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A Successful CDI Monitoring Process Can Help Hospitals Avoid Audit Surprises

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Healthcare systems are missing an opportunity if their clinical documentation improvement (CDI) staff are not an integral part of their denial management program. CDI departments can continue to contribute to the success of healthcare organizations if they expand their efforts to include strategies that minimize reimbursement leakage associated with claim denials. It seems denials management efforts are lagging even though there may be significant revenue at risk.

Documentation deficiencies cause inaccurate, incomplete, or imprecise diagnosis and procedure codes to be assigned, contributing to medical necessity, clinical validation, and coding denials. "One study estimated that the aggregate value of challenged claims ranges from $11 billion to $54 billion annually."[1] In 2017, that translated into an initial denial rate of around 9 percent of medical claims submitted in the United States, costing the typical health system as much as 3.3 percent of net patient revenue, or an average of $4.9 million per hospital.[2] Perhaps there is less urgency around denials management efforts because most organizations believe they will win on appeal, and an average of 63 percent of denied claims were recovered in 2017; but organizations lost roughly $118 per claim, or as much as $8.6 billion in appeals-related administrative costs.[3] A robust CDI department can assist with denials management by potentially preventing future denials and assisting with appeals efforts.

Implementing a monitoring process for known improper payment issues as identified through the Medicare Fee-for-Service (FFS) Program may reduce revenue leakage associated with denials management. The basis for all federal audit programs is the Comprehensive Error Rate Testing (CERT) program. According to the Centers for Medicare and Medicaid Services (CMS), the CERT program considers any paid claim that should have been denied or paid at another amount to be an improper payment. To meet their objective, a stratified random sample of Medicare FFS claims is selected for review; supporting documentation is retrieved from the provider who submitted the claim for payment; and the documentation is reviewed by independent medical reviewers to determine if the claim was paid properly under Medicare coverage, coding, and billing rules.[4] If the documentation does not support that Medicare rules were met, the claim is counted as either a total or partial improper payment based on one of five major categories: (1) No Documentation, (2) Insufficient Documentation, (3) Medical Necessity, (4) Incorrect Coding, or (5) Other.[5] It is important to note that the CERT program is the only CMS entity that can randomly select claims for review. All other CMS auditors, including Recovery Auditors, The Office of the Inspector General, and Medicare Administrative Contractors (MACs), target topics identified as vulnerable to improper payment by the CERT program.

CDI leadership should be monitoring CERT findings and how each of the Medicare auditors plan to either prevent or recoup improper payments through strategies within their scope of practice. MACs are required to submit an annual Improper Payment Reduction Strategy that outlines priorities for the year related to each payer type. MACs also have a Targeted Probe and Educate program that focuses only on providers who have the highest claim denial rates, or who have billing practices that vary significantly from their peers.[6] CDI leadership can use Program for Evaluating Payment Patterns Electronic Report (PEPPER) data to see how they compare within their state, their MAC jurisdiction, and nationally. According to Wilson, "PEPPER data provides provider-specific Medicare data statistics for discharges and services vulnerable to improper payments. PEPPER can support a hospital or facility's compliance efforts by identifying outliers for these risk areas."[7] When an organization is found to be a high outlier, they should sample records to identify potential vulnerabilities and substantiate compliance with billing requirements. The U.S. Department of Health and Human Services (HHS) Office of the Inspector General (OIG) currently has audits related to billing for severe malnutrition, bariatric surgeries, and selected inpatient billing requirements.[8]

MAC can be a great source to help narrow which DRGs to target with internal monitoring. For example, CERT Review Error 32 is DRG Change Due to Wrong Diagnosis or Principal Diagnosis Code. In South Carolina, this includes errors associated with DRGs 292, 870, 056, and 193. The MAC associated with Palmetto GBA in South Carolina also lists their active medical reviews, which currently includes DRGs 470, 885, 291, 292, 682, and 683. To support denial management efforts, the CDI department could monitor these DRGs through second-level review or some other process to validate accuracy. Findings could be used to guide education and promote consistent documentation and coding practices. An internal monitoring program targeting denials management should be continuously updated as new potential improper payment targets arise, but should also periodically monitor performance on past targets to

ensure continued compliance. Identifying potential claims issues can minimize revenue leakage by proactively addressing potential improper payment issues so they can be corrected prior to billing to avoid the cost associated with appealing denials, as well as protecting the reputation and integrity of the healthcare organization.

NOTES

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