The Role of an Advanced CDI Program in a Clinical Validation Denial Appeals Process

A WEBINAR PRESENTED ON AUGUST 16, 2023

1

Presented By

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2

2

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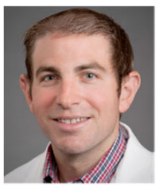

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Joy Bombay, RN, MSN, MHA, CCDS, is inpatient manager for clinical documentation excellence (CDE) at Atrium Health Wake Forest Baptist in Winston-Salem, North Carolina. She performs a clinical/leadership position that coordinates all activities related to compliance, denials management, mortality reviews, and quality assurance as well as education with the CDE team and providers. Her CDI career started in 2014 after spending 20 years in bedside nursing, providing care in the acute care setting as well as nursing leadership.

Learning Outcomes

- At the completion of this educational activity, the learner will be able to:
  - Describe the role of an advanced CDI program in a clinical validation denial appeals process.
  - Discuss how to build a CDE/PA/Coding denials appeal team and workflow.
  - List key metrics for measuring performance of a denials appeal team.

5

Advanced CDI Programs

6

What Is an Advanced CDI Program?

Clinical Indicator Policies System Wide	Defined Review and Query Processes	Physician Accountability	New Provider Onboarding Sessions
Monthly Resident Education Sessions	Team Leaders	Care Team Member	Monthly Meetings with Administration
Engagement in Facility Initiatives	Committee Participation	Revenue Impact Tracking	Concurrent HAC/PSI Review

7

7

What Is an Advanced CDI Program?

Clinical Validation	Specialized Experience	Global Focus	Multi-department Collaboration
Outpatient CDI Team	Advanced Certification(s)	Physician Advisor(s)	Quality, Quality, Quality
Risk Adjustment	Supporting Electronic Resources	Frequent Training	Denial Prevention and Appeal Support

8

8

Role in a Clinical Validation Appeal Process

9

CDI Role in Clinical Validation Denial Appeals

- Multidisciplinary team
  - Use coding and clinical knowledge
  - Focus on reviewing denials of key diagnoses resulting in DRG downgrades
- Help in determining when to continue the appeal process using a confidence scale.
- Working collaboratively to appeal these denials when appropriate
  - Recovering potentially lost revenue

10

10

Key Diagnoses

AHWFB Top Ten Denied Diagnoses by volume (1,482)

1. Sepsis (50.27%)
2. Respiratory failure (15.32%)
3. Encephalopathy (6.48%)
4. Pneumonia (5.4%)
5. Hyponatremia or SIADH (5.06%)
6. Acute Kidney Injury (4.93%)
7. Malnutrition (4.12%)
8. Heart failure (3.64%)
9. Acute blood loss anemia (2.9%)
10. Myocardial Infarction (1.89%)

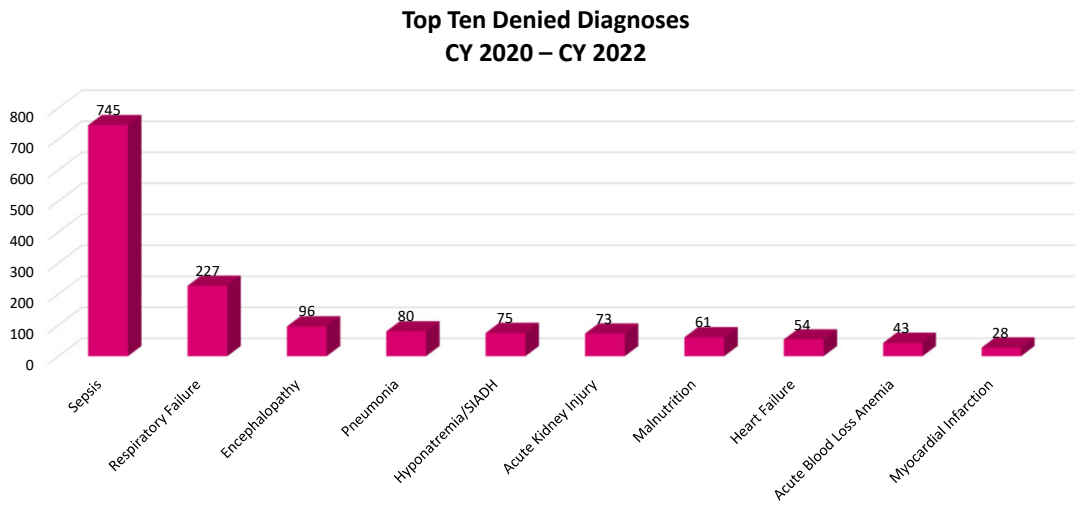
AHWFB Diagnoses with Definitions

- Sepsis
- Respiratory Failure
- Malnutrition
- Heart Failure
- Acute Blood Loss Anemia
- Acute Renal Failure
- Hyponatremia
- Encephalopathy
- Coma

11

11

Top Denied Diagnoses



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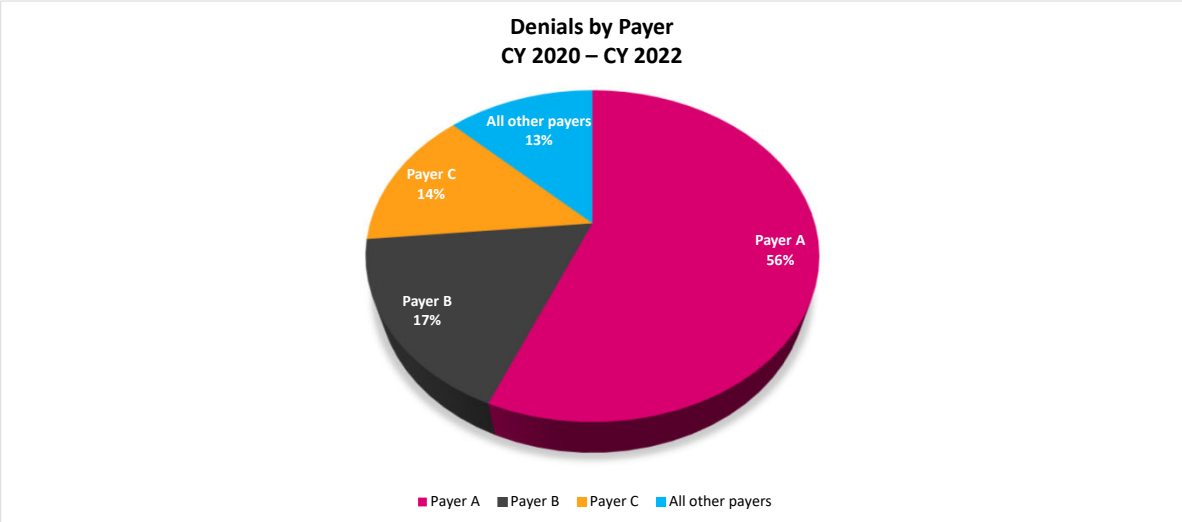
Distribution By Payer



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Rationale for Denials

- **Clinical Validation**
- Sequencing of diagnoses
- Root operation and approach on procedure codes
- Cases with only one CC or one MCC

14

14

What Is Clinical Validation?

- AHIMA references the Recovery Audit Contractor (RAC) Scope of Work (SOW) from 2013 to derive the definition.
- The 2013 RAC SOW states:
  - "Clinical validation is an additional process that may be performed along with DRG validation. Clinical validation involves a clinical review of the case to see whether or not the patient truly possesses the conditions that were documented in the medical record. Recovery Auditor clinicians shall review any information necessary to make a prepayment or post-payment claim determination. Clinical validation is performed by a clinician (RN, CMD or therapist). Clinical validation is beyond the scope of DRG (coding) validation, and the skills of a certified coder. This type of review can only be performed by a clinician or may be performed by a clinician with approved coding credentials."

What Is Clinical Validation?

- AHIMA goes on to quote the FY 2017 ICD-10-CM Official Coding Guideline A.19 and the AHA Coding Clinic (Fourth Quarter 2016, pp. 147-149), where it says that, "clinical validation is a separate function from the coding process. The codes assigned by the coding professional are based on the documentation by the physician, not on a particular clinical definition or criteria. This guidance emphasizes the need for facilities to have a process in place to validate the patient's clinical conditions prior to completing the coding process."

What Is Clinical Validation?

- ACDIS states in its 2021 updated white paper, *Clinical validation and the role of the CDI professional, "*[clinical validation is] ensuring documented conditions are supported by the totality of the health record. The goal of clinical validation is ensuring that the health record is not only coded accurately, but also accurately reflects the clinical scenario within the health record."

17

17

What Is Clinical Validation?

ICD-10-CM/PCS *Coding Clinic*, Fourth Quarter ICD-10 2016 Pages: 147-149 Effective with discharges: October 1, 2016

Important points:

- Coding must be based on provider documentation.
- Diagnosing a patient's condition is solely the responsibility of the provider. Only the physician, or other qualified healthcare practitioner legally accountable for establishing the patient's diagnosis, can "diagnose" the patient.
- Although ultimately related to the accuracy of the coding, clinical validation is a separate function from the coding process and clinical skill.
- Clinical validation involves a clinical review of the case to see whether or not the patient truly possesses the conditions that were documented in the medical record. Clinical validation is performed by a clinician (RN, CMD, or therapist). Clinical validation is beyond the scope of DRG (coding) validation, and the skills of a certified coder. This type of review can only be performed by a clinician or may be performed by a clinician with approved coding credentials.
- While physicians may use a particular clinical definition or set of clinical criteria to establish a diagnosis, the code is based on his/her documentation, not on a particular clinical definition or criteria.
- Coders should not be disregarding physician documentation and deciding on their own, based on clinical criteria, abnormal test results, etc., whether or not a condition should be coded.
- **A facility or a payer may require that a physician use a particular clinical definition or set of criteria when establishing a diagnosis, but that is a clinical issue outside the coding system.**

18

18

Preventing Denials in the First Place

- CDI can assist with avoiding the denials by:
  - Creating clinical definitions of problematic diagnoses for use by CDI/Coding.
  - Educating providers on these definitions.
  - Creating electronic tools to help providers with documentation of supporting clinical indicators.
  - Educating providers about how to use these tools.
  - Query to have clinical indicators clarified.
  - Look for opportunities to capture additional CCs or MCCs.

Building a Denials Appeal Team and Workflow

Building the Team

- Determine who needs to be on the team
  - HIM/Revenue Integrity
  - Physician advisor
  - Coding expert
  - CDI expert
  - Administrative support
  - Billing denials
  - Patient accounts services
    - Follow up at 14 and 60 days

Who Are the Best People for the Team?

- Not an entry level CDIS or Coder
  - CDI team leader or manager
  - CDI director
  - Coding analyst/educator
- More seasoned/advanced staff
  - 20+ years experience in CDI and coding
  - Advanced certifications in coding and CDI
- Physician advisor with good background in CDI/Coding
  - CDI certification
  - Background in medical education
  - Certification in physician advising

Establishing a Workflow

- Considerations
  - Technology
    - EMR worklists
    - Handoffs and communication
    - Shared information
    - HIM management software
  - Tools
    - Appeals templates
    - Clinical definitions
    - Confidence scale
  - Workflow steps

Technology

- EMR worklists
  - Created a worklist in the EMR where cases are placed by the coding analyst/educator when a denial is received.
  - The CDI expert or the PA accesses the patient's record via the worklist.
  - Once the review is complete, the CDI or PA records whether the case will be appealed or not.
  - Coder is able to see the response and acts accordingly.
  - Once case is complete, the coder removes the case from the worklist.
- Handoffs and communication
  - While cases are accessed through the worklists, there is some additional communication needed.
  - Emails and Instant Messaging is often used as needed.
  - Handoffs are understood by each member of the team as defined by their role.

Technology

- Shared information
  - Platform used for managing files
  - Utilized to house all patient level information.
  - Folders are labeled and files are moved into the file indicating the next activity needed in the process.
  - Resource folder
    - Appeal templates
    - Clinical definitions
    - Additional references
- HIM management software
  - Release of records by HIM/Revenue Integrity
  - Tracking of cases

25

25

Tools

- Appeals templates
  - Mostly created internally
  - Saved from successful appeals
  - Added to as various circumstances arise
- Clinical definitions
  - Screenshots are included in appeal letters
  - Referenced for appeals in each case as appropriate
  - Utilize biomedical evidence/peer-reviewed literature for conditions for which we do not have an internal clinical definition

26

26

Confidence Scale for Denials for Diagnoses With a Definition

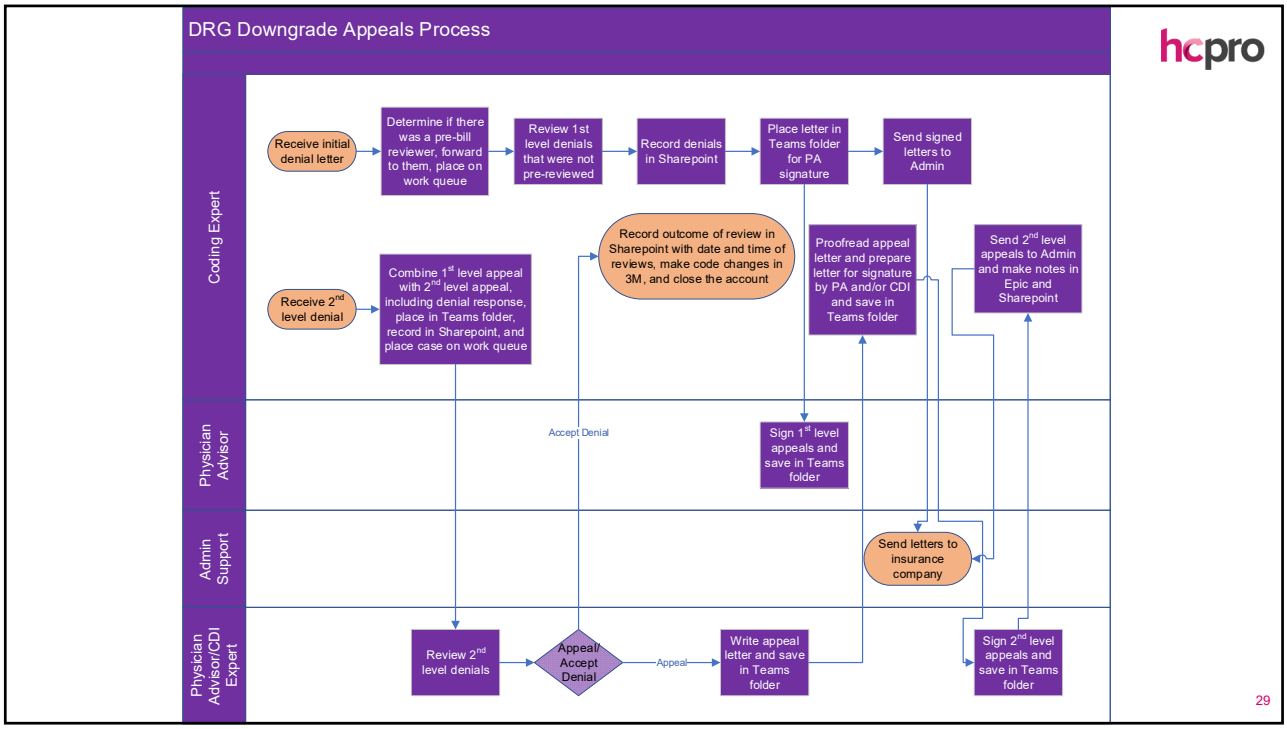
0	• Do not feel we should re-appeal due to inadequate clinical documentation AND lack of clinical indicators.
1	• Diagnosis is inconsistently documented by the provider and the minimum clinical indicators according to our institutional definition for the diagnosis is not met. • The provider may provide an alternate justification for the diagnosis that deviates from our institutional definition OR provides NO justification to support the diagnosis.
2	• Diagnosis is consistently documented by the provider AND at least the minimum clinical indicators according to our institutional definition is present, but clinical indicators in our definition policy are not consistently linked by provider to the diagnosis.
3	• There is clear, consistent clinical documentation of the diagnosis, linked by the provider with ample/well rounded clinical indicator support linked to the diagnosis by the provider in the documentation.

27

Confidence Scale for Denials for Diagnoses Without a Definition

0	• Do not feel we should re-appeal due to inadequate clinical documentation AND lack of clinical indicators.
1	• Diagnosis is inconsistently documented by the provider and has only the minimum clinical indicators or does not provide justification to support the diagnosis.
2	• Diagnosis is consistently documented by the provider without linkage to clinical indicators or justification is inconsistently linked in documentation.
3	• Clear, consistent clinical documentation of the diagnosis, linked by the provider with ample/well rounded clinical indicator support linked to the diagnosis by the provider in their documentation.

28

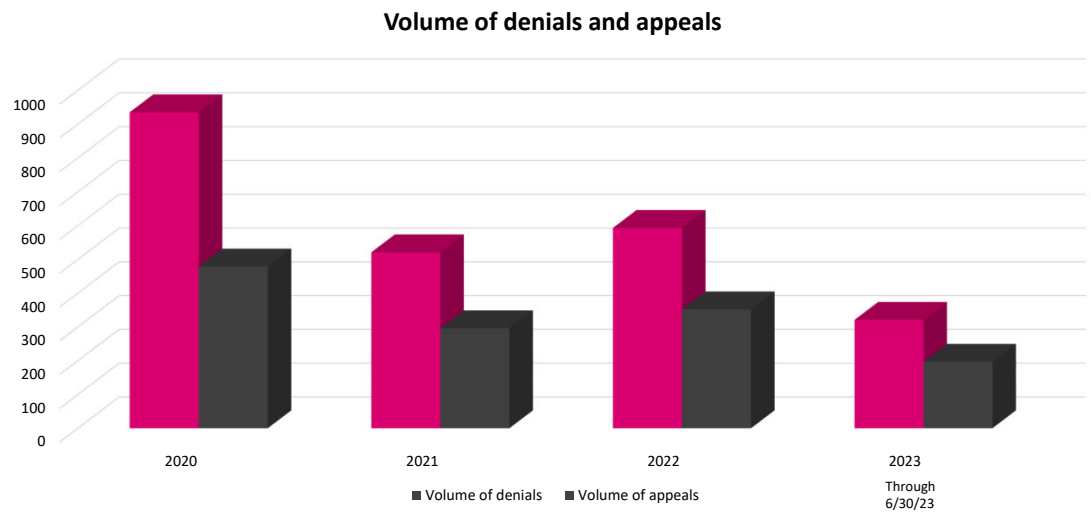

DRG Downgrade Appeals Process
hcpro
Coding Expert
Physician Advisor
Admin Support
Physician Advisor/CDI Expert
Receive initial denial letter
Determine if there was a pre-bill reviewer, forward to them, place on work queue
Review 1st level denials that were not pre-reviewed
Record denials in Sharepoint
Place letter in Teams folder for PA signature
Send signed letters to Admin
Receive 2nd level denial
Combine 1st level appeal with 2nd level appeal, including denial response, place in Teams folder, record in Sharepoint, and place case on work queue
Record outcome of review in Sharepoint with date and time of reviews, make code changes in 3M, and close the account
Proofread appeal letter and prepare letter for signature by PA and/or CDI and save in Teams folder
Send 2nd level appeals to Admin and make notes in Epic and Sharepoint
Accept Denial
Sign 1st level appeals and save in Teams folder
Send letters to insurance company
Review 2nd level denials
Appeal/ Accept Denial
Appeal
Write appeal letter and save in Teams folder
Sign 2nd level appeals and save in Teams folder
29

Key Metrics

Lead Metrics

- Volume of denials reviewed
- Volume of appeal letters

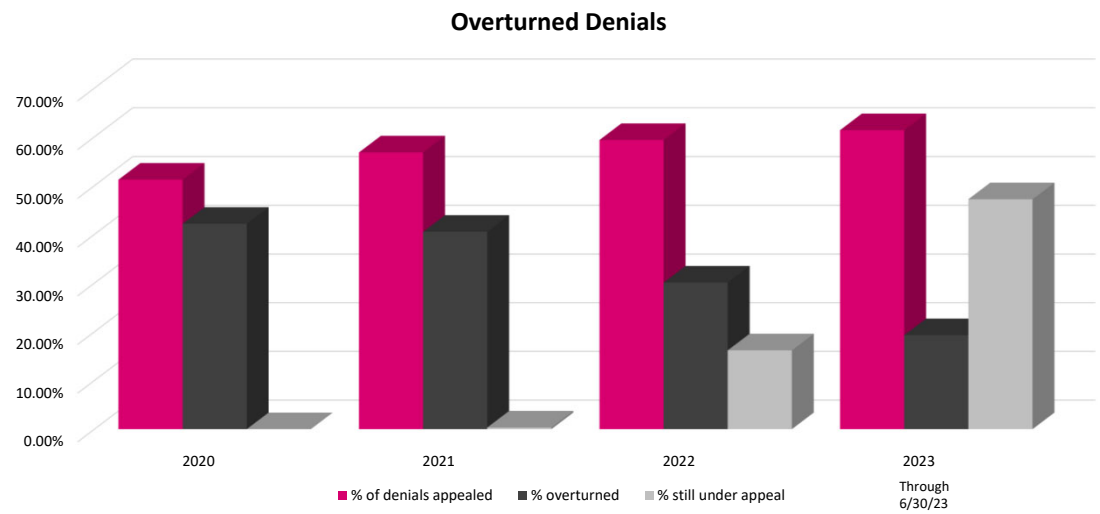
Denial and Appeals Data



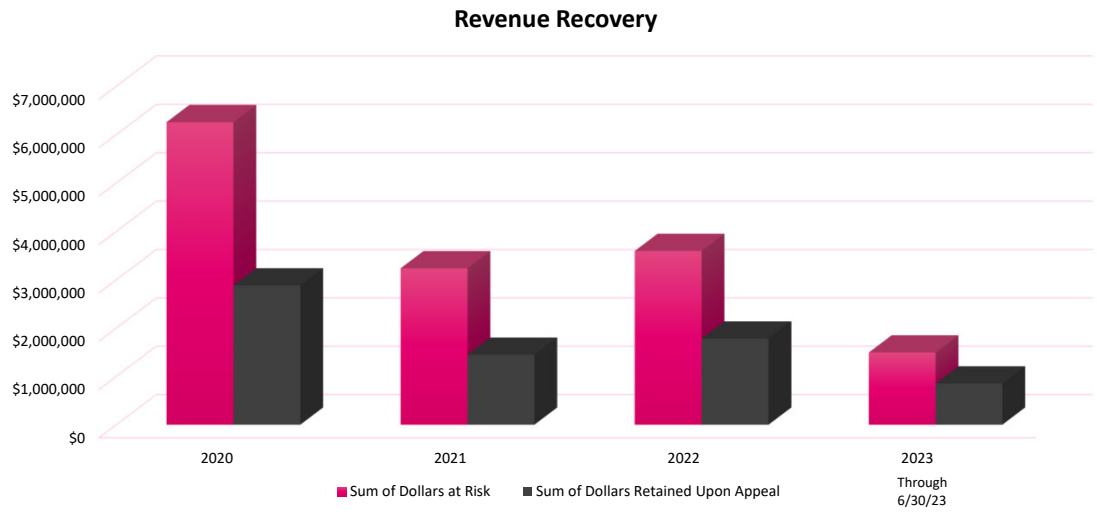
Lag Metrics

- Overturns
- Revenue recovery

Overturned Denials Data



Revenue Recovery



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Tips for Building a Denial Review Team

- Choose your team wisely
  - Make it a multidisciplinary team
  - Include those who are strong and high performing
  - Look for experience and intellect
  - Strong written communication and organizational skills
- Identify key performance indicators
  - Lead and Lag measures
  - ROI
- Utilize technology
- Create strong process
  - Make sure all teammates understand their role

36

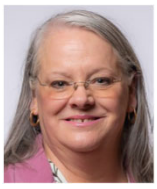
36

Lessons Learned

- Preventing denials is a lot less costly than defending them.
- Critical to have institutional clinical definitions.
- Utilize biomedical evidence and peer-reviewed literature.
- Become familiar with frequently cited coding clinics pertinent to high volume denied diagnoses.
  - Always remember that the hierarchical importance of official coding guidelines which precede coding clinic guidance.
- **Teamwork is key!**
- Important to maintain a growth mindset.
  - Utilize lost appeals to learn from and apply it to the next case.
  - Can also learn from those that we are able to overturn.
- CDI plays a crucial role by conducting clinical validation queries.

37

Questions & Answers



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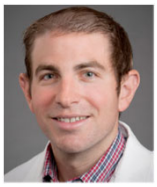

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38

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39

39

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40

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