Practice Brief: A Summary of the AHIMA CDI and Coding Collaboration in Denials Management Toolkit

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Healthcare insurance payment structures in the United States have processes in place to monitor for appropriate payments to submitted insurance claims. Identifying the data to support an appropriate claim payment can be a complex process, which has an element of subjective judgments from claim reviewers. If a claim is deemed inappropriate, then it may be paid at a reduced amount or denied for payment altogether. It is vital for healthcare organizations to have a process in place to review claim denials and appeal when necessary. This process can be difficult and requires the participation of subject matter experts (SMEs) to accurately prepare a response when appealing a denied claim.

Organizations and denials specialists are now reaching out to industry experts for information to guide them in the appeals process and denials prevention. A workgroup composed of AHIMA volunteers has come together to share their expertise in developing the CDI and Coding Collaboration in Denials Management Toolkit. This toolkit focuses on how coding and clinical documentation improvement (CDI) professionals can collaborate to work on claim denials related to medical necessity, coding, and clinical documentation.

Each insurance plan will have individual policies in place for claim reviews and denials. However, many payers follow some of the same processes that Medicare utilizes. The toolkit evaluates some of the other insurance plans, but mainly focuses on the Medicare denials process. This Practice Brief will examine some of the key topics discussed in the toolkit.

It is important for denials specialists to understand the variety of Medicare reviews and the review contractors who perform these reviews. By understanding what the reviewer is looking for, the organization can better develop compliant processes to avoid potential denials.

Some of the Medicare reviewers include Medicare Administrative Contractors, Recovery Audit Contractors, Comprehensive Error Rate Testing Contractors, Supplemental Medical Review Contractors, Zone Program Integrity Contractors, and Unified Program Integrity Contractors. The duties of these Medicare contractors are discussed in detail within the toolkit. The main purpose of Medicare medical reviews is to confirm that payments are processed for claims that reflect covered services, correctly coded services, and reasonably necessary services.

There are three basic types of Medicare reviews:

- Automated Review: This is a review that utilizes electronic data to detect improper payments.
- Non-Medical Record Review: This type of review includes manual intervention but the determination is based on the information submitted with the claim.
- Medical Record Review (Complex Review): This review is a manual analysis of the health record. The information in this review may come from the information submitted on the claim or from additional documentation requests (ADR).

When a denied claim is received, it is vital for an organization to decide if they agree or disagree with the accuracy of the denial. Some organizations may choose to appeal every denial, but not all organizations have the resources to support that process. Organizations should consider the likelihood of overturning the denial to determine if they can dedicate the manpower needed for the appeal process. A best practice approach is the use of a denials team that includes SMEs in coding, clinical validation, and medical necessity. In addition to including SMEs, there are several steps an organization can take to assist in developing a successful denials management process. These steps include:

- Monitoring of timelines
- Collecting data
- Identifying a potential appeal
- Collaborating with SMEs
- Developing a strong case outline

The information within the health record that is evaluated by the review contractor will vary depending on the reason for the denial. When developing a denials process it is crucial for an organization to have a strong process for collaboration and research. Collaboration includes working in cooperation with other ancillary teams to address relevant issues in appeals. An example mentioned in the toolkit is, "When a malnutrition diagnosis is the reason a claim has been denied, including the nutrition department in the denials team process would be sensible. A pre-approved letter indicating the criteria used by the registered dietician to determine malnutrition could be sent along with the appeal."

Research involves analyzing prior information and helping create historical data and trends from previous appeals. This will help develop a better appeal process as the same targets are noted.

When creating an appeal letter there are several essential components that should be included. The following appeal letter outline, referenced from the toolkit, is an example of these components:

- Patient Identifiers:
    - Name
    - Date of Birth
    - Date(s) of Service
    - Hospital Account Number
    - Insurance information (policy number, group number, claim number)
- Restatement of the reason for denial that was explained in the denial letter
- Include the date of the letter in the heading
- A concise and factual statement explaining why the organization believes the payer decision is inaccurate
- Supporting medical necessity documentation:
    - Synopsis of the history of presenting illness
    - Diagnostic results
    - Clinical findings, including vital signs at time of admit decision
    - Medications and their routes of administration, noting differences from home medication regimens
    - Nursing documentation
    - Additional clinical team member documentation
    - Physician orders (admission level of care)
    - Admission level of care review
    - Level of care criteria screening tool utilized, if any
    - Criteria present at time of admission decision
    - Documentation of unexpected recovery
    - Supporting DRG documentation
        - Physician documentation including specific location within the health record (ED, H&P)
        - Clinical findings related to specific diagnosis
        - Ancillary notes, if warranted (RD, RT)
        - Treatment (medication)
        - Flow sheets (any other documentation that supports the appeal)
        - Corrective information
    - If the denial resulted from an error, provide the correct information. (For example, the denied procedure differs from the procedure performed. This may be the result of a coding error or missed documentation.)
- Compliance or regulatory guidance

    - Reference the Centers for Medicare and Medicaid Services (CMS) Conditions of Participation, American Hospital Association's *Coding Clinic*, Official Guidelines for Coding and Reporting, local coverage rules, hospital policies, etc.
- Requested outcome

The denials team should have a good understanding of the payer's appeal process when appealing a denied claim. The bullet list below, from the toolkit, outlines the Medicare appeals process.

- **First Level of Appeal:** Redetermination made by a Medicare Administrative Contractor (MAC)
    - A redetermination is the first level of appeal after the initial determination on a claim. It is a second look at the claim by MAC staff unassociated with the initial claim determination.
- **Second Level of Appeal:** Reconsideration by a Qualified Independent Contractor (QIC)
    - This is an independent review of the initial determination conducted by a QIC that includes the redetermination and all issues related to payment of the claim. The reconsideration may include review of medical necessity issues by a panel of physicians or other healthcare professionals.
- **Third Level of Appeal:** Hearing by an Administrative Law Judge (ALJ)
    - This level provides the organization with an opportunity—via video teleconference, via telephone, or in person—to present the case to an ALJ, or waive a face-to-face and respond by mail with an appeal letter. The ALJ, under the US Department of Health and Human Services Office of Medicare Hearings and Appeals, is independent of CMS.
- **Fourth Level of Appeal:** (Peer-to-peer) Review by the Medicare Appeals Council
    - If the hospital disagrees with the ALJ decision, or they wish to escalate your appeal because the ALJ ruling timeframe has passed, a request to the Medicare Appeals Council is appropriate. The Medicare Appeals Council can overturn a previous denial in whole or in part based on evidence presented.
- **Fifth Level of Appeal:** Judicial Review in Federal District Court
    - If the organization feels the Medicare Appeals Council decision is not favorable, or wishes to escalate the appeal because the council's ruling timeframe passed, they may request judicial review in a US District Court.

The data obtained from claim denials can be beneficial in identifying educational opportunities and process improvements. This information can assist organizations with decreasing future denials for similar reasons. An example of a process improvement mentioned in the toolkit is utilizing a pre-bill diagnosis or DRG validation process for conditions recognized as being a high risk for denial (also called high risk diagnoses). Educational opportunities may be developed for a specific team, an individual physician, or collectively for the organization's development of clinical processes and guidelines.

It is also important for organizations to circumvent possible overreactions to denials. An overreaction mentioned in the toolkit is "no longer allowing a particular diagnosis to be coded just because it is frequently denied." A more effective approach would be to understand why the diagnosis has become a target—then processes can be created or streamlined to decrease prospective risks for such denials.

Organizations can also use denial data to work with provider service lines to establish clinical evidence guidelines that are usually associated with high-risk diagnoses. CDI and coding professionals can then use these clinical guidelines to identify when clinical validation is required from providers. Clinical validation is the process of validating the clinical evidence within the health record to support each diagnosis and procedure that is documented. Providers can also utilize peer-to-peer alliances between physician liaisons and the medical groups to incorporate the guidelines into provider practices.

CDI and coding programs can assist organizations in preventing denials due to missing or inaccurate documentation. When the health record provides accurate and thorough documentation, the probability of having a condition, treatment, or code denied for reimbursement is lessened. Many inpatient CDI teams perform concurrent reviews of the health record documentation at

the time care is being provided. CDI teams that perform concurrent reviews are invaluable in ensuring accurate health record documentation is in place at the time of discharge.

A query (which may be referred to as a "clarification" in some organizations) is sent by the CDI and/or coding professional when a question arises regarding the health record documentation. The provider reviews the query to determine if further specificity can be brought into the documentation. It is essential that the documentation is specific enough to ensure that the principal diagnosis or procedure, as well as all secondary diagnoses and procedures, is accurately recognized and coded correctly. The documentation should also support the present on admission (POA) status. If it is unclear whether a condition was POA or developed after admission, then a query may be needed.

DRG validation is another process organizations can implement. This is a process that reviews for the correct assignment of all diagnoses and procedures that impact DRG assignment, ensuring that they are coded correctly based on the ICD-10-CM and ICD-10-PCS Official Guidelines for Coding and Reporting.

In order to capture a diagnosis, the condition must meet any combination of these:

- Clinical evaluation
- Therapeutic treatment
- Diagnostic procedures
- Increase nursing care
- Extended length of hospital stay

The CDI and Coding Collaboration in Denials Management Toolkit also provides several appendices with examples of denial codes, appeal letters, query examples, policies and procedures, job descriptions, and interview questions, as well as a pre- and post-hire assessment and documents that are frequently not part of the legal medical record. To access the toolkit, visit www.ahimastore.org. It will also be available in AHIMA's HIM Body of Knowledge at http://bok.ahima.org.

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