

The Trinity Health logo is a stylized teal figure with three rounded shapes representing arms or leaves, set against a light blue circular background. The figure is positioned on the left side of the slide, partially overlapping the title text.

# **Trinity Health RAC Response Team Audit Defense**

**COPAM Presentation**

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# Discussion Topics

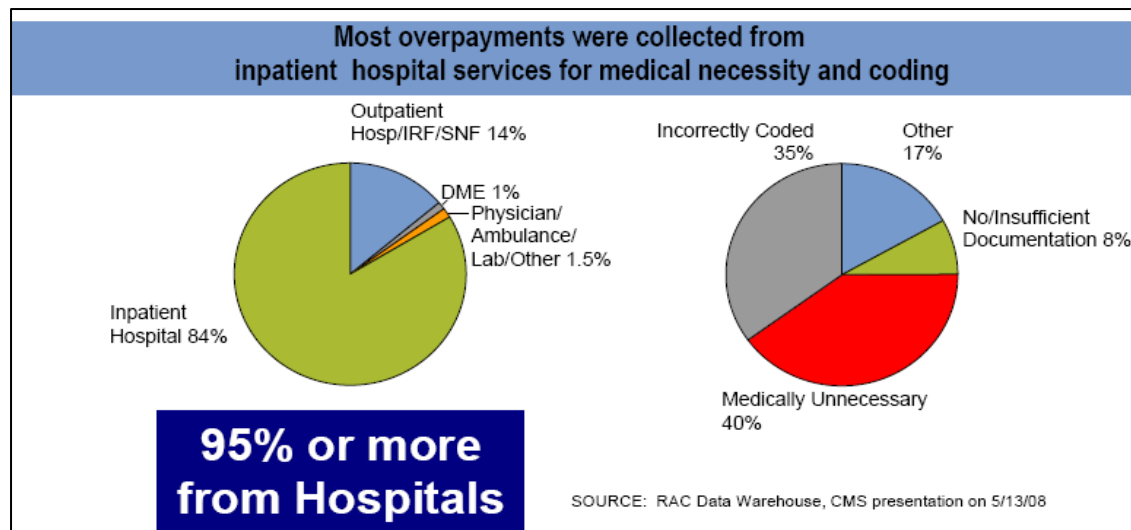
- RAC Coding Determinations
- Defense Strategies
  1. Risk Assessments
  2. Coding Education
  3. Appeal Strategy
  4. Cross-functional Teams
- Trinity Health RACI Matrix

# Coding Determinations- URO RAC Team Focus

- Primary Defense Focus is on Coding determinations:
  - Incorrect coding may result in overpayments or underpayments.
  - Both will result in education to the facilities
  - Overpayment determinations will result in appeal defense
  
  - Incorrect DRG assignment
  - Claims coded incorrectly, either DX or PX
  
  - This includes codes that fail to meet the coding requirements in a National Coverage Decision (NCD), Local Coverage Decision (LCD), The Official ICD-9-CM Guidelines, AHA Coding Clinic, the AMA's CPT or CPT Assistant.

# RAC Demonstration project findings

- Most overpayments were collected from inpatient hospital services from coding and medical necessity.
- 95% of claims reviewed were hospital claims
- 85% of those claims were inpatient claims, 4% were outpatient, 6% were rehab, 6% other.
- 35% of those claims were coded incorrectly, 40% were medically unnecessary, 8% had insufficient documentation, 17% were other reasons.



# Defense Strategy 1: Determination of Risk Areas

## Current:

Data Mining- ie TH reports, high volume DRG's, Benchmarking reports, ie CMS-PEPPER reports

Demonstration Project- RAC findings and targets

Internal Audits- OI&AS RAC Prep Audit

## Future:

URO RAC Team to continually assess risk areas through analysis of RAC denial data to identify trends across Trinity Health and at the specific Hospitals.

# Initial Risk Assessment: Proactive Strategies for High Risk Areas

Top 10 Risk Areas		Proactive Strategies
291 - Heart Failure w/MCC		Common MCC's in HF patients include valvular disease, ventricular tachycardia, Atrial Flutter, CRF, HTN kidney disease, COPD; Physician Documentation of condition/treatment can often be vague or missed.
313 - Chest Pain		This condition should not be used when a related definitive condition is present. Related conditions may include GastroIntestinal Disorder, Heart Failure, Arrhythmias, COPD. Need to query physician for treatment rendered.
312 - Syncope		Principal Diagnosis of Syncope is a symptom that may be sequenced first if no definitive condition found, or if followed by comparative/contrasting conditions. Ie. TIA, heart block, sick sinus syndrome, anemia
195 - Simple Pneumonia wo MCC/CC		Look for possible organisms to code Pneumonia more specifically, query for physician documentation of relevance to cultures; consider common MCC's such as decubitus ulcer, acute renal failure, COPD exac
189 - Simple Pneumonia w MCC		Look for organism, ie bacterial to specify type of Pneumonia. Consider co-morbidities as possible PDX: Respiratory Failure, COPD Exac, Septicemia, CHF
641 - Nutr/Metab w/o MCC		Underlying conditions or manifestations for treatment may be not be clearly defined in this group, ie. UTI, candidiasis, pleural effusions, gastrointestinal disorders.
177 - Respiratory <i>Inf</i> w/MCC		Clear physician documentation to support specific pneumonia or infectious organism for this DRG, & specific treatment relevant to condition. Common MCC's to look for: development of septicemia, acute resp failure, COPD or HF exac.
65 - Infarct w/CC		Atrial arrhythmias are often found in these patients, need to assess for further heart conditions including Acute Heart Failure. CC's may include malnutrition, paralytic dz.
392 - Esophagitis/GERD wo MCC		Co-morbid related conditions to assess for: esophageal or GI hemorrhage, candidiasis, infectious processes or other conditions such as malnutrition or infectious processes.
249 - Perc CV PX w/ NDES w/o MCC		Documentation of type & # of CV stents placed is necessary for coding assignment which impacts DRG. MCC's to consider: Acute MI, Acute Heart Failure, Pulmonary Heart Dz.
189 - Respiratory Failure		Acute Respiratory Failure may be incorrectly used as principal diagnosis when there are chapter specific (poisoning, HIV, OB & NV) guidelines that provide alternative sequencing directions

# Trinity Health RAC Risk Assessment Report

Purpose: to focus on RAC program risk for Trinity Health and to develop actions to mitigate future risk

Risk Assessment Report\* includes the following details:

- Areas of Exposure- most vulnerable to TH
- Risk Details-what factors create a risk
- Appeal Strategies – use of appeal templates to include guiding references
- MO Education/References – provide resources for further education and resources used for assessment defense strategy

\*includes risk for both overpayment and underpayment

# Risk Assessment Report Example

Provider Type	Area of Exposure Incorrect Coding/Reporting	Risk Details	Actions	
			Appeal Strategy	MO Education
Inpatient Acute Hospital	<b>Congestive Heart Failure</b>	<p>Medicare RAC 3-year demonstration project reflects that circulatory system diagnoses ranked fifth in underpayments to providers due to incorrect coding.</p> <p>Incorrect assignment of principal or secondary diagnosis.</p> <p>Incorrect reimbursement due to over-coding and/or under-coding.</p> <p>Pre 10/1/2007 (CMS DRGs) All CHF codes were CCs</p> <p>Post 10/1/2007 (MS DRGs)</p> <ul style="list-style-type: none"> <li>CHF codes are now categorized by Non CC/MCC, CC or MCC</li> <li>Reflects severity of illness</li> </ul> <p>Physician documentation is critical in coding CHF</p>	<p>Review record for documented clinical indicators</p> <ul style="list-style-type: none"> <li>Chest Xray</li> <li>Echocardiogram</li> <li>Treatment with Lasix</li> <li>Thoracentesis</li> <li>Edema</li> <li>Pleural effusion</li> <li>Site of CHF</li> <li>Severity of CHF</li> </ul> <p>Post bill physician queries</p> <p>Additional supporting documentation from official coding guidelines and sources</p> <p>Concurrent and pre-bill physician queries</p> <p>ICD-9_CM Official Guidelines for Coding and Reporting</p> <ul style="list-style-type: none"> <li>Section II. Selection of Principal Diagnosis</li> <li>Section III. Reporting Additional Diagnoses</li> </ul>	<p>ICD-9-CM Official Guidelines for Coding and Reporting</p> <ul style="list-style-type: none"> <li>Section II. Selection of Principal Diagnoses</li> <li>Section III. Reporting Additional Diagnoses</li> </ul> <p>AHA Coding Clinic for ICD-9-CM: Coding guidelines for coding Congestive Heart Failure in different scenarios</p> <ul style="list-style-type: none"> <li>2009, first quarter, page 8 (coding scenario 1): Systolic dysfunction with congestive heart failure</li> <li>2008, third quarter, page 12: Exacerbation of diastolic congestive heart failure</li> <li>2008, third quarter, page 12-13: History of diastolic congestive heart failure (coding scenario 2)</li> <li>2006, third quarter, page 7: Systolic and diastolic congestive heart failure</li> <li>2004, fourth quarter, page 140: Acute systolic/diastolic congestive heart failure</li> </ul> <p>Maxim Health Information Coding Corner April 2008 The MS-DRG Training Handbook, HCPPro AHIMA Audio Seminar, June 3, 2004 Medicare RAC 3-year Demonstration Project Evaluation</p>
Inpatient Acute Hospital	<b>Respiratory Diagnoses with ventilator support</b>	<p>Demonstration project areas of risk for both overpayments and underpayments.</p> <ul style="list-style-type: none"> <li>#5 in the Top Services with RAC initiated overpayment collections</li> <li>#4 in the Top Services with underpayments refunded to</li> </ul>	<p>Reference to Official Coding Guidelines, including, the 'Selection of Principal Diagnosis' Section (II) within the ICD-9-CM Official Guidelines.</p> <p>Also, use of ICD-9-CM instructional notes, "use</p>	<p>Procedure codes 96.71 and 96.72 that drive DRG's 207 and 208 must be appropriately assigned for the treatment provided.</p> <p>A code from category 96.7 other continuous mechanical ventilation, is only assigned when there is evidence of an endotracheal tube or tracheostomy, as required for the use of category 96.7 (see instructional note under category 96.7 in ICD-9-CM manual)</p>

# Additional Data Mining for RAC Targets

Additional Trinity Health RAC team activities:

- Auditing at the facilities & data mining through financial reports or benchmarking reports for potential risk areas
- Analyze RAC denial data as reported from our RAC tracking database to identify trends in denials across Trinity Health and at specific Facilities
- Identify subject areas for targeted physician and staff education and intervention to reduce future denials

# Defense Strategy 2- Coding Education

Education Sessions target High Risk Areas

Trinity Health RAC team offers monthly coding education sessions to the Hospitals within the organization to:

- Identify high risk RAC target areas
- Provide current Coding education and references/resources
- Strategies for the RAC team coding appeal process
- Include Case scenarios

# Coding Education

- Sessions are recorded on Centra sessions for repeated review
- Provided to Coding and Clinical Documentation teams
- Live Q/A and Discussion session follows each presentation
- Document (zip file) created for all references and resources used in the presentation
- Available to all Trinity Health via Nexus Intranet

# Defense Strategies 3- Appeal Strategy

The Trinity Health RAC appeal process has been designed with the expectation that we will aggressively appeal all denials

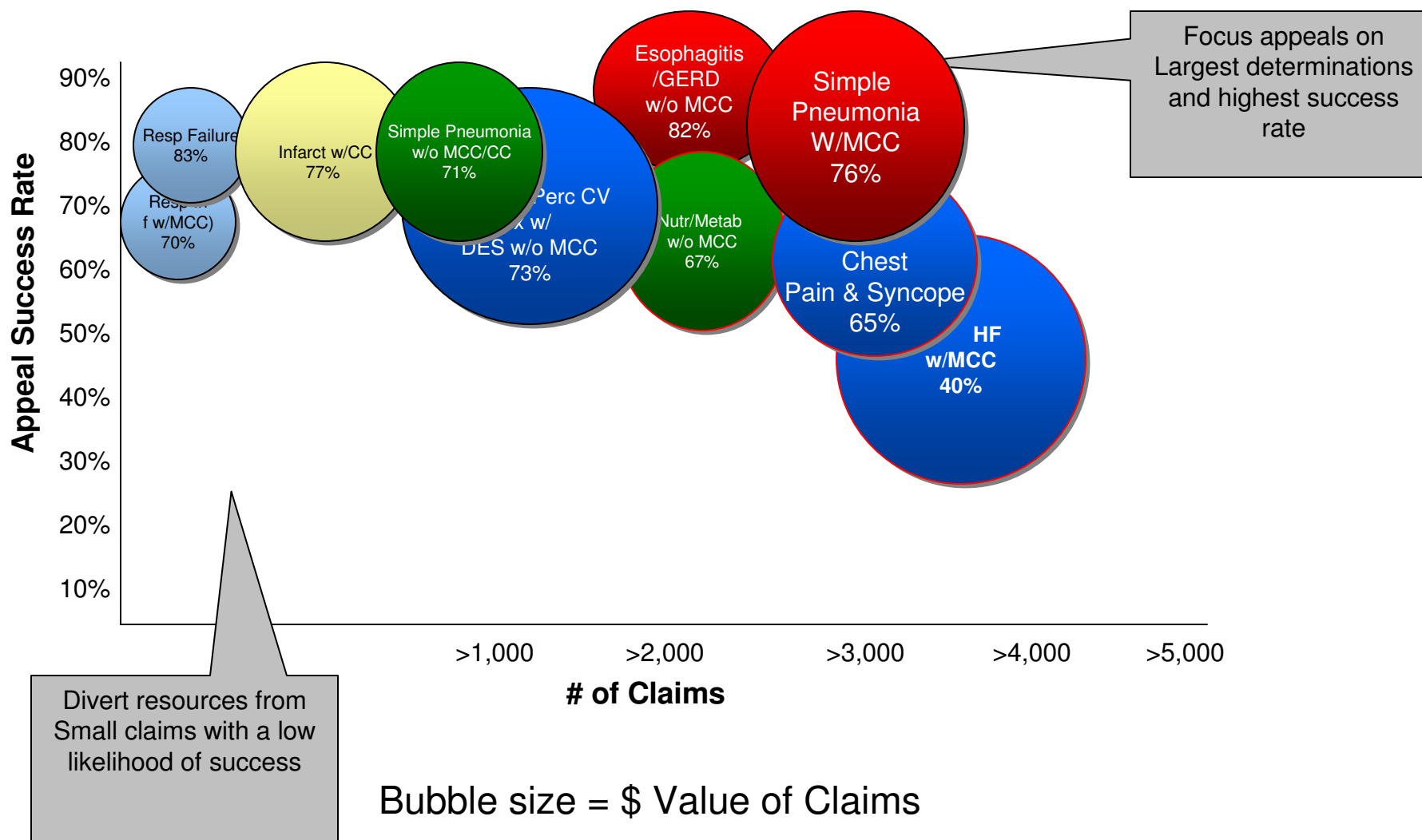
# Processes to Manage Appeals

- The URO RAC Defense Unit will:
  - Process all RAC record requests and initial denials to allow for tracking of volumes, types of denials and turn around times
  - Coding Denials: Review and assess RAC findings in comparison to the facility coding and supporting medical record documentation to pursue appeal as appropriate
  - Decide to agree with the RAC or pursue coding appeals, as appropriate. Represent the hospital during the appeal process
  - Medical Necessity Denials: Review and assess RAC basis for claim denial, coordinate response with site Case Management including physician reviewers and consulting resources to appeal as appropriate
  - Coordinate medical necessity determination review with Case Management and EHR management of appeals Level 1 – 3.

# Demonstration Project Lesson Learned- Tracking Appeals

- “Tracking appeals is the single most important way to survive a RAC audit because it allows you to prioritize your appeals”
- Trinity Health Response
  - In the RAC Tracking Database appeals will be categorized into coding/DRG, medical necessity (one-day inpatient stays) and other (outpatient billing guidelines, unanswered CMS questions, incorrect discharge status)
  - Strategies developed for denial types
  - High risk denials will be prioritized
  - Preventive education will be developed

# RAC Risk Assessment Findings: Strategically Appeal High Dollar and Success Rate



# Coding Appeal Templates

URO RAC Team is developing Coding Appeal Templates

- For high-risk target areas identified in the RAC education sessions, and include such topics as Sepsis, Acute Respiratory Failure and Discharge Disposition
- Templates include the references for appeal support, including billing regulation guidelines, official coding guidelines or local policies.
- The appeal templates are posted on the Nexus RAC site and also can be used by Ministry Organizations for denials issued by other entities such as Medical Administrative Contractors (MACs)

# Demonstration Project Lesson Learned: Need for cross-functional team

- Importance of a cross-functional team that oversees risk assessment, physician education and collaboration
- Trinity Health Response
  - Hospitals have established RAC Coordinators and RAC Response teams responsible for providing continuous education on documentation necessary for medical necessity and coding, as well as process
  - The risk assessments are completed to identify education opportunities for Facility specific RAC Response teams
  - Trinity Health RAC team is collecting Facility RAC Response team minutes to track education provided by the site RAC Response team
  - RAC Advisory and Steering team charters and standing agendas in place, include members from TH home office and each Facility
  - RAC Advisory team meetings, for touch- base calls, to discuss process
  - RAC Steering team meetings to discuss trends and education needs across Trinity Health

# Strategies to Prevent Future Denials

- UEM and MO RAC Response teams to address the RAC process and findings
- Implement concurrent best practices and tools in the following areas:
  - **Case Management** best practices, using Executive Healthcare Resource physician advisors, insure appropriate compliance with admission criteria and documentation
  - **Clinical Documentation Improvement programs** aimed at providing MOs with the organization structure to support standards in practice; re-enforcing physician change through one-on-one education
  - **Charge Assignment** validation pilot
  - **Coding pilot** focused on automating data mining capabilities, producing quality monitoring reports, conducting internal chart audits of potential risks, and to provide standard and custom-based edits to address inconsistencies in practice
  - **Billing** auditing focus to identify pre-claim edit violations and developing best practices to process and report overpayment take-back and communicate take-back and deductible impacts to patients
  - **Audit process** to manage RAC requests and denials, analyze trends and rationale across Trinity Health. Identify areas to reduce future denials and provide education to Documentation Improvement Steering Teams and RAC Response Teams

# Managing Appeals of RAC Denials - In Progress

Developing aggressive appeal strategies and education material to share with MO Documentation Improvement Steering teams.

Documentation Improvement steering teams and task forces are driving education of compliant documentation to physicians and hospital staff.

*Process drills insure the roles and responsibilities of Central Operations and Hospitals are in place prior to RAC audits to avoid missing deadlines; as well as address process improvement requirements.*

Developing billing and patient communication practices based upon what we learn from the RAC Demonstration project. Providing training updates to facilities.

Developing RAC operational and financial metric reports using both Quickbase Business Objects reporting tools.

# Managing Appeals of RAC Denials - Completed

Created a Central Operations team

Developed a RAC tracking database to monitor record requests and capture the status of the RAC determination.

Variance-based data mining and chart audits identify areas of risk and action plan

Developed physician documentation clarification and coding query policy and procedures

The Health Record Quality and Coding Functional Change Management model provides guidance for decision-making when systemic changes to the EMR and/or standard processes or policies are necessary

# High Level RAC Team Work Plan

Activity	Completed By:	Who	Status
1. Monthly Risk Assessment	February 2009	RAC Mgr & team	Completed
2. Monthly MO Coding Education	April 2009	RAC Coding team	Completed
3. Implement UEM Data reporting & metrics at all MOs	September 2009	All MOs	Planning Initiated
4. Identify EMR/Cerner improvements required and develop a work plan for development/Implementation	March 2009	DI Steering, TIS, Cerner	In Progress
5. Implement Continuing Education Improvements	June 2009	All MOs	In progress
6. Increase compliance with DI program framework standards, including increasing the number of CDS staff to conduct concurrent review within 8-24 hours of admission at all MOs for all DRG-based payers	June 2009	All Mos	In progress
7. Conduct LEAN process improvement initiative	TBD	TBD	Planning Initiated
8. Monitor Metrics, identify best practices, identify variations and improvement opportunities	On-going	All MOs DI Steering URO Leadership	Initiated
9. Implement a Physician Advisor Process for medical necessity supporting case management and RAC activity	December 2008	All MOs	Complete
10. Establish a DI physician champion network and education/mentoring program by FY09	June 2009	All MOs	In progress

# CMS Updates Timelines (June 2009)

- RAC Automated Reviews are expected to begin in late June or July-*as of July 24<sup>th</sup> no issues have been posted, no reviews have been received*
- RAC Complex Reviews (Diagnostic Related Group validation and coding) to begin in the Fall 2009
- RAC Complex Reviews for Medical Necessity to begin in early 2010
- RAC Discussion period has been extended to give providers the option of 41 days following the date of the demand letter

# Trinity Health RAC RACI Matrix

- **R “Doer” = Responsible for the completion of the action**
- **A “Buck Stops Here” = Accountable for the success of the action**
- **C “Included” = Consulted to provide guidance prior to decision-making**
- **I “FYI” = Informed of the action post decision-making**
- **- “N/A” = This touch point does not have a role**

Activities	RAC Workstream									Touch Points					
	HIM ROI	HIM Director/Coding Mgr	URO RAC Project Team	URO RAC MGR	Health Port	MO UR/CM & EHR	MO PFS	RAC	Director VP QHR/Coding	MO RAC Response Team	Quality Health Record Council	UEM Clinical Leadership Council	MO Document Improve Steering	UEM Document Improve Steering	URO Revenue Advisory Council
Receive Record Request from RAC & Process	I	I	R	A/C	-	-	-	-	-	-	-	-	-	-	-
Prepare Record/Scan letter and Chart into PowerChart	I	I	R	A/C	-	-	-	-	-	-	-	-	-	-	-
Process request via Vista Report, enter into Quickbase	I	-	R	A/C	-	-	-	-	-	-	-	-	-	-	-
Review Record for Completion/Validate quality of data/documentation	R	A/C	I	I	-	-	-	-	-	-	-	-	-	-	-
Process requests for record print/burn to CD	R	A	I	I	R	-	-	-	A	-	-	-	-	-	-
Review Record in HealthPort Connect & Approve/Disapprove	R	A	I	I	I	-	-	-	A	-	-	-	-	-	-
Send Record to RAC	A	I	C	C	R	I	-	-	A	-	-	-	-	-	-
Approved or Deny Claim	I	I	I	I	-	I	I	R	-	-	-	-	-	-	-
Receive Determination Letter/Scan into Powerchart	-	I	R	A/C	-	-	-	-	I	-	-	-	-	-	-
Process Determinations via Vista Report, update Quickbase	-	I	R	A/C	-	-	-	-	A	-	-	-	-	-	-
Process Technical Denials	-	A	C	R	-	-	I	I	A	-	-	-	-	-	-
Review & Process Coding Denials	-	C	R	A	-	-	-	I	A	-	-	-	-	-	-
Review Automated Denials	-	I	C	R	-	I	C	I	A	-	-	-	-	-	-
Review & Process Medical Necessity Denials	-	C	C	I	-	A/R	-	-	A	-	-	-	-	-	-
Notify PFS when no appeal	-	A/C	R	C	-	R	I	I	A	-	-	-	-	-	-
Payment Adjustments in Healthquest	-	C	-	I	-	-	R	-	A	-	-	-	-	-	-
Appeal Coding Denial	-	C	R	C	-	-	-	I	A	-	-	-	-	-	-
Appeal Medical Necessity Denial	-	C	I	I	-	A/R	-	I	-	-	-	-	-	-	-
Mail additional supporting documentation with appeal letters	-	C	R	A	-	C	-	I	A	-	-	-	-	-	-
Update Quickbase	-	I	R	A/C	-	R	-	-	A	-	-	-	-	-	-
Process additional Coding Levels same as Initial Determination Letter	-	C/I	R	R/C	-	-	-	-	A	-	-	-	-	-	-
Process additional Medical Necessity Levels same as Initial Determination Letter	-	C/I	I	A	-	A/R	-	-	-	-	-	-	-	-	-

Activities	RAC Workstream									Touch Points					
	HIM ROI	HIM Director/Coding Mgr	URO RAC Project Team	URO RAC MGR	Health Port	MO UR/CM & EHR	MO PFS	RAC	Director VP QHR/Coding	MO RAC Response Team	Quality Health Record Council	UEM Clinical Leadership Council	MO Document Improve Steering	UEM Document Improve Steering	URO Revenue Advisory Council
URO RAC to MO RAC: Coding & Standards, Oversight, Training, Education	-	-	R	R	-	-	-	-	I	A	C	-	-	-	I
MO RAC to URO RAC: Report progress, Escalate issues	-	-	A	A	-	-	-	-	I	R	C	-	I	C	I
URO RAC to URO REV: Recommendations, Report progress, Escalate issues	-	-	R	R	-	-	-	-	A	I	C	I	C	C	A
URO REV to URO RAC: Approval, Oversight, Prioritization	-	-	C	A	-	-	-	-	C	I	C	I	I	C	R
UEM DIST to MO DIST: Standards, Oversight, Training, Education	-	-	C	C	-	-	-	-	C	I	C	C	A	R	I
MO DIST to UEM DIST: Report progress, Escalate Issues	-	-	C	C	-	-	-	-	C	I	C	C	R	A	I
UEM DIST/QHRC to UEM CLC: Recommendations, Report progress, Escalate issues	-	-	C	C	-	-	-	-	C	I	R	A	I	R	I
UEM CLC to UEM/QHRC: Approval, Oversight, Prioritization	-	-	C	C	-	-	-	-	C	I	A	R	I	C	I
QHRC to UEM ClinGrps: Direction, Standards, Priorities	-	-	I	I	-	-	-	-	C	I	R	A	I	C	I
UEM ClinGrps to QHRC: Recommendations, Escalate issues	-	-	I	I	-	-	-	-	C	I	A	R	I	C	I
Decision making for Cost (\$)	-	-	A	A	-	-	I	-	C	-	-	-	-	-	R
MO Issue/Solution	-	-	C	A/R	-	-	-	-	I	A/R	C	I	C	C	I
Systemic Issue/Solution Approval	-	-	R	R	-	-	-	-	A	I	C	C	I	R	R
Systemic Issue/Solution Review & Establish Standards/Oversight	-	-	R	R	-	-	-	-	I	A	C	I	C	R	I
Education & Training/ Communication of Solution	-	-	R	R	-	-	-	-	I	A	C	-			