Improving Revenue Integrity Through Effective Coding and Denials Management

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OBJECTIVES:

• Understand audit and denial landscape
• Data Mining for Denial Trends
• Improving claim quality and overall revenue integrity
• Best practices for reducing audits and denials
Understand Audit and Denial Landscape

Denials: The Good, The Bad, The Ugly

Most health systems lose between 3 and 5 percent of their net patient revenue as a result of denials. (1)

The cost to denials makes up an estimated 20% of revenue cycle expenses (2).

90% of Denials are preventable when feedback from denials management is implemented with associated departments (3).

References:
1. Modern Healthcare
2. HFMA - Creating a Unified Revenue Cycle
The Payer Audit Environment

• Audits originate with both private payers and government agencies

• Contracts should govern the number of audits

• Audits often lead to denials or adjustments

• Auditors are using data and technology to become more effective

• Do you know what percentage of your audits lead to denials?

Private Payer and Commercial Audits

➢ PRIVATE PAYER AUDITS

✓ Avoid improper payments (over and under payments)

✓ Recoup what they say are improper payments at a (much) later date.

✓ Based on contractual issues

✓ Rules are a bit nebulous (depends on economy)

✓ There is no limit on number of records

✓ Most often based on CMS and Government rules
Types of Audits

• Billing Focus
  • DRG/Coding
  • Charge Capture, line item review
  • Medical necessity
  • 2 Midnight Rule

• Other Health Plan Audits
  • Medicare Advantage Risk Adjustment Validation (RADV)
  • Healthcare Effectiveness Data & Information Set (HEDIS); Quality Measure Set
  • CMS, Quality Improvement Organization
Federal and State Audit Landscape

US Department of Health and Human Services

CMS Center for Medicare and Medicaid

Medicare

Medicaid

RAC (Recovery Audit Contractor)
MAC (Medicare Administrative Contractors)
CERT (Comprehensive Error Rate Testing)
QIO (Quality Improvement Organization)
SMRC (Supplemental Medical Review Contractors)
Medicaid RAC
MIC (Medicaid Integrity Contractors)
PERM (Payment Error Rate Measurement)

Denial causes

Denial causes span the entire revenue cycle, although the largest percentage are associated with front-end processes.

- Registration/Eligibility: 23.9%
- Missing or Invalid Claim Data: 14.6%
- Auth/Pre-Cert: 12.4%
- Medical Documentation Requested: 10.8%
- Service Not Covered: 10.1%
- Other: 9.6%
- Medical Coding: 5.8%
- Medical Necessity: 5.8%
- Untimely Filing: 3.7%
- Appropriateness of Care: 3.4%

Front-End
Front-End/Mid-Cycle
Mid-Cycle
Back-End
WHY FOCUS ON REVENUE INTEGRITY??

If we don’t focus, the government will

REGULATION AND AUDIT EXAMPLES:

• False Claims Act
• Affordable Care Act 2010
• RAC – Recovery Audit Contractor (including Medicaid)
• ZPIC – Zone Program Integrity Contractors
• MIC – Medicaid Integrity Contractor
• MAC – Medicare Administrative Carrier
• CERT – Comprehensive Error Rate Testing
• PERM – Payment Error Rate Measurement
• PSC – Program Safeguard Contractor MIP
• OIG – Office of the Inspector General
• DOJ – Department of Justice

Payer Audit Environment

Increasing audit volumes means more opportunity for denials and adjustment.

Auditors use sophisticated data, technology, and tactics to deny more claims.

What percentage of your audits lead to denials?
Data Mining to look for Denial Trends

Meaningful Data Analytics

• Starts with asking the right questions
  • Communication is key!
  
  • Train communication as personal development
    • Learn to ask payer-specific questions
    • Communicate internally as well as externally (interdepartmental, patients, payers)
    • Employees get better overall the more questions they ask
Structure of Denial Data

• CHALLENGE→ Denials are dumped into denial buckets which then require further root cause analysis.

Can your internal processes or reporting assign denial reasons and root cause descriptor for performance tracking???

✓ Root Cause by Denial- No chance at preventing without root cause. You really do want to identify internal problems.
✓ Denial Rate/ Root Cause by Payer
✓ Overtturn Analysis by Denial and Root Cause
✓ Structuring your denial data is useful for training, contract negotiations, and payer mix decisions.

Better Reporting = Better Development

• Staff Development

✓ Onboarding- Does each team member understand their role in denial management / prevention?

✓ Day-to-Day Claim Management- How is staff performance measured?

✓ Ongoing training- Reimbursement is always changing, as must training. Plan for the who, what, why of ongoing training.

✓ Reports the team can trust and act upon are critical.
Denial Categories by Department-

- Eligibility, Authorization, Pre-Auth, Referral, and Coordination of Benefits
- Medical Necessity- Lack of MN, treatment limitations/caps, wrong setting, type of provider, experimental
- Timely filing and pending information
- Coding, bundling, MUE, payment variations

Improve Claim Quality and Overall Revenue Integrity
Reports your team can use

- Reduce the Noise!
- Measure what matters

“A lot of health systems measure too many things. If you are measuring things that you can’t act on, you may be measuring the wrong things.”

Source: www.healthleadersmedia.com/finance/4-stickiest-revenue-cycle-issues 02/15/2018

BENCHMARKING: Best Practices

Coding Audits
- Performing routine, internal coding audits and monitoring KPIs for coders.
- Performing routine 3rd party coding audits and trending accuracy by coder & physician.
- Providing routine and targeted education for coders and physicians.
- Maintaining a CDI program.

Denial Review
- Examining code changes and denials by coders and physicians.
- Tracking claim denial rates by type of category.
- Cross-referencing claim denials by type or category.

Payer Audit Tracking
- Maintaining a payer audit tracking system.
- Utilizing payer audit tracking system to trend results by DRG, ICD-10, CPT Code and/or physician.
- Comparing coding audits, denials, and payer audits to reveal targeted areas for improvement.
Reports that Teams Can Act Upon

• At your organization, that may mean:
  ➢ Look at KPI performance on top procedure or top payer. These can often drive most denial volumes
  ➢ Consider outside vendor and/or auditor who can provide trending analysis and look at bigger picture
  ➢ Get staff input. What numbers are helpful, what numbers seem falsely manipulated or hard to utilize. You don’t get insight without emphasis encouraging input.

Have an internal coding audit process

Your organization’s coding practices and trends demand serious attention on a regular basis. In fact, the US Health and Human Services Office of Inspector General (OIG) recommends that hospitals, physician practices and other healthcare providers conduct an external review of coding practices at least once a year.

Establish internal audit policy that identifies:
• Frequency of audits (monthly, quarterly, annual)
• Sample size and margin for error (2.5% sample size and 95% accuracy rate)
• Audit focus (random sample, problem focus, coder, provider)
• Post Audit Education
• Corrective Action, when necessary
• Follow-up audits

Focus on proactive compliance to avoid auditor scrutiny and possible financial penalties or denials down the road.
Coding Audits

- How frequently are you performing coding audits?
  - Quarterly
  - Bi-annually
  - Annually

- Are you performing targeted or random audits?
  - Targeted audits - can allow for dedicated focus on specific, problem-prone or high risk areas
  - Random - Recommend at least annually for a baseline audit.

- What are you doing with the results?
  - Transparency and quantifiable results are key!

INTERNAL CODING AUDITS

- IDENTIFY COMPLIANCE RISKS BEFORE EXTERNAL AUDITORS AND PAYERS DO

- Use data analytics to target high risk areas that could fall under audit scrutiny
  - Trended denial data or billing rejections
  - Physicians that bill higher than normal levels of more intensive codes
  - “Established” patient reported as “new” and vice versa
  - Medically Unlikely Edits (MUEs)
  - Once in a lifetime procedures
  - Inpatient hospital DRG cases with only one CC or MCC condition
  - Medical Necessity
  - PEPPER Reports (Program for Evaluating Payment Patterns Electronic) Report
  - Unspecified codes and/or unlisted CPT codes
  - Surgical Procedures requiring documentation

Internal auditing tips:

- Select relevant and appropriate sample size
- Keep tabs and stay abreast of audit trends
  - Know what your RAC and MACs are looking for
    - Inpatient vs. Observation
    - 2 Midnight Rule Compliance
    - Inpatient Only Surgery List
    - Medical Necessity
  - Monitor RAC websites for any new issues that are approved
  - Monitor MAC website, provider manual, and FAQ
- Address copy/paste issues in your EMR to reduce cloned documentation

Best Practice Revenue Integrity = Documentation

The Joint Commission Sentinel Event Alert 54, March 31, 2015 “Safe use of health information technology”
Report on Medicare Compliance, March 24, 2013, “Medicare contractor downcodes claims because of copy and paste in EHRs”

Electronic Health Records
- Documentation integrity
- EHR templates, check off options
- “Cloning” and “auto populate”
- Voice recognition
- Assuming author has proof read, detects and corrects errors
CDI or “Pseudo-CDI” Training

- CDI (Clinical Documentation Improvement) is a great source of information on how clinical actions get translated into documentation which gets translated to billing.

- No organization is too large or too small for a CDI program. Every organization needs clinical expertise on documentation, what to look for, how to correct, audit issues/awareness, diagnosis-specific issues, ability to communicate and relay information to providers.

Clinical Documentation Improvement

- Reduce Cloned Documentation
- Medical Necessity
- Diagnosis Specificity
- Missing or conflicting diagnosis clarity
- E/M Levels
- Modifier Usage
- Missed Charges
Best Practice to Reduce Audits and Denials

Why so much $$$ left on the table??

- Decentralized and Dispersed Accountability
- Informal process around the prioritization of prevention initiatives
- Non-standardized practices to work denials
- Informal status reporting and progress monitoring tools
- Appeals researched and worked by staff with other competing job responsibilities
- Ability to triage denial and distribute to functional area that owns the underlying root-cause process.

Big Picture:
Simply managing denials does not and will not correct the problem. Instead, organizations should invest in time, resources, and technology to prevent denials.
Back to the basics for denial prevention

- Form cross-functional teams
- Formalize processes
- Starts at top
- Accountability that flows throughout organization

Culture of Accountability

Focus on Prevention

Transparent Reporting

Payer Relations

- Aggressive Appeals approach
- Leadership council that provides feedback to payers, managed care, and departments
- Strategy for contract management and negotiations

- Formalized feedback process and tools
- Formalized management of prevention initiatives
- Escalation process for roadblocks
- Centralized status reporting on key prevention initiatives

- Don’t hide from the data
- Ability to track/trend by CARC and RARC codes
- Proactive approach to analytics
- Ability to trend data to easily identify patterns and work prioritization

Proven Process for Denial Prevention

Payer Audits
- Track and trend all audits in one central database

Coding & Documentation Audits
- Perform quarterly coding and documentation audits

Denial Review
- Track and trend all denials via 835 and 837 transaction sets

Education & Improvement
- Target education by using data from: payer audits, coding audits, and denials
Preventing Denials

Questions??????

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