Q&A: CDI and RAC Defense

CDI WEEK

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As part of the first Clinical Documentation Improvement Week, ACDIS has conducted a series of interviews with CDI professionals on a variety of emerging industry topics. ***Trey La Charité, MD,*** *physician advisor for the clinical documentation integrity project at the University of Tennessee in Knoxville, answered the following questions from ACDIS regarding CDI and RAC defense.*

Q ***Can you provide an example of how a CDI specialist helped with a RAC denial in your facility?***

Our CDI specialists play an indispensable role in the prevention of RAC denials. Despite the fact that their role in the appeal process once a denial has been received is limited, the prevention of future denials based on the lessons learned from that initial denial is invaluable.

In particular, this has greatly helped with reducing our facility's vulnerability to excisional debridement denials. Once the facility understood that RACs had targeted excisional debridement, the CDI staff mobilized to make sure they understood the reasons for the denials and focused on improving current documentation for the concern through physician education and queries. The CDI staff makes sure that all necessary documentation elements are present prior to a patient's discharge.

Additionally, our CDI specialists are quick to recognize when documentation may be conflicting between two different providers. They know to query for the establishment of the appropriate linkage of disease processes if it was not obvious in the chart.

When denials are appropriate, we share that information with our CDI staff and look for ways to make sure those denials do not happen again.

Q ***In what ways do good general documentation practices help with RAC defense?***

Good documentation habits help prevent denials because they paint a clear and precise picture of a patient's problems and medical situation. These habits clearly and accurately spell out which disease processes are present and how they are being treated. Good documentation is consistent from admission through discharge. It is declarative, unambiguous, and illustrates the necessary cause-and-effect relationships of symptoms and diseases.

In our experience, the RAC focuses on the appropriateness of our principal diagnosis selection and the discrediting of solitary CCs and MCCs. When providers consistently declare the main reason for a given hospitalization and accurately record the associated secondary diagnoses, there is little room for the RAC to negatively impact that submission. Any given medical record should tell a story, tell it well, and stick to it.

Q ***How can CDI specialists help with establishing medical necessity for inpatient admissions, which are a huge RAC target? Or is this a case management function?***

While I believe this is primarily a case management issue, CDI specialists can certainly have a positive impact. Diligent, effective queries that help physicians see their patients from a different point of view can strengthen hospitalizations in meeting the current medical necessity requirements.

For example, while a patient may have been initially admitted for pneumonia, the CDI specialist's review might raise the possibility of sepsis given certain findings present at the time of admission. If the physician realizes that the patient was indeed septic at the time of admission and documents that diagnosis, it will be much harder for an auditor to say that the admission in question was not medically necessary.

Q ***What are the "dangerous diagnoses" or MS-DRGs that are easy RAC targets?***

The most common MS-DRGs that are denied in the complex medical reviews for DRG validation are 312, 166, 981, 189, and 813. The most common MS-DRGs denied for a perceived lack of medical necessity are 312, 313, 069, 249, and 142.

While we have seen a similar preponderance for these MS-DRGs at our facility, we have also seen a heavy focus on excisional debridements. A lack of supporting documentation to warrant the coding of an excisional debridement has been by far our most frequent reason for a RAC denial. This was easily the reason for at least one-third of all our 2010 RAC denials. (We did not receive any medical necessity denials in 2010.)

We have received a limited number of DRG validation denials thus far for 2011 as the RAC has switched to medical necessity reviews. However, 75% of those 2011 DRG validation denials were also for excisional debridements.

Q ***What lessons does the RAC program have to teach CDI specialists? What can we be doing better?***

If nothing else, the RAC has clearly sent the message that the status quo is no longer acceptable. Physicians must document more, and document more accurately, while coders must improve their accuracy for the medical records they review and submit to billing.

CDI specialists are now poised as the fulcrum point in the balancing act between these two necessities. The CDI specialist's role is to engender better documentation from the physician. Better documentation significantly improves the chances that the coder has the material with which to make the appropriate code choices. The more positive influence we can exert on our medical staff, the stronger the position our coders will have when submitting charts that we all know are going to be extensively reviewed.

Dr. La Charité serves as the physician advisor for coding at the University of Tennessee Medical Center. He is board certified in internal medicine and has been a practicing hospitalist since completion of his residency in 2002. He is also a clinical assistant professor in the department of internal medicine, where he currently serves as the curriculum director for the internal medicine residency program's hospitalist rotation. Dr. La Charité is a member of the ACDIS advisory board. Contact him at Clachari@UTMCK.EDU.