PANACEA
A Career Step Company

Combating Denials and DRG Downgrading

Contents

We help healthcare organizations improve their bottom line and strategic market position with front line expertise in revenue cycle management, smart software and enterprise-level educational solutions.

Introduction

Payer strategies are evolving quickly, and healthcare organizations must be alert to make the most of revenue opportunities while mitigating claims denials.

Will you overreact and implement strategies that can unnecessarily constrict your revenue or will you prepare by consolidating an optimal approach grounded in best practices? These questions must be asked because, based on our recent experience, facilities are vulnerable.

In this paper, we discuss why it is vital to follow best-practice strategies in ICD-10-CM, PCS, and DRG coding to ensure your organization is meeting today's guidelines and to prepare for fiscal year (FY) 2018. In light of recent denials and DRG downgrading by payers, how your organization adapts will profoundly affect your reimbursements. An organization's own internal review can set the stage for monitoring and remediating any inappropriate downgrading of DRGs by the payer.

The Basics

Understanding the basics of DRGs, clinical documentation queries, and the Recovery Audit Program helps put claim denials and DRG downgrading by payers in perspective and sets your organization on the road to reversing denials through improved DRG coding, education, and documentation and query processes.

DRG Basics

Medical severity diagnostic related groups (MS-DRGs), often called DRGs, are payment classifications that group hospitalized patients with the same or similar conditions. Patients with the same DRG are projected to require the same resources while they are hospitalized. All DRGs have a relative weight assigned to them, reflecting the resources for the average case based on national averages.

DRGs change every year, and a best practice is to evaluate their changes to pinpoint any that are especially relevant to your organization. For example, several DRGs may relate to a similar diagnosis or procedure. One DRG can represent a diagnosis that is without complication or comorbidity (CC). A different DRG will represent the same diagnosis that is complex (CC), and a third DRG will represent the same diagnosis that has a major CC (MCC). The MCC has the highest relative weight, and therefore the highest reimbursement.

Claim Denials and Recovery Audit Program Basics

Uptick in Denials

One in five claims is denied. Denials occur for many reasons. Coding errors, poor documentation, queries, and DRG downgrading by Recovery Audit contractors (RAC) and other third-party auditors all contribute to the growing trend. Our clients tell us that the most common cause of claims denial is inpatient coding error.

Coding errors. The American Hospital Association has published data indicating that coding errors, while responsible for 79% of claim denials during first quarter 2016, had dropped to 56% of denials by the end of third quarter, presumably reflecting improved coder knowledge of DRGs and ICD-10. We expect to see further decreases in the rate of denials attributable to coding errors when the AHA releases updated and new quarterly statistics.

Clinical documentation and poor query processes. To a lesser degree, claims are also denied for poor documentation and query responses. To secure a DRG with an accurate relative weight, the physician must provide accurate documentation that supports the diagnosis. Hospitals should maintain an up-to-date physician query process so that coders have complete health information and can code the most accurate and descriptive DRG. (See the Best Practices section.)

DRG downgrading. Overall, denials related to DRGs are increasing. In our experience, it appears that third-party auditors are conflating DRG and clinical validation approaches and are targeting highest-risk CC and MCC codes. We find that RAC auditors are downgrading targeted DRGs without even requesting documentation. Auditors appear to be contesting the diagnosis and procedure DRGs based on their evaluations of clinical indicators merged with DRG coding validations. These are two different validations, but third-party auditors appear to be combining validation types.

At risk for the healthcare organization are CC and MCC conditions targeted by RAC and other third-party auditors as well as other conditions including:

- Acute kidney failure
- Acute respiratory failure
- Ulcer specificity—type/location/stage
- Acute encephalopathy
- Sepsis
- Acute blood loss anemia

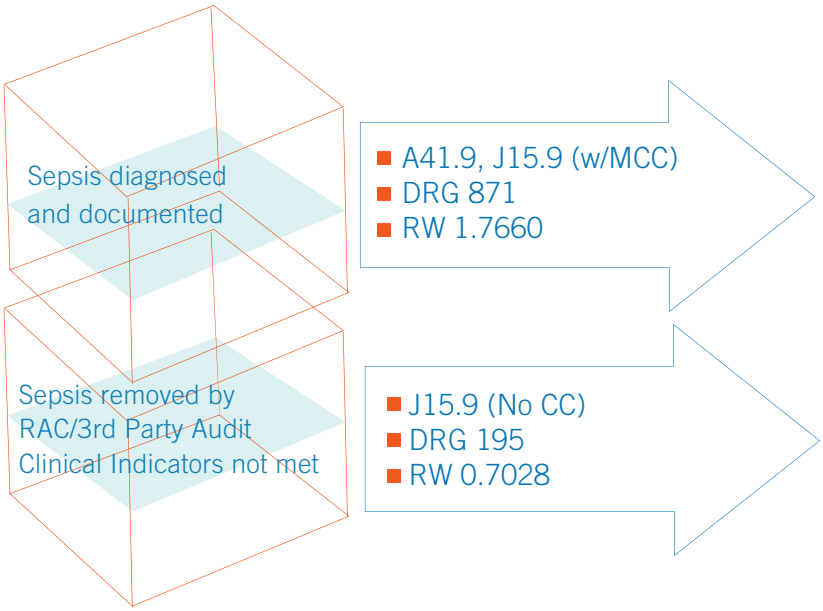


Figure 1 Reimbursement Difference = $5,316.

In the example in Figure 1, the physician clearly documented a diagnosis of sepsis and bacterial pneumonia for the patient. However, the post-payment auditor reviewed the case and decided there was not enough clinical criteria documented in the chart to support a diagnosis of sepsis and removed sepsis from the claim, leaving just pneumonia as the patient's diagnosis—as if sepsis had been coded in error. This action significantly changed the DRG and the reimbursement to the facility. This is a good example of how RAC and third-party auditors are inappropriately combining a clinical validation review with a DRG validation review.

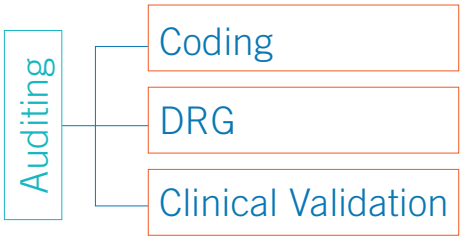
This example demonstrates the potential effect on revenue when a diagnosis is removed from an encounter. In the example, the original MCC pneumonia has lost the MCC designation, which completely shifts the DRG assignment. The difference in reimbursement is $5,316.

When a coder sees clear physician documentation that the patient has a particular diagnosis, it is their responsibility to code the conditions documented and diagnosed by the physician—as directed by the *ICD-10-CM Official Guidelines for Coding and Reporting* and Coding Clinic in the fourth quarter of 2016. Coding for sepsis in a situation like this should not be counted as a coding error when supported by physician documentation. A solid physician query process can ensure the documentation is as accurate as possible and clarify any vague or missing documentation, including clinical support for the condition.

Recovery Audit Program

Payers (including Medicare) have begun to deny more claims than ever, and paid claims have been scrutinized by third-party auditors—many working as contractors in the CMS Medicare Fee for Service (FFS) Recovery Audit Program. This program aims to identify and correct improper Medicare payments to healthcare organizations. Auditors look for a variety of issues with claims, including missing or incomplete information. The auditors also review claims (both pre- and post-payment) to identify and investigate those that have potential to be costly. In addition, auditors have been downgrading DRGs.

Correct Auditing Processes



RAC and other third-party auditors must follow CMS statements of work. According to CMS, auditors separately evaluate DRG validations and clinical validations. For DRG evaluations, they are directed not to look beyond what is documented by the physician. The auditors must make determinations that are consistent with guidance in the Coding Clinic.

Clinical validation in a RAC audit is a separate process, which involves a clinical review of case documentation to determine if the patient was correctly coded for the conditions. Clinical validation is beyond the scope of DRG (coding) validation and the skills of a certified coder. Clinical validation reviews can be performed only by a clinician, who may also have approved coding credentials.[1]

Healthcare Organizations Response to DRG Downgrading

We have found that in an attempt to mitigate CC and MCC payer denials and DRG downgrades, healthcare organizations have started to under-code—a dangerous strategy.

Faced with the recent surge in claim denials and DRG downgrades, some organizations have started to respond by instructing their coders to eliminate CC and MCC DRG codes unless specific clinical criteria are included in the chart documentation. Coders are given lists of clinical criteria they must identify in the diagnosis at hand; if these specific criteria are not present, the coders are asked not use certain CC and MCC codes.

Without a solid query process, under-coding is occurring, which is a defensive strategy with negative effects for the organization. It can undermine the organization's case mix index (CMI) and CC/MCC reporting, resulting in enormous consequences that affect revenue and quality reporting.

[1] https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/recovery-audit-program/downloads/090111racfinsow.pdf

Value of Case Mix Index (CMI)

CMI

Reflecting the diversity, clinical complexity, and resource needs of all the patients in the hospital, CMI is the average relative DRG weight of a hospital's inpatient discharges. It helps determine reimbursement by measuring the cost of resources to treat patients. CMI also represents risk. A higher CMI indicates a more complex and resource-intensive case load. MS-DRG weights are provided by CMS for the Medicare population, regardless of payer.

Managing the CMI

Healthcare organizations cannot control many aspects of the CMI, such as their geographic location and the urban and rural areas they serve.

In contrast, organizations can control their denials, to some extent, by taking all necessary steps to accurately apply DRG assignments before claims are submitted. The organization can ensure that the full diagnosis is documented by the physician with sufficient clinical support and that the full diagnosis is used by a trained coder to accurately represent the acuity of the patient during hospitalization. But a coder can't code what's not in the documentation.

Having a process in place to query physicians to improve their documentation of a case is critical to a coder's ability to accurately represent the case through the most appropriate DRG and code assignment. With a good query process, a hospital can code the acuity and severity of their patients.

Best Practices

Healthcare organizations have some control over the effectiveness of their DRG coding, CMI, and CC/MCC reporting through regular internal audits, excellent coding practices, and efficient and accurate clinical documentation processes. There are industry best practices that healthcare organizations can employ, but it is helpful to start by identifying the organization's goals. We can ask ourselves, "How will we know we are doing all we can to achieve optimum reimbursements?"

Goals

These are goals we believe organizations can strive to achieve:

1. Base all coding on the physician's complete documentation. Seek physician clarification.
2. Code to the highest level of specificity:
    a. Capture acuity by coding CCs and MCCs and coding as many on these diagnoses as the physician's documentation supports.
    b. Code all conditions—including CCs and MCCs—when supported by the documentation, official coding guidelines, the UHDDS, and the direction of Coding Clinic.

3. Follow coding specifications documented by the coding guidelines, always following the *ICD-10-CM Official Guidelines for Coding and Reporting*.

To achieve these goals, organizations want to understand trends in denials and DRG downgrading as well as

1. Develop and periodically review processes.
2. Ensure staff have access to full documentation on patients' diagnoses and procedures.
3. Strive for legibility, completeness, clarity, consistency, and precision in clinical documentation and in physicians' responses to queries.
4. Ensure the coding team is linking documentation to optimum coding. Correct DRGs (MS and APR) must be assigned and present-on-admission indicators and hospital-acquired conditions must be accurately identified.
5. Determine that documentation is complete for each admission and visit.

These goals can be achieved through best-practice internal audits, educating the entire revenue cycle team, and excellent clinical documentation and query processes.

Internal Audits

Organizations want to ensure audits are completed periodically to manage denials and DRG downgrades. The best defense is a great offense, which means preventing post-payment denials as much as possible. Organizations should develop an audit plan, which can include outside services in addition to internal audits performed by their own teams.

Some organizations have not audited their reimbursements since the transition to ICD-10, but they are developing a pool of new data based on submitted claims. They can be certain that payers are analyzing this data, too, and using their results to fine-tune reimbursement strategies.

Use your audits prospectively.

Audit Triggers

There are a number of issues that should motivate an organization to review DRG coding processes. Red flags include claims reimbursements that lag and denials that increase. Other audit triggers include:

1. Case mix index changes
2. Length of stay (LOS) higher than geometric mean
3. Large number of contract coding staff
4. Documentation issues
5. Concerns about compliance
6. Upcoming DRG changes proposed by CMS for any new fiscal year

Preliminary Audit Planning

The first step is to determine how to approach your analysis. Tracking DRGs is the best place to start.

Your organization's preparation to master the complexities of changing DRGs starts with the basics:

- Understand your CMI
- Understand your top DRGs
- Fine tune your staff's skills with education
- Ensure integrity and consistency in documentation

1. Examine your top 5, 10, or 20 volume-based DRGs and compare them to the CMS changes list.[2] Monitor trends and patterns of inappropriate denials or lower-than-expected DRG payments.
2. Track reimbursement effects on the top 5 DRGs. Smaller audits of the top 5 DRGs are less expensive to perform and can return results quickly. However, the goal remains the same as for larger audits. The smaller audits follow the same process, including a review of the appropriateness of reimbursement, clinical documentation, and the query process.
3. Focus on DRG denials.
4. Examine DRGs without CCs and MCCs.
5. Focus on DRGs with CCs and MCCs. Look for missed documentation opportunities.
6. Focus on education-based findings.

By auditing, analyzing, remediating, and periodically validating the remediation, reimbursement is optimized, denials decrease, and reimbursements become timely.

[2] https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY2018-IPPS-Proposed...;

Another important benefit is often overlooked in a cost/benefit decision of whether to audit the effectiveness of the DRG assignment: over time, audits become smaller, less costly, and more efficient. By routinely rechecking, remediation becomes a maintenance strategy. It is cost effective to maintain excellent processes that result in best-practice DRG coding.

Education

Education will sharpen the skills of your Coding and Clinical Documentation Improvement or Integrity Specialist (CDIS) teams. Coders want to have excellent skills in guidelines and coding clinics, and they want to understand the effects of DRGs on their organizations.

1. Educate the teams on ICD-10-CM and PCS and DRGs. Refresh those ICD-10-CM and PCS skills, and ensure that the entire revenue cycle management team understands DRG changes because they all affect reimbursements.
2. Measure team skills before and after education refreshment. Keep education focused on the team's critical capability of linking documentation to codes in order to receive the highest valid level of reimbursement.
3. Make it a priority. Staff education is frequently targeted by budget cuts, but it is important to recognize the critical relationship between accurate coding and your organization's reimbursement.

Clinical Documentation Integrity (CDI) and Query Processes

Audits frequently recommend that clinical documentation integrity (CDI) should be monitored and nurtured. The process starts by developing a procedure and ends with a subsequent review to validate that it is working. Here are several considerations for a CDI initiative.

A best-practice query process is periodically reviewed to ensure that the process continues to:

1. Help capture documentation issues upfront so there is no delay in coding and consequent billing cycle disruption.
2. Ensure queries meet compliance guidelines under CMS.
3. Ensure queries are clear and concisely written.

4. Bridge the work between the coding and CDI teams, refining staff knowledge of coding and reimbursement.
5. Identify potential challenges with CDI, e.g., lack of education on MS-DRGs or lack of education on the query process.

Conclusion

Healthcare reimbursement has one constant—rapid change. Organizations must remain alert to changes in MS-DRGs because they will continue to affect reimbursements.

CMS has many DRG changes for 2018 resulting from its analysis of a year's worth of claims data under ICD-10. The new changes will compound the increase in payer denials and DRG downgrades.

We recommend that healthcare organizations prepare for DRG downgrading by implementing best-practice processes for clinical documentation and query management as well as in-house DRG and clinical validation. Internal auditing and reviewing will improve reimbursements in the long term, unlike the recent coding practice of deliberately downgrading diagnosis and procedure DRGs. Monitor the top DRGs, improve clinical documentation, and ensure that your CDI and coding teams understand how important coding is to the financial health of your organization.

Reimbursement managers must remain change-hardy to succeed in the coming fiscal year.

Help for Claims Denials and DRG Downgrading

Organizations may need help navigating the waters of regulatory changes and payer practices that affect every reimbursement stream. Panacea and Career Step, its parent company, can perform the auditing and training necessary to help you succeed in combatting claims denials and DRG downgrades.

About Panacea and Career Step

Our services include:

1. DRG Validation Review that analyzes and makes recommendations on the validation of principal diagnosis, CC/MCC codes, procedure codes, and other secondary codes that may affect DRG assignment. The DRG Validation Review provides insight into coding education needed for your team.
2. Inpatient Compliance Review is a full coding review of principal diagnoses, secondary diagnoses codes, and procedure codes—a quality review of all codes on the claim. Inpatient Compliance Review also provides coding education and documentation integrity opportunities.
3. Inpatient Post-Discharge CDI Review that increases revenue by focusing on severity of illness (SOI)/Risk of Mortality (ROM) scores and documentation integrity opportunities.
4. CDI Concurrent Review that ensures accurate DRG assignment by validating SOI, ROM, and the complaint query process. Clinical documentation is analyzed to identify missing opportunity trends.
5. Education and Training to refresh coders' skills and help them make the link between documentation and code assignment for appropriate reimbursement.

We help healthcare organizations improve their bottom line and strategic market position with front-line expertise in revenue cycle management, smart software, and enterprise-level educational solutions.

PANACEA
A Career Step Company

Learn more at panaceainc.com, or call us at 1-866-926-5933.

About the Authors

Sandra L. Brewton
RHIT, CCS, CHCA, CPC,
AHIMA-Approved ICD-10-CM/PCS Trainer
Senior Healthcare Consultant

As a Senior Healthcare Consultant, Sandy provides inpatient record audits, including the review/validation of MS-DRG assignment and quality of physician documentation; coder and provider training and education to improve documentation quality and clarify code assignment; and recommendations for medical records operations and instructing facility staff on ICD-9-CM, ICD-10-CM/PCS, and CPT coding guidelines.

Laurie A. McBrierty,
MLT, ASCP,
Vice President of Product Management

Laurie brings close to 30 years of experience in healthcare, healthcare information systems, and product management to Career Step, where she drives the product management of the company's offerings. Prior to joining Career Step, Laurie served in various executive positions with companies such as xG Health Solutions, WellPoint, Resolution Health, QuadraMed, Kaiser Permanente, SoftMed, 3M HIS, and Stanford Health Services. She has also served on various boards and committees within the American Health Information Management Association (AHIMA) and is a respected leader in health information management.
Laurie holds a bachelor's degree in Information Systems Management from the University of San Francisco.