Clinical Validation – Back to the Basics

Christi Drum, BSN, RN, CCDS, CCS
Karla Hiravi, BSN, RN

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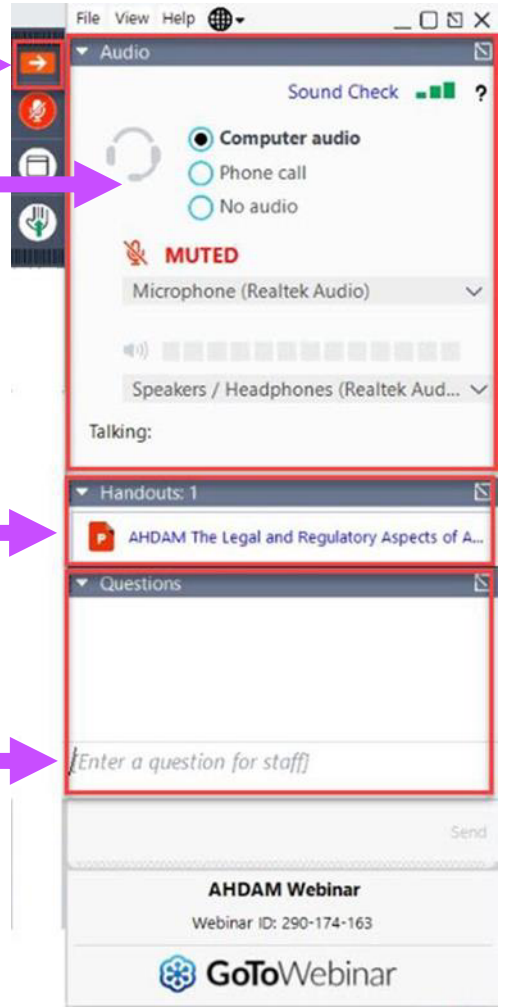

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HAPPY CDI WEEK!

Host and Presenter

Karla Hiravi, RN, BSN
Vice President | PayerWatch - 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 (CDI), management of a CDI department, 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.

She was a frequent guest speaker at the University of Pittsburgh, Johnstown for many years, and served as a preceptor for nurse practitioner and Pharm D. students while they studied medical research through the University of Pittsburgh. Karla has been with PayerWatch – AppealMasters since 2016 and continues to participate in and educate clinicians and coders about the medical appeal process.

Presenter

Christi Drum, RN, BSN, CCDS, CCS
Senior Director, Clinical Appeals: Clinical Validation and Coding

Christi is a registered nurse with over 17 years of experience in emergency services, interventional radiology, cardiovascular services, and administration. In 2013, Christi joined the Clinical Documentation Integrity department where she completed concurrent and retrospective reviews with a broad work scope of DRG reimbursements, CC/MCC capture, SOI/ROM improvements, mortality reviews, and HAC and PSI improvements. She found great success in query writing with excellent capture/agreement rates. Christi also became the first CDI Educator for the health system and was privileged to share her CDI passion through teaching and training nurses and physicians.

Currently, Christi works for PayerWatch where she is the Senior Director of Clinical Appeals for Clinical Validation and Coding, leading a team of expert appeal writers who generate high quality appeal letters for clients across the nation. She also presents cases at the Administrative Law Judge level. Christi has presented in past webinars for ADHAM and PayerWatch and was a previous speaker at the national ACDIS conference.

Learning Objectives

At the conclusion of the webinar, the learner will be able to:

Self-report they can identify one characteristic of a clinical validation denial as opposed to a coding denial, one source document acceptable for use in a clinical validation appeal, and one strategy that could be used in a clinical validation appeal.

POLL!

Does your hospital have contracts that state your hospital has a policy to use specific sepsis criteria and the payers agreed?

1. Yes
2. No
3. I have no idea

A few words about CONTRACTS

Somebody from the clinical side should be involved.

Why?

If a contract states they will only accept certain criteria for a particular diagnosis, you will likely not win an appeal from the payer using anything else but the criteria listed in the contract.

Is It a Coding or Clinical Validation Denial?

CMS tells us:

"The purpose of DRG validation is to ensure that diagnostic and procedural information and the discharge status of the beneficiary, 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. Reviewers shall validate principal diagnosis, secondary diagnoses, and procedures affecting or potentially affecting the DRG…

The contractor shall base DRG validation upon accepted principles of coding practice, consistent with guidelines established for ICD coding, the Uniform Hospital Discharge Data Set data element definitions, and coding clarifications issued by CMS…

Contractors shall ensure that the hospital reports the principal diagnosis and all relevant secondary diagnoses on the claim. The relevant diagnoses are those that affect DRG assignment…

The contractor shall exclude diagnoses relating to an earlier episode that have no bearing on the current hospital stay. Delete any incorrect diagnoses and revise the DRG assignment as necessary…

The contractor shall ensure that the hospital has reported all procedures affecting the DRG assignment on the claim…" *(emphasis added)*

Medicare Program Integrity Manual Chapter 6.5.3 -DRG Validation Review (Rev. 10365, 10-02-20)

Is It a Coding or Clinical Validation Denial?

DRG denials are denials based on coding guidance and are generally best appealed using coding guidelines, Coding Clinics, and coding conventions.

- *An appeal using clinical rationale for a coding denial will likely be unsuccessful.*
- *An appeal proving that the diagnosis or procedure in question was coded correctly per applicable coding sources should be successful.*

Is It a Coding or Clinical Validation Denial?

Example of a coding denial:

"**AKI is denied because there was no treatment.**"

- *This has to do with criteria for a reportable diagnosis, which is something a coder determines, based on coding guidance.*
- *Whether or not a diagnosis is reportable is not something a provider considers when making the diagnosis.*
- *Coding guidance is generally used as source documents for a coding decision.*

Is It a Coding or Clinical Validation Denial?

Clinical validation (CV) denials are denials based on clinical factors and generally best appealed using clinical criteria from evidence-based medical sources.

- *Coding guidance will likely not be effective in the argument for the clinical validity of a diagnosis.*
  - *though there is a place for just a little bit of coding info – more later….*

- *An appeal proving that the diagnosis in question was diagnosed correctly per applicable clinical sources should be successful*.

Is It a Coding or Clinical Validation Denial?

Example of a CV denial:

Encephalopathy is denied because the patient was described as being alert and neurologically intact.

- *This is clinical rationale that a **provider** considers when making the diagnosis.*
- *Coding rules and regulations do not govern clinical rationale.*
- *Clinical information from clinical journals, textbooks, etc. are generally used as source documents for a CV decision.*
  - *But not always! We will get to that later…*

Clinical Validation Denials

When you boil it all down, a CV denial is saying:

“Doctor, you misdiagnosed your patient and we are removing your diagnosis from the claim.”

The Dreaded Dual Denial

This type of denial is based on both clinical criteria AND coding guidance for one or more diagnoses.

- *A successful appeal should incorporate proof that the denied diagnosis was diagnosed correctly and then coded correctly.*
- *Source documents should be from both coding guidance and peer reviewed current clinical literature.*

The Dreaded Dual Denial

Example of a dual (coding and CV) denial without sources listed:

Sepsis will be removed from the claim as it was noted as a suspected condition in the ED and not corroborated, confirmed, or noted as still suspected at the time of discharge. In addition, the SOFA criteria was only 1.

Who Should Write CV Appeals?

Some hospitals use:

- coding professionals
- clinicians
- a combination of clinicians and coding professionals
- clinical documentation specialists
- vendors

Regardless of who writes the clinical validation appeals, be sure that reasons for denial are addressed thoroughly, and on a clinical basis.

Appeal Strategies

Appeal Strategies

First and foremost:

Never, EVER believe that the payer's rationale is correct.

- ***Scrutinize EVERY reason given to deny.***
- ***Push back at EVERY reason given that is not correct.***

Appeal Strategies – Direct Rebuttals

Example:

Payer: Best Insurance stated that Sepsis-3 criteria were not met.

Hospital Response: The patient had a SOFA score of 3, thus meeting Sepsis 3 requirements as evidenced by….

- Be sure to give page numbers where the information can easily be found in the medical record.
- Reference your medical source either here or in a separate section of your appeal.

Payer: Another erroneous statement

Hospital Response: specific response directly related to the erroneous statement

Appeal Strategies- Rebuttals

Your appeal should demonstrate:

1. **where** the diagnosis was documented.

In a perfect world:

- first time suspected
- when confirmed
- in the middle of the hospital stay
- in the discharge summary
- as a query answer, if applicable

Appeal Strategies- Rebuttals

Your appeal should demonstrate:

2. why the diagnosis was made:

- pertinent lab results
- pertinent physical exam findings
- pertinent VS
- pertinent radiology results
- surgical findings
- treatment
- response to treatment

Appeal Strategies- Rebuttals

3. Just a little bit of coding rationale

Note: you do not have to be a coder to learn and apply this.

a. If the principal diagnosis, insert the definition of the principal diagnosis.

b. If a secondary diagnosis, explain why the denied diagnosis met ONE of the following criteria to be a reportable diagnosis

- Clinical evaluation
- Or Therapeutic treatment
- Or Diagnostic procedures
- Or extended length of hospital stay
- Or increased nursing care and or monitoring

If a newborn, any of the above or:

- Has implications for future health needs

Appeal Strategies: Clinical Source Documents

Check source documents listed by the payer.

- Were they in effect at the time the patient was in the hospital?
- Do they apply to the reason for denial?
- Was the information misinterpreted or misrepresented?

Use pertinent excerpts from peer reviewed medical journals, textbooks, etc. in your appeal and reference them appropriately.

- Be sure they were in existence at the time the diagnosis was made.

When a payer uses clinical information from Coding Clinics, push back hard.

Appeal Strategies: Clinical Source Documents

Clinical criteria found in Coding Clinics are NOT acceptable to deny on a clinical basis or appeal on a clinical basis.

Source/Reference	**Applying Past Issues of AHA Coding Clinic for ICD-9-CM to ICD-10** ***Coding Clinic*, Fourth Quarter 2015: Page 20**
Practice Guideline Recommendation	*…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.**

Appeal Strategies: Clinical Source Documents

Source/Reference	**Use of *Coding Clinic* as Clinical Criteria for Code Assignment** ***Coding Clinic*, Third Quarter 2008 Page: 16**
Practice Guideline Recommendation	**Question:** Can background clinical information published in Coding Clinic be used as clinical criteria for code assignment? **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…

Appeal Strategies: Contracts and Policies

Payers often use their own criteria to deny.

- What does your contract with the payer say?
  - ➢ Did your facility agree to use only certain criteria for certain diagnoses (like Sepsis-3 for sepsis)?
    - ✓ If providers are using Sepsis-2, you will likely not get those denials overturned
  - ➢ Did the payer agree to accept Sepsis 2 criteria?
    - ✓ A copy of the contract could be sent with the appeal.

Does your facility have a policy about certain diagnoses, such as AKIN criteria is to be used to diagnosis AKI?

- If yes, send with your appeal.
  - ➢ It can't hurt.

CASE STUDIES

Denial 1:

Acute hypoxic respiratory failure denied:

RR <24
only low flow O2
no retractions
no intense treatment

Review of the medical record revealed:

- Worsening SOB
- RR > 24 numerous times
- Sats in 80s on RA
- Low flow O2 (2-3L - new requirement)
- Markedly decreased breath sounds
- CXR: Right lung consolidation/compressive atelectasis
- Thoracentesis for 750cc

Denial 1:

Show the pertinent information and where it can be found (*don't stop with ED*)

ED Triage, date	**Mid 80s on RA. 93% on 2L**	56
ED Provider Note, date	91 year old female with worsening dyspnea Worsening weakness doesn't have enough energy to chew or lift her arms to eat Shortness of breath for quite some time but over the last couple of weeks it is **worsened substantially**. **Not typically on oxygen** **Pulse 100, SpO2 89%, RR 30** **Pulse ox: 88% on RA: abnormal oxygenation** Lungs: **Markedly diminished breath sounds on the right long** She is **hypoxic on room air**. Chest X-ray with **large right-sided pleural effusion** and signs of fluid overload…**compressive atelectasis** versus pneumonia **Acute respiratory failure with hypoxia**	89, 51, 50, 53

Denial 1:

Justify your appeal.

Connect the dots for the reviewer.

Justification for Appeal

Per the medical record, the patient met the clinical criteria based on **new oxygen requirement due to shortness of breath with oxygen saturations in the 80's on room air due to compressive atelectasis and diffuse consolidation of her right lung.**

The patient's respiratory status was stabilized with titration of oxygen and a **thoracentesis that removed 750cc of fluid**.

Please note that she had **greatly diminished breath sounds in her right lung with diffuse right lung consolidation. In essence, her right lung had failed**.

High flow oxygen, a certain respiratory rate, and retractions **are not required for a licensed provider to establish the diagnosis.**

Of note, the reviewer was incorrect when it was stated that there were no documented respirations greater than 24.

Denial 1:

Just a bit of coding information….

ICD-10-CM Official Guidelines for Coding and Reporting

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 provider documentation and treatment plan**

or Therapeutic Treatment; **MET as evidenced by oxygen titration and a thoracentesis**

or Diagnostic Procedures; **MET as evidenced by a thoracentesis and serial chest x-rays**

or Extended Length of Hospital Stay,

or Increased Nursing Care and/or Monitoring. **MET as evidenced by close monitoring of pulse oximetry**

Denial 1:

Why are you right on a clinical basis?

Source/Reference	**Pinson, R. (2013). Revisiting respiratory failure. Part one of a two-part series. *ACP Hospitalist*. As found on:** *http://www.acphospitalist.org/archives/2013/10/coding.htm*
Evidence Based . Guideline/Practice Guideline Recommendation	• "**Acute respiratory failure is defined by <u>any one of the following</u>**: ○ pO2 <60 mm Hg or **SpO2 (pulse oximetry) <91% breathing room air** ○ pCO2 >50 and pH <7.35 ○ P/F ratio (pO2 / FIO2) <300 ○ pO2 decrease or pCO2 increase by 10 mm Hg from baseline (if known)." [p.2] • "**On the normal oxygen/hemoglobin dissociation curve, a pO2 less than 60 mm Hg is equivalent to oxygen saturation less than 91%.** ○ **While the saturation measured by pulse oximetry (SpO2) is less precise than on the ABG (SaO2), it may be used as the only practical surrogate for serial monitoring of oxygenation**."[p.2] • **There ought to be some indication that a patient with acute respiratory failure has, for example, respiratory distress (even if mild), tachypnea (normal respiratory rate is generally 8 -16), dyspnea, shortness of breath**, wheezing, etc. [p. 2]

Denial 2:

Sepsis denied

Sepsis 3 criteria not met

Auditor main points:

Normal bilirubin and creatinine levels

MAP did not go <70

No ABGs

No SOFA score of 2 post hydration

Denial 2:

Show the pertinent information and where it can be found

Document Source & Date	Pertinent Information	Page(s)
ED Provider Note Date	The patient's labs concerning for **leukocytosis** and urinalysis did come back consistent with **UTI**. I suspect that the patient likely has some degree of dehydration and **severe sepsis** as a result of her underlying infection. Patient also noted to have **thrombocytopenia** Clinical Impression: **1. Severe sepsis (HCC)** 2. Leukocytosis, unspecified type 3. **Thrombocytopenia** (HCC) 4. Urinary tract infection without hematuria, site unspecified	57 59 60
Progress Note, Date	**Severe sepsis POA** **Cultures E.coli, + blood cultures** **PLT count improving, most likely 2/2 sepsis**	121

Denial 2:

Show the pertinent information and where it can be found

Vital Signs/Measurements	Date(s)	Results	Reference Range of values that are representative of Sepsis	Page(s)
Heart Rate	5/1/23 1736 5/1/23 1905 5/2/23 1613	**102 (H)** **96 (H)** **92 (H)**	≥ 90 beats/min	63 238 265
Respiratory Rate	5/1/23 1905	**23 (H)**	≥ 20 breaths/min (or PaCO2 ≤ 32 mm Hg)	238
Systolic Blood Pressure	5/1/23 2248 5/2/23 1613 5/2/23 2321	**94/61 (L)** **93/48 (L)** **95/52 (L)**	<100 mmHg	78 265 265
Sepsis: Mean Arterial Pressure (MAP)	5/1/23 2248 5/2/23 1613 5/2/23 2321	**70 (L)** **63 (L)** **66 (L)**	<70 mmHg	238 265 265

Test	Date(s)	Results	Reference Range of values that are representative of Sepsis	Page(s)
WBC – Leukocytes	5/1/23 5/3/23 5/4/23	**22.49 (H)** **14.76 (H)** **13.57 (H)**	≥ 12 000 cells/µL or ≤ 4000 cells/µL	57 149 152
% Bands	5/1/23	**15 (H)**	>10%	57
PaO2/FiO2	5/1/23 5/1/23 5/1/23 5/2/23	**305 (L)** **324 (L)** **268 (L)** **286 (L)**	<400mmHg	78 79 80 265
Platelets	5/1/23 5/3/23 5/4/23	**33 (L)** **55 (L)** **137 (L)**	<150	57 149 153
Procalcitonin	5/1/23	**3.21 (H)**	>0.10 ng/mL	143
Blood Culture	5/1/23	**+E coli**	Negative	159

Denial 2:

Justify your appeal – connect the dots

Justification for Appeal

The patient met Sepsis-2 criteria based on the following:

- Heart rate greater than or equal to 90
- Respiratory rate greater than or equal to 20
- WBC count greater than or equal to 12,000
- Bands greater than 10%
- Elevated procalcitonin level
- Blood cultures + for E. coli
- Infectious source of pyelonephritis
- Acute organ dysfunction as evidenced by SOB with P/F ratios less than 300, thrombocytopenia due to sepsis, and hypotension with mean arterial pressures less than 70

The patient also met qSOFA score based on the following:

- Respiratory rate ≥ 22 = 1 point
- Systolic blood pressure ≤ 100 mmHg = 1 point
- Total qSOFA score = 2 points

The patient also met Sepsis-3 criteria based on the following:

- Respiratory (P/F Ratio): < 300 = 2 points
- Coagulation (platelet count): <50,000 = 2 point from baseline
- Cardiovascular (MAP): MAP < 70 = 1 point
- Total SOFA score = 5 (accounting for baseline platelet values of <150,000

Denial 2:

Justify your appeal with rebuttals

It should be noted that the auditor erred in dismissing the patient's shortness of breath and low oxygen saturation levels on admission resulting in low P/F ratios. No other respiratory conditions were present to account for this acute change from baseline.

Likewise, the auditor failed to account for the patient's hypotension and low MAP values.

Furthermore, the auditor erred in claiming that platelet values are only determined after hydration. There is no consideration given to hydration status in SOFA scoring – only in assessing the patient's baseline status and calculating score in consideration of such.

The patient's total SOFA score was 5. Thus, the patient met EVERY consensus-based criteria for sepsis, thereby validating the diagnosis in question.

Denial 2:

Just a bit of coding information and clinical references….

ICD-10-CM Official Guidelines for Coding and Reporting
Section II. Selection of Principal Diagnosis

The circumstances of inpatient admission always govern the selection of principal diagnosis. **The principal diagnosis is defined in the Uniform Hospital Discharge Data Set (UHDDS) as "that condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital for care."**

Evidence Based Clinical References

Source/Reference	**Singer, M., Deutschman, C.S., Seymour, C.W., Shankar-Hari, M., Annane, D., Bauer, M…Angus, D.C. (2016). The Third International Consensus Definitions for Sepsis and Septic Shock (Sepsis-3). *JAMA*. As found on:** *http://jama.jamanetwork.com/article.aspx?articleID=2492881*
Evidence Based Guideline/Practice Guideline Recommendation	**"Sepsis should be defined as life-threatening organ dysfunction caused by a dysregulated host response to infection. For clinical operationalization, organ dysfunction can be represented by an increase in the Sequential [Sepsis-related] Organ Failure Assessment (SOFA) score of 2 points or more**, which is associated with an in-hospital mortality greater than 10%." [p.1]

Summary

1. Read the denial rationale thoroughly and ascertain if it's a CV denial, coding denial, or a dual denial prior to starting to appeal
2. Never, EVER believe the payer is correct
3. Look for ways to rebut the auditor's reasons for denial
4. Make it easy for the reviewer – show them exactly where pertinent information in the medical record can be found
5. Use accepted medical and peer reviewed literature - in effect at the time of the patient's hospitalization - to support your arguments
6. Consider adding just a bit of coding information in your appeal
7. A clinician knowledgeable about CV denials should be involved with contract negotiations

Questions and Answers

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Thank you for attending!

For more information, please contact:

khiravi@payerwatch.com
or
denise@ahdam.org

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