorporate UR to handle medical necessity

- **Data Collection**
  - Input into a worksheet
    - Spreadsheet, intranet, software database
  - patient name, acct #, MRN, DOB, DOS, claim #, payer, contractor, diagnosis, ICD code(s), DRG (pre- and post-), associated dollars

- **Review each letter**
  - Appeal or self-deny

How to Operationalize

- **Collaborate with patient accounting**
  - They submit letters to payer
  - They submit the self-denial and refund back to the payer
- **Collaborate with coding team**
  - They re-code the chart if self-denial
  - Open dialogue for coding questions – they are the experts ☺
- **Collaborate with physician advisors**
  - They review self-denials, to validate clinically
  - They review our 2nd appeal letters and add any additional information needed to clinically strengthen the rebuttal
  - 3 separate physician advisors: Adult, pediatric, and obstetric

How to Operationalize

- Many moving parts and pieces
- Need to stay organized
- We created a digital manual
  - Team has access to view and modify
  - Helps with training new employees
  - Standardization of workflow

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Writing the Appeal Letter

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Writing the Appeal Letter

Review the payer's letter

- Type: Clinical validation, Resequencing, PCS coding, POA Status
- Diagnosis in question
- Look at payer's references (if they list any).
- Often, they utilize wrong criteria in their defense, or they don't utilize any references but give you a criteria.

Select the correct letter template (Have a generic template if no diagnosis specific)

Add patient demographic information

Brief clinical summary:

- Make it relevant to the diagnosis
- Include patient name, age, PMHx, presenting diagnosis, any details that would support your diagnosis in question (labs, diagnostic imaging, vitals, etc.), consultants, and treatment (supporting diagnosis question)

Writing the Appeal Letter

Justification for appeal

- Utilize the payer's words in your appeal
  - Your denial letter states, "XXX"

- Utilize evidence from the medical record to support
  - In the History and Physical, the provider states, "XXX". On 12/30, Infectious disease specialist states, "XXX"
  - Look in every nook and cranny!
    - Nursing notes, physical therapy notes, EMS documentation, dietitian notes, admission order, respiratory therapy, etc
    - *Think outside the box!*
    - Utilize this evidence as well for support of your diagnosis

- Add statements utilizing your references
  - Coding guidelines
  - Coding clinics
  - Evidence-based medical articles

Writing the Appeal Letter

Close your appeal with a statement summarizing the intent to keep the DRG the same

- For these reasons, the diagnosis A41.89, Other specified sepsis, is correct and supports the original DRG 871.

Provide a timeframe for response

- We look forward to your response to our appeal within 30 days. Thank you.

Provide physical address, email, and/or fax where you want correspondence to be returned (just as the payers do)

Writing the Appeal Letter

Be sure to include your name and credentials.

- Add additional name/credentials as necessary
- Leadership or physician advisors

Include all references

- If using a template for a specific diagnosis, that template should already have the references listed
- ALL letters must have a reference!
  - This is your solid evidence why you are RIGHT, and the payer is WRONG!
  - Can be OCG or *Coding Clinic*

Writing the Appeal Letter

- Tactics for second appeal letters
  - **Bold** – underline – *italics* where necessary
  - Utilize payers' own words
  - Maintain updated references
  - Include physician advisor signature (if able)

Sepsis Sample 2nd Appeal Letter

Dear Clinical Validation Appeals Auditor:

Attached is our response to the clinical validation denial issued by your company for the following beneficiary:

Patient Name: [redacted]	Account No: [redacted]
DOB: [redacted]	Control No: [redacted]
DOS: [redacted] - [redacted]	MRN No: [redacted]

Type of Denial

We received a DRG validation denial which was suggesting a change in the DRG from 871 to 177. The letter below gives justification for why the diagnosis, A41.89, Other specified sepsis, supports the original DRG 871.

Clinical summary

[redacted] is a 72-year-old male with a past medical history of dementia, chronic kidney disease, sleep apnea, nephrectomy, coronary artery disease status post CABG, atrial fibrillation, congestive heart failure, and obesity, who was admitted with severe sepsis due to COVID pneumonia with acute respiratory failure and acute kidney failure. He presented with complaints of shortness of breath. Vital signs on admission were as follows: temperature 98.6, heart rate 108, respiratory rate 24, oxygen saturation 87% on 2 liters nasal cannula. Lab work reveals COVID PCR positive. Chest x-ray shows, "Bibasilar pulmonary infiltrates." CT scan of the chest reveals, "Bilateral interstitial airspace disease likely due to an atypical infection including Covid." He was seen by infectious disease, nephrology, cardiology, and palliative care specialists. His treatment included IV Decadron, IV fluid continuous infusion, IV remdesivir, and supplemental oxygen. He expired on 1/26/2021.

Your denial letter states, “The determination to remove principal diagnosis code assignment of diagnosis codes A41.89 (Other Specified Sepsis) with a final DRG of 177 is upheld.”

However, we *STILL* disagree!

You go on further to state, “Even though viral sepsis was documented in the history and physical, supporting medical record documentation was not found within the record.” However, we maintain there *IS* supporting documentation within the medical record. As we stated previously, vital signs on admission included **heart rate 108** and **respiratory rate 24**. Lab work reveals **COVID PCR positive**. Chest x-ray shows, “**Bibasilar pulmonary infiltrates**.” CT scan of the chest reveals, “Bilateral interstitial airspace disease likely due to an **atypical infection including Covid**.” [redacted] meets Sepsis 2 criteria as noted in the chart above with tachycardia, tachypnea, and COVID pneumonia. She also presented with **end organ dysfunction, with documentation of hypoxia** (oxygen saturation 87% on 2 liters nasal cannula).

In regard to the documentation, you have acknowledged that sepsis is documented in the medical record. There is clear and consistent documentation that [redacted] presented with severe sepsis due to COVID pneumonia with associated organ dysfunction. In the History and Physical, the provider notes, "**Dyspnea secondary to COVID-19 viral pneumonia, Hypoxic respiratory failure secondary to above, O2 sats 90% RA, Severe sepsis secondary to above, tachycardia, tachypnea**. COVID-19 positive, Pulmonary infiltrates on CT and chest x-ray." Subsequent internal medicine progress notes on 11/21, 11/22, and 11/24 states, "**COVID-19 RT-PCT 19 bilateral pneumonia/Severe sepsis… Acute on chronic hypoxic respiratory failure due to COVID-19 pneumonia**." Critical care progress notes on 11/23 states, "Severe Sepsis due to COVID PNA." On 11/25 and 11/26 Internal medicine progress notes state, "Severe Sepsis due to COVID PNA." The clinical resume notes, **"Primary Diagnosis: COVID PNA… # Severe Sepsis due to COVID PNA**."

You also stated, "During the admission there was no acute hepatic failure, hyperglycemia, hypotension, oliguria, coagulation abnormalities, ileus, thrombocytopenia, hyperlactatemia, or decreased capillary refill." You have not provided any evidence-based research to support this arbitrary list of criteria. At Orlando Health, we developed a committee consisting of experts in the field of infectious disease, critical care, and hospitalist medicine. We have researched the data and collectively agreed that Sepsis 2 would be our choice for defining sepsis. In our clinical experience and validated by many studies, Sepsis 2 has saved many lives. Sepsis 2 has improved the morbidity and mortality associated with sepsis at our healthcare system.

Denials Management Impact on the Organization

- Helps mitigate lost revenue
- Identifies root cause of denials for organization
- Utilizing a dedicated team INVESTED in the well-being of the organization
  - Helps the organization and employee engagement
- Educating the CDE department has proven to be very helpful and impactful in their operations
- Representing CDE in JOC
- Representing CDE in contract management negotiations
- Organizational process improvement

Denials Management Impact on the Organization

- Noticing trends with letter volume for specific payers and bringing that to light
- Noticing trends with payer tactics and bringing that to light
- Identifying trends with provider documentation and providing feedback to the education team
- Breaking the silos!
  - Committed to have a healthy working relationship with all the teams we collaborate with!
  - No back biting
  - No blaming
  - Truly collaborative and appreciative dynamic

DON'T FORGET…

- Celebrate the victories!
  - They may be far and few between, but they are there!
  - Easy to get lost in the continued "losses" when the payer upholds decision
  - ***You deserve a pat on the back for the great work you do!***
  - Sometimes small victories are enough to continue lighting the fire within you

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Thank you. Questions?

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