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Leveraging ADT, HL7 Data May Help Hospitals Prevent Denials

By Nina Youngstrom

A Medicare auditor downcoded a hospital's high-dollar MS-DRG claim for an implantable cardioverter defibrillator (ICD) because the cardiologist's documentation didn't square with Medicare's revised national coverage determination (NCD 20.4).[1] There was no evidence of formal shared decision-making between the physician and the patient before the procedure using an evidence-based decision tool, and the medical necessity boxes weren't checked, leaving the hospital to foot the bill for the device when the MS-DRG was changed to heart failure and shock.

"If you don't get this right in the clinic before the scalpel touches skin, you will get a denial later by audit, whether it's a private payer or CMS," said Kendall Smith, M.D., chief medical officer of Intersect Healthcare + AppealMasters in Towson, Maryland. "We can argue until we're blue in the face to administrative law judges. They're sympathetic to hospitals, but they're limited by what's in the medical record."

Hospitals are far better off preventing denials by getting payer-specific coverage requirements (e.g., NCDs, clinical policy bulletins)[2] into the hands of physicians and other clinicians before patients have procedures or are discharged from the hospital rather than appealing them, he said at a May 26 webinar[3] sponsored by the company. This is very challenging because hospitals treat patients covered by many different payers that change their payment and coverage policies on a regular basis. To do a better job of preventing denials, hospitals may move in the direction of payer documentation integrity (PDI), an "amalgamation" of utilization review and clinical documentation integrity (CDI) and "the future of CDI," Smith said. Hospitals would leverage their own data sets from admissions, discharges and transfers (ADT) and Health Level 7 International (HL7).