



A Team Approach to Outpatient Denials: CDI and Coding Working Together to Improve Documentation and Reduce Outpatient Denials

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Presented By



Kim Conner, BSN, CCDS, CCDS-O, is a CDI education specialist for ACDIS/HCPPro. She serves as a full-time instructor for HCPPro's CDI Boot Camps and PROPELCDI advisory services. She is a subject matter expert for ACDIS and frequently writes for ACDIS publications and speaks at ACDIS events. Conner has 20 years of clinical experience as a surgical ICU/burn trauma nurse at large academic medical centers. In 2013, she shifted her focus from the bedside to CDI. During her career, she has been responsible for initiating CDI programs in both the inpatient and outpatient settings, developing ongoing education across the continuum of care, and, most recently, was a CDI director where she led education and support programs to maximize CDI success.

Learning Objectives

- At the completion of this educational activity, the learner will be able to:
 - Describe how many layers there are to the billing process
 - Identify one way documentation practices connect to denials within the billing cycle
 - Describe how to collaborate with outpatient HIM departments to identify areas of opportunity to reduce account receivable days
 - Identify areas to improve education and documentation to reduce denials within the billing cycle



Outpatient Denials

CDI in the Outpatient Arena



- Outpatient encompasses:
 - ED
 - Physician practice (PCP and specialists)
 - Observation
 - Same day surgery
 - Outpatient clinics
- CDI reviews outpatient records for:
 - HCC capture
 - Claim denials
 - Charge capture
 - Evaluation and management
 - OCE Edits (outpatient code edits)

Adverse Effects of Delayed or Denied Reimbursement

- Claim denials cause significant revenue leakage for healthcare organizations
- Volume of outpatient denials has increased causing:
 - Increased days in accounts receivable (A/R)
 - Increase in write-off rates
 - Increase cost to collect
 - Stagnant cash flow

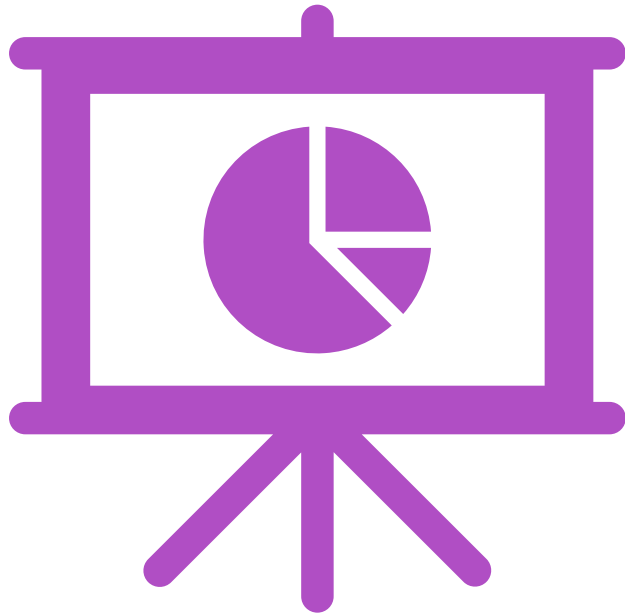


Adverse Effects of Delayed or Denied Reimbursement

- Delayed claim reimbursements can have a cascading effect on patient care
- Lack of resources can cause:
 - Lower staff ratios to handle patient flow
 - Lower patient volumes which leads to lower revenue
 - Increase risk on patient safety
 - Poor quality metric reporting
- Improved processes ensures providers have the resources to deliver quality care



Denial Stats



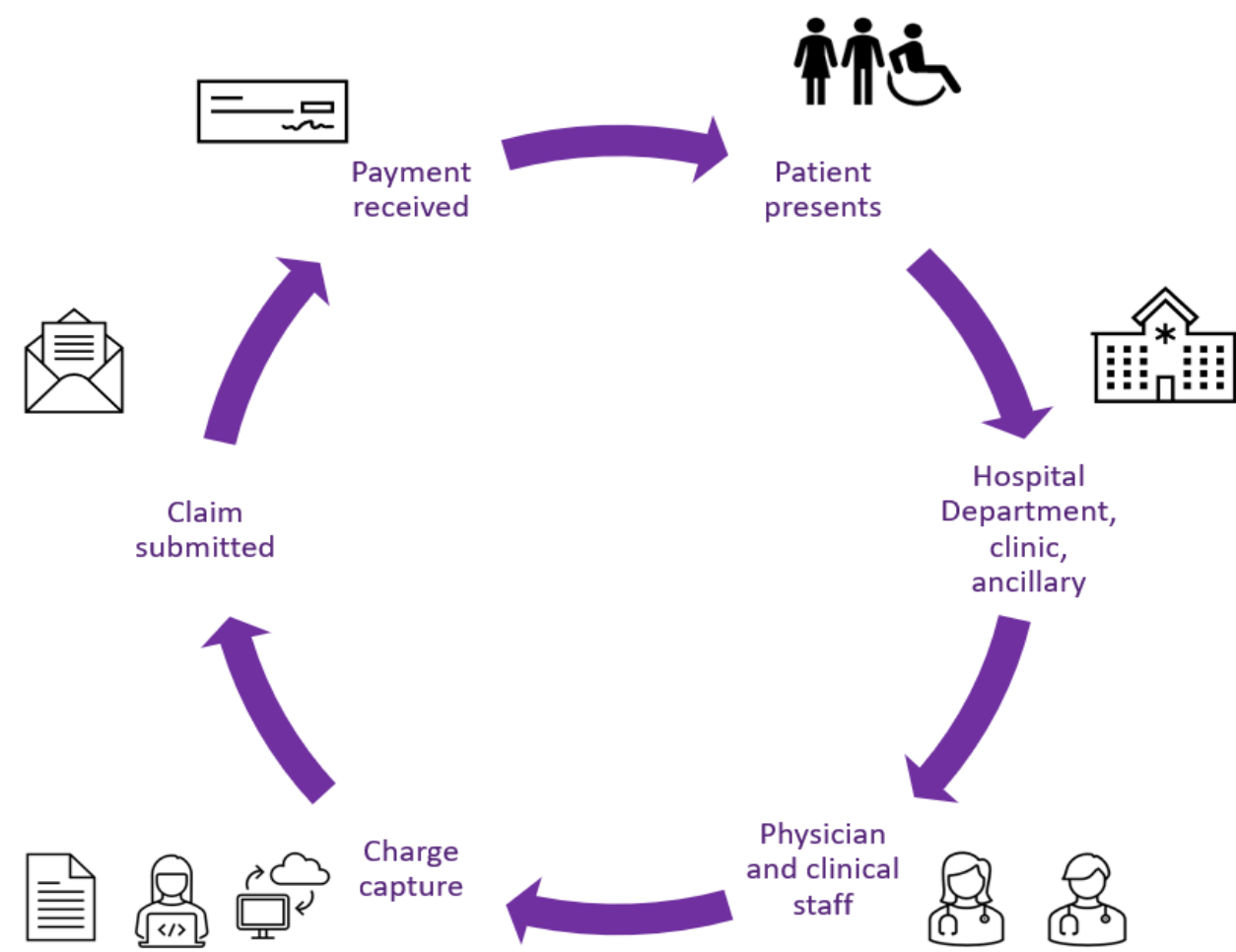
- According to recent research into denials, out of \$3 trillion in total claims submitted by healthcare organizations, \$262 billion were denied
- 90% of all denials are preventable
- Two-thirds of the preventable denials can be successfully appealed
- The remaining one-third of those denials represent missed opportunities for prevention and the lost revenue cannot be recovered

Collaborative Approach

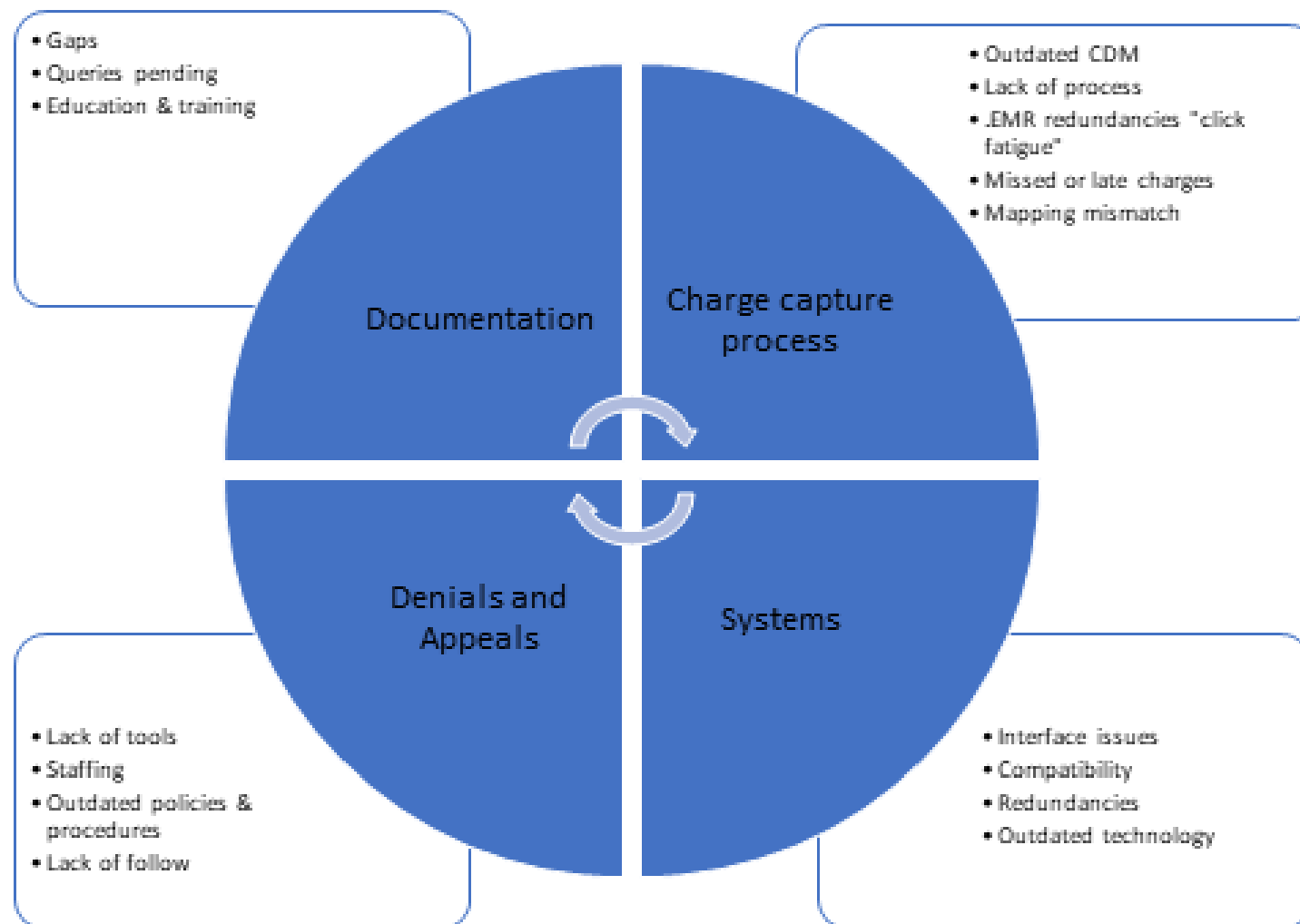


- Reimbursement regulations are complex
- Documentation elements need to support more than diagnoses
- Understanding the elements promotes an overall improved process with less room for a denial
- Knowing all the departments that touch the record is vital to reducing denials
- Collaboration allows for better identification of root causes for denials which opens the door for CDI opportunity
- So, how does the cycle work?

Revenue Cycle Process



Revenue Cycle Delays

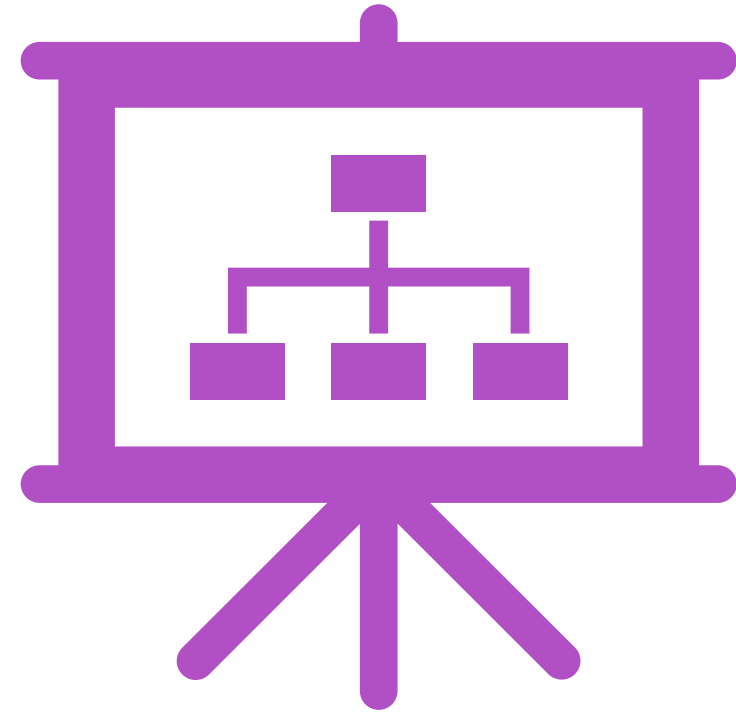


Outpatient Claims Denial Management

- Denials management process
 - Identify: Teams must collaborate to identify the root causes of the denials
 - Analyze: Focus initially on identifying root causes
 - Goal of simplifying the appeals process and implementing effective preventive measures
 - Prevention: Denials prevention requires cooperation and corrective actions at every point in the revenue cycle
 - Patient access in the front
 - Clinical services and HIM in the mid cycle
 - Patient financial services in the back

Possible Root Causes for Denials

- Lack visibility into denials data
- Inadequate support for process improvement can cause denials (quick fixes are not sustainable)
- Difficulty finding where denial letters are received and what the denial is for
- Having multiple disjointed systems, processes, and workflows
- Documentation is not supportive to bill services
- Lack of provider education and follow up for documentation requirements



Where Does CDI Fit In?



- Ensures complete and accurate clinical documentation sets up appropriate payment expectations
- Complete clinical documentation leads to accurate coding
- Complete documentation ensures the organization upholds the highest standards of revenue integrity and data management
- Documentation turns information into process improvements that can eliminate revenue leaks

CDI Focus: Documentation

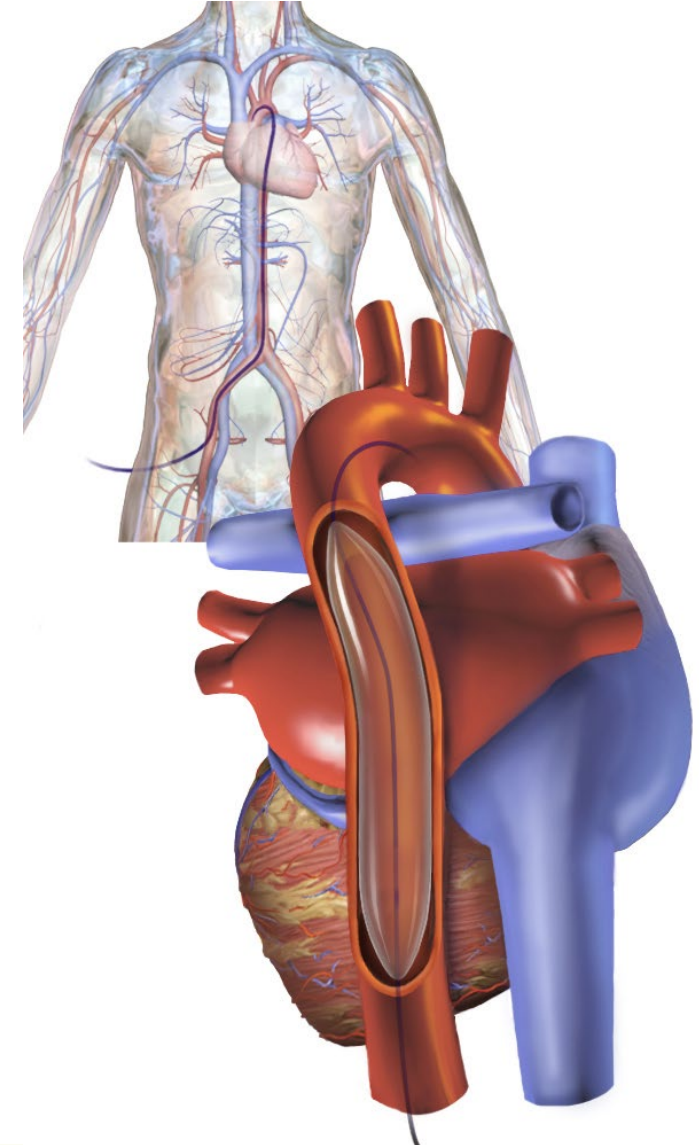
- Understanding documentation requirements and outpatient coding guidelines is essential
- Outpatient CDI is not just about HCC capture
- Denial prevention strategies involve
 - Understanding where claims can be denied in the rev cycle and why
 - Reporting findings to the appropriate department
 - Communicating with the rev cycle team on trends/documentation issues
 - Educating providers and giving feedback
 - Advocating for providers as it relates to documentation problem areas
 - Working with IT and providers to simplify documentation elements

CDI Focus: Documentation

- ED is a focus area for improved documentation
- ED documentation has to cover:
 - Inpatient
 - Observation
 - Sent home after ED treatment
- First listed diagnosis needs to be documented to the highest degree of specificity
- ED typically documents signs and symptoms as first listed diagnosis
- Cannot capture “uncertain” diagnoses in the outpatient setting
- Does ED documentation support the level of service billed (E/M)

Educational Opportunities: Inpatient Only Procedures

- ED providers do not have admitting privileges
- ED providers have to treat the patient regardless of the level of care status
- For example, a patient is admitted with an MI, is taken to the cath lab and has an IABP placed
- The facility needs to transfer the patient to a hospital due to the higher level of care needed
- The IABP procedure is an inpatient only procedure, the ED cannot admit the patient
- Interventional Cardiology, “You want me to admit a patient I know we are going to transfer”?



Inpatient-Only Procedures

Inpatient-only procedures (IPO) are occasionally performed in an outpatient setting. These procedures cause denials on both Surgical and Emergency Department patients.

- Case
 - Day surgery patient scheduled and authorized for a vaginal hysterectomy (CPT 58260).
 - A vaginal hysterectomy with stress incontinence repair (CPT 58267) is performed
 - CPT 58267 is an IPO procedure.
- Exceptions
 - Patient dies before inpatient admission or transfer
 - Performed other procedures with “T” or “J1” APC SI
 - Provided on inpatient admission date
 - Admitted as Inpatient within 3 days of IPO
 - Related to inpatient admission

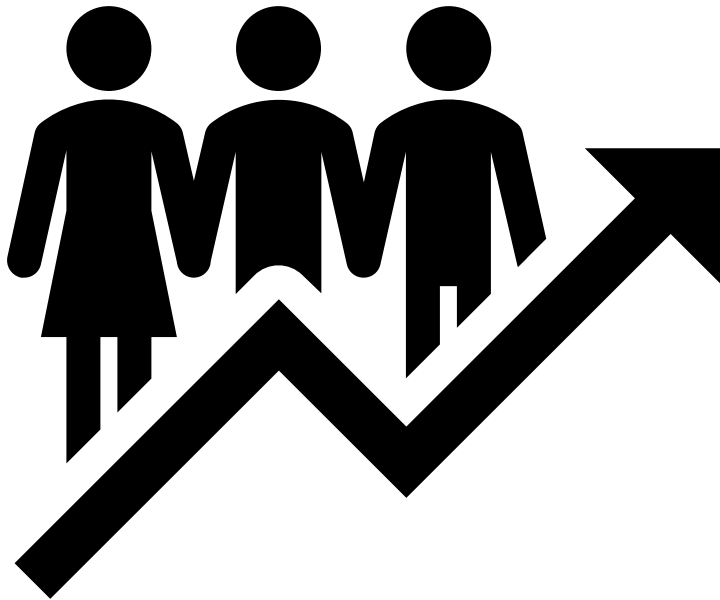


What Is Charge Capture?

Charge Capture Methods

- Documentation-based charge
 - Emergency Evaluation and Management (E/M) level code
 - System charge
 - Supply or drug cabinet on dispense
 - Lab test on the result
 - OR preference card on exception
 - Blood on administration
 - Paper-based charge
 - Charge slip
 - Other
 - Manual credit/debit
- The chargemaster is a hospital data file containing pricing for billable hospital services, drugs, supplies, etc.
 - The various charge capture methods interface with the hospital's accounting system cross-walking to the chargemaster to generate a charge on the claim.
 - HIM coders apply diagnosis codes and procedure codes and resolve any coding edits.
 - Billing applies any claim data required

Claims Denial Reduction and Prevention



- Reduction and Prevention
- Update the CDM
- Define the department charge reconciliation process and review the responsibility
- Review and revise current work queues
- Update charge capture policies and procedures
- Education, education, education

What Is Evaluation and Management (E/M)?

- E/M coding is the process by which physician-patient encounters are translated into CPT codes for professional billing
- E/M represent services provided by a physician or other qualified healthcare professional
- E/M guidelines were developed by the Center for Medicare and Medicaid Services (CMS) in conjunction with the American Medical Association
- E/M codes (levels) require supportive documentation especially as it pertains to the medical decision making (MDM) elements
- The provider ensure that **documentation** supports the level of service reported to a payer

CDI and E/M

- CDI's role in the outpatient setting has not traditionally included evaluation and management
- With the increased volume of outpatient denials, E/M leveling and professional billing regulation can no longer be siloed
- Providers typically perform their own E/M leveling (what could go wrong?)



E/M Levels Comparison

Facility Charge Capture

- Hospitals are to develop their own E/M level criteria
- Based on volume and hospital resources utilization

Professional Charge Capture

- Based on the complexity and intensity of the provider's efforts

Medical Decision Making

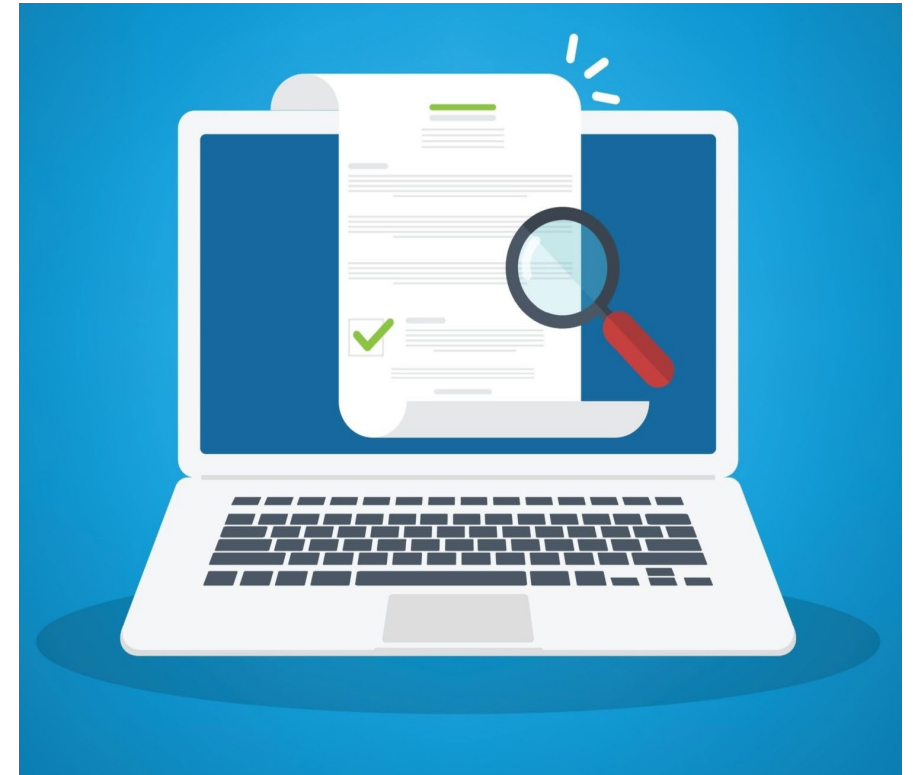
- Medical decision making refers to the complexity of establishing a diagnosis and/or selecting a management option
- Outpatient E/M leveling is heavily based on MDM
 - The number and types of problems addressed during the encounter
 - The complexity of establishing a diagnosis
 - The management decisions made by the physician
- Other factors for E/M leveling
 - New or established patient
 - New or established diagnoses
 - Documented diagnoses are supported by M.E.A.T. (monitoring, evaluation, assessment and/or treatment)



At last he had found the Regulatory Guidelines.

E/M Claim Denials

- Insufficient documentation in relation to the billed service
- Typically, no record of the extent and amount of time spent in counseling and/or coordination of care
- A level 5 should not be billed for a patient with a cold and no comorbid conditions



Payer Policy Changes



Payers typically communicate policy changes (utilization review, clinical guidelines, payment, billing, etc.) throughout the year



Notifications in many formats, including letter, newsletter, email notifications, and joint operating committee meetings



Policy changes affect all departments (providers, hospital departments, and revenue cycle)



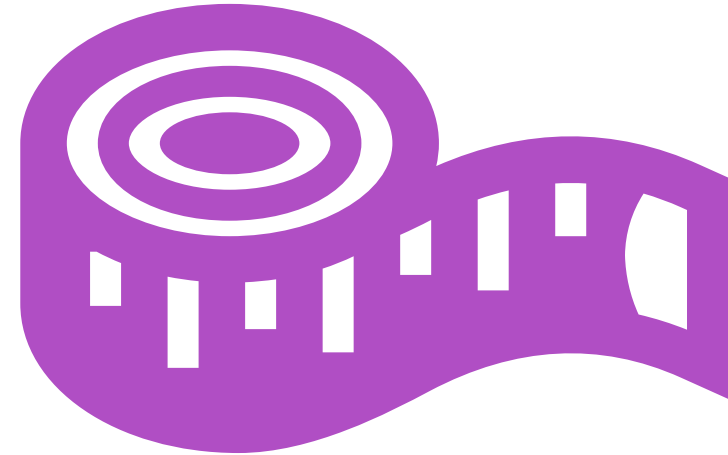
Every department should know what the changes are and what adjustments need to be made

Data and Analytics

- Ensure the right people/departments are at the table
- Have defined roles and responsibilities
- Who is designated to appeal denials
- How does the documentation line up with the denial (are there areas for improvement)
- Identify trends that can be avoided
 - By payer (identify payers for special focus)
 - By denial reason
 - By payer according to reason and service location

Measuring Impact

- Current denial rate and which part of the rev cycle does the denial fall in
- Decrease in denials once prevention strategies are in place
- Percentage of appeals to denials (average is 80%)
- Upheld to overturned ratios (needs to be in relation to the other metrics)
- No metric stands alone (Without this context, overturn rates or loss rate can be misinterpreted)



CDI Impact on Outpatient Denial Prevention



- A proactive approach to denial prevention will reduce denial volumes
- Transparency with every department in the rev cycle is crucial to prevention
- Education and follow/follow through is where CDI can have tremendous impact
- Documentation is the focus for any denial prevention program



Thank you.

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