AMERICAN HEALTH INFORMATION MANAGEMENT ASSOCIATION

CDI and Coding Collaboration in Denials Management TOOLKIT

FOCUSING ON FACILITY MEDICAL NECESSITY, CODING, AND CLINICAL DOCUMENTATION

AHIMA
American Health Information Management Association®

CDI and Coding Collaboration in Denials Management

TOOLKIT

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FOREWORD

Insurance claim denials occur across the healthcare spectrum. These denials are a costly occurrence in the healthcare industry. For this reason, it is crucial for organizations to have a process in place to review claim denials and appeal when necessary. Healthcare organizations are looking for tools to guide them through the process of denials management. The appeals process can be challenging and exhausting, and it requires the participation of subject matter experts (SMEs) to effectively prepare a response to a denial.

This toolkit will discuss the appeals process for denials management as well as ways to prevent denials from occurring. The information provided is beneficial for new and experienced denials specialists. The focus of this toolkit will be on claim denials for medical necessity, coding, and clinical documentation. Each payer will have their own policies in place for claim reviews and denials. Many payers follow some of the same processes that Medicare utilizes; for that reason, this toolkit will focus largely on the Medicare denial process.

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INTRODUCTION TO DENIALS MANAGEMENT

To protect the Medicare trust fund, there are several Medicare contractors who perform claim reviews resulting in denials for healthcare providers. These reviewers include the Medicare Administrative Contractors (MACs), Recovery Audit Contractors (RACs), Comprehensive Error Rate Testing (CERT) Contractors, Supplemental Medical Review Contractors (SMRCs), Zone Program Integrity Contractors (ZPICs), and Unified Program Integrity Contractor (UPICs).[1] Since 2008, MACs have been responsible for performing medical reviews of acute Inpatient Prospective Payment System (IPPS) hospital claims. The purpose of medical reviews is to validate that Medicare payments are only made for claims that are for covered services and correctly coded services and reflect reasonably necessary services rendered. Commercial payers also have medical review processes in place to identify claims susceptible to overpayment. Commercial review processes are often proprietary and vary by payer.

TYPES OF REVIEWS

Chapter 3 of the *Medicare Program Integrity Manual* discusses the different types of claim reviews. There are three basic types of reviews:

- Automated review
- Non-medical record review
- Medical record review, also known as "complex" review[2]

Most reviews can be performed by any type of Medicare review contractor on either a prepayment or post-payment schedule.

An automated review includes those reviews where electronic information is used to detect improper payments. These reviews are also referred to as technical denials. Automated reviews often occur when either the wrong information or incomplete information is identified on a claim. One of the primary software tools used by CMS is the Medicare Code Editor (MCE) used to check the accuracy of code assignment prior to grouping. The MCE checks each diagnosis and procedure code against a table of valid codes and identifies claims where an unacceptable code is used as a principal diagnosis. Examples of codes that are unacceptable as principal diagnosis include external cause of injury codes or manifestation codes. The CMS data mining tools will compare the submitted codes against the unacceptable principal diagnosis list because these conditions usually don't provide sufficient justification for an admission.[3,4] Additional issues identified by MCE checks include filters to identify when a code is duplicated as both a principal diagnosis and a secondary diagnosis,[5] and inconsistencies between a patient's age and/or gender and the submitted diagnosis codes.[6]

CMS has also developed the National Correct Coding Initiatives Edits (NCCI), which are non-complex reviews that can be performed by any type of Medicare reviewer. The NCCI promotes national correct coding methods and seeks to identify improper coding that can lead to improper payments. Accurate assignment of modifiers can prevent these types of denials. The coding policies are based on the following conventions:[7]

- American Medical Association Current Procedural Terminology (CPT) Manual
- National and local Medicare policies and edits
- Coding guidelines developed by national societies, standard medical and surgical practice, and current coding practice

Non-medical record reviews are a newer process compared to automated reviews and medical record reviews. This review process includes manual intervention, but the determination is based only on the information included in the claim. These are only performed for denials of related claims and/or when additional documents are not submitted in response to an additional documentation request (ADR). An ADR occurs when additional documentation is needed to ensure appropriate payment. The additional documentation needed will be listed in the request (e.g., discharge summary, plan of care updates, initial assessments and visits for services, etc.).

Complex reviews require a manual review of the health record. The Medicare contractors can review any information necessary to make a determination including documents submitted with the claim and any other documentation subsequently submitted as requested. They will review the Official Guidelines for Coding and Reporting,

AHA *Coding Clinic*® advice, Medicare Program Manuals, and other federal and local regulatory guidelines to ensure the claims are accurately reported. Reviewers can also consider billing history or other information obtained from the Common Working File to validate the discharge disposition reported on the claim, the outcome assessment and information set (OASIS), or the minimum data set (MDS). The reviewer considers all health record entries made by physicians and licensed/certified medical professionals in any format, (i.e., hard copy or electronic). CMS does not prohibit the use of templates to facilitate record keeping and does not endorse or approve any particular templates. However, CMS discourages the use of templates that provide limited options (check boxes and predefined answers) and/or limited space. Claim review experience shows that limited space templates often fail to reflect sufficient, detailed clinical information necessary to demonstrate all coverage and coding requirements are met. It is very important for an organization to have a robust tracking process for ADRs, because failure to submit requested documents is a primary reason for denials. It is important for the person submitting the ADR documents to validate that all the documents that justify the claim have been submitted.

An ADR can be linked to unique documentation requirements for the services provided and may require the submission of records outside of the traditional record request. Organizations often differentiate between the patient's legal health record and the business record. Much of the time, only the legal health record is released with document requests. Organizations should verify if queries are part of the legal health record or part of the business record. Medicare will accept queries to support submitted claims. Other payers may or may not accept queries to justify reported codes.[8]

See Appendix H for a list of documents that are frequently not part of the legal health record.

MEDICARE REVIEW CONTRACTORS

Contrary to popular belief, Medicare contractors cannot randomly choose payment targets. The only Medicare contractor who can obtain random samples of Medicare claims is the contractor for the CERT Program. It is the role of a CERT auditor to monitor the accuracy of MAC payments in accordance with coverage, coding, and medical necessity guidelines.[9] CERT findings are the road map for future audits by all types of Medicare auditors, including MACs and recovery auditors. CERT reports are public data. It is beneficial for organizations to be familiar with their findings and implement internal auditing and monitoring processes to avoid submitting claims with the identified issues.

According to the Medicare Learning Network, CERT has the following error categories:

TYPE	DESCRIPTION
No Documentation	Provider or supplier fails to respond to repeated requests for the medical records or they do not have the requested documentation.
Insufficient Documentation	Submitted medical documentation is inadequate to support payment for the services billed; the CERT contractor reviewers could not conclude that the billed services were actually provided, were provided at the level billed, and/or were medically necessary; or a specific documentation element that is required as a condition of payment is missing (for example, a physician signature on an order)
Medical Necessity	There is adequate documentation in the medical records to make the informed decision tht the service billed were not medically necessary based upon Medicare coverage and payment policies.
Incorrect Coding	Provider or supplier submits medical documentation supporting: • A different code than was billed • The service was performed by someone other than the billing provider or supplier • The billed service was unbundled • A beneficiary was discharged to a site other than the one coded on the claim
Other	When a claim error does not fit in any other category (for example, duplicate payment error, non-covered, or unallowable service).

Source: Medicare Learning Network, "Medicare Claim Review Programs." September 2016.

Although the MACs have more latitude when conducting medical reviews, organizations are typically more concerned with the RACs. The RACs are responsible for reviewing claims where improper payments frequently occur or where there is a high probability that improper payments will be made. Improper payments are often the result of billing for non-covered services, including those that are not reasonable and necessary, billing for incorrectly coded services including prospective payment systems (PPS), billing duplicate services, and billing incorrect payment amounts.

Historically, the RACS conducted coding validations, medical necessity reviews, and clinical validation reviews in both the inpatient and outpatient setting. The RACs, like other Medicare review contractors, must adhere to a scope of work approved by CMS. For example, the RACs must employ certified coders with at least five years of experience to perform coding reviews/DRG validation. Registered nurses are employed to perform medical necessity reviews and clinical validation reviews. However, since 2014 the quality improvement organizations are now responsible for medical necessity reviews, which include validation of patient status. Correct assignment of patient status as an inpatient or an outpatient is necessary for accurate payment, since different reimbursement methodologies are used for Medicare Part A (reimburses inpatient care) and Medicare Part B (reimburses both facility and professional outpatient care).

SMRCs are Medicare contractors that support several tasks that focus on decreasing improper payments and increasing the proficiencies of the medical review process. Their reviews may be performed on Medicare Part A and B and durable medical equipment (DME) providers. Their review may include liabilities identified by CMS's CERT program, internal databases, professional organization, and federal oversight agencies; however, they are not limited to these liabilities.[10]

The goal of ZPIC and UPIC is to recognize cases of suspected fraud and to then perform an investigation to recoup inappropriate Medicare payments. The actions utilized by UPIC and ZPIC to detect and deter fraud could include:[11]

- Investigations
- Interviews
- Medical reviews
- Data analysis
- Administrative actions (e.g., payment suspension, auto-denial edits)
- Refer cases to law enforcement

MEDICAL NECESSITY REVIEWS

The *Medicare Program Integrity Manual* (Chapter Six) discusses the requirements associated with medical review for determining medical necessity, referred to by CMS as "patient status reviews." These reviews are performed by a licensed medical professional (e.g., RN, LPN, PA, MD, etc.) who applies clinical review judgment to evaluate the health record documentation. A clinical review judgment involves both the synthesis of all the submitted health record information to create a longitudinal clinical picture of the patient and the application of this clinical picture to the review criteria such as any relevant policies, such as national coverage determinations. CMS requires reviewers to use screening tools as part of the medical review process; contrary to popular belief, it does not require specific criteria sets. Information used to decide includes:

- Admission criteria
- Invasive procedure criteria
- CMS inpatient-only procedures
- CMS coverage guidelines
- Published CMS criteria
- DRG validation guidelines
- Coding guidelines
- Other criteria such as practice guidelines that are widely accepted by the medical community

When performing patient status reviews, the two-midnight presumption and benchmark should be considered to identify claims not suitable for payment under Medicare Part A. Medicare contractors should presume hospital stays spanning two or more midnights after the beneficiary is formally admitted as an inpatient are reasonable and necessary for Part A payment. Based on the two-midnight benchmark, inpatient admissions are generally payable under Medicare Part A if the admitting practitioner expects the beneficiary to require hospital care spanning two or more midnights and such reasonable expectation is supported by the health record documentation. Documentation that supports the provider's judgment includes documentation of the beneficiary's history and comorbidities, the severity of the patient's signs and symptoms, the current medical needs of the patient, and the risk of an adverse event. Diagnosis sequencing can impact the likelihood of claim selection for validation. Remember, the ICD-10-CM Official Guidelines for Coding and Reporting require the principal diagnosis to be the condition after study that occasioned the admission. Patients often have multiple conditions that are present on admission (POA), but many are co-morbidities and do not demonstrate the need for an inpatient level of care. Other conditions that are POA may require inpatient service and meet secondary diagnoses guidelines but do not require the level of treatment to be sequenced as the principal diagnosis.

DIAGNOSIS-RELATED GROUP (DRG) VALIDATION REVIEWS

DRGs are the classification system used for the IPPS. DRG validations include a review to determine if the appropriate DRG has been assigned based upon the supplied clinical documentation and ICD-10-CM/PCS code assignment. The Medicare Severity-DRG (MS-DRG) system is the severity structure utilized by CMS to represent the appropriate acuity level of the patient and the resources that were utilized. The relative weight of each MS-DRG can change when conditions that are recognized as Complications and Comorbidities (CCs) or Major Complications and Comorbidities (MCCs) are coded on a claim.

Medicare contractors will perform DRG validation to ensure the diagnostic, procedural, and discharge information has been assigned appropriately. In this process the reviewer will assess that the appropriate principal diagnosis and relevant secondary diagnoses are on the claim. They evaluate all procedures that affect the DRG assignment and validate they were reasonable and medically necessary.[12]

This table displays the types of reviews performed by the Medicare contractors.

	PREPAYMENT			POSTPAYMENT	
Contractor Type	Medical Record Review	Non-Medical Record Review	Automated Reviews	Medical Record Review	Non-Medical Record review
MACs	Yes	Yes	Yes	Yes	Yes
CERT	No	No	No	Yes	No
RACs	No	No	No	Yes	No
SMRC	No	No	No	Yes	Yes
ZPIC/UPIC	Yes	No	No	Yes	Yes

Source: CMS. Medicare Program Integrity Manual, Chapter 3, "Verifying Potential Errors and Taking Corrective Actions," Rev. 755, 11-09 17, pp. 27-28.

BUILDING A CASE FOR A POSSIBLE APPEAL

When a denied claim is received, it is crucial to determine the accuracy of the denial. In other words, does the organization agree with the auditor's findings or not? Although many organizations choose to appeal every denial, not all organizations have the resources to do so. Some organizations must also consider the likelihood of overturning the denial and determine if the financial loss is enough to offset the manpower associated with the appeal process. A recent article in *Modern Healthcare* found payers initially deny about 9 percent of hospital claims.[13] Additionally, the article estimates hospitals ultimately receive payments for about 65 percent of denied claims, but it costs an average of $118 per claim to obtain recoupment.

A best practice approach is the use of a denials team where coding, clinical validation, and medical necessity denials are reviewed by those with expertise in documentation, patient status assignment, and coding, since some medical necessity denials can be the result of code sequencing. Historically, a claim could initially be denied on the basis of code assignment and then be denied for medical necessity; however, changes in the most current RAC contract prevents this practice so all issues with a claim are submitted at one time. Consequently, a multidisciplinary approach is needed when addressing denials.

The members of a denial management team can vary by organization and may include denials specialists, case managers, quality and compliance specialists, clinical documentation improvement (CDI) professionals, physician advisors, and HIM coding and record management professionals. Members of the denial team should understand what each payer requires to initiate the appeal process as well as how the appeal process is structured i.e., time frames, types of appeals, what documents can be submitted, etc. Another important piece of information is the insurer's policy on denials. This can help guide review of the health record to validate the denial. Several steps can be taken when reviewing the validity of the denial. These include data collection, identification of a potential appeal, collaboration with a subject matter expert, and development of a strong case outline. If the denial is validated, then the organization would submit the requested repayment of the denied funds when necessary.

The Medicare Learning Network indicates what Medicare ADR letters should include:

- Reason your claim was selected
- What actions you need to take
- When you need to reply
- Consequences of not replying
- Instructions for replying
- Contractor contact information[14]

An organization can take several steps to develop a successful denials management process. These include monitoring timelines, collecting data, identify a potential appeal, collaborating with subject matter experts (SMEs), and developing a strong case outline.

MONITORING TIMELINES

Complying with deadlines sounds simple enough, but many organizations fail to submit required documentation in a timely manner, thus allowing the denial to stand. The timing of several events must be monitored, including when the denial was issued, when the notice of denial was received, and when the notice of appeal must be received by the payer. Unfortunately, if an organization does not have a robust process for identifying and processing a denial, they can sit in someone's inbox and important deadlines can be missed. When receiving a denial, take note of the deadline to appeal, this will provide guidance in the denials process timeline. Appeal letters have guidelines and standards regarding the timeline. The process in receiving and replying to appeals in a timely fashion is critical:

- Responses to denials are usually mandated by the sender and must be received by the payer within a 30- to 90-day period. For example, providers must submit health records to MACs and RACs within 45 calendar days of the request
- Each organization should be aware of the contract language for individual payers
- It is important to consider the date the letter was written and not the date the letter was received as the timeframe to count for the 30, 45, or 90-day period
- Potential mailing delays and the impact of non-business days must also be factored into the timeline. Deadlines reflect the date when the letter must be received by the payer. Letters received after the deadline are typically not processed by the payer

It is often helpful for organizations to employ a denial tracking database or a log to enter when appeal letters are received, dated, and returned, since it is possible for there to be multiple levels of appeal, each with different time frames. This log can assist with prioritization. The log should also capture the final disposition of each denied claim to be tracked as well as the financial impact of the claim. Often organizations fail to adjust their case mix index so it reflects paid claims rather than billed claims, which can cause an overestimation of future revenue.

DATA COLLECTION

When reviewing denials, the entire health record should be reviewed. For an inpatient admission, the review should begin with the emergency department (ED) documentation when applicable. The ED notes can provide valuable information to support the reason for admission including the principal diagnosis. An astute CDI or coding professional should be able to distinguish between conditions that resolved during the ED visit that would not be applicable to report as the principal diagnoses, but may be valid secondary diagnoses. ED documentation can also support POA assignments, as often only symptoms are present during the ED visit with a definitive diagnosis occurring during the admission. It is very important that those performing denials reviews can connect the dots between the patient's presentation and the reported diagnoses. ED documentation frequently results in queries. Validation queries may be necessary to ensure documentation in the record accurately reflects which diagnoses, if any, are ruled out during the admission, as well as which diagnoses remained during the admission, even if the condition was not carried through the health record.

The next step includes evaluating the history and physical (H&P) and the timing of the inpatient admission order to verify if there is a consistent theme between the ED documentation and H&P documentation. The documentation within these notes supports the principal diagnosis as POA which drives the Diagnosis Related Group (DRG) assignment. In instances when a patient is initially admitted to observation status and then advances to inpatient status, validate that the principal diagnosis is reflective of the reason for inpatient status. This diagnosis may be the same or differ from the reason for observation status. The next step is to review the progress note's documentation. Progress notes should continue to demonstrate consistency in the conditions diagnosed and the care plan implemented to support the principal diagnosis and secondary diagnoses codes reported on the claim. Documentation within ancillary notes and consulting notes should be reviewed for consistency with the attending provider's representation of the episode of care. On occasion you may have to search nursing notes to confirm findings that can be coded from other qualified providers, such as BMI and stages of pressure ulcers. The discharge summary will also need to be reviewed and should be consistent with all the other health record documentation and follow the Joint Commission established standard requirements.[15] These requirements include:

- The reason for the hospitalization
- Significant findings
- The procedures and treatments that were provided
- The patient's discharge conditions
- Instructions for the patient and family
- Attending physician signature

IDENTIFY IF A POTENTIAL APPEAL IS INDICATED

After reviewing the health record, the denials specialist will evaluate the collected data to determine how well it supports the reason for denial. The reviewer should be able to easily identify the admitting diagnosis, admitting orders, medications, clinical indicators, documentation, and treatments that support the reason for the appeal. It is also important to assess any lab findings, tests, biopsies, cultures, radiology reports, and procedures that were provided to support an appeal. If the data collected appears to support appealing the denial, the next step is to determine if subject matter experts (SMEs) are needed as a second-level review to provide additional clinical support or coding guidelines verification.

COLLABORATE WITH SUBJECT MATTER EXPERTS (SMES)

The SMEs will vary by organization and scenario. The process may include the attending physician or a physician specialist. If a physician specialist is brought in, they should have expertise in the condition that has been denied. Some examples of physician specialists include pulmonologists, cardiologists, nephrologists, neurologists, and surgeons. Other SMEs may include professionals that work in case management, CDI, quality, compliance, and HIM departments. When reaching out to a SME it is important to recognize their time constraints to determine if their schedule will allow them time to review the denial before the appeal due date. The SME provides a written letter/documentation from the record addressing the clinical judgment reflected in the case that clearly supports medical necessity, DRG validation, and/or of services rendered. Other documents of which reviewers should be aware of include articles from peer-reviewed clinical journals that support the case and illustrate best practice. Remember to include any internal policies that support the clinical or coding criteria.

It is beneficial to have a policy and procedure in place that recognizes the SMEs that will be involved in the denials process and the expected turnaround times for a denials review. Detailed policies and procedures can provide guidance to all the professionals who are involved in the denials process.

DEVELOP A STRONG CASE OUTLINE

After data collection is complete and the denials team has identified a need for an appeal, it is time to create an outline that lists the evidence and documentation that supports the denied diagnosis or procedure. This outline will provide the framework to construct an appeal letter.

CREATING A CONCRETE APPEAL LETTER

A well-thought-out written appeal letter is the key to overturning a payer denial. After the preliminary information has been gathered and a basic understanding of the illness and the insurance policy have been identified, the appeal process can begin. The appeal letter should only include pertinent information. Each patient and denial is unique; thus, it is recommended that the original denial letter be reviewed and that important details that should be included in the appeal letter are identified.

RESOURCES

The information reviewed within the health record will vary depending on the reason for the denial. There are valuable resources to help the denials specialist gain insight when creating a solid appeal:

- **Collaboration:** Collaboration includes working with other ancillary teams to address relevant issues in appeals. For example, 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:** Research involves utilizing previous information and to help create historical information and trends in appeals. The log of appeals can document DRG changes that appear consistently. This will help build a better appeal as the same DRG targets are noted.

SAMPLE APPEAL LETTER TEMPLATE

- 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 CMS Conditions of Participation, AHA *Coding Clinic*®, Official Guidelines for Coding and Reporting, local coverage rules, hospital policies, etc.
- Requested outcome
  - Typically, you are asking the insurer to overturn the denial and approve payment of the claim.

All content should be placed together in a "packet" and submitted to the denial issuer by registered mail or some other form that allows the ability to track the delivery date and identify who signed for it. This will alleviate the excuse that the information was "never received." A duplicate copy of all submitted information should be kept on file for future reference. If necessary, you can call and confirm receipt of the packet. Please see Appendix A to view some sample appeal letters.

MEDICARE APPEAL PROCESS

The Medicare appeal process consists of five different levels, outlined below.

FIRST LEVEL OF APPEAL

Redetermination made by a Medicare Administrative Contractor (MAC)

A redetermination is the first level of appeal after the initial determination of 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 which 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 (VTC), telephone, or occasionally 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 Department of Health & 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 wants to escalate your appeal because the ALJ ruling timeframe has passed, a request to the Medicare Appeals Council is appropriate. The Appeals Council based on evidence presented, can overturn a previous denial in whole or in part.

FIFTH LEVEL OF APPEAL

Judicial Review in Federal District Court

If the organization feels the Appeals Council decision is not favorable or wishes to escalate your appeal because the Appeals Council ruling time frame passed, they may request judicial review in a US District Court.[16]

OTHER PAYERS

It is important to understand that other payers will have different procedures that guide their denials process. For example, Medicaid appeals processes will vary by state. It is important for organizations to review each applicable state's Medicaid procedure to understand their appeals processes and timelines. Medicaid Integrity Contractors are engaged by CMS to review and audit Medicaid claims to identify overpayments and provide education on program integrity issues.

It is also vital for organizations to review each commercial payer contract, as these will vary according to the commercial payer. Managed care and fee-for-service plans are other examples that can have variations in the appeals processes. When organizations take the time to review and understand each payer's contract and appeals process, it will help them be more prepared for any denial that may come through. Larger organizations may decide to have each member of the denial team specialize by payer to promote familiarity with the specifics of each payer.

TRACKING AND TRENDING DENIALS DATA

There are several benefits that can be obtained when organizations track their denied claims. Examples of information frequently tracked include:

- The reason for the denial
- Denied principal diagnoses
- Denied impactful secondary diagnoses
- Denied procedures
- Revised MS-DRG (CC/MCC)
- Revised APR-DRG (SOI/ROM)
- Payer trends
- Physician, coding professional, or CDI professional associated with the denied claim
- Level of care change
- Diagnosis inconsistent with procedure

Trending this information can be used to identify educational opportunities and process improvements to mitigate future similar denials. An example of a process improvement might be a pre-bill diagnosis or DRG validation process for conditions identified as being a high risk for denial. Educational opportunities may be identified for a specific team, a specific physician, or may be universal to the organization in the development of clinical guidelines. It is important for organizations to avoid overreacting to denials, such as no longer allowing a particular diagnosis to be coded just because it is frequently denied. A better approach is to try to understand why the diagnosis is targeted so efforts can be made to reduce future vulnerability.

ESTABLISH CLINICAL GUIDELINES

Organizations can work with physician service lines to establish clinical guidelines outlining the clinical evidence necessary to support high-risk diagnoses. CDI and coding professionals would use these clinical guidelines to consistently identify a potential missed diagnosis as well as when clinical validation is required. Providers can utilize peer-to-peer collaboration between physician liaisons and the medical director(s) to present the guidelines and incorporate them into physician practice.

EXAMPLES OF HIGH-RISK DIAGNOSES

- **Acute Kidney Failure/Injury:** Policies should include what clinical criteria the facility used to determine AKI. It would be beneficial to have a nephrologist involved in this process to confirm the information.
- **Debridement:** It is important for the documentation to reflect if a debridement was excisional (root operation—excision) or non-excisional (root operation—extraction). Policies should include the clinical evidence used to support a debridement being excisional or non-excisional. Facilities may want to have a template in the electronic record with drop-downs for excisional or non-excisional.
- **Respiratory Failure (Acute/Post-Operative):** It is crucial to include information regarding post-operative conditions for those patients who remain on the ventilator post-op for a reason other than actual failure. Work with the pulmonary and/or intensive care physicians for acceptance of the information. Have a coding policy indicating how many days after extubation supports post-op respiratory failure.
- **Sepsis:** Organizations may work with infectious disease physicians, intensive care physicians, and general medicine to identify the criteria that are used in practice to adopt a consistent practice and diagnosis of sepsis. Often providers are unaware of coding requirements regarding sepsis, so it is important that any criteria consider the Official Guidelines for Coding and Reporting.
- **Malnutrition:** This is a diagnosis that is reviewed closely by auditors to ensure there is clinical evidence to support the condition and the treatment supports the severity of the condition.
- **Encephalopathy:** A consensus among a variety of physician specialties will be necessary to establish criteria because encephalopathy can present in a variety of ways and may be associated with many different underlying conditions. Key elements of this definition should be differentiating it from delirium and dementia.

PROCESS IMPROVEMENT EDUCATION

It is beneficial to set up educational opportunities, both formal and informal, to share the information with all the providers and applicable staff regarding denials. If the organization has a CDI program there are many opportunities for provider education on a daily basis, such as when the attending is discharging a patient or during patient care rounds. Other educational opportunities include scheduling a provider lunch and learn, requesting permission to present the information at various service line monthly practice meetings, or scheduling a quick time (approximately 5 to 10 minutes) to review the information at the provider offices. Be sure that all staff involved in the coding process is educated on the denial findings. A process should be in place to address any individual physician opportunities.

Collaboration between the CDI program and the denials management team is key in identifying common denial trends and developing an education action plan. This should occur through scheduled joint meetings, at least quarterly, with the purpose of determining topics for documentation improvement. Once topics are identified, be creative and innovative with how the education will be delivered while setting expectations for best practice at all levels of care. Once accomplished, the results should be increased physician engagement and decreased denials.

TRAINING AND HIRING APPEALS STAFF

When hiring appeals staff, there are several areas of healthcare experience that may be considered for these roles. These may include nursing, HIM, quality, compliance, utilization review, and administration. It is always advantageous if the candidate has experience working in denials management and writing appeal letters. The following professional traits are found to be beneficial and increase the likelihood of success as an appeals team member:

- Dependability
- Problem solving
- Attention to details
- Organizational skills
- Good time management
- Good oral and written communication

It is crucial to have a detailed orientation plan, so new denials management team members are trained for a successful transition into their role. It is also important to determine if new members who have previous denials experience, worked with processes that fall in line with the current organizational expectations. When differences in practice are identified, the variation should be explained during orientation, to ensure adherence to the correct processes. Experienced denials staff should be available to answer questions from new staff members as they arise. Additionally, clear policies and procedures need to be in place and reviewed with new staff.

Cross-training between professionals may be required to support the interdisciplinary team environment. Since there are many departments within an organization that are impacted by denials it is beneficial for everyone to understand each role and associated scope of work. Open communication between departments is necessary to prevent duplication of work efforts while focusing on a shared goal.

See Appendix E for interview questions and Appendices F and G for a possible pre-hire and post-hire assessment.

DENIALS PREVENTION

CDI PROGRAMS

Organizations may utilize CDI programs to assist in denials prevention due to missing or inaccurate documentation, including clinical validation of reported diagnoses. When the health record provides clear documentation the likelihood of having a condition, treatment, or code denied for reimbursement is decreased. Having CDI professionals perform concurrent reviews can be critical to facilitating complete, consistent, and accurate health records.

CMS can review the health record documentation to apply value based purchasing guidelines. There are specific conditions, treatments, and outcomes that are supported by the information provided to scientifically support precise treatment for the desired outcomes. Medicare Severity (MS)-DRGs were designed for the Medicare population only; higher-complexity DRGs (those with co-morbid conditions) are formed based on resource intensity and do not address severity of illness nor risk of mortality.[17]

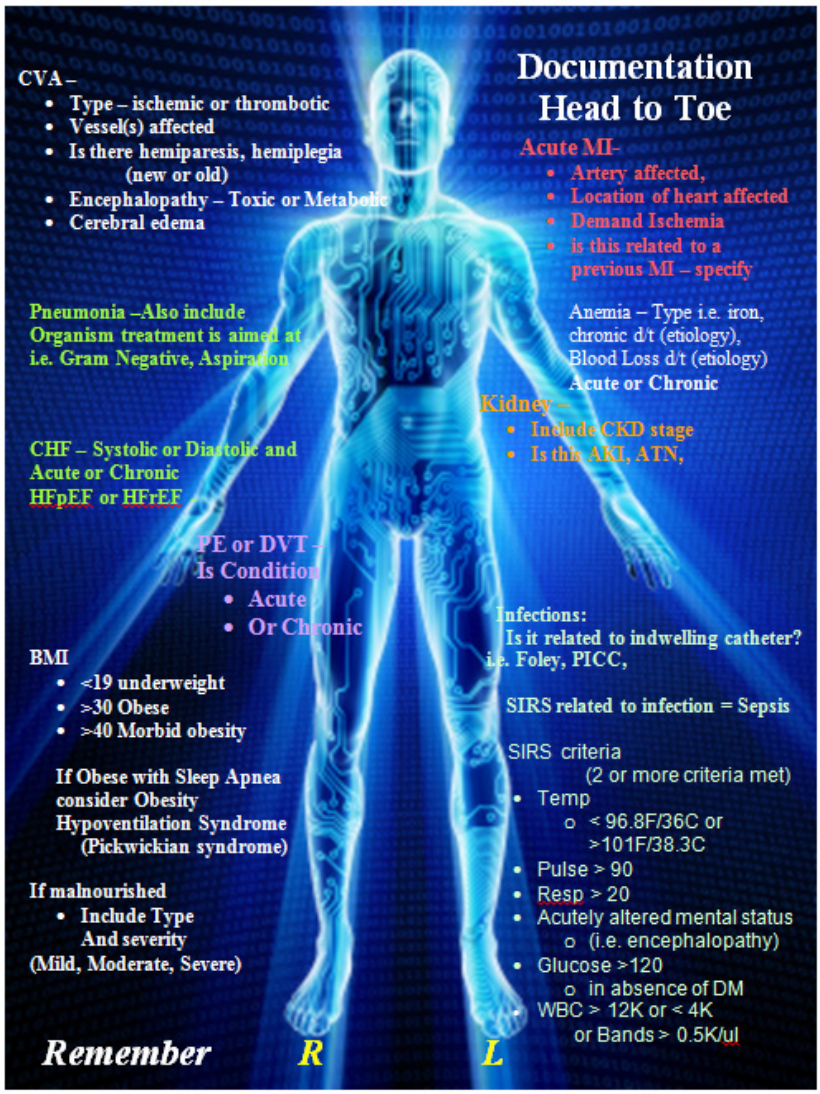
The 3M All Patient Refined (APR)-DRG system is based on a clinical rather than a statistical model. This model uses a four-point scale to identify severity of illness (SOI) and risk of mortality (ROM) scores. The underlying clinical principle of APR-DRGs is that the SOI and ROM of a patient depend to a great extent on the patient's underlying conditions. The presence of multiple co-morbid conditions in combination increases the severity of illness of a patient which reflects the increased difficulty and costs involved in treating the patient. Documentation and coding must be done for all diagnoses and procedures, not just to the point of full reimbursement.[18] If the code is not assigned to the highest level of specificity, there is a chance it may not be properly captured, thus reducing the number of conditions a patient has, and creating a different picture of the patient's illness. Complete and accurate coding not only equals full reimbursement, it is also a strong foundation for quality measurement.

Healthcare is ever-changing, and the CDI professional is essential to validate that complete, compliant, and accurate documentation exists within the health record. One key element of CDI success is performing concurrent reviews; this allows documentation to be updated at the time of care. There is movement toward expanding CDI programs to include reviews of outpatient and emergency departments due to denials for outpatient services. CDI can be the first line of defense against denials that are issued for lack of medical necessity by confirming the clinical documentation for the patient's diagnosis, treatment, and the level of care that exists in the health record.

TIP SHEETS

CDI programs may create tip sheets as a quick reference pocket card and/or place them on the intranet at the organization for easy access for the physician. Some facilities have developed reference information that can be clipped to a name badge for quick reference. It is important to create tip sheets that are appropriate for the provider's specialty area. For example, a CDI tip sheet for a nephrologist should be focused on documentation needed for that specialty such as acute renal failure and chronic kidney disease.

Example head to toe information



This is an example of a tip sheet graphic used by permission from Therese Peyton, one of the authors of this toolkit. This graphic is used by her CDI team as a tip sheet that is updated on a regular schedule.

COMPLIANT QUERIES

When a question arises within the documentation, a query (which may be referred to as a clarification in some organizations) is used to clarify ambiguity. The AHIMA practice brief "Guidelines for Achieving a Compliant Query Practice" explains that the generation of a query should be considered when the health record documentation reflects one of the following:

- Is conflicting, imprecise, incomplete, illegible, ambiguous, or inconsistent
- Describes or is associated with clinical indicators without a definitive relationship to an underlying diagnosis
- Includes clinical indicators, diagnostic evaluation, and/or treatment not related to a specific condition or procedure
- Provides a diagnosis without underlying clinical validation
- Is unclear for present on admission indicator assignment[19]

Coding and CDI professionals, regardless of their professional experience and credentials, must follow the guidance within this practice brief when writing queries. Those performing clinical validation reviews should also adhere to the guidance within the AHIMA practice brief "Clinical Validation: The Next Level of CDI."

DRG VALIDATION

During DRG validation, the focus is on the correct assignment of the principal diagnosis, any procedure, and reportable secondary diagnoses that impact DRG assignment based on the ICD-10-CM and ICD-10-PCS Official Guidelines for Coding and Reporting.

For example, if a patient presents with hypertension (HTN) and heart failure and the renal labs are reported consistently with a GFR of 30–60, this supports the need for a query for the stage of chronic kidney disease (CKD) as well as the acuity and type of heart failure. If there is no mention in the record of CKD, a query can be placed asking for a diagnosis associated with these findings. The resulting impact could result in a final coding of heart failure with a MCC if the type of heart failure is provided and the acuity level is acute (the combination code for HTN and CKD with the acute heart failure now captured as an MCC), which would increase the relative weight, length of stay, and risk of mortality.

Accurate principal diagnosis assignment is vital for several reasons. The principal diagnosis establishes the base DRG assignment, influences the medical necessity of patient status determinations, and is also the basis of cohort selection for many quality measures. There are many examples where denials occur due to the reported principal diagnosis not being substantiated.

SPECIFICITY

The accurate reporting of co-morbid conditions impacts the severity of illness of a patient and validates the intensity of services. Documentation must support coding specificity for all diagnoses and procedures, not just to the point of full reimbursement. The level of specificity should be reviewed regardless of the impact on reimbursement. Specificity can impact principal and secondary diagnosis assignment, which can then result in the appropriate reimbursement, accurate quality scores, and decrease the risk for claim denials. For example, when a patient is admitted with a stroke, diagnosed with pneumonia, and failed a swallow study, a query is usually needed to determine pneumonia specificity, (e.g., clarifying if it's an aspiration pneumonia).

PRESENT ON ADMISSION

It is critical to ensure the principal diagnosis is correctly identified and coded appropriately. Coding professionals should ensure the documentation of signs/symptoms, clinical criteria or specific diagnosis support POA or a query should be posed. If a patient presents with vague symptoms and lab findings with one diagnosis suspected but another is subsequently confirmed after three days of diagnostic testing, the CDI professional should consider sending a query to the physician to clarify the onset of the condition, (i.e., was it POA or did it develop during the admission?). It is important to note that there is a difference between conditions that occur while the patient is receiving hospital care and those that occur during an admission. Conditions that occur in the ED or during observation services are considered present on admission, even though they may have occurred during the same hospital visit.

CLINICAL VALIDATION

The role of a CDI and coding professional is to verify that the clinical evidence within the health record supports the diagnosis reporting for accurate code assignment and claims processing. For example, if there is a positive urinalysis and culture and the patient is receiving antibiotics, the CDI and coding professional cannot "assume" a UTI and include the code. It is outside the CDI or coding professional's scope of practice to establish a diagnosis even if they have a medical background. It is not appropriate for a CDI or coding professional to enter a diagnosis into the health record. A CDI or coding professional's role is to work in the fine details of clinical information and help the provider document their findings in language that accurately reflect the clinical scenario into coded data. The role of coding validation is to ensure that the principal/first listed diagnosis and secondary diagnoses and procedures are coded appropriately.

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 *Medicare Quarterly Provider Compliance Newsletter* offered the following guidance on how to avoid these problems: "The condition chiefly responsible for a patient's admission to the hospital should be sequenced as the principal diagnosis, and the other diagnoses identified should represent all CC/MCC present during the admission that affect the stay. Code only those conditions documented by the physician. Refer to the *Coding Clinic* guidelines and query the physician when clinical validation is required. Inquire about conflicting documentation."[20] The goal of clinical validation is ensuring that "the health record is not only coded accurately, but also accurately reflects the clinical scenario within the health record."[21]

Regarding diagnoses that are most vulnerable to clinical validation denials (e.g., acute respiratory failure, encephalopathy, sepsis, and severe protein-calorie malnutrition), supportive documentation from multiple members of the healthcare team should be present. It is important to note that supportive documentation is not necessarily the same as the diagnosis being documented throughout the health record; rather, the documentation should support that the diagnosis under review complies with appropriate, established clinical criteria. Regardless of whether an organization includes clinical validation as part of routine CDI review or considers it a special function performed in conjunction with DRG validation, the focus is the same: ensuring documented conditions are supported by the totality of the health record. Clinical validation and the role of the CDI professional team, including providers and clinicians, should be in evidence—or, at the very least, the documentation should not cast doubt on the validity of the documented diagnosis.

To minimize clinical variations of care, providers should base decisions around diagnosis definitions grounded in evidence-based medicine and the respective discipline's recommendations. Organizations may work with their physician leaders to develop best practice guidelines for providers to follow when diagnosing conditions.

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DENIALS MANAGEMENT GLOSSARY

(adapted from the *AHIMA Pocket Glossary of Health Information Management and Technology*, fifth edition. Chicago, IL: AHIMA Press, 2017.)

A

Addendum: A late entry added to a health record to provide additional information in conjunction with a previous entry. The late entry should be timely and bear the current date and reason for the additional information being added to the health record

Additional documentation request (ADRs): A request made for additional documents to be submitted for review to validate appropriate claim payments

Admitting diagnosis: A provisional description of the reason why a patient requires care in an inpatient hospital setting

All patient refined diagnosis-related groups (APR-DRGs): An expansion of the inpatient classification system that includes four distinct subclasses (minor, moderate, major, and extreme) based on the severity of the patient's illness

Amendment: Alteration of health information by modification, correction, addition, or deletion

Appeal letter: A formal letter written to appeal a denied health care claim

B

Best practice: professional procedures that are accepted as being correct or the most effective process

C

Case management: 1. The ongoing, concurrent review performed by clinical professionals to ensure the necessity and effectiveness of the clinical services being provided to a patient 2. A process that integrates and coordinates patient care over time and across multiple sites and providers, especially in complex and high-cost cases, with goals of continuity of care, cost-effectiveness, quality, and appropriate utilization 3. The process of developing a specific care plan for a patient that serves as a communication tool to improve quality of care and reduce cost

Centers for Medicare and Medicaid Services (CMS): The division of the Department of Health and Human Services that is responsible for developing healthcare policy in the United States and for administering the Medicare program and the federal portion of the Medicaid program and maintaining the procedure portion of the International Classification of Diseases, 10th revision, Clinical Modification (ICD-10-CM)

Clinical documentation: Any manual or electronic notation (or recording) made by a physician or other healthcare clinician related to a patient's medical condition or treatment

Clinical documentation improvement (CDI): The process an organization undertakes that will improve clinical specificity and documentation that will allow coding professionals to assign more concise disease classification codes

Commercial payer: A healthcare insurance company that acts at the payer of healthcare based on coverage provided in a healthcare plan

Compliance: 1. The process of establishing an organizational culture that promotes the prevention, detection, and resolution of instances of conduct that do not conform to federal, state, or private payer healthcare program requirements or the healthcare organization's ethical and business policies 2. The act of adhering to official requirements 3. Managing a coding or billing department according to the laws, regulations, and guidelines that govern it

Comprehensive Error Rate Testing (CERT) contractor: The CMS program that calculates the improper payment rates

Clarifications: The action of making a statement or situation less confused and more comprehensible

Clinical validation: The process of validating each diagnosis or procedure documented within the health record, ensuring it is supported by the clinical evidence

D

Dashboards: Reports of process measures to help leaders follow progress to assist with strategic planning; also called scorecards

Denied claim: Submitted insurance claims that were denied for payment

Diagnosis-related groups (DRGs): A unit of case-mix classification adopted by the federal government and some other payers as a prospective payment mechanism for hospital inpatients in which diseases are placed into groups because related diseases and treatments tend to consume similar amounts of healthcare resources and incur similar amounts of cost; in the Medicare and Medicaid programs, one of more than 500 diagnostic classifications in which cases demonstrate similar resource consumption and length-of-stay patterns. Under the prospective payment system (PPS), hospitals are paid a set fee for treating patients in a single DRG category, regardless of the actual cost of care for the individual

Diagnosis-Related Group (DRG) Validation: The act of reviewing the DRG assignment for accuracy

E

Electronic health record (EHR): An electronic record of health-related information on an individual that conforms to nationally recognized interoperability standards and that can be created, managed, and consulted by authorized clinicians and staff

Encoder: Specialty software used to facilitate the assignment of diagnostic and procedural codes according to the rules of the coding classification system

H

Health information management (HIM) professional: An individual who has received professional training at the associate or baccalaureate degree level in the management of health data and information flow throughout healthcare delivery systems

Health record: 1. Information relating to the physical or mental health or condition of an individual, as made by or on behalf of a health professional in connection with the care ascribed that individual 2. A medical record, health record, or medical health record that is a systematic documentation of a patient's medical history and care

High-risk diagnosis: A diagnosis that is at a higher risk of being flagged for an audit, than most diagnoses

I

International Classification of Diseases, Tenth Revision, Clinical Modification/Procedural Classification System (ICD-10-CM): A coding and classification system used in the United States to report diagnoses in all healthcare settings

International Classification of Diseases, Tenth Revision, Clinical Modification Procedural Classification System (ICD-10-PCS): The coding and classification system used in the United States to report inpatient procedures

L

Legal health record (LHR): Documents and data elements that a healthcare provider may include in response to legally permissible requests for patient information

Licensed/Certified Medical Professionals (LCMPs): Individuals who have successfully completed programs of study in a healthcare field and obtained a license or certificate declaring the person's competency

M

MCC/CC: acronym to describe major complication/co-morbid and complication/co-morbid conditions in reimbursement methodology

Major Diagnostic Categories (MDCs): Under the diagnostic-related groups (DRGs), 25 mutually exclusive categories grouped by similar diagnostic-related conditions that affect a specific organ system or systems of the body

Medicaid: An entitlement program that oversees medical assistance for individuals and families with low incomes and limited resources; jointly funded between state and federal governments and legislated by the Social Security Act

Medicaid Integrity Contract (MIC): CMS contracts with eligible entities to review and audit Medicaid claims to identify overpayments and provide education on program integrity issues

Medical necessity: 1. The likelihood that a proposed healthcare service will have a reasonably beneficial effect on the patient's physical condition and quality of life at a specific point in his or her illness or lifetime 2. Healthcare services and supplies that are proven or acknowledged to be effective in the diagnosis, treatment, cure, or relief of a health condition, illness, injury, disease, or its symptoms and to be consistent with the community's accepted standard of care. Under medical necessity, only those services, procedures, and patient care warranted by the patient's condition are provided

Medicare: A federally funded health program established in 1965 to assist with the medical care costs of Americans 65 years of age and older as well as other individuals entitled to Social Security benefits due to their disability

Medicare Administrative Contractors (MACs): The MMA Act of 2003 permitted CMS to consolidate the Fiscal Intermediary (Part A) and Contractors (Part B) systems into a new system administered by Medicare Administrative Contractors (MAC), covering both Part A and Part B claims in one or more geographic jurisdictions

Medicare Advantage (Medicare Part C): Optional managed care plan for Medicare beneficiaries who are entitled to Part A, enrolled in Part B, and live in an area with a plan; types include health maintenance organization, point-of-service plan, preferred provider organization, and provider-sponsored organization

Medicare contractors: Organizations that perform claim reviews for Medicare

Medicare Provider Analysis and Review (MEDPAR) database system: A database containing information and files submitted by fiscal intermediaries that is used by the Office of the Inspector General to identify suspicious billing and charge practices

Medicare severity diagnosis-related groups (MS-DRGs): The US government's 2007 revision of the DRG system, the MS-DRG system more accurately reflects the severity for severity of illness and resource consumption

Minimum data set (MDS): A federally mandated standard assessment form that Medicare and Medicaid certified nursing facilities must use to collect demographic and clinical information on all residents; includes components for screening, clinical, and functional status elements that serve as the basis for documentation and reimbursement

O

Office of the Inspector General (OIG): Mandated by Public Law 95-452 (as amended) to protect the integrity of Department of Health and Human Services (HHS) programs, as well as the health and welfare of the beneficiaries of those programs. The OIG has a responsibility to report both to the Secretary and to the Congress program and management problems and recommendations to correct them. The OIG's duties are carried out through a nationwide network of audits, investigations, inspections, and other mission-related functions performed by OIG components

Outcome assessment and information set (OASIS): A group of data elements that represents core items for a comprehensive assessment for an adult home care outcome-based quality improvement. The OASIS is a key component of the Medicare's partnership with the home care industry to foster and monitor improved home healthcare outcomes and is proposed to be an integral part of the revised Conditions of Participation for Medicare-certified home health agencies

P

Pay for performance (P4P): 1. A type of incentive to improve clinical performance using the electronic health record that could result in additional reimbursement or eligibility for grants or other subsidies to support further HIT efforts 2. The Integrated Healthcare Association initiative in California based on the concept that physician groups would be paid for documented performance

Performance improvement (PI): The continuous study and adaptation of a healthcare organization's functions and processes to increase the likelihood of achieving desired outcomes

Performance measure: A quantitative tool used to assess the clinical, financial, and utilization aspects of a healthcare provider's outcomes or processes

Physician champion: An individual who assists in communicating and educating medical staff in areas such as documentation procedures for accurate billing and appropriate EHR processes

Present on admission (POA): A condition present at the time of inpatient admission

Principal diagnosis: The disease or condition that was present on admission, was the principal reason for admission, and received treatment or evaluation during the hospital stay or visit or the reason established after study to be chiefly responsible for occasioning the admission of the patient to the hospital for care

Prospective payment system (PPS): A type of reimbursement system that is based on preset payment levels rather than actual charges billed after the service has been provided; specifically, one of several Medicare reimbursement systems based on predetermined payment rates or periods and linked to the anticipated intensity of services delivered as well as the beneficiary's condition; See acute care prospective payment system; home health prospective payment system; hospital outpatient prospective payment system; skilled nursing facility prospective payment system

Q

Query: The process by which questions are posed to a provider to obtain additional, clarifying documentation to improve the specificity and completeness of the data used to assign diagnosis and procedure codes in the patient's health record

Quality improvement organization (QIO): An organization that performs medical peer review of Medicare and Medicaid claims, including review of validity of hospital diagnosis and procedure coding information; completeness, adequacy, and quality of care; and appropriateness of prospective payments for outlier cases and non-emergent use of the emergency room. Until 2002, called peer review organization

Quality management: Evaluation of the quality of healthcare services and delivery using standards and guidelines developed by various entities, including the government and independent accreditation organizations

R

Recovery Audit Contractors (RAC): A governmental program whose goal is to identify improper payments made on claims for healthcare services provided to Medicare beneficiaries. Improper payments include over-payments and underpayments

Reimbursement: Compensation or repayment for healthcare services

Relative weight (RW): Assigned weight that reflects the relative resource consumption associated with a payment classification or group; higher payments are associated with higher relative weights

Retention: 1. Mechanisms for storing records, providing for timely retrieval, and establishing the length of times that various types of records will be retained by the healthcare organization 2. The ability to keep valuable employees from seeking employment elsewhere

Revenue cycle: 1. The process of how patient financial and health information moves into, through, and out of the healthcare facility, culminating with the facility receiving reimbursement for services provided 2. The regularly repeating set of events that produce revenue

Risk of mortality: The likelihood of dying

S

Secondary diagnosis: A statement of those conditions coexisting during a hospital episode that affect the treatment received or the length of stay

Severity of illness (SI or SOI): A type of supportive documentation reflecting objective clinical indicators of a patient's illness (essentially the patient is sick enough to be at an identified level of care) and referring to the extent of physiologic decompensation or organ system loss of function

Supplemental Medical Review Contractor (SMRC): Medicare contractors who perform and/or provide support for a variety of tasks aimed at lowering the improper payment rates and increasing efficiencies of the medical review functions of the Medicare and Medicaid programs

Z

Zone program integrity contractor (ZPIC): A CMS program that replaces the Medicare Program Safeguard Contractors (PSCs). ZPICs are responsible for detection and prevention of fraud, waste, and abuse across all Medicare claim types by performing medical reviews, data analysis, and auditing

APPENDICES

APPENDIX A: SAMPLE APPEALS LETTERS

Template Appeal for Inpatient Short Stay—Hospital Logo

Name of Appeal Recipient Date:
Address:
Fax
RE: Patient Name
DOB:
Dates of Service
Member ID #:
Claim #:

To Whom It May Concern:

We wish to appeal the initial decision that the above-named patient was not appropriate for inpatient status. We acknowledge that Mr. Patient was here for one/two day/s, but this does not automatically place him in an outpatient status. In your review you note that Mr. Patient (i.e., did not have recurrent angina, signs or symptoms of heart failure or an unstable comorbidity supporting the need for an inpatient admission).

We have attached the documentation from the patient's physician office visit, along with the H&P from this visit that document Mr. Patient clinical findings:
(List of pertinent findings)

- Increased dizziness/diaphoresis with exertion
- Shortness of breath with exertion
- Positive chest pressure, positive tightness
- He was scored as an Angina classification of 3–4.
- Diagnosed with unstable angina
- Documented that he has been having spells of dizziness, sweats, and fatigue. Went to see his PCP who thought his visit with the cardiologist should be moved up and he was identified as urgent.

Mr. Patient's (Add supporting interventions/treatments/findings) e.g. cath, with intervention was on 5/14/12. It is identified on the cath report that he had "significant coronary artery disease" and he had a successful PCI to proximal LAD. Mr. Patient was admitted as an inpatient by his physician for treatment, follow-up care post cath and evaluation. Add in Level of Care Criteria as appropriate)

Our Utilization Management Committee agrees with our physician's decisions and feels that this case meets for clinical reasons, and under the Medicare policies. We feel the standard below is appropriate in this case.

Pursuant to the Medicare Benefit Policy Manual (CMS Internet-Only Publication 100-02), Chapter 1, Section 10:

> An inpatient is a person who has been admitted to a hospital for bed occupancy for purposes of receiving inpatient hospital services.
> **Generally, a patient is considered an inpatient if formally admitted as an inpatient with the expectation that he or she will remain at least overnight and occupy a bed even though it later develops that the patient can be discharged or transferred to another hospital and not actually use a hospital bed overnight.**
>
> The physician or other practitioner responsible for a patient's care at the hospital is also responsible for deciding whether the patient should be admitted as an inpatient. **Physicians should use a 24-hour period as a benchmark**, (i.e., they should order admission for patients who are expected to need hospital care for 24 hours or more, and treat other patients on an outpatient basis). **However, the decision to admit a patient is a complex medical judgment which can be made only after the physician has considered a number of factors**, including the patient's medical history and current medical needs, the types of facilities available to inpatients and to outpatients, the hospital's by-laws and admissions policies, and the relative appropriateness of treatment in each setting. Factors to be considered when making the decision to admit include such things as:
>
> - The severity of the signs and symptoms exhibited by the patient;
> - The medical predictability of something adverse happening to the patient;
> - The need for diagnostic studies that appropriately are outpatient services (i.e., their performance does not ordinarily require the patient to remain at the hospital for 24 hours of more) to assist in assessing whether the patient should be admitted; and
> - The availability of diagnostic procedures at the time when and at the location where the patient presents.

Admissions of particular patients are not covered or noncovered solely on the basis of the length of time the patient actually spends in the hospital…

Again, we feel Mr. Patient was appropriate for an inpatient status. Please feel free to contact (staff name) if you need any additional information. Please send any and all correspondence to: (staff name and address)

Respectively Submitted,
Name
Title
Hospital Name
Contact Information

Template Appeal Retrospective DRG Audit

Date:

Denial issuer name and contact number

Audit Type: i.e. DRG Validation

Denial issuer address

Audit#

Patient Name:

Contract Number:

Group Number:

Date of Admission:

Date of Discharge:

To Whom It May Concern:
During the week of (date) (Payer name) conducted an on-site DRG Assignment and Coding Audit (#) at (Hospital name). On (date) we received the DRG Assignment Changes and Coding Revisions report and this letter is being written as an appeal to the denial of DRG Assignment for the above-named patient.

Synopsis
It is our opinion that it is appropriate to code -------as a secondary diagnosis in this case based on the following:
Clinical evaluation: Physician evaluation and documentation of ---------as a working diagnosis.
Therapeutic treatment:
Further evaluation by diagnostic studies:
Nursing/monitoring:

Example:
"Early" or "Clinical" sepsis, or sepsis with SIRS, may be supported with documentation of 2 or more of the following clinical indicators:
- Temp<96.8F/36C or >100.4F/38.C
- Resp >20 rpm
- Pulse >90 bpm
- WBC >12K or <4K or Bands >10%

With or without: AMS, relative hypotension, oliguria, metabolic acidosis, or other signs of organ dysfunction

After further review of the medical record, the coding of --- as a secondary diagnosis is appropriate and accurately reflects the severity of illness and intensity of service provided during inpatient admission for this patient. There is supporting documentation in the medical record for clinical evaluation, therapeutic treatment, and diagnostic studies related to ---. It is our opinion that the final DRG of --- is accurate. We look forward to your positive response and appreciate your time and consideration on this matter.
Respectfully submitted,
Name
Title
Hospital Name
Contact information

Sample Appeal letter for Elective Outpatient Surgery resulting in Inpatient Admission

Hospital Logo and address

(Denial Determination Department Name)

Fax #:

Re: (Patient Name)

DOB:

Date of Service/s:

ID#:

Policy No:

To Whom It May Concern:

We are appealing the determination by (contracted auditor/payer name) that the inpatient admission for the above patient on (service dates) was not medically necessary.

(Patient Name) is a (age and gender) who underwent a (Outpatient Procedure name, on date, and detail). She was admitted to the inpatient unit following the procedure for (supporting orders: i.e. continuous telemetry monitoring, neurochecks and neurovascular checks every 4 hours, and pain control)

We acknowledge that the procedure was an elective procedure when the patient first presented. However, her history included (i.e.: a symptomatic "disabling claudication with rest pain" of the lower extremity). The patient also had a known history of (multiple allergies, with an allergy list of over a dozen medications including contrast medium,) and received (supporting treatments/medications: an IVP Solu-Medrol on the morning of the procedure).

The operative report confirmed (condition) with the following findings:

(Operative report pertinent findings that lead to inpatient admission)

The above findings, the patient's know history of (…), and the fact that the patient had (procedure findings or interventions) warranted an inpatient confinement. The patient met inpatient criteria per (Level of Care Criteria tool i.e. InterQual, MCG) review:

Product:

Subset:

Level of Care:
Criteria points selected with supporting comments

Our Utilization Management Committee agrees with our physician's decisions and feels this meets under the following nationally recognized practice.

> Pursuant to the Medicare Benefit Policy Manual (CMS Internet-Only Publication 100-02), Chapter 1, Section 10:
>
> An inpatient is a person who has been admitted to a hospital for bed occupancy for purposes of receiving inpatient hospital services. **Generally, a patient is considered an inpatient if formally admitted as an inpatient with the expectation that he or she will remain at least overnight and occupy a bed even though it later develops that the patient can be discharged or transferred to another hospital and not actually use a hospital bed overnight.**
>
> The physician or other practitioner responsible for a patient's care at the hospital is also responsible for deciding whether the patient should be admitted as an inpatient. **The decision to admit a patient is a complex medical judgment which can be made only after the physician has considered a number of factors**, including the patient's medical history and current medical needs, the types of facilities available to inpatients and to outpatients, the hospital's by-laws and admissions policies, and the relative appropriateness of treatment in each setting.

The (Audit Contractor/Payer name's) review summary determination appears to be based on the outcomes of the case, consistent with a retrospective review, while the decision to admit this case of a patient with multiple high risk factors was based on a concurrent review of the patient's clinical presentation. The absence of complications from the procedure do not negate the fact that this patient needed monitoring and management beyond a usual outpatient management. We disagree with the (Audit Contractor/Payer name) review summary statement that the "patient's past medical history and pre-existing conditions were stable" (Add supporting documentation: i.e. because considering the patient's findings of….this patient was not stable).

We are appealing the (Audit Contractor/Payer name) determination on the basis that admitting this patient post-procedure was warranted considering her (Supporting medical necessity condition documentation) with high risk for complications from the (Procedure interventions and findings: i.e. extensive, multiple stent placements, and history of contrast allergy). There was some urgency in the situation; just because the patient did not present through the emergency room with her symptoms did not mean that she was stable.

Please feel free to contact (staff person) if you need any additional information. Please send any and all correspondence to: (staff person name and address)

Respectfully submitted,

Name, Title, Name of facility, Contact info

APPENDIX B: QUERY EXAMPLES

1. CLINICAL EVIDENCE WITHOUT A SUPPORTING DIAGNOSIS

Dear Doctor

Azotemia was documented within the H&P on 7/27/17

Clinical Indicators: Creatinine 8.2, GFR 20, shortness of breath, fluid retention, diabetes,

And was treated with Normal Saline

Based on the clinical indicators and your professional judgment can an associated diagnosis be documented? Please complete by selecting one of the options below.

- Acute renal failure
- Acute renal injury
- Acute renal insufficiency (abnormal lab finding)
- Chronic kidney disease (if so please specify the stage)
- Other explanation of clinical findings _____
- Unable to determine
- No further clarification needed

2. DIAGNOSIS WITHOUT CLEAR SUPPORTING CLINICAL EVIDENCE

Dear Doctor

Acute Respiratory Failure was documented within the H&P on 8/2/17, Progress notes on 8/3/17

Clinical Indicators: respiratory rate of 24, shortness of breath with activity, COPD exacerbation,

Pulse oximetry 88%, Oxygen 2L/NC, Duonebs,

Based on the clinical indicators and your professional judgment can this diagnosis be confirmed? Please complete by selecting one of the options below.

- Respiratory failure ruled in (if so please document the clinical evidence used to support this diagnosis)
- Respiratory failure ruled out
- Other explanation of clinical findings _____
- Unable to determine
- No further clarification needed

3. PRESENT ON ADMISSION:

Dear Doctor

Sepsis was documented within the progress notes on 8/10/17. The patient was admitted on 8/7/17

Clinical Indicators: the patient presented with shortness of breath, HR 102, respiratory rate 24, WBC 14, CKD stage 4, Pneumonia

Treated with Normal Saline, Vancomycin, Oxygen

Based on the clinical indicators and your professional judgment can this diagnosis be further specified as present on admission or developed after admission? Please complete by selecting one of the options below.

- Sepsis was present on admission
- Sepsis developed after admission
- Other explanation of clinical findings _____
- Unable to determine
- No further clarification needed

APPENDIX C: SAMPLE POLICY AND PROCEDURE

Policy and Procedure

Title:	Policy #:	Effective Date:
Revision:	Prepared by:	Date Prepared
Reviewed by:	Date Reviewed:	
Approved by:	Date Approved:	

Policy:

This policy and procedure is to verify that any denied claim is reviewed by a denials specialist to determine if the denial is agreed with or if an appeal is warranted.

Scope:

This policy and procedure covers all inpatient admissions claims that have received a denial of payment.

Procedure:

1. All claim denials will be sent to the denials management team for review.
2. A denials specialist will perform an initial review to determine if they agree with the denial reason or if an appeal may be warranted.
3. If the denial reason is deemed appropriate, then the request for refund will be granted. If an appeal is warranted then denials specialist will send the health record, their notes with the evidence from the health record to support the appeal, and the denial letter to a subject matter expert (SME) for review. *See the SME guide below*
4. If the SME agrees to move forward with an appeal they will submit their opinion is writing to the denials specialist including the evidence found in the health record that supports the appeal.
5. The denials specialist will write up the denial letter following the time frame allowed within the payer's appeals process.
6. The denial specialist will send the appeal letter to the SME for review.
7. SME will review the denial letter and track any edits or suggestion. The SME will then send the edited letter back to the denial specialist.
8. The denial specialist will then follow the payer's appeals process until final determination is made. The denial specialist will include the SME on all correspondence and take their opinion into consideration with each step of the appeals process.

Denial Reason	SME Department Assigned to Review Denied Claim
Medical Necessity	Case Management
Coding Error	HIM/Coding
Missing or Inadequate Documentation	Clinical Documentation Improvement

APPENDIX D: JOB DESCRIPTION

Job Description

Job/Position Title: Clinical Denials Specialists

Reports To: Director of Denials Management

Department: Denials Management

Job/Position Code: Status: Exempt/Nonexempt

Purpose: This position is a comprehensive role which requires clinical and analytical skills to manage denied claims to determine if an appeal is warranted.

Duties:

- Review denied claims and the patient health record to determine if an appeal is warranted
- Prepare appeal letters using the clinical evidence from the health record to develop well supported arguments
- Prepare feedback to providers and staff regarding denial trends
- Follow all organizational policies and procedures
- Handle all appeal and denial related correspondence
- Attend administrative law judge hearings

Education: Associate's degree in a healthcare field (such as nursing or health information management)

Minimum Experience: three years of experience in clinical quality, utilization management, case management, nursing, coding or a related field.

Preferred Experience: Five years of experience in a denials management, knowledge of payer requirements, experience in preparing arguments for administrative law judge hearings, experience in working independently and adapting to changes in regulations

Education: Healthcare-related credential (such as RN, RHIA) with additional clinical documentation improvement credential preferred (such as CDIP, CCS)

APPENDIX E: SAMPLE INTERVIEW QUESTIONS

KNOWLEDGE/SKILL QUESTIONS:

- Please explain in your own words your understanding of the denials management process.
- Can you explain the Medicare appeal process?
- Please explain in your own words how your professional experiences make you a good candidate for a role in denials management.
- Please explain your understanding of the role of a Medicare Administrative Contractor?
- Have you ever analyzed data to use in educating others? If so please provide an example.
- Have you ever written an appeal letter? If so please explain the key elements of information that would need to be included.

BEHAVIOR QUESTIONS:

- Explain how you organize yourself each day?
- Please provide an example of a time when you had competing priorities to complete and explain how you manage them.
- Please provide an example of a goal you have achieved and explain how you went about achieving the goal.
- Please provide an example of a time you had to provide education and explain how you organized your information.
- Have you ever had a time where you had to put the needs of other before your own? If so please explain.

APPENDIX F: PRE-HIRE ASSESSMENT

PRE-HIRE ASSESSMENT (WITHOUT ANSWERS)

1. True or False? Medicare Administrative Contractors (MACs) are responsible for performing medical reviews of acute IPPS hospital claims.
   a. True
   b. False

2. Which of the following tools is the primary software used by CMS to check the accuracy of code assignment prior to grouping?
   a. ZPIC
   b. MCE
   c. PSC
   d. SMRC

3. Which of the following reviews is a non-complex review that can be performed by any type of Medicare reviewer?
   a. NCCI edits
   b. Medical reviews
   c. CERT reviews
   d. Recovery Audit Program

4. Which of the following are only performed for denials of related claims and/or when additional documents are not submitted in response to an Additional Documentation Request (ADR)?
   a. Medical review
   b. NCCI edit
   c. Non-medical reviews
   d. CERT reviews

5. The _____are responsible for reviewing claims where improper payments frequently occur or where there is a high probability that improper payments will be made.
   a. Zone Program Integrity Contractors
   b. Recovery auditors
   c. Medicare Administrative Contractors
   d. CDI professionals

6. Which of the follow criteria can be used by CMS to make payment determination?
   a. Admission criteria
   b. Published CMS criteria
   c. DRG validation guidelines
   d. All of above

7. Which of the following is the classification system used for the inpatient PPS?
   a. APCs
   b. DRGs
   c. RUGs
   d. None of the above

8. Which of the following professionals may be seen on a denials management team?
   a. Case managers
   b. CDI professionals
   c. Coding professionals
   d. All the above

9. Which of the following is the first step taken when reviewing the validity of a denial?
   a. Identify a potential appeal
   b. Collaboration with a subject matter expert
   c. Develop a strong case outline
   d. Data collection

10. Which of the following elements is vital to understand when reviewing a denied claim?
    a. Denial timelines
    b. Name of the auditor
    c. Name of the CDI professional who reviewed the record
    d. None of the above

11. True or False? When reviewing a denial only a portion of the health record will need to be reviewed.
    a. True
    b. False

12. Which of the following statements is true regarding bringing in a physician as a subject matter expert regarding a denial?
    a. Any physician specialist would be appropriate to bring into the denial review.
    b. The attending physician would be appropriate to bring into the denial review.
    c. A physician specialist who specialized in the condition that was denied would be an appropriate to bring into the denial review
    d. Both b and c

13. _____ should be included in the appeal letter.
    a. Queries
    b. Patient identifiers
    c. Both a and b
    d. Neither a nor b

14. True or False? Insurance payers will have different procedures that guide their denials process.
    a. True
    b. False

15. Which of the following is a benefit of tracking denied claims?
    a. Improve patient satisfaction
    b. Improve staff satisfaction
    c. Identify high risk diagnoses
    d. All the above

16. Which of the following is an appropriate step to take with the information obtained from tracking denials?
    a. Set up educational sessions to applicable professionals
    b. Determine punitive actions
    c. Both a and b
    d. Neither a nor b

17. Which of the following are desired professional traits of an appeals team member?
    a. Dependability
    b. Attention to detail
    c. Good time management
    d. All the above

18. Which of the following programs are being initiated by some organizations to assist with preventing denials?
    a. CDI programs
    b. Wound care programs
    c. Core measure teams
    d. Health coaches

19. Which of the following classifications uses a four point scale to identify severity of illness (SOI)?
    a. MS-DRGs
    b. APCs
    c. APR-DRGs
    d. RUGs

20. CDI professionals can be the first line of defense against denials that are issued for lack of medical necessity by ensuring the clinical documentation for the patient's_____ exists in the health record.
    a. Patients diagnosis
    b. Treatment
    c. Level of care
    d. All the above

21. A (n) _____ is used as a tool to clarify any health record ambiguity.
    a. Inboxes
    b. Sticky notes
    c. E-mails
    d. Query

22. Which of the following focuses on the correct assignment of the principal diagnosis, procedure, and reportable secondary diagnoses based on the ICD-10-CM Official Guidelines for Coding and Reporting.
    a. Clinical validation
    b. DRG validation
    c. Both a and b
    d. Neither a nor b

23. If a patient presents with vague symptoms and lab findings with one diagnosis suspected but another is subsequently confirmed after three days of diagnostic testing, the CDI professional should do which of the following?
    a. Send a POA status query
    b. Do nothing, a diagnosis was confirmed
    c. Call the physician advisor for advice
    d. Report the provider to the medical team

24. When reviewing a health record that has a high risk (vulnerable) diagnosis which of the following documentation should be reviewed by the CDI professional?
    a. Provider notes
    b. Nursing notes
    c. Nutrition notes
    d. All the above

25. The Medicare Program Integrity Manual (chapter six) discusses the requirements associated with medical review for determining medical necessity, referred to by CMS as _____.
    a. Patient status reviews
    b. Health record reviews
    c. Query reviews
    d. Care coordination reviews

PRE-HIRE ASSESSMENT (CORRECT ANSWERS ARE MARKED WITH A "*")

1. True or False? Medicare Administrative Contractors (MACs) are responsible for performing medical reviews of acute IPPS hospital claims.
   a. True*
   b. False

   Feedback:
   This is true. Medicare Administrative Contractors (MACs) are responsible for performing medical reviews of acute IPPS hospital claims

2. Which of the following tools is the primary software used by CMS to check the accuracy of code assignment prior to grouping?
   a. ZPIC
   b. MCE*
   c. PSC
   d. SMRC

   Feedback:
   One of the primary software tools used by CMS is the Medicare Code Editor (MCE) which is used to check the accuracy of code assignment prior to grouping.

3. Which of the following reviews is a non-complex review that can be performed by any type of Medicare reviewer?
   a. NCCI edits*
   b. Medical reviews
   c. CERT reviews
   d. Recovery Audit Program

   Feedback:
   National Correct Coding Initiatives Edits (NCCI) are non-complex reviews that can be performed by any type of Medicare reviewer.

4. Which of the following are only performed for denials of related claims and/or when additional documents are not submitted in response to an Additional Documentation Request (ADR)?
   a. Medical review
   b. NCCI edit
   c. Non-medical reviews*
   d. CERT reviews

   Feedback:
   Non-medical record reviews are only performed for denials of related claims and/or when additional documents are not submitted in response to an Additional Documentation Request (ADR).

5. The _____are responsible for reviewing claims where improper payments frequently occur or where there is a high probability that improper payments will be made.
   a. Zone Program Integrity Contractors
   b. Recovery auditors*
   c. Medicare Administrative Contractors
   d. CDI professionals

   Feedback:
   The Recovery auditors are responsible for reviewing claims where improper payments frequently occur or where there is a high probability that improper payments will be made.

6. Which of the follow criteria can be used by CMS to make payment determination?
   a. Admission criteria
   b. Published CMS criteria
   c. DRG validation guidelines
   d. All the above*

   Feedback:
   All of the listed criteria can be used by CMS to make payment determinations.

7. Which of the following is the classification system used for the inpatient PPS?
   a. APCs
   b. DRGs*
   c. RUGs
   d. None of the above

   Feedback:
   DRGs are the classification system used for the inpatient PPS.

8. Which of the following professionals may be seen on a denials management team?
   a. Case managers
   b. CDI professionals
   c. Coding professionals
   d. All the above*

   Feedback:
   Denial management teams can vary by organization and may include denials specialists, case managers, quality and compliance specialists, clinical documentation improvement (CDI) professionals, physician advisors, and HIM coding and record management professionals.

9. Which of the following is the first step taken when reviewing the validity of a denial?
   a. Identify a potential appeal
   b. Collaboration with a subject matter expert
   c. Develop a strong case outline
   d. Data collection*

   Feedback:
   Data collection is the first step taken when reviewing the validity of a denial.

10. Which of the following elements is vital to understand when reviewing a denied claim?
    a. Denial timelines*
    b. Name of the auditor
    c. Name of the CDI professional who reviewed the record
    d. None of the above

    Feedback:
    Denial timelines must be monitored including when the denial was issued, when the notice of denial was received and when the notice of appeal must be received by the payer.

11. True or False? When reviewing a denial only a portion of the health record will need to be reviewed.
    a. True
    b. False*

    Feedback:
    When reviewing a denial the entire health record should be reviewed.

12. Which of the following statements is true regarding bringing in a physician as a subject matter expert regarding a denial?
    a. Any physician specialist would be appropriate to bring into the denial review.
    b. The attending physician would be appropriate to bring into the denial review.
    c. A physician specialist who specialized in the condition that was denied would be an appropriate to bring into the denial review
    d. Both b and c*

    Feedback:
    The denial review process may include the attending physician or a physician specialist. If bringing in a physician specialist they should have expertise in the condition that has been denied.

13. _____ should be included in the appeal letter.
    a. Queries
    b. Patient identifiers*
    c. Both a and b
    d. Neither a nor b

    Feedback:
    Patient Identifiers should be included in the appeal letter.

14. True or False? Insurance payers will have different procedures that guide their denials process.
    a. True*
    b. False

    Feedback:
    This is true. Insurance payers will have different procedures that guide their denials process.

15. Which of the following is a benefit of tracking denied claims?
    a. Improve patient satisfaction
    b. Improve staff satisfaction
    c. Identify high risk diagnoses*
    d. All the above

    Feedback:
    The information obtained from tracking denials can be used to identity diagnoses that are a high risk of being denied to allow validation prior to billing in an effort to prevent future denials.

16. Which of the following is an appropriate step to take with the information obtained from tracking denials?
    a. Set up educational sessions to applicable professionals*
    b. Determine punitive actions
    c. Both a and b
    d. Neither a nor b

    Feedback:
    It is beneficial to set up education opportunities, both formal and informal to share the information with all the providers and applicable staff regarding the reasons for denied claims.

17. Which of the following are desired professional traits of an appeals team member?
    a. Dependability
    b. Attention to detail
    c. Good time management
    d. All the above*

    Feedback:
    The following professional traits are found to be beneficial and increase the likelihood of success as an appeals team member.

    - Dependability
    - Problem Solving
    - Attention to details
    - Organizational skills
    - Good time management
    - Good oral and written communication

18. Which of the following programs are being initiated by some organizations to assist with preventing denials?
    a. CDI programs*
    b. Wound care programs
    c. Core measure teams
    d. Health coaches

    Feedback:
    Some organizations are implementing CDI programs to assist in denials prevention due to a lack of documentation.

19. Which of the following classifications uses a four point scale to identify severity of illness (SOI)?
    a. MS-DRGs
    b. APCs
    c. APR-DRGs*
    d. RUGs

    Feedback:
    The 3M™ All Patient Refined (APR)-DRG system uses a four point scale to identify a severity of illness (SOI) and risk of mortality (ROM) score.

20. CDI professionals can be the first line of defense against denials that are issued for lack of medical necessity by ensuring the clinical documentation for the patient's_____ exists in the health record.
    a. Patients diagnosis
    b. Treatment
    c. Level of care
    d. All the above*

    Feedback:
    CDI professionals can be the first line of defense against denials that are issued for lack of medical necessity by ensuring the clinical documentation for the patient's diagnosis, treatment, and level of care exists in the health record.

21. A (n) _____ is used as a tool to clarify any health record ambiguity.
    a. Inboxes
    b. Sticky notes
    c. E-mails
    d. Query*

    Feedback:
    When a question arises within the documentation a query is used as the tool to clarify any ambiguity in the health record.

22. Which of the following focuses on the correct assignment of the principal diagnosis, procedure, and reportable secondary diagnoses based on the ICD-10-CM Official Guidelines for Coding and Reporting.
    a. Clinical validation
    b. DRG validation*
    c. Both a and b
    d. Neither a nor b

    Feedback:
    In DRG validation, the focus is on the correct assignment of the principal diagnosis, procedure, and reportable secondary diagnoses based on the ICD-10-CM Official Guidelines for Coding and Reporting.

23. If a patient presents with vague symptoms and lab findings with one diagnosis suspected but another is subsequently confirmed after three days of diagnostic testing, the CDI professional should do which of the following?
    a. Send a POA status query*
    b. Do nothing, a diagnosis was confirmed
    c. Call the physician advisor for advice
    d. Report the provider to the medical team

    Feedback:
    If a patient presents with vague symptoms and lab findings with one diagnosis suspected but another is subsequently confirmed after three days of diagnostic testing, the CDI professional should consider sending a query to the physician to clarify the onset of the condition (i.e., was it present on admission (POA) or did it develop during the admission).

24. When reviewing a health record that has a high risk (vulnerable) diagnosis which of the following documentation should be reviewed by the CDI professional?
    a. Provider notes
    b. Nursing notes
    c. Nutrition notes
    d. All the above*

    Feedback:
    Regarding diagnoses that are most vulnerable to clinical validation denials (e.g., acute respiratory failure, encephalopathy, sepsis, and severe protein-calorie malnutrition), supportive documentation from multiple members of the healthcare should be present.

25. The Medicare Program Integrity Manual (chapter six) discusses the requirements associated with medical review for determining medical necessity, referred to by CMS as _____.
    a. Patient status reviews*
    b. Health record reviews
    c. Query reviews
    d. Care coordination reviews

    Feedback:
    The Medicare Program Integrity Manual (chapter six) discusses the requirements associated with medical review for determining medical necessity, referred to by CMS as "patient status reviews."

APPENDIX G: POST-HIRE ASSESSMENT

POST-HIRE ASSESSMENT (WITHOUT ANSWERS)

1. Which of the following reviews do not require a clinical review of medical documentation?
   a. Non-complex review
   b. Complex review
   c. Recovery Audit Program
   d. CERT Program

2. The_____ checks each diagnosis and procedure code against a table of valid codes and identifies claims where an unacceptable code
   a. Medicare Code Editor (MCE)
   b. Recovery Audit Program
   c. Medical review
   d. Medicare Administrative Contractors

3. _____reviews require a manual review of the health record.
   a. Non-complex
   b. Complex
   c. Medically unlikely edits
   d. National Correct Coding Initiative Edits

4. Medicare contractors _____randomly choose payment targets.
   a. Cannot
   b. Always
   c. Can
   d. Should

5. True or False? Correct assignment of patient status as an inpatient or an outpatient is unnecessary for accurate payment.
   a. True
   b. False

6. The _____ of each MS-DRG can change when conditions that are recognized as complications and comorbidities (CCs) or Major Complications and Comorbidities (MCCs) are coded on a claim.
   a. Hierarchical Condition Categories
   b. Relative weight
   c. Risk score
   d. Ambulatory Payment Classification

7. True or False? RAC contract states that all issues with a claim are submitted at one time.
   a. True
   b. False

8. Medicare ADR letters will include which of the following?
   a. What actions you need to take
   b. Instructions for replying
   c. When you need to reply
   d. All the above

9. Providers must submit health records to MACs and Recovery Auditors within _____ calendar days of the request.
   a. 50
   b. 20
   c. 45
   d. 10

10. An inpatient health record review should begin with which of the following documentation notes, when applicable?
   a. Progress notes
   b. Discharge summary
   c. Emergency department
   d. Nursing notes

11. Which of the following is Joint Commission-established standard documentation requirements?
   a. Insignificant findings
   b. Reason for hospitalization
   c. Both a and b
   d. Neither a nor b

12. After reviewing the health record and evaluating the collected data, which of the following is the next step for the denial specialist?
   a. Write an appeal letter
   b. Educate staff
   c. Determine if the data supports the denied diagnosis
   d. Consult with a subject matter expert

13. Which of the following best describes the role of the subject matter expert (SME) in the denials management process?
   a. The SME provides a written documentation from the record addressing their clinical judgment.
   b. The SME performs the initial review of the denial to determine if the denial is supported.
   c. The SME should always appeal a denial.
   d. None of the above

14. Which of the following should be included in an appeal letter?
   a. Restatement of the reason for the denial
   b. The denial specialists opinion why the organization believe the payer decision in inaccurate
   c. A statement from the physician advisor
   d. A statement from the CEO

15. Which of the following documentation note supports medical necessity?
   a. Diagnostic results
   b. Clinical findings
   c. Nursing documentation
   d. All the above

16. Which of the following is the component of the appeal letter that is requesting the insurer to overturn the denial and approve payment of the claim?
    a. Requested outcome
    b. Reinstatement of the denial reason
    c. Clinical evidence
    d. Treatment

17. Which of the following is an independent review of the initial determination conducted by a QIC which includes the redetermination and all issues related to payment of the claim?
    a. First-level appeal
    b. Second-level appeal
    c. Third-level appeal
    d. Fourth-level appeal

18. Organizations can work with_____ to establish clinical guidelines outlining the clinical evidence necessary to support high-risk diagnoses.
    a. Case managers
    b. CDI professionals
    c. Physician service lines
    d. Senior leadership

19. Which of the following staff should receive education regarding denial findings?
    a. Physicians
    b. Coding professionals
    c. CDI professionals
    d. All the above

20. True or False? There may be cross-training between professions involved in denials management to support the interdisciplinary team environment.
    a. True
    b. False

21. The AHIMA practice brief "Guidelines for Achieving a Compliant Query Practice" explains that the generation of a query should be considered when the health record documentation reflects which of the following?
    a. Documentation that is conflicting
    b. Documentation that is precise
    c. Documentation that is complete
    d. Documentation that is reliable

22. The role of _____ is to ensure that the clinical evidence supports the diagnosis provided.
    a. DRG validation
    b. Clinical validation
    c. Code validation
    d. CPT® validation

23. Which of the following can be done to assist in minimizing clinical variation of care?
    a. Base medical decisions on evidence-based medicine
    b. Document the highest reimbursed conditions
    c. Document the lowest reimbursed conditions
    d. Both b and c

24. Which of the following is an issue that can be identified by the MEC check?
    a. Missing clinical evidence
    b. Inconsistent documentation
    c. Duplicated codes as the principal and secondary diagnosis
    d. Both a and b

25. Which of the following is an error category in CERT?
    a. Incorrect coding
    b. Medical necessity
    c. Insufficient documentation
    d. All the above

POST-HIRE ASSESSMENT (CORRECT ANSWERS ARE MARKED WITH A "*")

1. Which of the following reviews do not require a clinical review of medical documentation?
   a. Non-complex review*
   b. Complex review
   c. Recovery Audit Program
   d. CERT Program

   Feedback:
   Non-complex reviews do not require a clinical review of medical documentation.

2. The_____ checks each diagnosis and procedure code against a table of valid codes and identifies claims where an unacceptable code
   a. Medicare Code Editor (MCE)*
   b. Recovery Audit Program
   c. Medical review
   d. Medicare Administrative Contractors

   Feedback:
   The MCE checks each diagnosis and procedure code against a table of valid codes and identifies claims with an unacceptable code.

3. _____reviews require a manual review of the health record.
   a. Non-complex
   b. Complex*
   c. Medically unlikely edits
   d. National Correct Coding Initiative Edits

   Feedback:
   Complex reviews require a manual review of the health record

4. Medicare contractors _____randomly choose payment targets.
   a. Cannot*
   b. Always
   c. Can
   d. Should

   Feedback:
   Contrary to popular belief, Medicare contractor cannot randomly choose payment targets.

5. True or False? Correct assignment of patient status as an inpatient or an outpatient is unnecessary for accurate payment.
   a. True
   b. False*

   Feedback:
   This is false. Correct assignment of patient status as an inpatient or an outpatient is necessary for accurate payment.

6. The _____ of each MS-DRG can change when conditions that are recognized as complications and comorbidities (CCs) or Major Complications and Comorbidities (MCCs) are coded on a claim.
   a. Hierarchical Condition Categories
   b. Relative weight*
   c. Risk score
   d. Ambulatory Payment Classification

   Feedback:
   The relative weight of each MS-DRG can change when conditions that are recognized as complications and comorbidities (CCs) or Major Complications and Comorbidities (MCCs) are coded on a claim.

7. True or False? RAC contract states that all issues with a claim are submitted at one time.
   a. True*
   b. False

   Feedback:
   This is true. Historically, a claim could initially be denied on the basis of code assignment and then be denied for medical necessity; however, changes in the most current RAC contract prevents this practice so all issues with a claim are submitted at one time.

8. Medicare ADR letters will include which of the following?
   a. What actions you need to take
   b. Instructions for replying
   c. When you need to reply
   d. All the above*

   Feedback:
   Medicare ADR letters will include:
   - Reason your claim was selected
   - What actions you need to take
   - When you need to reply
   - Consequences of not replying
   - Instructions for replying
   - Contractor contact information

9. Providers must submit health records to MACs and Recovery Auditors within ____ calendar days of the request.
   a. 50
   b. 20
   c. 45*
   d. 10

   Feedback:
   Providers must submit health records to MACs and Recovery Auditors within 45 calendar days of the request.

10. An inpatient health record review should begin with which of the following documentation notes when applicable?
    a. Progress notes
    b. Discharge summary
    c. Emergency department*
    d. Nursing notes

    Feedback:
    For an inpatient admission the health record review should begin with the emergency department (ED) documentation when applicable.

11. Which of the following is Joint Commission-established standard documentation requirements?
    a. Insignificant findings
    b. Reason for hospitalization*
    c. Both a and b
    d. Neither a nor b

    Feedback:
    The Joint Commission established documentation standard requirements that include the reason for hospitalization.

12. After reviewing the health record and evaluating the collected data, which of the following is the next step for the denial specialist?
    a. Write an appeal letter
    b. Educate staff
    c. Determine if the data supports the denied diagnosis*
    d. Consult with a subject matter expert

    Feedback:
    After reviewing the health record and evaluating the collected data, denial specialist will evaluate the collected data to determine well it supports the denied diagnosis.

13. Which of the following best describes the role of the subject matter expert (SME) in the denials management process?
    a. The SME provides a written documentation from the record addressing their clinical judgment.*
    b. The SME performs the initial review of the denial to determine if the denial is supported.
    c. The SME should always appeal a denial.
    d. None of the above

    Feedback:
    The SME provides a written letter/documentation from the record addressing their clinical judgment reflected in the case that clearly supports medical necessity DRG validation and/or of services rendered.

14. Which of the following should be included in an appeal letter?
    a. Restatement of the reason for the denial*
    b. The denial specialists opinion why the organization believe the payer decision in inaccurate
    c. A statement from the physician advisor
    d. A statement from the CEO

    Feedback:
    Restatement of the reason for denial that was explained in the denial letter should be included in the denial letter.

15. Which of the following documentation notes supports medical necessity?
    a. Diagnostic results
    b. Clinical findings
    c. Nursing documentation
    d. All the above*

    Feedback:
    Supporting medical necessity documentation includes diagnostic results, clinical findings, and nursing documentation.

16. Which of the following is the component of the appeal letter that is requesting the insurer to overturn the denial and approve payment of the claim?
    a. Requested outcome*
    b. Reinstatement of the denial reason
    c. Clinical evidence
    d. Treatment

    Feedback:
    The requested outcome is the component of the appeal letter that requests the insurer to overturn the denial and approve payment of the claim.

17. Which of the following is an independent review of the initial determination conducted by a QIC which includes the redetermination and all issues related to payment of the claim?
    a. First-level appeal
    b. Second-level appeal*
    c. Third-level appeal
    d. Fourth-level appeal

    Feedback:
    A second level appeal is an independent review of the initial determination conducted by a QIC which includes the redetermination and all issues related to payment of the claim.

18. Organizations can work with_____ to establish clinical guidelines outlining the clinical evidence necessary to support high risk diagnoses.
    a. Case managers
    b. CDI professionals
    c. Physician service lines*
    d. Senior leadership

    Feedback:
    Organizations can work with physician service lines to establish clinical guidelines outlining the clinical evidence necessary to support high risk diagnoses.

19. Which of the following staff should receive education regarding denial findings?
    a. Physicians
    b. Coding professionals
    c. CDI professionals
    d. All the above*

    Feedback:
    Physicians, coding professionals, and CDI professionals should receive education regarding denial findings.

20. True or False? There may be cross-training between professions involved in denials management to support the interdisciplinary team environment.
    a. True*
    b. False

    Feedback:
    This is true. There may be cross training between professions involved in denials management to support the interdisciplinary team environment.

21. The AHIMA practice brief "Guidelines for Achieving a Compliant Query Practice" explains that the generation of a query should be considered when the health record documentation reflects which of the following?
    a. Documentation that is conflicting*
    b. Documentation that is precise
    c. Documentation that is complete
    d. Documentation that is reliable

    Feedback:
    The AHIMA practice brief "Guidelines for Achieving a Compliant Query Practice" explains that the generation of a query should be considered when the health record documentation reflects documentation that is conflicting.

22. The role of _____ is to ensure that the clinical evidence supports the diagnosis provided.
    a. DRG validation
    b. Clinical validation*
    c. Code validation
    d. CPT® validation

    Feedback:
    The role of clinical validation is to ensure that the clinical evidence supports the diagnosis provided

23. Which of the following can be done to assist in minimizing clinical variation of care?
    a. Base medical decisions on evidence-based medicine*
    b. Document the highest reimbursed conditions
    c. Document the lowest reimbursed conditions
    d. Both b and c

    Feedback:
    In order to minimize clinical variations of care, providers should base decisions around diagnosis definitions grounded in evidence-based medicine and the respective colleges' recommendations.

24. Which of the following is an issue that can be identified by the MEC check?
    a. Missing clinical evidence
    b. Inconsistent documentation
    c. Duplicated codes as the principal and secondary diagnosis*
    d. Both a and b

    Feedback:
    MCE checks can identify if a code is duplicated as both a principal diagnosis and a secondary diagnosis.

25. Which of the following is an error category in CERT?
    a. Incorrect coding
    b. Medical necessity
    c. Insufficient documentation
    d. All the above*

    Feedback:
    Incorrect coding, medical necessity, and insufficient documentation are all error categories in CERT.

APPENDIX H: DOCUMENTS FREQUENTLY NOT PART OF THE LEGAL HEALTH RECORD

Below is a list of documents that are often not part of the legal health record:

- Authorization forms for release of information
- Correspondence concerning requests for records
- Correspondence to resolve the patient's bill
- Birth and death certificates
- Event history/audit trails
- Patient-identifiable abstracts in coding system
- Patient-identifiable data reviewed for quality assurance or utilization management
- Administrative reports
- State-required patient registries
- Accreditation reports
- Best practice guidelines created from aggregate patient data
- ORYX reports, public health records, and statistical reports
- Compilations of data for research purposes
- Draft documents. Electronic processes and workflow management require methods to manage work in progress. These work-in-progress documents are often available in the system as "draft documents," viewable to a limited number of users. They are not generally viewable to clinicians until the document is sent for final signature. Draft documents are not considered part of the legal health record until they have been signed by an authorized signer. Draft documents include physician dictation, history and physicals, and discharge orders until the foregoing are signed by the physician. Preliminary results are not included in the category of "draft documents" and are part of the legal health record.
- Employee health record (e.g., fitness for duty examinations)
- Shadow health records not relied upon during patient care
- Workflow tools such as protocols/clinical pathways, best practice alerts, and other knowledge sources; alerts, reminders, pop-ups, sticky notes, Kardex, patient lists, post-it notes, work lists, administrative in-baskets, messaging, sign out reports, and similar tools (collectively, the "workflow tools") that may be used as aids in the clinical decision-making process. While workflow tools are not themselves part of the legal health record, documentation of actions taken by a clinician, including the condition acted upon and the associated progress note, are considered a part of the legal health record. Certain "workflow tools" (e.g., sticky notes) are not maintained after a patient's discharge.
- UR and billing records/notes
- CDI/Coding queries
- CDI worksheet

Adapted from "Fundamentals of the Legal Health Record and Designated Record Set," *Journal of AHIMA* 82, no.2 (February 2011): expanded online version. http://library.ahima.org/doc?oid=104008.