10 tips for appealing MS-DRG denials

by Sam Antonios, MD, FACP, FHM, CPE, CCDS

PHYSICIAN ADVISOR’S CORNER

Over the last 18–24 months, healthcare organizations have seen a surge in MS-DRG denials, sometimes referred to as clinical validation denials.

When reviewers from Medicare Advantage health plans, Recovery Auditors, or other private or contracted health plans analyze a clinical case submitted for reimbursement, they may determine that a particular disease should be removed from the claim. They argue that the clinical documentation in the medical record does not support the diagnosis submitted. In the vast majority of these cases, the removed diagnosis is a CC or MCC, which causes the MS-DRG to shift to a lower payment.

MS-DRG audits are nothing new, but their frequency has significantly increased over the last two years. In some circumstances, the volumes have been overwhelming. There have also been reports of cases where denials have been egregious, unjustified, or made with disregard for the treating physician’s opinion.

Although there is no surefire way to win an appeal, here are some tips to increase the likelihood of overturning MS-DRG denials.

One: If you believe the case has merit, file an appeal, even if the variance in dollar amount is insignificant. It may be tempting to let go of denials that minimally affect the reimbursement, but when the treating provider’s documentation is available, complete, and accurate, and the coding is correct per official coding guidelines, organizations should appeal. This maintains consistency and makes the appeals about data integrity, rather than payment.

Two: Write clearly and summarize first. The appeal reader will likely not want to spend a lot of time figuring out the intent of the appeal. The first few lines need to describe the clinical case and need for appeal succinctly. Additional details can be included in later paragraphs.

Also, remember to reference review articles, clinical guidelines, or other findings to support your appeal.

Three: Learn how to navigate the electronic health record (EHR) to find relevant information. The history and physical and the discharge summary may not capture the entire clinical picture.

Learn where to locate, and how to decipher, emergency department documentation, consultant reports, progress notes, nursing notes, and other provider documentation, which can often include vital information to support an appeal.

Additionally, respiratory notes can reveal the status of the patient, including lung exams, respiratory effort, and need for respiratory treatments. The goal should be to offer a complete and accurate clinical picture of the patient.

Four: If possible, review records from transferring facilities to help describe the patient’s case. These records are likely scanned into the record later in the patient care process, but they should be collected before an appeal. Creatinine levels, electrolytes, and other laboratory findings can help differentiate acute and chronic symptoms and conditions.

Five: Keep track of denials electronically. Preferably, use denial tracking software. If such software is not available, or too costly for your facility, spreadsheets can be just as effective. Remember to update and back up these records regularly.

Six: Keep track of deadlines. Deadlines are different depending on the type of denial and the payer. When a claim is denied and a facility chooses to appeal, note the deadline and develop a plan of action.

Allow an optimal amount of time for appeals to be researched, developed, and written. It would be a shame to lose a denial for missing a deadline, especially when the documentation is present.

Seven: Centralize where appeals arrive in the organization. Denial letters may be sent to the HIM department,
the case management department, the revenue cycle office, or the chief financial officer. Establish a process to funnel all denials to a single team or department, which will facilitate management of the appeals and prevent delays.

Eight: Include the attending physician’s opinion. Appeals can carry more weight when the attending physician is able to review the case and provide supporting details and arguments. Review the case with the provider, or have him or her review the case independently and provide feedback.

Nine: Become familiar with Coding Clinic. This should go without saying, but an appeal can go very differently if its argument has to do with an area where Coding Clinic has made a comment. Keep up-to-date with coding and documentation requirements and references to support appeals.

Ten: Don’t appeal every case. In some cases, the coding may be wrong or the physician documentation may be weak—and that’s okay. Identify what went wrong and pinpoint opportunities to improve future processes. Strategic appeals ensure CDI efforts remain focused on preserving data integrity. Use these errors as a chance for CDI and provider education and engagement.

Editor’s note: Antonios is the CDI and ICD-10 physician advisor at Via Christi Health in Wichita, Kansas. A board-certified internist, he manages the hospital EHR system, works closely with quality leaders to tackle challenging documentation requirements, and engages with physicians on CDI and quality initiatives. Contact him at Samer.Antonios@via-christi.org.

OUTPATIENT EFFORTS
Putting the specific into unspecified

by Erica E. Remer, MD, FACEP, CCDS

The world didn’t end on October 1, 2015. After years of postponement, the proverbial “deal with the devil” made between CMS and the AMA to push ahead with ICD-10-CM/PCS implementation was a year’s grace period during which physician practices could continue using unspecified codes without worrying about Medicare denials or auditor reviews. That grace period ends this fall. No doubt it will be a rude awakening for providers and institutions who took it at face value rather than as an opportunity to educate themselves on the new codes and practice using them.

CMS’ intent was not to permit providers to select unspecified codes for yet another year; the grace period was meant to prohibit auditors from penalizing providers while the providers learned how to navigate the specificity of ICD-10. In fact, “ICD-10 flexibilities were solely for the purpose of contractors performing medical review so that they would not deny claims solely for the specificity of the ICD-10 code as long as there is no evidence of fraud,” CMS explained in a July 6, 2015 joint announcement and guidance with the AMA.

Specificity hurdles

So how do CDI specialists remedy the situation and help providers document to the level of specificity that is now needed?

The end results of unspecified documentation differ depending on the setting and focus. Are you considering inpatient DRG calculations or outpatient and professional billing? If you’re a CDI specialist working with physician practices, are you focused on fee-for-service or risk-adjusted capitation methodologies?

Using unspecified diagnoses in the inpatient world results in spuriously deflated quality metrics and decreased reimbursement. Unspecified diagnoses in the fee-for-service arena may result in medical necessity denials, but historically has not had a negative effect on payment, which is why it traditionally fell below the provider’s radar. However, as value-based payment risk becomes more substantial and the professional fee is tied to demonstration of severity and complexity, there may be more incentive for providers to get it right and provide greater specificity in their documentation.