

Podcast episode transcript: Diana Ortiz and Mary Bourland

Diana Ortiz: Welcome to Inside Angle from Solventum. I'm Diana Ortiz, and today I will be talking with Dr. Mary Bourland, who is representing Mercy Health. Today we're going to be focused on the discussion of denials. So welcome Dr. Bourland.

Mary Bourland: Thank you.

Diana Ortiz: Good to have you. So can you tell me a little bit about the work that you do and what your role is at Mercy Health?

Mary Bourland: Yes. So the role I play at Mercy is what I consider inpatient solutions in that we have our outpatient coding team, our inpatient CDI team and our inpatient physician advisors that are very tied together closely. And then we also have a DRG down code denial team that we interact with. And so what we try to do is educate where we can with documentation and intersect that with our physician advisors who really train the physicians on a peer-to-peer basis better than a CDI or coder trying to lead that conversation.

Diana Ortiz: That sounds fantastic. It sounds like the dream team bringing all the right roles together to drive change. So since we're talking about denials, and I'm sure you've got lots of data and insights into the struggles that you face on a daily basis, can you tell me what types of cases or diagnoses or clinical conditions you often see that are denied? And what kinds of changes have you been able to implement across your teams?

Mary Bourland: The types of denials have really not changed over the 10 years that I have been in this role. Sepsis is number one, acute respiratory failure, encephalopathy, malnutrition. Those are the top ones. Usually the payers. There's two kind of types of denials, very payer oriented, and then weak documentation. So more of a clinical validation denial. We see very few coding errors themselves anymore with all of our great tools with computer assisted coding and auditing, et cetera, very few actual coding errors. It all comes down to payer behavior and to validation of the documentation with the clinical indicators. And what we've seen at the top is sepsis, especially A41.9, which is unspecified sepsis where you have two SIRS and an infection, but the infectious source, there's no organism. And most of the payers almost deny that, just carte blanche.

And so that's a real challenge. We've tried lots of different things, but what we have found is that the payers follow Sep-3 guidelines. Even the government is starting to follow Sep-3 guidelines in the racks. We've seen rack denials come back with ... Appeals come back with Sep-3 criteria to deny once again. And so what we're finding is that even though CMS says that they have not officially recognized Sep-3 and their Sep-2 compliance bundle is based on Sep-2 criteria. What we're seeing is that that's not really what's working across the nation. I talked to some of our colleagues this morning about it because there's so much about sepsis and Sep-3, and it's a divided fence.

Many of them say we're following Sep-2 and we want to catch those early sepsis cases and identify them as such. And a whole other group is saying, we can't fight the denials anymore. We're just losing so much, not only workforce, but also reimbursement that's rightly ours. So

they've adopted Sep-3 criteria. And so I think we're all marching towards some kind of a modified Sep-3. At the end of the day, I don't think we're going to be able to survive the sepsis tsunami unless we adopt a different criteria and make it standard across the nation for both payers and providers.

Diana Ortiz: Yeah. Wow, that's a lot. So do you do a lot of education with your providers around clinical validation on that and other topics?

Mary Bourland: We do. And we have a sepsis task force in Mercy, and they help us do the education. So it's not just educating to prevent a denial. It's an education for preventative care and for patient care. And to really make those providers understand how to be aggressive with the severe sepsis patients with organ dysfunction, how to link that documentation, how important it is to identify the organism with sepsis if possible, and link it back to the sepsis. And that's important for our sepsis bundle compliance, which is the part of our value-based payment in today's world.

Diana Ortiz: Yeah, definitely the intersection of financial and quality. So have you guys implemented maybe beyond education or anything around things that are done to mitigate these challenges and denials? I know you mentioned coding and the tools that are in place on that side, but other maybe technology, things that you're thinking about or have done, interventions to try to work more proactively?

Mary Bourland: Two things we have done. The first, we have a virtual sepsis care team, which is a group of ICU nurses and physicians that are localized at our virtual center and they watch our Epic triggers for sepsis. And when a patient is identified as a septic risk, then they look at that patient's chart in real time and interact with the providing physician. If we need to start the sepsis bundle with time zero. They're so good at what they do and have really decreased our mortality rate. I can't tell you how having a virtual team or some type of team that is alerted by discrete data sets in Epic could help decrease our mortality and sepsis, which is what we're after at the end of the day.

And then the other part we've done is we've taken six of our CDI and made them sepsis experts and built a Epic work queue so we can put a stop bill on it so it doesn't get billed. So it's after it's coded, even if a CDI has seen it during their stay, after it's coded, if it's A41.9, which is unspecified sepsis, it will go to this work queue and stop for all payers. And then this team of six will work those, look at them for clinical validation, for further clarification of the documentation to enhance the documentation that needs to be interacted with the provider. So it's very close to when the provider has actually seen that patient so they haven't really forgotten the case, so to speak.

So we've used that for 30 days and we're already finding good results and being able to get better clinical indicators in the chart from the providers. And it's also a good training tool for them because they're able to talk to the providers and go back and forth with them about why. So looking forward to how that comes out. We're only 30 days into it, but I think we're going to see good value from that.

And then the last part is we have a sepsis task force, and from the providers, virtual, front end, ED, everybody's on it, coding, CDI, myself. And we're trying to solution for all of these things, looking at the pros and cons to each. I can tell you that the providers that we talk to about denials really push back and say, "Sepsis and the Sep-2 criteria were invented and were formed

because it saves lives. We're sorry you don't get paid a lot of times, but we're going to keep practicing the way we do because it saves patients' lives." So that led us to engage with a research team that's doing biomarkers, and I think they just got FDA approval and I'm sorry, I don't know, I can't remember their name. But they have been doing studies on patients that look early sepsis and doing biomarkers and can kind of stratify the patients into, they have a less than 10% chance of developing sepsis, or these patients with these biomarkers have a 90% chance of getting sepsis, and so start them on the pathway. Lots going on with sepsis and sepsis denials.

Diana Ortiz: That's fantastic. And phenomenal projects that you guys are doing. All of those things and the accuracy of reporting certainly drive towards outcomes and change and things that are measurable. So you talked a little bit about the interacting with physicians and since you're a physician, curious on your perspective on as we try to do things and intervene to mitigate denials, thoughts on surfacing intelligence much earlier in a physician's workflow at the point of documentation around concepts that could be mitigated very early on and prevent denial. So thoughts on that?

Mary Bourland: I think it's our upcoming future with physician documentation and physician interacting with AI tools. There's a lot of great tools out there, and they have come a long way since their invention, since they've been invented, and the physicians are starting to engage with it more and starting to actually seek out computer assisted physician documentation. Part of that is the AI tools have gotten better so that they're not getting interrupted. It's actually a part of their workflow. And so I do think that that's the future of provider documentation, and hopefully it'll do it for the nurses as well, because my goodness, they have a tremendous nurse documentation burden as well.

Diana Ortiz: Well, I want to thank you so much for coming and sharing your challenges, your successes, and the innovation that you bring to the industry. So thank you so much.

Mary Bourland: Thank you.