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Association for Healthcare Denial and Appeal Management

Presents

Identifying Clinical Validation Denials and Creating Successful Appeal Strategies

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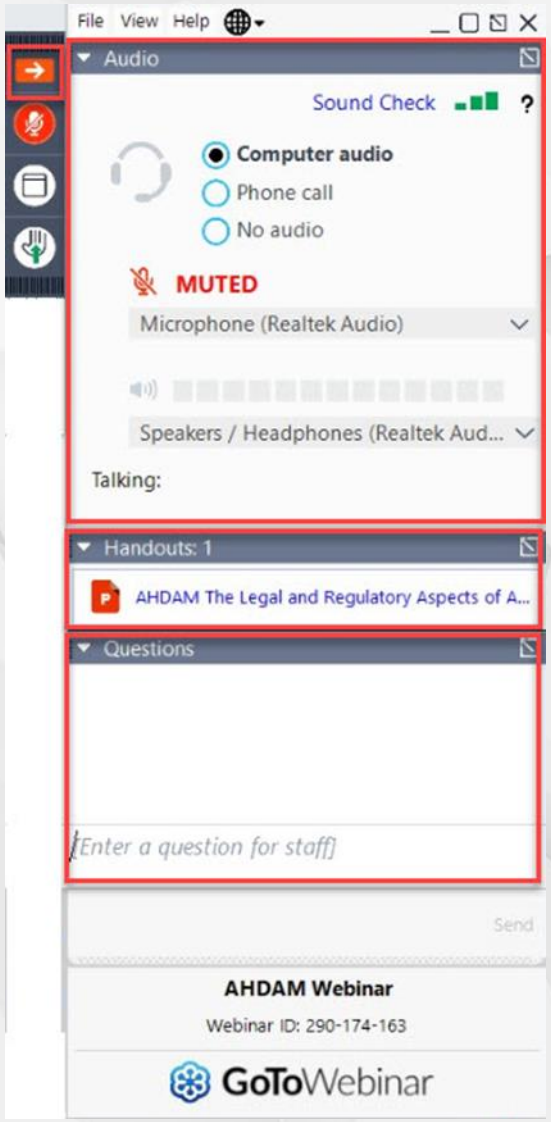

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- From the survey you will be prompted to select desired CEUs:
  - Association of Clinical Documentation Improvement Specialists (ACDIS): Certified Clinical Documentation Specialist (CCDS)
  - National Association of Healthcare Revenue Integrity (NAHRI): Certification in Healthcare Revenue Integrity (CHRI)
  - Commission for Case Manager Certification (CCMC): CCM board certified case managers
  - American Health Information Management Association (AHIMA): Certified health information management professionals
  - American Nurse Credentialing Center (ANCC): Continuing nursing education

    This nursing continuing professional development activity was approved by Northeast Multistate Division, an accredited approver by the American Nurses Credentialing Center's Commission on Accreditation.

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Next Webinar

Managing Level of Care Denials in a Managed Care World

Wednesday, December 2, 2020

2 P.M. Eastern Time

Featured Speaker: Denise Wilson, President AHDAM

Register at www.ahdam.org

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AHDAM – Association for Healthcare Denial and Appeal Management

- The nation's only association dedicated to Healthcare Denial and Appeal Management.
- Our mission is to support and promote professionals working in the field of healthcare insurance denial and appeal management through education and collaboration.
- Our vision is to create an even playing field where patients and healthcare providers are successful in persuading medical insurers to make proper payment decisions.

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Presenter

Karla Hiravi, RN, BSN; Clinical Audit and Appeal Services, Denial Research Group - AppealMasters

Karla is a registered nurse and holds a BSN from the University of Pittsburgh, Johnstown. She has over thirty years of varied experiences in healthcare, including Clinical Documentation Improvement/Integrity (CDI), development of a hospital based denial and appeal program, development of an oncology research program, nurse and physician education, appeal writing, presentations at the Administrative Law Judge (ALJ) level, and direct management of appeals at every level, up to post ALJ appeals. Karla has been with the Denial Research Group – AppealMasters since 2016 and continues to participate in and educate about the medical appeal process.

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Learning Outcomes

1. Explain 3 ways to determine if a denial is an inpatient clinical validation denial
2. Describe 3 winning strategies for appealing clinical validation denials

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Terminology

DRG Validation versus Clinical Validation (CV)

Per CMS, a DRG Validation Review:

- ✓ Ensures that diagnostic and procedural information**…**as coded and reported by the hospital on its claim, **matches both the attending physician's description and the information contained in the beneficiary's medical record.**

Medicare Program Integrity Manual Chapter 6.5.3 - DRG Validation Review (Rev. 608, Issued: 08-14-15, Effective: 01-01-12, Implementation: 09-14-15)

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/pim83c06.pdf

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Terminology

DRG Validation vs. Clinical Validation

- DRG Validation is the process of reviewing physician documentation and determining whether the correct codes, and sequencing were applied to the billing of the claim. This type of review shall be performed by a certified coder.

- For DRG Validations, **certified coders** shall ensure they are not looking beyond what is documented by the physician, and are not making determinations that are not consistent with the guidance in Coding Clinic.

Terminology

DRG Validation versus Clinical Validation (CV)

Directs reviewers to question the clinical validity of diagnoses.

"Clinical validation," becomes part of Centers for Medicare and Medicaid Services (CMS) Recovery Auditor Contractor (RAC) Statement of Work (SOW), Sept 2011

(This SOW is no longer available on the CMS website, but if you have a copy of the SOW, clinical validation appears on p. 23.)

Terminology

DRG Validation versus Clinical Validation (CV)

CMS RAC Statement of Work, Sept 2011

"Clinical validation is a separate process, which involves a clinical review of the case to see whether or not the patient truly possesses the conditions that were documented. Clinical validation is beyond the scope of DRG (coding) validation, and the skills of a certified coder. **This type of review can only be performed by a clinician** or may be performed by a clinician with approved coding credentials."

To be clear: This is a statement from CMS indicating their intent to employ clinicians, rather than coders, to perform clinical validation reviews. This does not mean coders at provider entities cannot or should not be involved in responding to clinical validation audits, denials, or appeals.

Coding Denial Examples

- AKI is denied based on Coding Clinic, Fourth Quarter 20xx: Page 20.
- AKI is denied because a nephrologist was not consulted.
- AKI is denied because the documentation is not clear or consistent and was not included in the discharge summary.
- AKI was sequenced as the principal diagnosis. The more appropriate principal diagnosis is syncope.

More Coding Denial Examples

- ATN is denied because significant resources were not used in the management of the diagnosis.
- ATN is denied because a query was warranted in the situation, but not found.
- ATN is denied because the query was noncompliant.
- The diagnosis of ATN is not found in the medical record.

Clinical Validation Denial Examples

- The diagnosis of ATN is denied based on no muddy casts in the U/A and no renal biopsy was performed.

  Source: Harrison's Principles of Internal Medicine

- Acute blood loss anemia is not validated because the EBL was only 100cc.

- Sepsis will be removed because SOFA criteria was not met.

  Source: The Third International Consensus Definitions for Sepsis and Septic Shock

More Clinical Validation Denial Examples

- Encephalopathy will be denied because the patient was described as being alert and neurologically intact.
- AKI is denied because the patient was not treated with aggressive hydration.
- Acute respiratory failure is denied because the patient responded quickly to oxygen supplementation, going from an O2 sat of 88% to 94% on 4L oxygen.

Strategy: Make It Easy For The Reviewer

Create a “Roadmap”

- The easier it is to find the information you state is true, the easier it will be for the reviewer to find in your favor.
- Utilize document names and page numbers to assist the reviewer

Your appeal should reveal:

1. WHERE the diagnosis is documented
2. WHY the diagnosis was made
3. Additional JUSTIFICATION for the appeal, as applicable
4. Supportive CODING rationale (only a little)
5. Applicable clinical medical sources to BACK UP YOUR ARGUMENTS

Let's Put It All Together: Case Study #1

Denial:

Per the guidelines referenced below, pancytopenia is a clinically significant and abnormally low level of all blood cells produced by the bone marrow. This includes a clinically significant low level of red blood cells (RBCs), white blood cells (WBCs), and platelets.

Though the WBCs and platelets were significantly low, the hemoglobin and hematocrit levels did not meet the clinical criteria for this diagnosis. The secondary diagnosis of pancytopenia continues to be denied.

Where Is The Diagnosis?

The diagnosis must be documented.

- If not, it is a hard stop.

In a perfect scenario, best practice is to show in your appeal where the diagnosis is documented at these times:

- when first considered (rule out...)
- when verified the first time
- from the middle of the hospital stay
- from any consultants
- at the time of discharge

Where Is The Diagnosis?

Document Source & Date	Pertinent Information	Page(s)
H&P, 12/17/19	77 yo Male direct admit from oncologist's office with weakness, cough, and **pancytopenia** ... CT showed LLL pneumonia	182
Progress Notes, 12/18/19	**Pancytopenia** likely from chemo. Slightly improved.	185
Oncology consult, 12/18/19	**Pancytopenia from Revlimid. No better. Will discontinue chemo and follow CBC.**	241
Discharge Note, 12/19/19	Pneumonia **Pancytopenia** from chemotherapy - stable	139

Why Was The Diagnosis Made?

Check:

- Provider documentation for the reasons
- Signs/symptoms
- Lab results
- Radiological findings
- Treatment required
- Response to treatment

Don’t forget:

- Prehospital documentation, triage and ED notes, nursing notes, flowsheets, therapy notes and evaluations

Why Was The Diagnosis Made?

Diagnostic Test Results

Test	Date	Result	Reference Range	Page
WBC	12/17/19 12/18/19 12/19/19	**3.15** **4.02** **3.56**	4.8-10.8 K/uL	12
RBC	12/17/19 12/18/19 12/19/19	**2.84** **2.89** **2.85**	4.6-6.2 M/uL	12
Platelets	12/17/19 12/18/19 12/19/19	**121** **135** **128**	150-400K/uL	12

Just a Bit of Coding Rationale

Learn the definition of what makes a secondary diagnosis reportable. Work with your professional coders or CDS' if you need assistance.

Reportable secondary diagnosis: Must meet 1 of the following:

- clinical evaluation
- or diagnostic procedures
- or therapeutic treatment
- or increased the length of stay
- or required additional nursing care and/or monitoring
- ***If a newborn***: as above, plus has implications for future health care needs

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Just a Bit of Coding Rationale

Reporting Additional Diagnoses
ICD-10-CM Official Guidelines for Coding and Reporting
Effective October 1, 2018
Section III. Reporting Additional Diagnoses

GENERAL RULES FOR OTHER (ADDITIONAL) DIAGNOSES

The UHDDS item #11-b defines Other Diagnoses as "all conditions that coexist at the time of admission, that develop subsequently, or that affect the treatment received and/or the length of stay.

For reporting purposes the definition for "other diagnoses" is interpreted as additional conditions that affect patient care in terms of requiring:

- **clinical evaluation; MET as evidenced by daily attending documentation of the status; oncology consultation**
- **or therapeutic treatment; MET as evidenced by discontinuation of the underlying cause of chemotherapy**
- **or diagnostic procedures**; **MET as evidenced by daily CBC**
- or extended length of hospital stay;
- or increased nursing care and/or monitoring.

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Medical Sources

Peer reviewed medical journal articles, textbooks, etc.

- Cite them appropriately
- Make sure they were in existence at the time the patient was in the hospital

Medical Sources

Source/Reference	Nagalla, S. (Updated Dec. 11, 2019). Bone Marrow Failure. *Medscape.* Retrieved from: *https://emedicine.medscape.com/article/199003-print*
Evidence Based Guideline/Practice Guideline Recommendation	The bone marrow failure syndromes include a group of disorders than can be either inherited or acquired. These diseases are disorders of the hematopoietic stem cell that can involve either 1 cell line or **all of the cell lines** (erythroid for **red cells**, myeloid for **white blood cells**, megakaryocytic for **platelets**). [p.1] **Pancytopenia** **A decrease in all three cell lines** is the most common manifestation of bone marrow failure.[p.3]

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Let's Put It All Together

Justification for Appeal

This is a good place to write a narrative and bring all the clinical information together for the reviewer. It is also a good place to make arguments why the reviewer's rationale was incorrect.

"It is concerning that the auditor appears to be confusing hemoglobin and hematocrit levels with an RBC count. They are different. Pancytopenia is defined, as the auditor stated initially, by a decrease in the three blood cell lines: RBCs, platelets, and WBCs. This patient had a decrease in all three cell lines, as evidenced by subnormal levels of the WBCs, RBCs and platelets, as found on page 12 of the medical record."

Case Study #2

Denial: The patient had a pulse oximetry of 86%, increased work of breathing, RR 32, required nasal O2 → CPAP to maintain a sat > 92%. The diagnosis of acute hypoxic respiratory failure is denied because ABGs were not drawn. Therefore, the diagnosis cannot be confirmed.

Source: Coding Clinic, Third Quarter 1988, p. 7 states the firm diagnosis of respiratory failure is based on measurements of blood gases. The PaO2 must be < 60 mmHg and/or the PaCO2 must be >50 mm Hg.

Case Study #2

Here is what is wrong…reviewers of Coding Clinics are explicitly instructed that clinical information is to be used only to aid a coder's understanding of clinical situations.

Coding Clinics are NOT to be used as a source for clinical criteria.

Strategy: Argue Against The Reviewer's Sources

Applying Past Issues of AHA Coding Clinic for ICD-9-CM to ICD-10
***Coding Clinic*, Fourth Quarter 2015: Page 20**
Coding advice or code assignments contained in this issue effective with discharges November 13, 2015.

In general, clinical information and information on documentation best practices published in Coding Clinic were not unique to ICD-9-CM, and remain applicable for ICD-10-CM with some caveats. **For example, *Coding Clinic* may still be useful to understand clinical clues** when applying the guideline regarding not coding separately signs or symptoms that are integral to a condition. **Users may continue to use that information, as clues—not clinical criteria.**

Strategy: Argue Against The Reviewer's Sources

Use of *Coding Clinic* as Clinical Criteria for Code Assignment

Coding Clinic, Third Quarter 2008 Page: 16

Effective with Discharges: September 19, 2008

Question:

Can background clinical information published in Coding Clinic be used as clinical criteria for code assignment?

Strategy: Argue Against The Reviewer's Sources

Answer:

No, background material published in *Coding Clinic* cannot be used as clinical criteria for code assignment. As stated in *Coding Clinic,* Second Quarter 1998, pages 4-5:

"Any clinical information published in *Coding Clinic*, is provided as background material to aid the coder's understanding of disease processes. The information is intended to provide the coder with 'clues' to identify possible gaps in documentation where additional physician query may be necessary. It is not intended to replace the need for specific physician documentation to substantiate code assignment."

Strategy: Argue Against The Reviewer's Sources

Coding Clinics come from a cooperative agreement between:

- AHA (American Hospital Association)
- CMS (Centers for Medicare and Medicaid Services)
- CDC (Centers for Disease Control and Prevention)
- AHIMA (American Health Information Management Association)
- and the NCHS (National Center for Health /Statistics)

Case Study #3

Scenario:
Patient admitted 7/2/2018 – 7/10/18 and had well documented severe malnutrition supported by ASPEN criteria.

Rationale for denial:
Severe malnutrition denied because GLIM criteria were not met.

Strategy: Look At Criteria Dates

Was the source material in effect at the time of the patient's hospitalization?

If not, point it out.

> "The GLIM criteria used to deny the well supported diagnosis of severe malnutrition were not in existence at the time of the patient's hospitalization.
>
> ASPEN criteria were in effect at the time of this patient's hospitalization and met that criteria as follows…"

Case Study #4

Denial:

To validate the diagnosis of chorioamnionitis, the medical record is examined for documentation of maternal fever plus other common findings including: baseline fetal heart rate >160 beats/min; maternal white blood cell count >15,000/mm3, purulent-appearing cervical fluid; or pathology findings of placental infection. Though there was a temperature reading of 100.9 F, WBC was noted to be at 13.3. Additionally, the pathology report revealed a placenta with pink-tan color and a transparent appearance. Amniotic fluid color was also described as clear. These findings did not support the presence of maternal chorioamnionitis.

Strategy: Never Assume The Auditor's Rationale Is Complete Or Correct

Response:

"The **pathology report (p. 151) reflected a definitive diagnosis of placental chorioamnionitis** and patchy parenchymal calcifications, in conjunction with **umbilical cord funisitis.**

Per the American Journal of Obstetrics and Gynecology (2014), "**If the inflammatory process in the placenta involves the umbilical cord** (umbilical vein, umbilical artery, and the Wharton's jelly), this is **referred to as funisitis**."

Kim, C.J. et al. (2014). Acute Chorioamnionitis and Funisitis: Definition, Pathologic Features, and Clinical Significance. *Am J Obstet Gynecol.* 213(40), 29–52. As found on: *https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4774647/pdf/nihms-719305.pdf*

Strategy: Never Assume The Auditor's Rationale Is Complete Or Correct

Response, continued:

The auditor acknowledges that validation of the diagnosis could include pathology findings of placental infection. It is, therefore, quite concerning that the reviewer used part of the pathology report to deny the condition existed and **ignored the pathology report's portions that dealt definitively with the acute infections of the placenta and umbilical cord."**

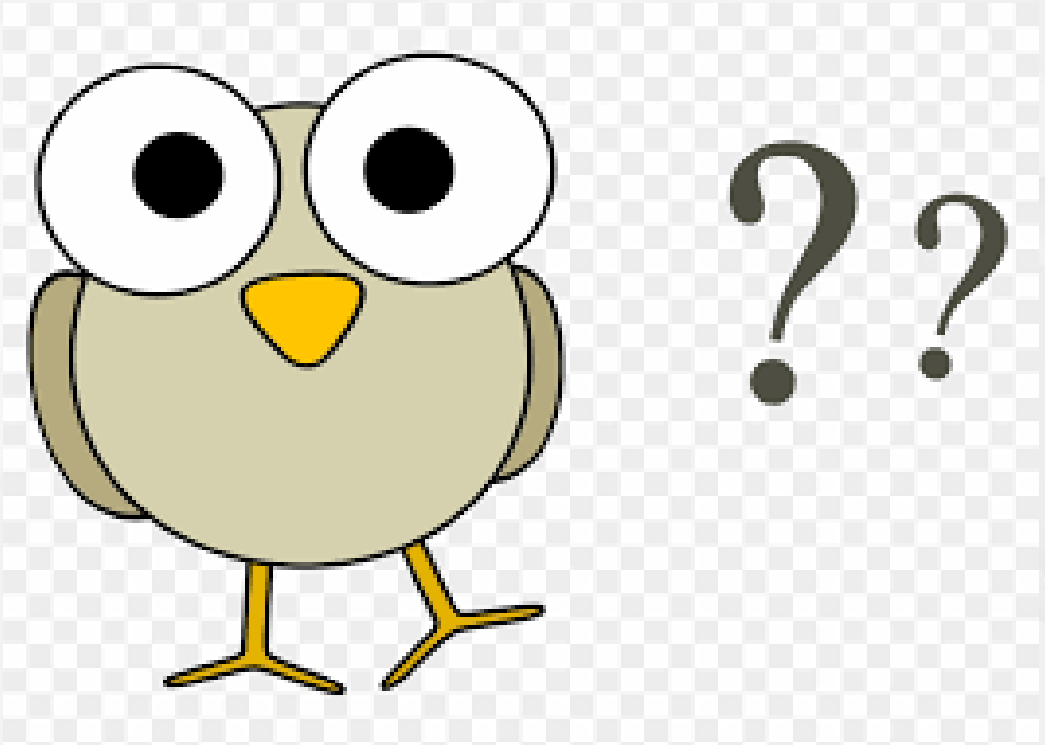
Take-Aways

1. Make it easy for the reviewer - create a roadmap that shows:
   - WHERE the diagnosis is documented
   - WHY the diagnosis was made
   - Additional JUSTIFICATION for the appeal, as applicable
   - Supportive CODING rationale (only a little)
   - Applicable clinical medical sources to BACK UP YOUR ARGUMENTS
2. Look at the reviewers' sources and verify:
   - they are clinical sources for clinical validation denials
   - they were in effect at the time of the patient's hospitalization

Take-Aways

3. Scrutinize all denial rationale with a critical eye – never assume it is complete and correct.
4. Learn what makes a diagnosis reportable and include in your appeal.
5. Make sure the dates of any criteria used to deny or defend the diagnosis were in existence when the patient was in the hospital.

Q&A



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Thank you for joining us for today's event!

Please contact us if we can assist you in any way. If you have suggestions or ideas on how we can serve you better, we want to hear them. We are here for you!

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