

CDI Field Guide

to

Denial Prevention

and

Audit Defense

CDI Field Guide to Denial Prevention and Audit Defense



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His comments and opinions do not reflect necessarily the standing, opinion, or assessments of UTMC or ACDIS. Contact him at Clachari@UTMCK.EDU.

Dedication

For all hospitals everywhere.

Few understand the extraordinary, daily struggles required to sustain a hospital's patient care mission. If the contents of this text protect enough resources to provide for the care of only one additional patient, it was worth it.

If the doors close, where will our patients go?

1

Understanding Healthcare Reimbursement

Current State of Affairs

The healthcare system in the United States is the most expensive system in the world. The United States spent \$3.0 trillion on healthcare in 2014, roughly \$9,523 per person and more than 17.5% of gross domestic product, according to the Centers for Medicare & Medicaid Services' (CMS) 2015 *National Health Expenditures Highlights* report. Almost half (45%) of healthcare costs are currently paid for through some form of local, state, or federal government sponsorship. CMS projects the cost of the U.S. healthcare system to mushroom to \$5.6 trillion by 2025, according to its *National Health Expenditure Projections 2015–2025* report. In fact, if the U.S. healthcare system were an independent country, it would have the fifth largest economy in the world, according to a 2016 *Investopedia* article.

No other advanced country even comes close to U.S. healthcare spending, but plenty of other countries see much better outcomes in actual overall health. The next most expensive healthcare system in the world costs approximately 50% less than that in the United States, according to a 2015 press release from the Commonwealth Fund. However, the United States ranks 42nd in life expectancy, according to the Central Intelligence Agency's *World Factbook*. Of the 27 wealthiest countries in the world, the United States has the highest infant mortality rate, with 6.1 infant deaths per 1,000 live births, *The Washington*

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Post reported. Yet, time and time again politicians and healthcare officials claim the U.S. system is the best in the world.

As of 2015, the U.S. population reached approximately 319 million people. Currently, the United States is the only wealthy industrialized country without universal healthcare coverage. No one in the United States is guaranteed healthcare, and not everyone has access to basic medical services. Roughly 29 million people, 9%, do not have health insurance, according to the Kaiser Family Foundation. Those with insurance fall into three buckets of coverage—43 million have Medicare (13.5%), 62 million have Medicaid (19.4%), and 178 million have private insurance (55.8%), Kaiser reported.

Healthcare Reform Efforts

As healthcare costs continue to rise, the results and outcomes of those expenditures continue to fall short. Many people—from government officials to physicians to individual residents—feel our country does not get what it pays for when it comes to healthcare. Add to that a disheartening lack of health insurance coverage for all, and it becomes easy to see why all healthcare payers increasingly look to reduce costs and improve outcomes for the individuals they cover.

Healthcare reimbursement methodologies need to shift. The current fee-for-service reimbursement system promotes volume-based practice patterns by providers. Today's healthcare reimbursement system still focuses on *how many* patients a physician must see a day, which is clearly a quantity-driven, as opposed to the needed quality-driven, system.

To understand current trends in healthcare reimbursement, and the inherent complexity of the claims auditing and audit-proofing process, one must understand that such discussions about the cost of care in America are nothing new. Steps to curb escalating costs and bring provider compensation closer to an

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outcome-based system ostensibly began with the creation of the Social Security Act and Medicare itself but certainly stem back to the early 1980s, with the implementation of the hospital prospective payment system, according to CMS. Today's healthcare reform increases such efforts tenfold, and hospitals and providers must deal with a bevy of reimbursement programs aimed to continue that shift away from payment for quantity toward quality.

Financial pressures

Currently, the U.S. Government Accountability Office (GAO) says the Medicare Trust Fund will run out of money in 2028. While current tax revenues do pay for Medicare beneficiaries, the number of potential Medicare beneficiaries is growing 10 times faster than the working age of the population paying those taxes. Roughly 10,000 people a day turn 65 in the United States, according to the Pew Research Center. In anticipation of this potential healthcare funding shortage, CMS is working as quickly as possible to cut all possible costs.

The MS-DRG payment system

Prior to 1983, Medicare reimbursed inpatient healthcare based on actual charges—physicians and hospitals received compensation based solely on what they billed the government. The more services provided, the greater the compensation. That year, however, CMS implemented the Medicare inpatient prospective payment system (IPPS), which tied inpatient facility reimbursement to provider diagnoses and treatment descriptions. The change, policymakers hoped, would encourage hospitals to more effectively manage medical care and limit the government's financial exposure, according to *The Physician Advisor's Guide to Clinical Documentation Improvement*.

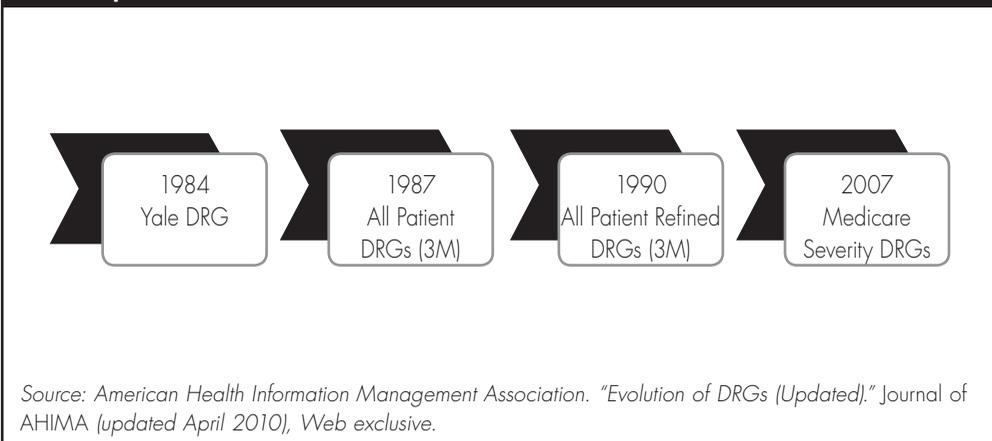
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As it turned out, however, this new system divorced the provider/facility relationship and established a payment disconnect between the two houses of patient care.

Hospitals were suddenly reimbursed for an individual hospitalization regardless of how long the patient remained in the hospital bed, while physicians still billed on a daily fee-for-service basis. Obviously, this led to significant disconnect between hospitals and doctors. Physicians often viewed hospitals through a corporate lens, as though administrators care only for facility finances at the expense of the patient's well-being. Since CMS paid physicians separately for the care they provide, physicians isolated themselves from awareness of, or commiseration with, their hospitals' predicament.

In 1984, CMS implemented the first of a long series of diagnosis-related grouping (DRG) methodologies designed to categorize patient care. (See Figure 1.1: A Timeline of DRG Development for an illustration of this shift.)

FIGURE 1.1 | A TIMELINE OF DRG DEVELOPMENT



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The original DRG system, developed at Yale University, categorized similar patients with theoretically similar treatments and charges based on the patient's principal diagnosis and up to eight secondary diagnoses. Age and discharge status also influenced the categorization of the approximately 538 DRGs, according to an article by American Health Information Management Association (AHIMA) titled "The Evolution of DRGs."

The following elements comprise the components of most inpatient DRGs:

- DRG number
- DRG title
- DRG type (e.g., medical or surgical)
- Major diagnostic category assignment
- Severity of illness indicator (APR-DRG only)
- Risk of mortality indicator (APR-DRG only)
- Relative weight (RW) (based on resource intensity subject to payment)
- ICD-10-CM/PCS codes, discharge statuses, birth weights, or other information driving assignment

Supplemental information that may accompany inpatient DRGs include:

- Geometric or arithmetic lengths of stay (LOS)
- Expected mortality or readmission coefficients
- Post-acute transfer policy indicators

In 2007, CMS developed a new DRG method, the Medicare Severity DRG (MS-DRG), in an effort to better capture the inpatient resources required to treat more severely ill patients. Governing principles included:

- Complexity: Hospital resource consumption not related to secondary diagnoses, e.g., the cost of a device
- Monotonicity: A parallel trend that should occur between severity of illness and average costs for certain DRGs (i.e., as severity levels rise so does the cost of care)

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According to CMS, the 2007 system enabled it to:

- Compare facilities across a wide range of resources and outcome measures
- Evaluate differences in inpatient mortality rates
- Implement and support critical pathways
- Identify continuous quality improvement opportunities
- Internally manage data

MS-DRGs also helped eliminate a perceived bias contained in the original DRG program where critics claimed the structure penalized facilities that treated the sickest and most resource-intensive patients. In the old system, hospitals were reimbursed the same for a COPD exacerbation in a patient with no other significant medical problems as they were for a COPD exacerbation in a patient with end-stage renal disease requiring frequent dialysis treatments.

The new system increased the number of DRGs to 750 and identified three levels of severity, which include:

- MS-DRG without a comorbidity or complication (CC) or major comorbidity or complication (MCC): no complications, lowest level of severity; reimbursed at baseline RW
- MS-DRG with a CC: moderate level of severity; increases surgical cases by an additional average RW of 0.7 and increases medicine cases by an additional average RW of 0.25
- MS-DRG with an MCC: highest level of severity; increases surgical cases by an additional average RW of 1.75 and increases medicine cases by an additional average RW of 0.5

(See Figure 1.2 for an example of this.)

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| FIGURE 1.2 MS-DRG SHIFT EXAMPLE | | |
|-----------------------------------|---------------------------------------------------------------|---------------|
| | <i>Surgical MS-DRG example (Whipple procedure)</i> | <i>RW</i> |
| <i>MS-DRG 405</i> | <i>Pancreas, Liver and Shunt Procedures with MCC</i> | <i>5.5888</i> |
| <i>MS-DRG 406</i> | <i>Pancreas, Liver and Shunt Procedures with CC</i> | <i>2.8075</i> |
| <i>MS-DRG 407</i> | <i>Pancreas, Liver and Shunt Procedures without CC or MCC</i> | <i>2.0026</i> |
| | | |
| | <i>MS-DRG example (Type 1 diabetic with DKA)</i> | <i>RW</i> |
| <i>MS-DRG 637</i> | <i>Diabetes with MCC</i> | <i>1.3823</i> |
| <i>MS-DRG 638</i> | <i>Diabetes with CC</i> | <i>0.8463</i> |
| <i>MS-DRG 639</i> | <i>Diabetes without CC or MCC</i> | <i>0.6007</i> |

CMS publishes subsequent adjustments to its payment rates and methodology annually in an IPPS “proposed rule,” allowing those vested in the healthcare industry to offer comments on the proposal. The agency takes some of these concerns into consideration, generates adjustments, and publishes a final rule typically every August in the *Federal Register*. Items within the new rule take effect each October 1 unless otherwise noted.

Enter the healthcare recovery auditor

Recovery auditing originated in the business world simply due to volume. If a small business performs only a few hundred transactions per month, chances are that the vast majority of those transactions would be executed without problem. However, as a business grows and the number of transactions increases, the chance for error, either in the form of an overpayment or an underpayment, increases substantially. If the business owner with several thousand transactions per month cannot adequately track all of them, he or she may not know what additional revenue is being lost through unpaid invoices or what extra capital is being mistakenly shelled out due to redundant supplier

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payments. Imagine the potential problems that could loom in global giants such as Walmart or Google if no one was watching things on the back end.

The business owner needs someone to track all those things to ensure they always receive appropriate remuneration for what they billed and that they never overpay a single bill received. Therefore, recovery auditing arose as a successful business strategy: find all the billing mistakes a business makes and keep a small percentage of what was returned to that business as payment.

Since recovery auditing is a business, the savvy Recovery Auditor (RA) is always looking for a new revenue source. With that in mind, one can now fully grasp why we have a healthcare system that has been ripe for the rise of the healthcare RA. First, there is tremendous financial pressure on all payers and the government to reduce healthcare costs. Second, we now have a hospital reimbursement system that provides additional reimbursement opportunities for improved provider documentation. With MS-DRG implementation, the greater specificity coders could assign to a particular case, the higher the reimbursement. Despite the fact that CMS says there is nothing wrong with clarifying documentation to capture the complete picture of patient care, payers perceived such efforts as solely an effort to maximize hospital reimbursements at the payers' expense. Conversely, to reduce compensation, payers merely need to prove that the documentation provided doesn't support the level of care billed.

As the reader likely knows well, physicians are notoriously poor documenters. Although physician handwriting is much less of a factor given the advent of the electronic health record, a doctor's desire to spend less time on paperwork and more time with hands-on patient care has not changed. Most coding and documentation errors mainly stem from this principal fact of physician physiological makeup and lack of understanding regarding the importance and wide-scale use of their documentation for a wide range of reasons—reimbursement being just one.

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Lastly, given the sheer size of the healthcare industry in the United States (i.e., trillions of dollars spent per year), there is a great deal of money at risk. If only a small percentage of healthcare spending could be returned to the payer via auditing efforts, it could equal a huge windfall for both the auditing firm and payer, be it a government agency or private insurer.

EXHIBIT A

CMS' CONTRACTED RECOVERY AUDITOR RESULTS

Calculating an estimation of how lucrative recovery auditing has been for CMS's contracted RAs can be done through periodically examining the American Hospital Association's RACTrac project. In Figure 1.3, the 2011 summary results suggest that only 20% of the hospitals that supplied data to the AHA appealed denials. This means RAs had an absolute minimum successful denial rate of 80% for 2011. The RA automatically wins if the hospital does not file an appeal. CMS' RAs successfully defended 26% of the appealed denials, for a total success rate of 85.2% of denials issued ($[(.26 \times .20) + .8] \times 100\%$). With results like these, RAs likely encourage staff to increase denials to see what sticks. Fortunately, by the end of 2015, the national hospital appeal rate for all hospitals supplying data to RACTrac increased to 49%. RAs kept a minimum of 68.1% of all denials issued for the calendar year of 2015 ($[(.35 \times .49) + .51] \times 100\%$). Any business with a two-thirds success rate for any given transaction or business endeavor would be considered inordinately successful.

FIGURE 1.3 | APPEAL RATES

| <i>Year</i> | <i>National appeal rate</i> | <i>Appeals won by facility</i> | <i>Percent of denials kept by RA</i> |
|-------------|-----------------------------|--------------------------------|--------------------------------------|
| 2011 | 20% | 74% | 85.2% |
| 2012 | 40% | 75% | 70% |
| 2013 | 47% | 67% | 68.5% |
| 2014 | 48% | 70% | 66.4% |
| 2015 | 49% | 65% | 68.1% |

The CMS Conundrum

As if the advent of the healthcare RA was not enough, CMS did not adequately factor in the success their new MS-DRG system would have on provider documentation practices. Initially, CMS supported facilities looking to obtain the most detailed documentation possible. In fact, CMS says accurate coding and reimbursement will follow if the documentation is complete in the fiscal year 2008 IPPS final rule:

"We do not believe there is anything inappropriate, unethical or otherwise wrong with hospitals taking full advantage of coding opportunities to maximize Medicare payment that is supported by the documentation in the medical record... We encourage hospitals to engage in complete and accurate coding."

Motivated by these factors, facilities began identifying capable individuals to help physicians improve the definition and documentation of conditions using the official International Classification of Diseases (the code system used for reporting and reimbursement purposes in the United States) language. As a result, the clinical documentation improvement (CDI) program was born.

However, based on statistical analysis, CMS determined that increased reimbursement during the first years of the new MS-DRG system was solely due to better documentation and coding, not due to patients being sicker and requiring more resources. CMS simply assumed that hospitals rushed to improve their documentation by implementing CDI programs and increasing physician queries for documentation specificity. Sadly, there was never any consideration to the idea that patients might actually be sicker than previously portrayed. Unfortunately, patients were never pictured in the medical record as sick as they were in reality since there was no impetus to do so until the MS-DRG system arrived.

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Consequently, CMS began incorporating a documentation and coding adjustment (DCA) that reduced the fiscal year 2008 reimbursement rate by 0.6%, the fiscal year 2009 base rate by 0.9%, and so on, culminating in the most recent 2017 fiscal year reduction of 1.5%. While financial gain is the byproduct of better provider documentation given the current hospital reimbursement system, there is obviously good reason for CDI program participants to feel frustrated. The annual DCA in combination with the new healthcare RAs certainly makes it appear as if the deck is truly stacked against a hospital's survival.

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CDI Field Guide

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Denial Prevention

and

Audit Defense

Trey La Charité, MD, FACP, SFHM, CCDS

How can your CDI program help defend your facility's medical records and claims submissions to ensure the appropriate reimbursement for its patient care?

The world of denial prevention and audit defense is filled with a host of watchdog agencies—an alphabet soup of acronyms—to audit claims and take back funds for inappropriate submissions. Your hospital must work hard to protect its reimbursement, and your CDI program can help. With more than a dozen years' experience working with CDI staff to defend claims and tighten procedures around documentation for auditor targets, author **Trey La Charité, MD, FACP, SFHM, CCDS**, provides step-by-step tools to help your program improve its denial prevention efforts.

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