Good defense: Manage denial and audit activity with strong coding and documentation

For most healthcare organizations, managing the impact of the novel coronavirus (COVID-19) pandemic has claimed the lion's share of resources. In some cases, that may have left fewer resources to devote to denials management and proactive efforts such as pre-bill reviews.

Although CMS pulled back significantly on its audit and even denial activity during the first half of the year, the agency *announced plans* to restart audits in August and published *several newly approved* Recovery Audit Contractor (RAC) topics. Meanwhile, Medicare Advantage and commercial payers saw little to no slowdown in their audit and denial activity.

It's more important than ever that revenue integrity keep ahead of audits and denials. The financial strain that many organizations are under makes it imperative to minimize disruptions to revenue. In addition, the documentation and coding practices supporting that effort will ensure complete and accurate clinical data. In the months and years to come, this data will be essential to understanding how the pandemic unfolded, how it impacted patients and organizations, and what its long-term effects might be.

CMS audits return

CMS suspended most of its pre- and post-payment medical review programs at the beginning of the public health emergency (PHE) in March. However, in July the agency *released* an FAQ

document stating that because states had begun to reopen and because of the importance of these reviews to CMS' program integrity efforts, the agency didn't expect to extend the enforcement discretion period. Regardless of the state of the PHE, CMS planned to restart RAC, Targeted Probe and Educate, and Supplemental Medical Review Contractor reviews in early August.

return of CMS audit programs. Some organizations have laid off revenue integrity, revenue cycle, and release-of-information staff due to the financial impact of COVID-19. In those instances, organizations should assess whether they have enough staff available to handle new potential audit requests and prepare options and plans for the various staffing scenarios.

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Although industry associations, including the American Hospital Association (AHA), urged CMS to extend the enforcement discretion period, the following five newly approved RAC topics were *published* on August 3:

1. Duplex scans of extracranial arteries
2. Reduction of technical component diagnostic cardiovascular services
3. Specialty care transport
4. Total hip arthroplasty
5. Total knee arthroplasty

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Current denial landscape

Although COVID-19 took over the clinical world starting in March, organizations might not have seen much change in the most frequently denied diagnoses and denial reasons, says **Emmel Golden, MD, FCCP, CCDS,** chief clinical officer for Enjoin in Eads, Tennessee. Sepsis, malnutrition, and acute respiratory failure are still the most likely to get pushback from payers, he says.

Acute respiratory failure could shape up to be particularly problematic for organizations that have treated surges of seriously ill COVID-19 patients. The most critically ill of these patients may also develop sepsis, either at the time of admission or as the disease progresses, Golden adds. That means organizations must remain vigilant to ensure appropriate coding and documentation for these conditions.

As the pandemic continues, payers may put COVID-19 claims under the microscope because the severity and complexity of these patients' condition could affect the MS-DRG, Golden says.

A principal diagnosis of COVID-19 is assigned to one of the following:

- MS-DRG 177 (Respiratory Infections and Inflammations with Major Complication/ Comorbidity [MCC])
- MS-DRG 178 (Respiratory Infections and Inflammations with Complication/ Comorbidity [CC])
- MS-DRG 179 (Respiratory Infections and Inflammations without CC/MCC)

Many COVID-19 patients who are admitted to the hospital are very ill and may have multiple CCs/MCCs, Golden explains. In general, most will be hypoxic and require oxygen support and may be experiencing acute respiratory failure. If their condition deteriorates, they may also experience acute kidney failure or secondary infections and could require mechanical ventilation. Many of these patients have existing chronic

conditions that add another layer of complexity to their care.

"Certainly for those patients that become sicker with this condition, there are a whole host of secondary diagnoses that will come up, so the intensity of illness is going to be quite high in these patients," Golden says. "That changes the MS-DRG, and that may be something that's going to come under scrutiny. If we come out of the public health emergency and Medicare looks back at these COVID-19 claims—which was something that at the very beginning they said they would do—they may target some of these COVID-19 cases for secondary diagnoses."

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If an organization already struggles with some of these common secondary diagnoses, it may be prudent to act now and tighten up coding and documentation.

Organizations can help ensure that claims are as clean and correct as possible through pre-bill reviews, states **Andrea Taylor, RHIT, CCS, CCS-P, CCDS,** senior clinical coding analyst for Enjoin. Addressing concerns before claims are submitted will reduce resource-intensive back-end denial processes and will help ensure that clinical data is as accurate and complete as possible.

High-risk diagnoses, such as acute respiratory failure and sepsis, should be a priority for pre-bill reviews—particularly as these may be common among hospitalized COVID-19 patients, Taylor says.

"We strongly believe that if you put that focus on the front end with the high-risk diagnoses and MS-DRGs, this can reduce the denials and the cost associated with reworking them later," Taylor says.

Accurately report severity

Nonemergent procedures were put on hold early in the year to mitigate the spread of COVID-19 and conserve resources such as personal protective equipment. This was necessary to give organizations the breathing room to focus on COVID-19 patients and attempt to shore up supplies, but it had a negative impact on much-needed revenue.

Although some organizations have restarted nonemergent and elective procedures, they're not out of the woods. During the early months of the pandemic, hospitals lost as much as $50 billion a month, *according* to the AHA. With hospital revenues predicted to remain low at least through the remainder of 2020, according to another *report* prepared for the AHA, there will be little chance to make up the loss.

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One way organizations can help mitigate the effect on revenue is by ensuring that severity of illness is accurately captured, Golden says. During periods when patient volumes are low, coding and CDI staff can take the opportunity to review documentation as thoroughly as possible to ensure that it appropriately and accurately supports patients' conditions.

Organizations must ensure that their query processes are up to par, Taylor says. Make note of weak points that must be addressed and position queries as part of the team-based approach clinical staff are already taking to treat COVID-19 patients. See the sidebar on p. 34 for a sample COVID-19 query.

"The collaboration between CDI, physicians, coders, and HIM needs to be taking place so the documentation is complete and accurate and those queries are being responded to so those bills can get out the door and that revenue can get captured," she says.

Taylor notes that when reviewing COVID-19 patients' charts, she

often queries for sepsis. Although CDI specialists and coders should be mindful of the added strain clinical staff may be under, they shouldn't avoid queries when they're necessary.

organizations may prefer Sepsis-2. It may be necessary to develop a query process that captures data for Sepsis-2 and Sepsis-3. See the sidebar on p. 38 for a sample sepsis query.

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"I think the key as CDI specialists is to make sure that diagnosis is clinically supported. If it's not, query the physician, ask for clarification, try to get them to reaffirm that diagnosis," Taylor says. "Because when it does come time to appeal that denial, if the query has already been submitted to the physician and they have reaffirmed that diagnosis, that is your defense for that denial."

Ensure your organization understands which sepsis criteria are used by clinical staff and by payers, she adds. Payers tend to use Sepsis-3, while many

Second wave

Organizations should also be on the alert for former COVID-19 patients returning with new illnesses, Taylor and Golden say. For example, a COVID-19 patient may have developed a deep vein thrombosis (DVT) during the illness. The patient recovers from COVID-19, but several weeks later the DVT develops into a pulmonary embolism and the patient is readmitted.

"That pulmonary embolism can be acute for about three months," Taylor says. "If they are readmitted, that could be an MCC that could really affect the MS-DRG down the line."

There are a host of new conditions related to COVID-19, or exacerbated chronic conditions, that could see these patients readmitted after their recovery, Golden adds. Although there's currently no ICD-10 code for history of COVID-19, clinicians should still be encouraged to document it.

"We're going to need to go back and look next year and try to get a grip on what happened during this. So much of that is going to be captured through documentation," Golden says. "That history of COVID-19 for that patient who's readmitted now with a pulmonary embolism or stroke or worsening of their kidney function, linking that to COVID-19 gives us a bigger understanding of the immediate impact and the long-term impact of COVID-19 in a population of patients. That's a key role of documentation and coding."

Upholding documentation and coding standards has an immediate impact on clean claim rates and protecting revenue when hospitals are more at risk than ever. And it will be the key to helping understand what's happened during the pandemic and what can be done better in the future, Golden says. NJ