Writing RAC Appeals, RAC Denial Prevention, and Case Management Collaboration

Kathy Shumpert, MSN, RN, CCDS
Clinical Documentation Improvement Specialist
Community Howard Regional Health
Kokomo, Ind.
Learning Objectives

- At the completion of this educational activity, the learner will be able to:
  - Describe the positive impact CDI can have on RAC audits
  - Explain how to integrate your CDI program
  - List helpful tips to engage physicians in the appeal process

City of Firsts
Integrated CDI Model

- CM/UR
- Medical staff
- Coding
- RAC
- CDI
- Quality
- HIM
- Nursing
- IT

Denials
Denial

• Per our medical record review, this 32-year-old male was transferred from an outlying emergency department with abdominal pain. Patient stated he had fever and chills 2 days prior and for the past 24 hours he had an onset of right upper quadrant and mid epigastric pain that radiated to his right upper chest associated with the diarrhea. Physician documentation indicates that patient had a fever of 103.3. Cardiac enzymes were negative. Physician’s impression was colitis, abdominal pain, fever, and diarrhea with unknown etiology. Orders were to admit as inpatient, gastroenterology consult, IV pain medication, IV antiemetics, IV antibiotic, stool for gram stain and culture, IV Protonix, and IV fluids at 150 mL/hr. This episode did not meet severity of illness or intensity of service.

Denial

• 74-year-old female presented ambulatory to the facility from physician’s office with a chief complaint of hypotension and abnormal U/A. Upon examination, patient’s lungs had bibasilar crackles, temperature was 99.1, respiratory rate of 16, B/P 77/40, room air oxygen saturation of 98%. The attending physician’s impression was dyspnea with hypotension and associated bibasilar crackles. Physician wrote an order for inpatient status, telemetry, IV fluid bolus with maintenance rate at 125 mL/hr, O2 to keep oxygen saturation greater than 92%, chest x-ray, lab studies, and IV antibiotics.
Common Themes

- No reason documented for inpatient order
- Does not meet severity of illness or intensity of service
  - Symptom DRGs
  - Treatment that could be performed in outpatient setting
  - Failed UR screening process
- Documentation does not support inpatient level of care
  - No documentation regarding risk to patient for alternative setting
- Lack of post-procedural complication documentation
- Lack of acute findings
  - Normal imaging
- Documentation does not support medical necessity
  - Lack of well-documented plan to support inpatient status
- Lack of inpatient order!

Denial Prevention Strategies

- House supervisor checking for admission order during nights, weekends, and holidays
- InterQual screening criteria documentation
- Failed InterQual screening is not documented; referred to second-level review
- Reason for admission required field for admission order
CDI Documentation Strategies

- Physician certification inpatient admit
- Estimated length of stay: 2 midnight(s)
- Reason for inpatient hospitalization (diagnosis): DVT with therapeutic INR
- Comorbid conditions/confounding factors: H/o DVT, and Coumadin toxicity/overdose
- Risks of NOT admitting to inpatient: Acute pulmonary embolism and progression of DVT and acute resp failure
- Post-hospital plans: Return home
- Inpatient physician certification statement: By completing and signing this document, I certify that hospital inpatient services are reasonable and necessary, and appropriately provided as inpatient services in accordance with the 2-midnight benchmark under 42 CFR 412.3(e)

Supportive Documentation

- Mr. XX is an 89-year-old gentleman with a history of COPD, atrial fibrillation, sick sinus syndrome, and pulmonary fibrosis. The patient was treated as an outpatient at the nursing home because of pneumonia. The patient has been treated with Avelox. Chest x-ray revealed infiltrate in addition to the pulmonary fibrosis. The patient developed hypoxia with O2 sat dropping to the mid 70%. The patient was placed on 100% oxygen and subsequently transferred to the emergency room. The O2 sat in the emergency room was 84%. The chest x-ray reveals bilateral airspace disease. BNP was 309. CT PE protocol reveals no evidence of pulmonary embolism. There is severe pulmonary fibrosis. Severe confluent honeycombing at both lung bases. There is a large area of ground-glass opacity in the right upper lobe, bilateral perihilar, and lower lobe region. There is also a thoracic aortic aneurysm noted. The patient is admitted to telemetry for acute hypoxic respiratory failure with pulmonary fibrosis and pneumonia.
Demonstrating Medical Necessity

1. Severe sepsis. She meets criteria for severe sepsis in view of her leukocytosis of around 30,000 and tachycardia and severe sepsis because of acute kidney injury, altered mental status. We will start her on septic protocol. Sepsis is most likely secondary to acute infectious colitis. Stool studies have been sent including stool C. difficile, stool culture. Blood cultures have been sent. Urinalysis shows evidence of 15–25 wbc, but there are significant epithelial cells and it is less likely from UTI. But we will send her urine culture. Will order for serum lactic acid. Will start her on empiric antibiotics including metronidazole, levofloxacin in view of her infectious colitis. We will start on aggressive fluid resuscitation as her blood pressure was on the lower side, and in view of her dehydration and it has improved with fluid resuscitation. Continue antibiotics, fluids. Continue to monitor CBC, vitals, and other labs.

2. Acute infectious colitis. As mentioned above stool studies including stool C. difficile, stool cultures have been sent and blood cultures have also been sent. We'll start her on empiric metronidazole, Levaquin. Continue fluid resuscitation. Continue to monitor.

Demonstrating Medical Necessity (cont.)

3. Altered mental status. Secondary to metabolic encephalopathy from severe sepsis and dehydration. Improved with fluid resuscitation. Continue antibiotics, fluid resuscitation, and management for sepsis as mentioned above.


5. Hyponatremia. Most likely secondary to hypovolemic hyponatremia. Started on fluid resuscitation which we will continue. Continue to monitor sodium.

6. History of hypertension. Stable. Continue home medications and hold blood medication if systolic blood pressure less than 100.

7. Other comorbidities stable. Continue medications for other medical problems.

8. DVT prophylaxis. Lovenox.
CDI Efforts in Recovery Audit Activity

- Paper chart audit
- Clarification of illegibility
- Physician input in appeal
- Writing medical necessity and coding appeals

CDI Audits

- Audit for patterns
  - PEPPER data
- Monitor Recovery Auditor activity
- Apply concepts to concurrent reviews
  - CDI
    - Medical necessity documentation
    - Presence in UR committee
    - Focus on documentation integrity
    - Presence in rapid rounds
  - UR/CM
    - InterQual screening
    - Standardized documentation
    - Review medical necessity denials for missed opportunities
Writing the Appeal

- Opening statement
  - CGI Federal denied the inpatient claim for xxxx alleging the documentation does not support the medical necessity for an inpatient status. Community Howard Regional Health (formerly Howard Regional Health System) is of the opinion that the inpatient status was reasonable and necessary under the circumstances and the findings by CGI Federal should be reversed.
Supportive Argument

- Diagnostic criteria
- Coding guidelines/*Coding Clinic*
- UHDDS

Arguments

- Unnecessary invasive testing would not have changed the treatment plan and was unwarranted
- Failed outpatient therapy
- Risk of mortality
- Comorbid conditions
- Supportive nursing and utilization review documentation
Appeal

- This 91-year-old male was admitted to an inpatient status on 11/28/2008 from the ED. He presented with hematuria, BP 84/45, P 68, R 16, T 95.8 and complaints of generalized abdominal pain all the time. Laboratory data revealed BUN 71, creatinine 2.67, anion gap 18.1, and urinalysis showed trace ketones, +3 blood, positive nitrite, +3 leuk esterase, 35–50 WBC, loaded RBC, and +2 bacteria. He received a dose of Levaquin 500mg IV in the ED. Upon admission to the hospital, Levaquin 500mg IV every 24 hours was ordered. Urine and blood cultures were obtained in the ED. The initial physician assessment considered the patient's age, multiple laboratory abnormalities, and low blood pressure. Therefore, the possibility of sepsis was entertained and resolution was not expected to occur within 24 hours, suggesting an inpatient status.

- According to InterQual Criteria 2008 Infectious Disease subset, severity of illness was met with systemic/organ infection, actual/suspected, and patient age greater than 75. Intensity of service was met with anti-infectives and pending cultures < 2 days. The patient's severity of illness and intensity of service were indicative of an inpatient status. Although the family was not in agreement with the physician regarding the possibility for observation status, this was not an attempt to place the patient in a facility. The patient was taken home following discharge from the hospital.

Appeal

- This 77-year-old gentleman presented to the emergency department with complaints of vertigo. Past medical history was significant for hyperlipidemia, CAD, hypertension, unstable angina, and CHF. He had episodes of bradycardia with a heart rate of 44 in the emergency room. Accordingly, the patient was placed in observation on 8/31/2010 with telemetry and a cardiology consult. The history and physical indicates concern for TIA, and cardiac arrhythmia had to be entertained as well. The patient was seen by the cardiologist, who suggested continued monitoring of the patient. Neurology consult was ordered and obtained. The neurologist felt that the patient's symptoms were vertiginous. He also noted the patient had bradycardia and orthostasis. On 9/1/2010, there is clear documentation by the cardiologist that the patient had continued bradycardia and continued dizziness. Additional documentation on 9/1 by the neurologist indicates that the patient may have had brainstem or cerebellar stroke. His progress note corroborates contemplation of treatment depending on the etiology of the stroke. Documentation indicates blood pressure variance with 118/61 supine and 66/44 on standing. On 9/2, CVA was ruled out. Etiology for the vertigo and gait instability was reasoned secondary to orthostasis, hypotension, and bradycardia. Given that the patient has underlying cardiac disease, the decision to admit to inpatient status was appropriate. The reviewer says that there was no physician documentation as to the reasons for conversion to an inpatient, but it appears that it is amply described in the progress notes as to the patient's condition, which was still unstable, warranting an inpatient admission.
• The utilization review policy at Howard Regional Health System defines the scope of admission review. In our policy, Section III, Part A. Admission Review, “All admissions will be reviewed and a determination of necessity for admission based on InterQual SI/IS criteria will be made.” The original status order was written on 2/28/2009 for observation status. On 3/3/2009 at 0808, XXX, PA, wrote an order to make the patient a regular admit. This order was cosigned by his supervising physician, Dr. XX. The intent by the physician was an inpatient admission. To reference the Centers for Medicare and Medicaid Services, CMS Manual System, Transmittal 107; Summary of Changes: This recurring update notification updates and applies to Chapter 6, Section 20.6. CMS updated that section by removing references to “admission” and “observation status” in relation to outpatient observation services and direct referrals for observation services. These terms may have been confusing to hospitals. The term “admission” is typically used to denote an inpatient admission and inpatient hospital services.

• Therefore, it is our belief that the order for regular admit is in compliance with the standards for CMS in relation to the status of the hospital stay.

Case Management/UR
UR/CM Issues

- Applying screening criteria, mind-set to find any subset to qualify
- Documentation or lack of documentation
- Timing of inpatient order
- Lack of inpatient order
- Lack of ownership
- Discrepancy in status order and screening

UR/CM Documentation Issues

- Documentation indicates InterQual screening for malignant HTN, yet no treatment rendered
- Use of intuition for screening
- Lack of follow-up
- Chart cannot be reviewed at this time without clinical data and H&P
Other Issues

- EMR documentation challenges
- Different interpretations of final rule
- Lack of nursing interventions
- Lack of nursing documentation
- Accessibility

Our Interventions
Continued Areas of Improvement

- EMR legibility
- Nursing documentation
- Order sets
- Medical necessity documentation

Process Changes

- Discharge summaries required on all inpatients
- UR screening all patients with InterQual, physician advisor contact as indicated
- RAC, CDI, and inpatient documentation discussion required for credentialing and re-credentialing
Education Tips

• Documentation should address the uniqueness of the patient’s care and the intensity of service needed
• If a field is not applicable, use an entry such as N/A to indicate that the field was reviewed
• Diagnosis lists
• Query for inpatient certification
• Provide examples of accurate and complete documentation; include the provider

Keeping Up With the Joneses

• CMS MLN Matters
• RAC Monitor
• MAC publications
• RAC Summit
Physician Engagement

- Findings letter
- Morbidity and mortality risks
- Medical necessity
- Report denials to medical audit review committee
- Offer expertise in appeal

“To improve is to change; to be perfect is to change often.”
— Winston Churchill

“The only way that we can live is if we grow. The only way that we can grow is if we change. The only way that we can change is if we learn. The only way we can learn is if we are exposed. And the only way that we can become exposed is if we throw ourselves out into the open. Do it. Throw yourself.”
— C. JoyBell C.
Thank you. Questions?

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