Q&A

CDI's role in audit defense

Clinical Documentation Improvement Week

As part of the second annual Clinical Documentation Improvement Week, ACDIS has conducted a series of interviews with CDI professionals on a variety of emerging industry topics. ***Virginia Bailey, RN, CCDS,*** *and* ***Kimberly A. Richert, RN, CCDS,*** *RAC denials coordinators at Morton Plant Mease Healthcare in Dunedin, Fla., and founders of the Florida ACDIS chapter, answered the following questions regarding the CDI specialist's role in denials management.*

Q ***How can CDI specialists assist with Recovery Auditor (RAC) defense?***

KR: Because they are reviewing the record concurrently, on the front end, CDI specialists see the chart in real time and can assess whether the information in the record captures the medical necessity required for inpatient admission. That is a really big issue right now with the Recovery Auditors and catching it on the front end is a big plus.

VB: As RAC denials coordinators we see these issues with a wonderful 20/20 hindsight. For example, the record indicates that the physician admitted a patient with syncope. The symptoms are documented but nothing else happens, and the patient goes home the next day. In hindsight, we have to wonder why that patient was admitted. In hindsight, we're dealing with a denial. If the CDI specialist had seen that record and queried the physician for clarity regarding what the syncope was ***due to,*** we might not have that denial. CDI specialists really need to become more aware about how their efforts affect this aspect of the process. I would love to have the CDI specialists sit with us and see what we see, see how much it means to a denial when you do not capture that "due to" link.

Q ***What is the best way to "audit proof" a record?***

KR: Morton Plant Mease implemented a hospital payment monitoring program for the medical necessity piece. In it, a reviewer pulls charts at random and looks to see if there are any discrepancies. If they find something, they can take the record back and reexamine it, even rebill it. It is sort of a self-audit.

VB: We also do a preemptive check on documentation for elective surgeries. Our orthopedics are not allowed to perform certain surgeries unless they have submitted the appropriate documentation supporting that service to ensure the procedure meets medical necessity. So, for example, we ask for any previously performed radiology reports and office visit documentation supporting the treatment. Getting that information up front, now ***that*** would be audit proof.

What are some of the problematic diagnoses/ MS-DRGs that RACs are targeting, and what are they finding?

KR: I can't say that they are targeting any specific DRGs. It is more like they are targeting short stays, one-day to three-day stays, and anything lacking medical necessity.

RACs are spending a lot of effort on medical necessity denials. Do you recommend CDI specialists assist in this area, or is this better left to UR/case management?

KR: All the teams should be tied together at this point. Tear down those walls. We are all in it together. From the moment the patient comes in the door, facilities need to be sure they are capturing that documentation of care in the medical record.

VB: On every level, accurate and complete reimbursement boils down to documentation. Why was the physician trying to admit that patient? From the nurse's information assessment, which can be used to support that admission, to the laboratory reports and so on, there isn't any point where the documentation doesn't affect what happens. It all boils down to what is written there in the record.

And I am not just talking about the financial aspect of this either, but for the care of [the] patient. Each day's note should stand on its own. On day three of the patient's stay I should be able to pick up that record and see what is going on with that patient. But that's not what's happening—you're lucky to get three lines written in the record each day.

There's been so much attention given to Medicare contractors, especially the RAC program. Can you touch on some of the other audit initiatives, like Medicaid contractors, ZPIC, and CERT?

KR: We haven't had any issues with ZPIC, but we have started seeing items related to CERT. The biggest thing for us right now is the prepayment reviews, which just started in August. Now they aren't going to take money back if the record isn't complete and accurate—they are not going to pay us to begin with.

VB: These programs are just further proof that CDI needs to be everywhere. They could be put in any department, but everyone is segregated now. Until we came to the denials department, we didn't even realize the larger need for CDI efforts throughout the hospital. Every little thing is getting denied. Outpatient services are one area I would like to see CDI programs expand into. CMS has all these national coverage determinations and local coverage determinations, which dictate when a service is supported. When something gets denied, we write those letters too. For example, consider a woman who needs a mastectomy and has reconstructive surgery and breast implants. Because the physician doesn't supply all the necessary documentation, CMS considers the procedure cosmetic and denies the claim. Then the patient gets stuck with the bill. It is really awful.

KR: If we can fight these types of denials, we do. We fight them to the end. But really it starts and ends with the documentation in the record, and it is the CDI specialists that can help ensure that the information needed gets into the record.

Bailey has been an RN since 1995. An original member of the Morton CDI team, which began in 2007, Bailey joined the RAC denials team there in 2011. Contact her at virginia.bailey@baycare.org.

Richert worked as a clinical resource coordinator before joining the Morton CDI team in 2007 and advancing to become that program's lead CDI coordinator for more than four years before joining the RAC denials team. She has worked as a U.S. Army nurse, furthering her nursing career of more than 30 years. Contact her at kimberly.richert@baycare.org.