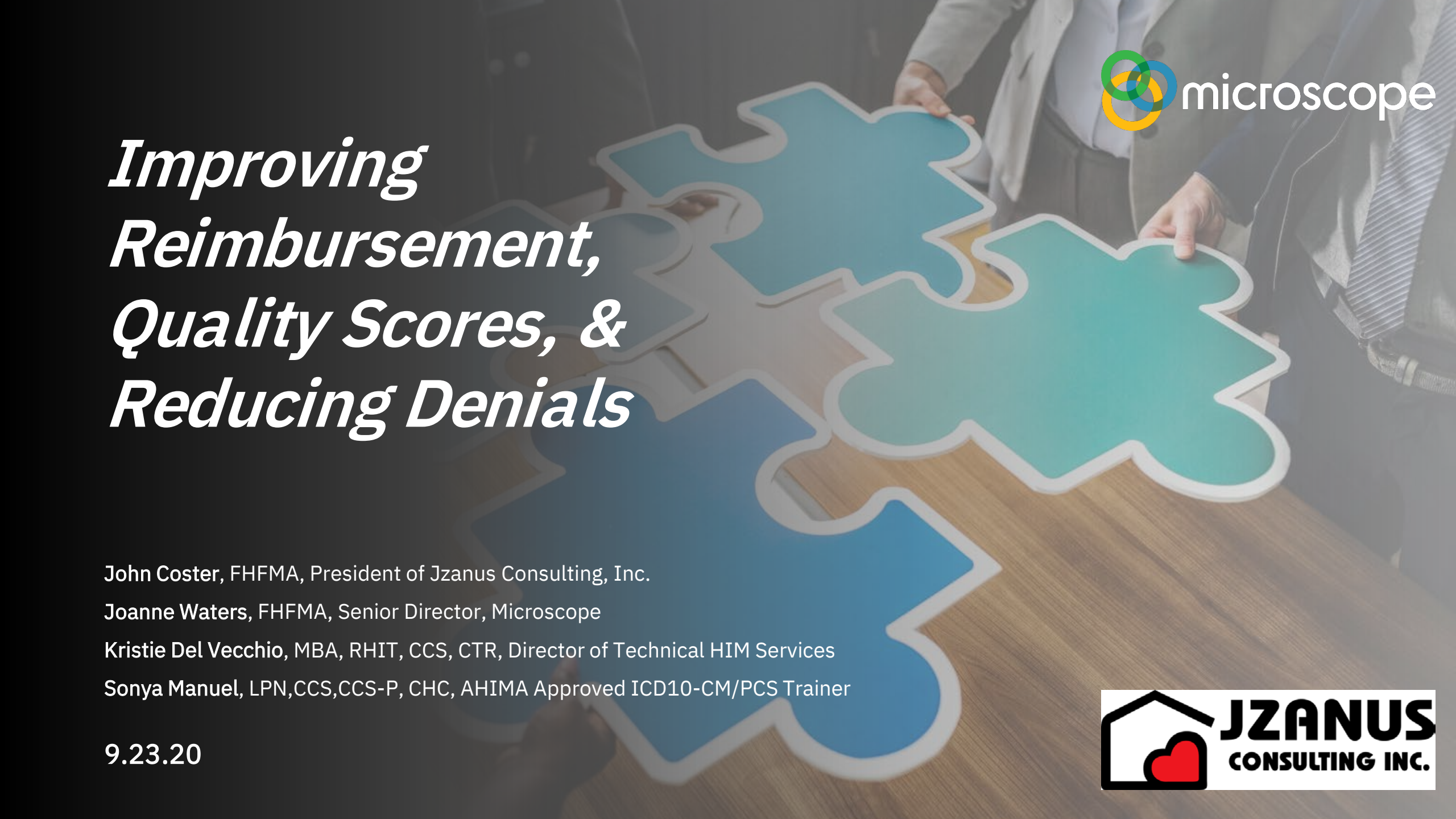

Improving Reimbursement, Quality Scores, & Reducing Denials

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Joanne Waters, FHFMA, Senior Director, Microscope

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TODAY'S PRESENTERS

John Coster, FHFMA

President of Jzanus Consulting, Inc.

John Coster is the President of Jzanus Consulting in West Hempstead, New York. Jzanus provides consulting services to hospitals and health systems throughout the country. Prior to founding Jzanus Consulting in 1998, Mr. Coster worked in the consulting practices of KPMG and Deloitte. John is extremely experienced in both New York State and Medicare hospital reimbursement. He has testified as an expert witness in a number of healthcare reimbursement litigations and has performed consulting engagements for more than 150 hospitals nationwide. At Deloitte, Mr. Coster served as the National Director of the Firm's Reimbursement Network.

Kristie Del Vecchio, MBA, RHIT, CCS, CTR

Director of Technical HIM Services, Jzanus Consulting, Inc.

Kristie has more than twenty years of experience in the Health Information Management field. She has managed multi-million-dollar revenue cycle engagements and assisted hospitals throughout the country with coding issues. Ms. Del Vecchio has performed and directed several very successful clinical validation engagements as they relate to quality, reimbursement, and compliance.

Joanne Waters, FHFMA

Senior Director, Microscope

Joanne brings over 33 years of experience in healthcare in hospital and physician practice organizations. As the leader of Microscope's Revenue Cycle Consulting Services, Joanne assists healthcare organizations and providers in optimizing performance and operational efficiency of their revenue cycle operations.

Sonya Manuel, LPN,CCS,CCS-P, CHC

AHIMA Approved ICD10-CM/PCS Trainer, Jzanus Consulting, Inc.

Sonya Manuel is a Senior HIM/Coding Consultant at Jzanus. Sonya has more than 25 years of industry experience. She conducts ICD-10-CM/PCS training and develops training content. Sonya has extensive background in coding education, DRG validation, DRG denials/appeals and consulting. Before joining the consulting arena Sonya served as Coding/Billing Compliance Specialist & Compliance Officer for a university doctor's office center & level-one trauma center. She was responsible for education and training for coders, physicians and CDI specialists.

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Agenda

- Introduction & Background
- Denial Prevention
- Successfully Appealing DRG Denials
- Common Inpatient/Outpatient Denials
- Quality Scoring
- Questions

Effective Denial Management

- Sustainable Strategy for Denial Management Includes:
  - Proactive MultidisciplinaryTeam Approach
  - Collaboration
  - Analytics, Tracking
  - Processes and Accountability
  - Identification of Root Causes
  - Technology
  - Education
  - Continuous Improvement

Effective Denial Management

- Denial Statistics
  - In 2016, a total of $262 billion total hospital charges were initially claim denials.
  - Approximately, 9% of all hospital claims were initially denied in 2016.
  - Denial rates average 5 to 10 % for commercial carriers and nearly 10% for Medicare and Medicaid.
  - In an analysis of over 3.3 billion provider transactions from approximately 724 hospitals in 2016, it was revealed that as much as 3.3% of net patient revenue was at risk due to claim denials at the typical health system.

Effective Denial Management

- Denial Statistics
  - In 2018, clinical validation represented 90 to 95% of coding related denials in hospitals according to Optum 360 internal data per a December 2019 Beckers article

BACKGROUND

Provide educational information on how to improve reimbursement, quality scores and avoid DRG denials.

Denial Prevention – Claims Data

- Proactive and preventative approach.
- Use claims data to:
  - Enhance revenue - minimize the number of denials.
  - Reduce the amount of uncollected revenue.
  - Lower costs associated with appeals process.
  - Identify accounts that may be at risk for denials

Denial Prevention – Claims Data

- Key elements of claims data include:
  - Patient demographics
  - Diagnoses & Procedure codes
  - Modifiers
  - Date(s) of service
  - Provider
  - Revenue codes
  - Plan and payer information
  - Charges

Denial Prevention – Data Analytics

- Data analytics can be used to:
  - Minimize claim denials & improve coding accuracy.
  - Identify denial-prone codes & potential denial trends.
  - Identify & establish education to prevent future errors.

Benchmarking Best Practices for Denial Prevention

- Coding Audits:
  - Perform routine internal coding audits
  - Trend accuracy by Coder & Physician.
- Denial Review:
  - Examine code changes & denials by Coders & Physicians
  - Track denial rates by type or category
- Payer Audit Tracking:
  - Trend results by payer

Pre-Billing Claim Validation

- The advantages of doing Pre-billing validation are:
  - Identify clinical documentation and coding issues prior to billing
  - Reduce potential claim denials and rejections
  - Prevent rework on backend denials
  - Expedite high-dollar claims, preventing delayed payment
  - Provide the coding & CDI staff immediate feedback

Challenges in Denials Management

- **Coding Changes (new CPT or ICD codes)**:
  - Delayed updates in software
- **Varying payer guidelines**:
  - Specific coding criteria.
  - Specific clinical criteria
- **EHR upgrades, conversions, and entire system transitions**:
  - Require more edits causing delay

Denial Prevention Strategies

- Implement a proactive appeal strategy
  - Multi-team approach - HIM, Coding, CDI, Physicians, managed care contracts, revenue cycle, legal, finance and compliance.
- Establish clinical criteria for high risk or targeted diagnoses & DRGs.
- Review high risk DRGs and targeted diagnoses, procedures & services
- Review DRGs with only one CC or MCC coded.
- Identify root causes of denials

Denial Prevention Strategies

- Review payer contracts
- Consider changing some of the language in contracts.
- Review every denial and when appropriate challenge and appeal.
- Monitor trends & patters of payers

The Most Common Denials

Top Coding Denials Identified Outpatient

- **Medical Necessity**
  - Ex) Radiology: lack of documentation of diagnosis to justify the test
- **Modifiers**
  - If caught on the front end, could eliminate many edits.
- **Hard code/soft codes**
  - Coders and charge analysts may add the same code
- **Technical denial**
  - Claim rejected for a non-medical reason.

Inpatient Top Reasons for Denials

- **Clinical Validation**:
  - Review for clinical indicators and treatment to justify a diagnosis.
- **Medical Necessity**:
  - Care that is reasonable, necessary, and/or appropriate, based on evidence-based clinical standards
- **Missing Documentation**:
  - Lack of or incomplète documentation
- **Inaccurate Coding Assignments:**
  - Incorrect code assignment in accordance with official coding guidelines

Clinical Validation Denials

- Hospitals have been inundated with clinical validation denials.
- Third Party Auditors benefit financially from generating denials.
- Payers manipulate coding rules and clinical criteria.
- Lack of transparency from payers and audit vendors
  - Ex) “The diagnoses on the claim could not be validated in the record”.

Clinical Denials

- Often clinical denials are not a coder error
- Coding and documentation guidelines agreed upon in a contract.
- CDI, Coding and HIM staff must be aware of contracted agreements

Clinical Validation Denials
How to Fight back

- Don’t hesitate to fight back
  - Escalate cases to the peer-to-peer level, outside arbitration or for external appeal
- Consider a Physician Advisor to review and/or respond to clinical denials.
- Include in the appeal letter:
  - Updated clinical references
  - Supporting clinical documentation from the medical record
- Create organizational clinical criteria

Clinical Validation Denials

- Escalation policies allow stronger paths for denial review
- Second-level review process to determine clinical validity of a diagnosis prior to bill drop
- Refer to a physician advisor any documented conditions that do not meet the established criteria
- Physician management should be made aware of denial trends

Targeted DRGs & Diagnoses

- **Commonly Targeted DRGs**:
  - 870, 871, 872, 853, 003, 291, 981, 982, 983, 987, 988, 989, 177, 178, 207
- **Commonly targeted diagnoses:**
  - Sepsis
  - Acute respiratory failure
  - Malnutrition
  - Encephalopathy
  - Pneumonia
  - AKI/Acute Kidney injury
  - Acute blood loss anemia

Sample Denial

- The billed DRG was 291 (heart failure with MCC).
  - Secondary diagnosis code pneumonia (MCC) is not clinically justified.
  - Potential DRG reassignment from 291 to 293.
    - 291(Heart failure with MCC)
      - RW: 1.3458
      - Reimbursement: $13,346.00
    - 293 (Heart failure W/O CC/MCC)
      - RW: 0.6553
      - Reimbursement: $6,553.00

Successfully Appeal DRG Denials

- If the case has merit, file the appeal.
- Provide a complete and accurate clinical picture of the patient.
- Track denials electronically - both successes and failures.
- Keep track of deadlines.
- Centralize were appeals arrive in the organization.
- Include attending physician feedback
- Provide Coding Clinic(s) to support appeals.

Patient Safety Indicators (PSI)

- What are Patient Safety Indicators?
  - Provide information on potentially avoidable safety events
  - Represent opportunities for improvement in delivery of care.
  - Focus on in-hospital complications and adverse events following surgeries, procedures, and childbirth.
- How are Patient Safety Indicators used?
  - Help hospitals assess the incidence of adverse events
  - Identify issues that might need further study.

Patient Safety Indicators (PSI)

- Second level review for cases that involve a PSI
- Documentation and coding process can affect the validity of Patient Safety Indicators (PSIs):
  - Improper coding of POA
  - Miscoding, assigning incorrect code, omitting a code, or coding irrelevant codes
  - Inclusion of non-elective surgical admissions
  - Inaccurate coding of history of events
  - Incorrect type of admission code

Mortality Measures & Methodology

- The Centers for Medicare & Medicaid Services' (CMS's) 30-day risk-standardized mortality measures assess activities that affect patients' well-being.
  - Better outcomes from transition to the outpatient setting
- The public reporting of 30-day risk-standardized mortality measures aims to:
  - a) promote effective communication and coordination of care;
  - b) promote effective prevention and treatment of chronic disease;
  - c) work with communities to promote best practices of healthy living;
  - d) make care affordable;
  - e) make care safer by reducing harm caused in the delivery of care and
  - f) strengthen person and family engagement as partners in their care.

Mortality Measures and Methodology

- Condition Specific
  - Acute Myocardial Infarction (AMI)
  - Chronic Obstructive Pulmonary Disease (COPD)
  - Heart Failure (HF)
  - Pneumonia
  - Stroke
- Procedure Specific
  - Coronary Artery Bypass Graft (CABG)
- Recommend second level review prior to bill drop

Expirations

- Severity of Illness and Risk of Mortality is an important quality indicator
  - Severity of Illness (SOI) – how sick is your patient (1 to 4)
  - Risk of Mortality (ROM) – what is the risk of death for your patient (1 to 4)
- The sicker your patient the higher the risk of mortality
  - SOI of 1 and ROM of 1 in an expirations raises questions
- Review all mortality cases to ensure validity of SOI/ROM

Hospital-Acquired Conditions (HACs)

- Based on Present on Admission (POA) indicators
- Not reimbursed as CCs and MCCs
- Penalty of 1% payment reduction for hospitals ranked at the bottom performance 25%
- Penalty affects the base diagnosis related group (DRG) for all discharges
- Second level review of all cases that involve a HAC to determine correct POA assignment
- Report findings to Physician Leadership

U.S. News & World (Health) Report - 2020-21 Best Hospital Rankings: Methodology Updates

Targeted methodological revisions:

- **TAVR cohort** – Transcatheter aortic valve replacement .
- **Stroke measure**
- **Knee outpatient volume**.
- **Medicare Advantage Adjustment** – Switched to a hospital-level Medicare Advantage (MA) adjustment factor from the county-level adjustment factor.
- **Transparency** – Incorporated transparency measure into Neurology & Neurosurgery.
- **Discharge to home**
- **Time period** - three years' worth of claims.
- **Best Regional Hospitals**
  - Provide general medical & surgical services
  - Receive at least Three High Performing rating across the procedures & conditions or at least one national ranking across the 12 data-driven adult specialties
  - Receive at least two more High Performing ratings than Below Average rating across the procedures & conditions

Display of outcome performance – Performance will be displayed on a scale of 1 (worst) to 5 (best) with a score of 3 indicating the hospital's risk adjusted performance is not statistically different from expected.

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QUESTIONS?

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