acdis 2022 IMAGINE
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What You Don't Know Can Hurt You: How Payers Use Your Documentation and Claims Data

Leah N. Savage, MSN, RN, CCDS
System Auditor/Educator CDI
Baptist Health
Louisville, Kentucky

Virginia "Jennie" Bryan, MBA, RHIA, CCS
Director of Provider Solutions
CGI, Inc.
Louisville, Kentucky

hcpro

Presented By

Leah N. Savage, MSN, RN, CCDS, is a CDI auditor/educator at Baptist Health Systems in Louisville, Kentucky. She has 17 years of experience in nursing and 12 years in CDI. Savage implemented the pediatric CDI program at her previous facility and was a co-leader of the pediatric networking group (APDIS). Savage presented on the topic of pediatric cardiac conditions at the 2017 ACDIS conference in Las Vegas and in 2017 in San Antonio. She also served as a contributor and reviewer of the book *Pediatric CDI: Building Blocks for Success*.

Presented By

Virginia "Jennie" Bryan, MBA, RHIA, CCS, is director of provider solutions at CGI, Inc. based in Louisville, Kentucky. She has more than 30 years' experience as an HIM director, prospective payment/coding consultant, and director of compliance and HIPAA privacy, as well as healthcare risk. Bryan served as president with the KHIMA and RVHIMA and has presented locally and nationally on topics such as coding, compliance, copy/paste, 2-midnight rule, 60-day provisions, and payment integrity.

Learning Objectives

- At the completion of this educational activity, the learner will be able to:
  - Understand payment integrity and the fraud waste and abuse (FWA) environment in the U.S.
  - List methods used by CDI and payers for payment integrity
  - Explain how technology changes the game
  - Identify prevention techniques for take backs and recoveries

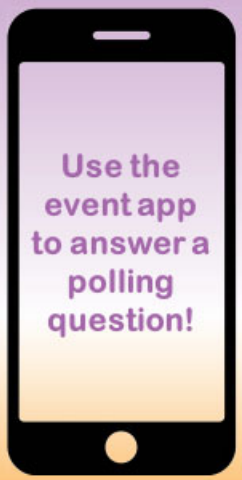
The Power of Seeing Things Differently

- Education and training
- Work experience and work culture
- Life experience and culture
- Leads to the ability to improve conflict resolution
- Improves generation of ideas and direction
- Improves ability to anticipate others' thoughts and interests
- Recommendation: Build teams that are diverse

Fraud, Waste, and Abuse

What's the big deal?

Steps for Attendees to Answer/View POLLING QUESTIONS



1. Navigate to the **Schedule** in the main menu.
2. Tap the **name of the current session** to view the session details page.
3. Scroll down the page to **Live Polls.**
4. Tap the **name of the poll.**
5. Tap your **answer** choice(s) and then tap **Submit.**

Polling Question

- **According to CMS-National Health Expenditure Data, approximately how much was spent on U.S. health care in 2019?**
  - A. Under $3 million
  - B. $300 trillion
  - C. Under $3.8 billion
  - D. $3.8 trillion

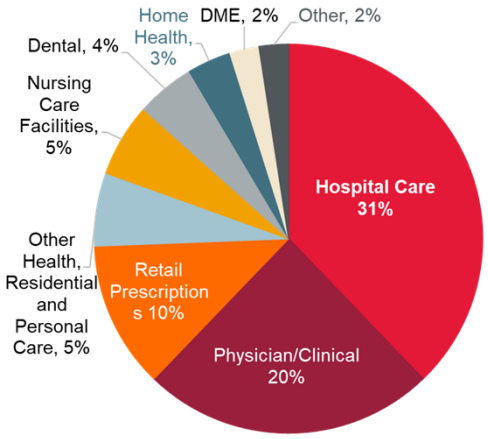
Source: https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsHistorical#:~:text=U.S.%20health%20care%20spending%20grew,spending%20accounted%20for%2017.7%20percent

POLLING RESULTS

Question 1

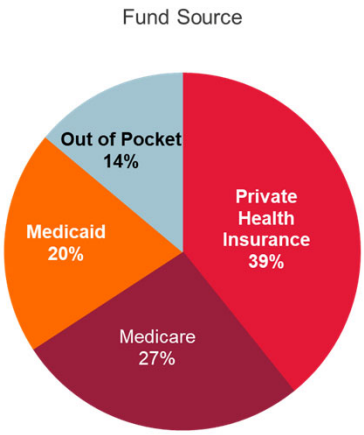
Gross Domestic Product (GDP) – Spending

- 17.6% of U.S. GDP is spent on health care
- Grows approximately 4.3% per year



Source: https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsHistorical#:~:text=U.S.%20health%20care%20spending%20grew,spending%20accounted%20for%2017.7%20percent

Healthcare Spending By Source of Funds



Source: https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsHistorical#:~:text=U.S.%20health%20care%20spending%20grew,spending%20accounted%20for%2017.7%20percent

Fraud, Waste, and Abuse – Payment Integrity

- $3.8 trillion spent on health care in 2019[1]
- ≈ Minimum 3% are fraudulent[2]
- At 3% that is $114 billion
- There are some that believe the rate is higher, possibly 10%. ($300+ billion)

1-https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsHistorical#:~:text=U.S.%20health%20care%20spending%20grew,spending%20accounted%20for%2017.7%20percent

2-https://www.nhcaa.org/tools-insights/about-health-care-fraud/the-challenge-of-health-care-fraud/

Federal Payment Integrity & Fraud Waste & Abuse Agencies

- Payment Integrity and FWA Agencies
  - Medicare Administrative Contractor (MAC)
  - Zone Program Integrity Contract (ZPIC)
  - Comprehensive Error Rate Testing (CERT)
  - Recovery Audit Contractor (RAC)
  - Government Law Enforcement
  - Data Analysis

Methodologies

Documentation and Coding: CDI and Payer Methodologies

CDI Clinical Validation

- Ensure diagnoses are supported throughout the medical record
  - Organizationally developed established guidelines with clinical indicators created in collaboration with the medical staff, CDI specialists, and coders for problematic or high-risk diagnoses can help support CDI professionals and coders in the clinical validation.
  - Baptist Health has established definitions with clinical criteria for:
    - Sepsis
    - Acute and chronic respiratory failure
    - Malnutrition
    - Anemia
    - Hyponatremia
    - Rhabdomyolysis
    - AKI
    - Ventilator associated pneumonia

How Insurers/Payers Prevent FWA

- Preauthorization
- Medical Necessity Review
- Pre-Payment Review
- Post-Payment Review
  - Automated
  - Semi-automated
- Continual focus on new concepts and edit development
- Technology and analytics
- Provider outreach and education

Payer Methodology – Coding Validation Review

- Review MD documentation and determine codes are correct and sequencing is correct on the claim.
- Is the exact condition represented by the code, documented consistently by a treating MD?
- Are all essential modifiers documented by the physician such as “acute,” “severe” and not just inferred by the coder?
- Does the diagnosis meet 1 of the 5 criteria for reportable secondary diagnosis
- Does the documented condition objectively exist?
- Do clinical findings accord with the standard accepted definition of the coded diagnosis?

Payer Methodology – Clinical Validation Review

- Clinical validation is the process of reviewing documented diagnoses to determine if clinical criteria generally accepted by the medical community are present to support each diagnosis reported.
- Validates there is sufficient documented clinical evidence to support the reporting of the code.
- Clinical significance – auditors validate claims match a complete and accurate representation of the patient’s clinical condition.
- Targets
  - Single CC/MCC
  - Short LOS/high charges
  - High weighted MS-DRGs

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Technology

What Is Technology's Role?

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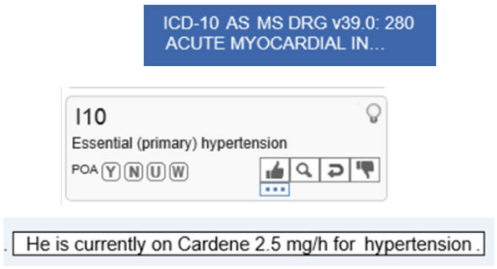
Computer Assisted Coding – CAC

- TOOL reads medical record and makes suggestions based on what it has been taught and thinks is the most appropriate option. These TOOLS are not BRAINS and cannot replace humans. They can serve as a resource and an aid, but not a replacement
- Options that can be offered:
  - Auto-suggest DRG
  - Click and code diagnosis
  - Prioritization



Payer Technology and the Audit Process

- Machine learning/natural language processing
- Predictive analytics
- Artificial intelligence
- Automated workflows/Robotic Process Automation (RPA)
- Human Intelligence

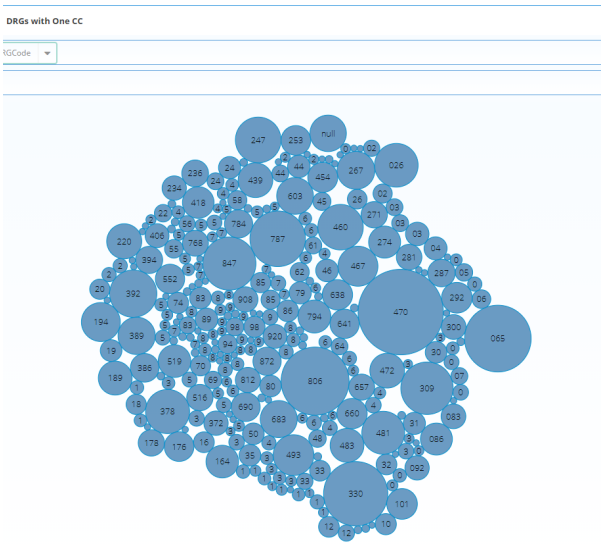
Payer NLP and ML

- Bill reviews use NLP/ML – Case Study
  - OCR content received from providers
  - Digitization of Itemized Bills (I-Bills) to allow sorting, sums, sharing
  - Validate line items prior to adjustment
  - Capture a significant percentage of adjustment via APIs with CMS, AMA, AHA, etc.
  - Customize machine learning models
    - Searches ranked by relevance
    - Predefined searches
  - Increases auditor productivity by 300% – 500%

Payer Edit Selection Process

- Selects only those claims with greatest probability of being improper
- Research based on incorrectly coded services (including DRG), duplicate services, non covered services, correct coding initiatives, *Coding Clinic*, etc.
- Any service that is billed and paid are potential targets (i.e., inpatient, outpatient, professional services.
- Edit selection uses technology to include predictive analytics

Identifying Claims for Audit Using Predictive Analytics (AI)



Never Underestimate the Value of Human Intelligence

- Typical RN auditors
  - 10 years acute care ICU experience
  - Critical thinking skills
  - Can identify clinical significance
- Typical code auditors
  - 10 years acute care coding experience
  - AHIMA certification
  - AAPC certification
- Specialty auditors
  - Behavioral health
  - Pharmacy
  - Home health

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Denials Management

A Potential Pot of Gold

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Audience Question: Show of Hands

- According to the 2020 Change Healthcare Hospital Revenue Cycle Index, "86% of denials are potentially avoidable; nearly a quarter (24%) of these are not recoverable."
  - True
  - False

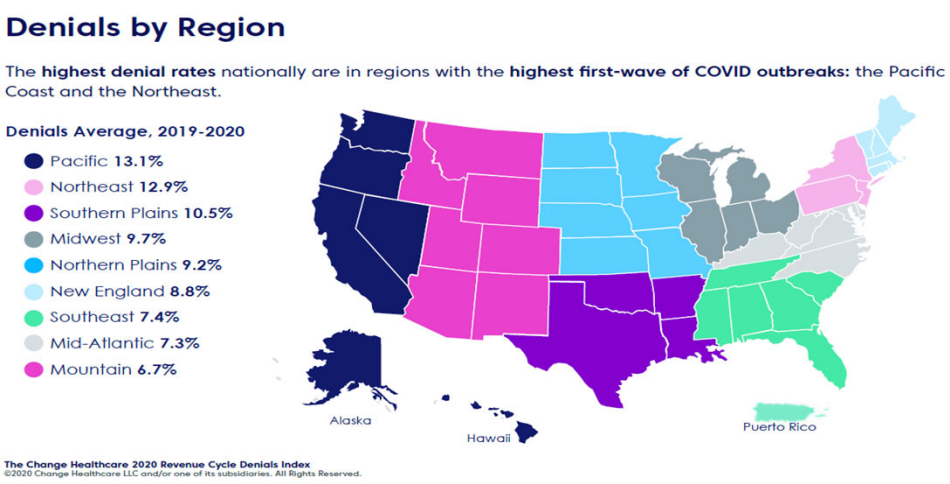
Source: https://www.ache.org/-/media/ache/about-ache/corporate-partners/the_change_healthcare_2020-revenue_cycle_denials_index.pdf

What Is Changing With Denials Management/Prevention

- Increasing need for clinical expertise to manage
- Key clinical elements
  - Medical necessity
  - Clarity of documentation
  - Accurate coding
- Need for input from a physician, nurse, or outside expert
- Must understand payer's behavior in order to package your response

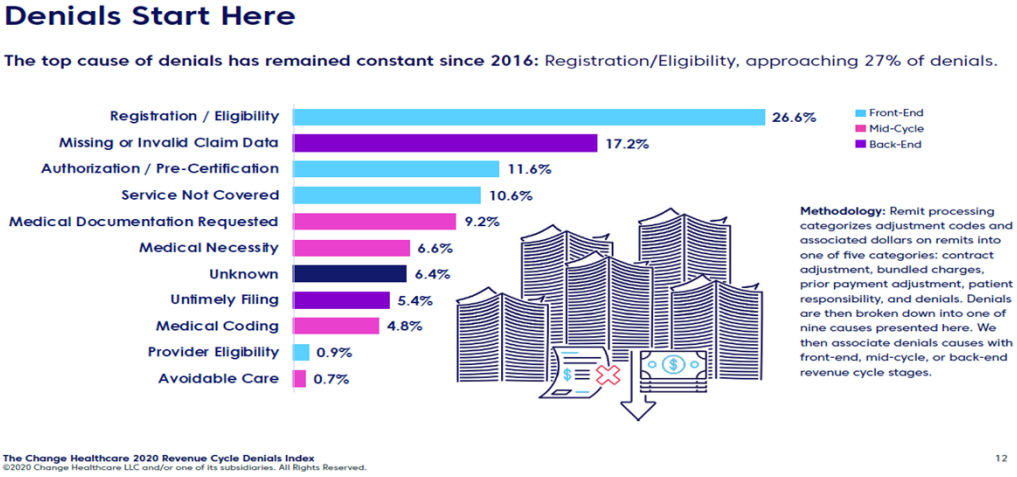
Source: 2017 HFMA Presentation: Revenue Cycle of the Future. Presented by Julie Kay, Cerner. http://www.hfmatxgc.org/wp-content/uploads/2017/02/170506-Kay-1.pdf

Data Analysis – Denials Rates By Region



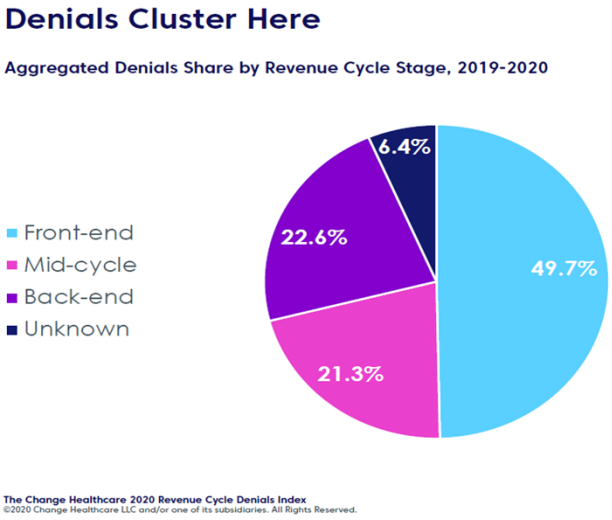
Source: https://www.ache.org/-/media/ache/about-ache/corporate-partners/the_change_healthcare_2020-revenue_cycle_denials_index.pdf

Data Analysis – By Cause



Source: https://www.ache.org/-/media/ache/about-ache/corporate-partners/the_change_healthcare_2020-revenue_cycle_denials_index.pdf

Denials By Revenue Cycle Stage



Source: https://www.ache.org/-/media/ache/about-ache/corporate-partners/the_change_healthcare_2020-revenue_cycle_denials_index.pdf

What Kind of Data is Being Analyzed?

- Claim data fields
  - Codes
  - Modifiers
  - Revenue Codes
  - Units
  - Place of Service
  - Admit Source
  - Discharge Status
- Medical record documentation
  - Physician order (authenticated)
  - Physician notes
  - Conflicting documentation
  - Missing documentation
- Longitudinal beneficiary claims
- Three-day rule
- Payer contract compliance

Cost To Get Paid

- It is cheaper to get it right the first time. Claim out the door = get paid
- Backend work = Payer sends denial to provider (hospital)
  - All overpayment letters are sent to the Revenue Integrity department who scans them into EPIC and then enters all information in Revenue Manager. Once information is entered and letter scanned, they route the audit to the appropriate party (i.e., coding or CDI) via Rev Mgr. A spreadsheet is sent out nightly to a distribution list with all outstanding audits.
  - Denials nurse either appeals or accepts denial
  - Appeal ➡ letter to payer with documentation and clinical from record to support denied diagnosis, also references to support the denial

What Does It Cost to Get Paid?

$6.50
The average cost to file a claim.[1]

$25 - $118
The cost to resubmit a denied claim (cost varies for professional and institutional claims)[2]

$31.50 – $124.50
The total cost to submit, correct, and resubmit a claim

1- Source of cost to file a claim - 3 Actionable Tips for Reducing Claim Rejections | AdvancedMD
2- Source of cost to resubmit taken from 2 sources. Source for $25- 3 Actionable Tips for Reducing Claim Rejections | AdvancedMD Source for $118 - Modern Healthcare, Insurance claim denials cost hospitals $262 billion annually https://www.modernhealthcare.com/article/20170627/NEWS/170629905/insurance-claim-denials-cost-hospitals-262-billion-annually Denial rework costs providers roughly $118 per claim: 4 takeaways (beckershospitalreview.com)

Hospital Example

- Cost to submit $6.50 x 100 monthly = $650
- Cost to resubmit a denied claim, 10 claims x $118 = $1,180 monthly (10% denial rate)
- Total monthly cost to submit claim + work and resubmit denials ($650 + $1,180 = $1,830)
- Additional cost – independent review and/or unable to recoup the denial

CDI Denials Process

- Front end
  - Clear definitions of dx for validation
  - Educate physicians
  - Educate CDI using real time data
  - Involve physicians in denial process, have PAs
  - Validate, validate, validate
  - Dedicated denials nurse – write denials, track and trend
  - Put definitions int payer contracts
- Back end
  - Write the denial appeal…it is their job to deny (our job to appeal)…sometimes just writing the letter overturns the appeal
  - Make sure you are comparing apples to apples
  - What are they denying-use their resources to argue back, use their argument to argue back
  - Use current resources. If the denial is using an outdated resource-point it out
  - If it a clinical denial, make sure a clinical person reviewed and denied the case

Hospital Clinical Denials Process

- Hospital sends claims with coded data (queries completed) – Payers/RAC auditors deny diagnosis that they think are not supported.
  - Diagnosis is not supported clinically
    - Hospital refutes with a letter including data from medical record to support or agrees and repays amount denied
    - At Baptist Health we have a dedicated FTE for denials management. This FTE, a CDI nurse is responsible for tracking all clinical denials. She reports them by facility and diagnosis. She knows how many have been overturned, how many have been taken to what level of the appeal process and in close contact with our physician advisors. She keeps our team abreast of the current trends and provides education based on “wins” and “losses”.

Clinical Denial Trends – Baptist Health Systems

- FY 2020
  - Total Number of Audits: 634
    - 263 Sepsis (41.5%)
    - 71 Respiratory Failure (11.2%)
    - 42 Encephalopathy (6.6%)
    - 22 Heart Failure (3.5%)
    - 20 AKI (3.2%)
- FY 2021 (to June 1)
  - Total number of audits: 134
    - 67 Sepsis (50%)
    - 20 Respiratory Failure (14.9%)
    - 9 Newborn Dx (6.7%)
    - 6 Encephalopathy (4.5%)

Why Do We Keep Getting It Wrong?

- Get it out the door mentality
- Lack of attention/understanding to encoder
- Note bloat/copy/paste
- Lack of adequate or appropriate clinical documentation to support the service provided and billed
- Lack of attention/understanding of claims scrubber edits
- Disparate systems and processes
- Complex insurance market
- Lack of systems that can truly analyze denials data and make the data visible and useful to the organization
- Lack of (or the inability to) identify the underlying causes for denials
- Lack of communication between departments
  - CDI
  - HIM coding
  - Billing
  - Case Management
  - Denials Management Team
- Lack of effective pre-bill review targets
- Lack of submitting pre-approval/appeal-lite (275 transaction) upon initial claims submission
- Lack of pre-authorization
- Lack of clinical validation

Consequences of Poor Denials Management or Lack of Prevention

- Interdepartmental bickering
- Increased cost to collect
- Delayed revenue
- Increased cost of health care
- Increased staffing costs
- Productivity standards seem unattainable
- Increased account receivable (AR)
- Increased write offs
- Less $ for patient care
- Less $ for new equipment/technologies
- Less $ for staff and/or salaries

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Strategies for Stopping the Insanity!

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How Do We Remediate? – All Hands On Deck

- Identified the underlying cause
  - Ask why 5 times
- Attack denials from all sides
  - Goal clean claims – no denials
- Stay up to date on regulatory guidance
  - Coding
  - NCCI
  - Payment changes
- Understand commercial payer contracts
  - Bill edits to mitigate commercial denials

Learning From Denials – What Can the Provider Do?

- Understanding payer behavior helps package response in a way that mitigates objections and, ultimately, preempts denials
- Have regular meetings with payers to review findings
- Use analytics
  - Identify trends and patterns from payer reports
  - APC mismatches
- Identify areas of weakness (e.g., registration, MD documentation, coding)
- Use audit findings for process improvements such as:
  - Templates for information gathering/registration
  - Build edits to identify high risk claim prior to submission
  - Coder and physician education

Review Your Audit Findings Carefully

Period 3/16/21 thru 4/16/21	Number Reviewed	Recovery Amount	Number with Recovery	Recovery Rate	Number Appealed	Number Upheld/ Modify
DRG Validation	96	$694,875.99	96	100.00%	14	10
Charge Audits	10	$8,527.67	10	0.00%	9	9
Other Audit Types	17	$43,508.16	17	100.00%		
Grand total	123	$746,911.82	123	100.00%	23	19

*Does not include audit cancellations

Period 2/13/21 thru 3/15/21						
Number Reviewed	Recovery Amount	Number with Recovery	Recovery Rate	Number Appealed	Number Upheld/ Modify
71	$222,789.71	47	66.20%	9	9
15	$4,763.66	13	0.00%	2	2
26	$24,645.73	19	73.08%	2	2
112	$252,199.10	79	70.54%	13	13

Inpatient Trends/Observations:

- Acute blood loss anemia (D62) removed 8 times (6 by clinical determination, 1 coding, and 1 dual)
- Hyponatermia (E87.1) removed 6 times (all by clinical determination)
- Respiratory failure removed 7 times (all by clinical determination)
- OB-related diagnoses removed 16 times (10 by clinical determination, 1 coding, and 5 dual)

- Overall, out of the 92 claims with recoveries, 60 were by clinical determination, 22 by dual (both coding and clinical), and 10 by coding determination.

DRG Validation Disposition Code Key:

CC and CCCV = Correct Coding (no savings)
D1 - PDX Change - Coding
D1CV - PDX Change - Clinical Validation
D2 - Secondary Diagnosis Change - Coding
D2CV - Secondary Diagnosis Change - Clinical Validation
DS - Discharge Status
NS - Issue Identified Results in no savings
PR - Procedure Code Change

Stopping the "Pay and Chase"

- Implement a second level pre-bill review process for high risk inpatient and outpatient cases
  - High risk MS-DRGs, diagnoses, and services that are targets for payer prepayment reviews
  - RAC Prepayment Review targets (see http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Recovery-Audit-Program/RecoveryAuditPrepaymentReview.html for the CMS payment edits schedule)
  - Review areas identified by MAC
  - Short-stay medical cases
  - Cases with only one complication/comorbidity (CC) or major complication/comorbidity (MCC)
  - Unrelated Operative Procedure MS-DRGs (981-983, 987-989)
  - Outpatient procedures on the inpatient-only list
  - Level 5 emergency department visits with discharge to home
  - Services with high denial rates at your facility

Avoiding Clinical Validation Denials

- Steps for success in clinical validation denial prevention audits include:
  - Know and understand how clinical validation relates to code assignment – CLINICAL SIGNIFICANCE!!
  - Work as a team with coding, CDI, and physicians/clinicians – EDUCATE!
  - Focus on COMPLETE AND ACCURATE documentation
  - Identify holes/shortcomings and deficiencies
  - Query, query, query
  - Know targets
  - Stay current with coding risk areas through the OIG, MAC, and CMS Compliance Newsletter communications

Patience, Persistence, Perseverance, Positive

Key Take-Aways

- Understand and communicate commercial and government contracts
- Focus root cause analysis to “fix it on the front end”. Use the Ask Why 5 times approach
- Robust data analytics is crucial
- Increase use of machine learning and artificial intelligence
- Become a team player
- Measure outcomes

Case Examples

Itemized Bill Case Example

UPTOWN MEDICAL CENTER
140 SECOND STREET
ANYTOWN CA 958235555

111

100115 100415

DOE, JOHN

04242007	M	100115	19	1		11	01	Y0

123	ROOM AND BOARD	3		1140 00
250	GENERAL PHARMACY			110 96
272	STERILE SURGICAL SUPPLIES			161 81
300	GENERAL LABORATORY			50 04
320	DIAGNOSTIC RADIOLOGY, GEN			880 33
360	OPERATING RM. SERVICES, GEN			640 00
370	ANESTHESIA, GEN			250 83
410	RESPIRATORY SERVICES, GEN			4 64
420	PHYSICAL THERAPY, GEN			390 00
450	EMERGENCY ROOM, GEN			50 00
710	RECOVERY ROOM, GEN			102 00
001	PAGE ___ OF ___	CREATION DATE	TOTALS	3780 61

Itemized Bill Case Example

001 PAGE ___ OF ___ CREATION DATE TOTALS 3780 61

90000000A95001

01234567890

D1D1D1D Y

0

P1P1P1P 100115

76 ATTENDING NPI 1234567890

77 OPERATING NPI 2345678901

78 OTHER NPI 3456789012

79 OTHER NPI

Itemized Bill Case Example

Date of svc	Rev. #	Svc Code	Diagnosis	Service	Charges
6/1/16	62700101	99284	G35	ER EVAL	200.00
6/1/16	60288001	99223	G35	PHYS INIT. CONSULT	458.00
6/1/16	60288002	99220	G35	INIT OBSV.	253.37
6/1/16	62700113		G35	RM CHRGE, SEMI-PRIVATE	1,847.81
6/1/16	61755606	J2930	G35	METHYLPREDNIS.	165.00
6/1/16	61755615	36640	G35	INF THERAPY	161.75
6/1/16	61755898	36641	G35	INF THERAPY, ADDNL	68.80
6/1/16	60700001	99070	G35	SPECIAL SUPPLIES PHYS/QHP	96.10
6/2/16	62700113		G35	RM CHRGE, SEMI-PRIVATE	1,847.81
6/2/16	60288105	99236	G35	PHYS OBVS	528.56
6/2/16	61755606	J2930	G35	METHYLPREDNIS.	165.00
6/2/16	61755615	36640	G35	INF THERAPY	161.75
6/2/16	61755898	36641	G35	INF THERAPY, ADDNL	68.80
6/2/16	60700001	99070	G35	SPECIAL SUPPLIES PHYS/QHP	96.10
6/3/16	62700113		G35	RM CHRGE, SEMI-PRIVATE	1,847.81
6/3/16	60288105	99236	G35	PHYS OBVS	528.56
6/3/16	64700101	70553	G35	F. MRI, BRAIN W WO CONTRAST	1,142.00
6/3/16	64700529	78807	G35	SPECT Ga-37	542.00
6/3/16	64700535	74400	G35	IVP	129.00
6/3/16	60700001	99070	G35	SPECIAL SUPPLIES PHYS/QHP	96.10
6/4/16	62700113		G35	RM CHRGE, SEMI-PRIVATE	1,847.81
6/4/16	60288105	99236	G35	PHYS OBVS	528.56
6/4/16	61755606	J2930	G35	METHYLPREDNIS.	165.00
6/4/16	61755615	36640	G35	INF THERAPY	161.75
6/4/16	61755898	36641	G35	INF THERAPY, ADDNL	68.80
6/4/16	60700001	99070	G35	SPECIAL SUPPLIES PHYS/QHP	96.10
6/4/16	61255000	E1388	G35	DUR. MED SUPPLIES	361.25
6/4/16	61255069	84436	G35	LABORATORY THS	769.49
6/4/16	63855010		G35	DISCH ADMIN	158.65
				TOTAL	**14,561.73**

Payer Outpatient Case Example
About Edits or Selection for Review

- Chargemaster issues (wrong codes mapped to charge)
- Bladder tumors
  - 52240 – Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) and/or resection of; LARGE bladder tumor(s)

  vs
  - 52235 – Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) and/or resection of; MEDIUM bladder tumor(s) (2.0 to 5.0 cm)
- Incision & drainage (hematoma/seroma vs no diagnosis) incision vs. poke
- APC mismatch between professional and facility
- Colonoscopy (polyp removal codes)

Payer Inpatient Case Example About Edits or Selection for Review

- Traumatic hemoperitoneum
  - K66.1 – Other disorders of peritoneum, hemoperitoneum (MCC)
    - Has a Type 1 Excluded Note (Traumatic hemoperitoneum (S38.8XXX)
  - S36.81XX – Injury of other intra-abdominal organs, peritoneum (CC)
  - Can result in a large overpayment (i.e. $30,000)
- One CC/MCC
  - Starting to see analytics around 2 CC/MCCs especially when the payer knows certain CC/MCC have a high incidence of denial.
- Clinical significance
  - Acute respiratory failure
  - Acute metabolic encephalopathy

Denial Example

- 95 yr. old w/ hx. of afib, HTN, CVA, CAD, CKD 3 admitted with hip fracture on 6/1. The provider assigned G93.41 Metabolic encephalopathy as a secondary dx. The clinical evidence in the medical record did not support the assignment of G93.41.
  - This is a 96-year-old.
  - Sedation, somnolence and memory loss following the administration of anesthesia combined with opiates are expected and sometimes desired effects of these medications should not be coded as additional diagnoses.
  - A review of the emergency department record and nursing notes prior to surgery reported the patient's mental status as "unremarkable," AxOx4, forgetful.
  - A review of the MAR reveal the patient was given Percocet, Fentanyl and Dilaudid prior to surgery.
  - Post-operatively the providers reported the patient had decreased responsiveness and neurology was called to consult.
  - By post op day 4 neurology reported the patient as "awake alert conversing with and joking with me."
  - There was insufficient clinical evidence and supportive documentation in the records available for review to substantiate the coding of this condition.

Denial Example

- **Payer referenced the following *Coding Clinic* and *Official Guidelinesfor Coding and Reporting* as support for the denial**
  - Medically induced coma and Glasgow coma score
  - *ICD-10-CM/PCS Coding Clinic*, Fourth Quarter, 2017, p: 95, effective with discharges: October 1, 2017

    Question: A critically ill patient had a medically induced coma. Should we assign a Glasgow coma score for a patient in a medically induced coma?

    Answer: Do not report individual or total GSC scores codes for a patient with a medically induced coma. This type of reversible coma is induced with drugs to help protect the brain from swelling by decreasing blood flow as well as the metabolic rate of brain tissue.
  - *Official Guidelines for Coding and Reporting* Section I.B.5 – Conditions that are an integral part of a disease process. The only disease process this lady had was a broken hip that we fixed!

Denial Example

How to argue this denial

- "Sedation, somnolence, and memory loss following the administration of anesthesia combined with opiates are expected and sometimes desired effects of these medications and should not be coded as an additional diagnosis." Auditor says the MAR reveals that patient was given Percocet, Fentanyl, and Dilaudid prior to surgery. None of these would be given to induce memory loss – that's more of a Versed medication. Memory loss is not an expectation of any of these medications.
- The diagnosis of **metabolic encephalopathy** was made after the patient had surgery-the clinical documentation referenced in the denial is all before the patient had surgery. (Also, the clinical documentation referenced would be toxic encephalopathy, if appropriate, not metabolic)
- The actual documentation of the **metabolic encephalopathy** spells out the diagnosis and the underlying etiology and treatment. (Patient developed a left thigh hematoma post-op)
  - 6/18 neurology consult – "**decreased responsiveness status post hip fracture surgery"**

    "First of all, this patient has a significant **metabolic encephalopathy**. This may be secondary to her age of 96 plus the fact that she is status post surgery and has anemia that is going to require transfusions of 2 units packed red cells.

    Nonetheless, I cannot absolutely positively rule out a new bihemispheric stroke that would give her this appearance.

    I will check a plain CT of the brain today to rule out subdural hematoma or hygroma as well as to rule out any intracranial hemorrhage. Note that the CT on 6/14/2021 was within normal limits and we will be able to compare with that when if she remains about the same tomorrow, we will probably try to get an MRI scan of the brain if she can get one with the new rod in her leg.

    So, we start out with plain CT tonight and I will look at what she looks like tomorrow and will go from there"

Denial Example

- How to argue this denial
  - 6/19 Neurology- **Chief complaint: Metabolic encephalopathy anemia**
    - "She is dramatically better for me today awakens carries on a little bit of a conversation and has no objective evidence of a focal neurologic deficit/CVA. Note that the CAT scan of her head shows no acute stroke she received 2 units of packed red cells yesterday hemoglobin was 7.2 now it is 10.7 she is pink more alert and again able to talk to me today quite well compared to yesterday!"
    - "This patient's mental status is dramatically better today she awakens and is able to comprehend name and repeat and smiles at me and responds appropriately. She is still sleepy but still has a nonlateralizing exam which typically goes against any type of acute stroke note the CT performed yesterday by my independent eyeball review shows atrophy only but no evidence of an acute stroke. At this point we have not absolutely positively rule out the possibility of bihemispheric strokes but based upon her improvement today as well as her nonlateralized exam, that is seemingly less likely. She is more awake and alert after the 2 units of packed red cells yesterday. Today her hemoglobin is better at 10.7 and she is off of the Lovenox"
  - 6/20 Neurology- **Chief complaint: Metabolic encephalopathy**
    - "She is dramatically better today awake alert conversing with me and even making some jokes. Wow! Her metabolic encephalopathy is dramatically better she is awake alert conversing with me and joking with me. At this point neurology does not have a lot else to offer I will sign off and follow-up as needed reconsult thanks"
  - 6/20 Hospitalist- "Her mentation is significantly better for me this morning. She is smiling, alert noted x3, and will have a pleasant conversation. Interestingly enough, her hemoglobin this morning is 12."

Case Study Discussions

- **Query or not???**
  - CHF- no treatment
  - Hyponatremia- with one low NA
  - UTI- culture +, no s/s

***These are common CCs that are becoming common denials, this meant to be for open discussion to share what we are all doing in our organizations to help combat denials.

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"No matter how GOOD you are, you will always miss some DETAILS when making decisions. Partner with people who see what you don't."

~John Maxwell

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Thank you. Questions?

leah.savage@BHSI.com
virginia.bryan@cgi.com

In order to receive your continuing education certificate(s) for this program, you must complete the online evaluation. The link can be found in the continuing education section of the program guide.

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References

- www.modernhealthcare.com/revenue-cycle/why-your-denials-are-skyrocketing-and-3-ways-hospitals-can-respond
- www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsHistorical#:~:text=U.S.%20health%20care%20spending%20grew,spending%20accounted%20for%2017.7%20percent
- www.nhcaa.org/tools-insights/about-health-care-fraud/the-challenge-of-health-care-fraud/
- www.ache.org/-/media/ache/about-ache/corporate-partners/the_change_healthcare_2020-revenue_cycle_denials_index.pdf
- Actionable Tips for Reducing Claim Rejections | AdvancedMD
- www.modernhealthcare.com/article/20170627/NEWS/170629905/insurance-claim-denials-cost-hospitals-262-billion-annually
- www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Recovery-Audit-Program/RecoveryAuditPrepaymentReview.html

Additional References

- CGS KY Part A - https://www.cgsmedicare.com/parta/index.html
- CGS KY Part B - https://www.cgsmedicare.com/partb/index.html
- CERT - https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Improper-Payment-Measurement-Programs/CERT
- KY RAC - https://secure.performantrac.com/
- RAC Prepayment Review targets - http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Recovery-Audit-Program/RecoveryAuditPrepaymentReview.html
- OIG Work Plan - https://oig.hhs.gov/reports-and-publications/workplan/index.asp
- Medicare Program Integrity Manual (100-08)