Collaboration "The Secret Sauce"

nThrive Speakers Bureau // Sample Presentation

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Agenda

- Introduction
- Regulatory Issues impacting healthcare
- Coding and CDI Role in Revenue Integrity
- What is Denials Management and strategies to prevent downstream revenue cycle problems?
- Discover best practices for effective implementation strategies
- Process Improvement Initiatives
- Metrics
- Technology
- CDI link to Quality Measures, Care Coordination, Revenue Integrity and Denials Prevention

ICD-10 Denial Rate Starting to Climb

May 2016 ICD-10 Monitor Survey[1]

After the ICD-10 implementation, "for an average-sized hospital the average increase in denials could be $1 to $3 million."

Top four ICD-10 denial types were related to:

1. Medical necessity
2. Use of unspecified codes
3. Hospital/provider procedure coding errors
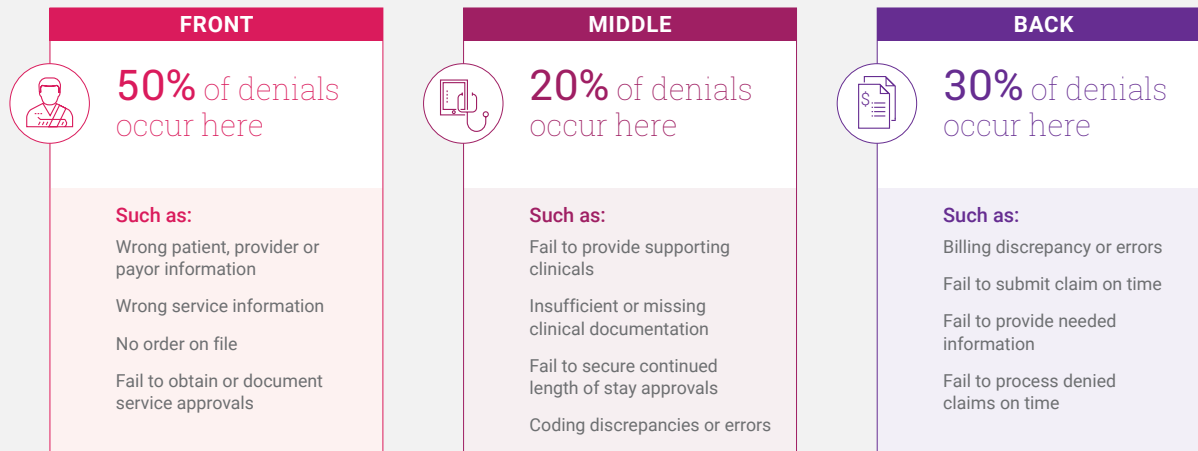4. Hospital/provider diagnosis coding errors

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CDI Role in Denial Prevention

CDI's role is to verify clinical evidence within the medical record documentation to ensure diagnoses that are most vulnerable to clinical validation denials. 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.

About Denials
Denials occur when a claim payor does not pay all or part of a claim. Most denials are the result of process failures occurring upstream in the revenue cycle process (i.e., before the denial is received).

FRONT

50% of denials occur here

Such as:

Wrong patient, provider or payor information

Wrong service information

No order on file

Fail to obtain or document service approvals

MIDDLE

20% of denials occur here

Such as:

Fail to provide supporting clinicals

Insufficient or missing clinical documentation

Fail to secure continued length of stay approvals

Coding discrepancies or errors

BACK

30% of denials occur here

Such as:

Billing discrepancy or errors

Fail to submit claim on time

Fail to provide needed information

Fail to process denied claims on time

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COLLABORATION
Coding and CDI Leadership Working with Providers

Educate **providers** on quality documentation to meet **ICD-10-CM** and **ICD-10-PCS** coding guidelines as well as success under MIPs/APMs

Review any trend in **DRG** or **APR-DRG** discrepancy or denials

All HACs are reviewed pre-bill

Discuss clinical indicators of commonly targeted **CCs/MCCs and Principal Dx by RACs**

All DRG denials accepted by the facility are reviewed

Validation Process of CDI diagnoses and coding summary align

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Collaboration is Needed to Result in Clinical Documentation Integrity

- IP OP ED Patient Encounter
- Clinical Documentation
- CDI & Case Management
- ICD-10 & CPT Coding
- Compliance Monitoring
- Quality Collection Reporting
- Informatics & Analytics

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