Clinical Validation – Back to the Basics Part 2: Questions and Answers

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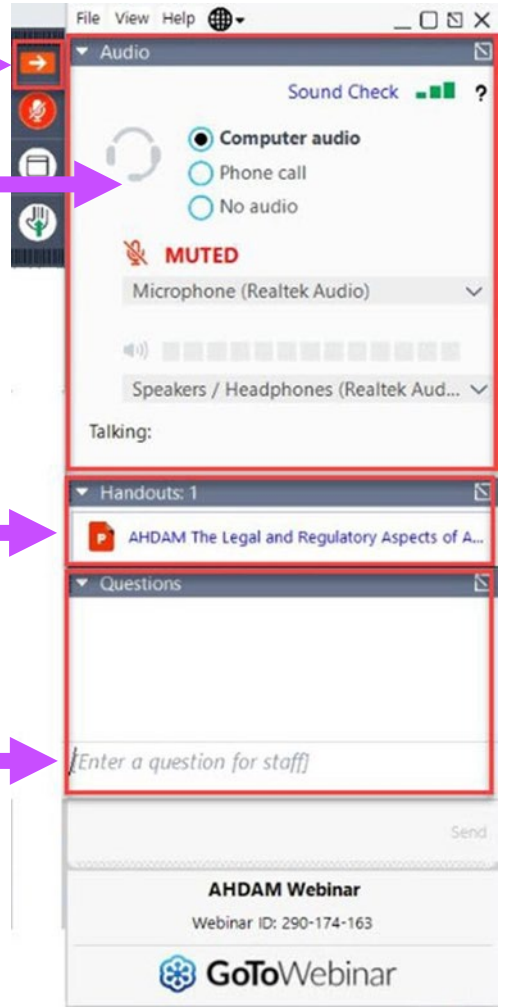

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Host and Presenter

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.

RECAP of Clinical Validation – Back to the Basics (Part 1)*

Presented September 2023

*Refer to Clinical Validation Appeals – Back to the Basics, 9/2023

at

AHDAM.org

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RECAP: Is It a Coding or Clinical Validation Denial?

Would a coder consider the factors* in the denial rationale — to verify that the diagnosis was **correctly coded**?

**Coding factors* such as wrong code used, sequenced improperly, in conflict with Coding Clinics or guidelines, conflicting documentation, not reportable*

Answer: Yes → likely a coding denial and needs appealed from a CODING perspective

No → likely not a coding denial and appealing from a coding perspective will not get it overturned

Clue it's a coding denial: the denial letter implies, "Coder, the **coding** of this condition/diagnosis/procedure was not correct."

Examples:

a. A41.9 (sepsis) is denied because there is conflicting documentation in the medical record, no query was found, and Coding Clinic xxx states...

b. D62 (acute blood loss anemia) is denied as there was no treatment.

RECAP: Is It a Coding or Clinical Validation Denial?

Would a provider consider the factors* in the denial to verify that a diagnosis was **made correctly**?

*_**Clinical factors** such as pertinent vital signs consistent with the diagnosis, physical examination, test results, operative findings, treatment appropriate for the diagnosis, response to treatment_

Answer: Yes → likely a clinical validation denial and needs appealed from a clinical perspective

No → likely not a clinical validation denial and appealing from a clinical standpoint will not get it overturned

Clue it's a CV denial: The denial implies, "Doctor, your diagnosis was WRONG."

Examples:

a. A41.9 (sepsis) will be removed because while sepsis 2 criteria were met, sepsis 3 were not. The patient had a SOFA score of 1.

b. D62 (acute blood loss anemia) is denied as the patient was asymptomatic, blood loss was <500cc, and the H&H did fall below 10/30.

RECAP: Is It a Coding or Clinical Validation Denial?

Dual CV and coding denial

- Denied on a clinical and coding basis
- Needs appealed on a clinical and coding basis

Example:

Acute respiratory failure will be removed as ABGs did not exhibit hypoxia or hypercapnia and the patient only received 4 L of oxygen. (CV)

In addition, pneumonia will be resequenced as the principal diagnosis and sepsis will be resequenced as a secondary diagnosis *(side note – the sepsis was POA and did not develop during the hospitalization, was not due to a complication of some type)* (Coding)

RECAP: 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.***
- ***Start thinking of how to push back while you are reading the denial letter***

RECAP: Clinical Validation Appeal Strategies- Rebuttals

In a perfect world, your appeal should demonstrate WHY the diagnosis was made and include:

1. **where** the diagnosis was documented

- when first suspected
- when confirmed
- in the middle of the hospital stay
- in the discharge summary
- as a query answer, if applicable – yes, once is enough (Check out the ACDIS/AHIMA guidelines)

2. **pertinent** vital signs/physical exam results, test results, other clinical findings that ***support why the diagnosis was made***
   - *Clinical rationale a provider would consider to make the diagnosis*

3. appropriate **treatment** for the diagnosis in question
   - *Clinical rationale a provider would consider to treat the condition*

4. **response** to treatment
   - *Clinical rationale a provider would consider to determine if treatment working or not*

5. just a wee bit of coding information
   - Very limited – ***do not need to be a coder***
     - ✓ Definition of a principal diagnosis or why the secondary diagnosis was reportable and/or why clinical rationale taken from Coding Clinics is not permitted or acceptable

6. **clinical source documents** that help support your argument that the diagnosis was made correctly by the provider (NOT coded correctly by a coder)
   - Clinical, peer reviewed articles, books, etc. that a **provider** might reference to help determine if a diagnosis was correct
     - ✓ Examples: Journal of the American Medical Association (JAMA), New England Journal of Medicine (NEJM), Global Initiative for Chronic Obstructive Lung Disease (GOLD) Report

RECAP: Contracts and Policies

Payers often use their **own criteria** to deny diagnoses.

- ***check the payer website.***

What does **your contract** with the payer say?

- Did your hospital agree to use payer criteria for certain diagnoses?
  - Example: your hospital uses sepsis 2 criteria but the **payer website** states the payer uses only sepsis 3.
    - ✓**VERY difficult to get overturned**

Appeal Suggestion: prove the payer was wrong in their rationale – they often are

Prevention Suggestions:

1. Try to get an addendum to your contract to allow the criteria your hospital uses for commonly denied diagnoses
2. Somebody from the clinical side well versed in CV denials and appeals should be involved in contract negotiations.

QUESTIONS and ANSWERS from the September Webinar

Question 1

Question:

Optum consistently uses Coding Clinic 4th Q 2016 claiming a payer may use a specific clinical definition of set or criteria when establishing a diagnosis. How do you feel it is best to negate that approach?

Question 1 Answer

Answer:

Payers are permitted to use any criteria they wish to use unless your hospital has something in the contract that both parties (your hospital and the payer) have agreed to.*

Most payers also have their criteria listed on their website.

The best way to negate that reason for denial is to have a clinical person, well versed in denials/appeals/ and possibly CDI, involved with discussions with payers at contract time.

- A physician representative (perhaps a Physician Advisor for Denial and Appeals or CDI) should be there as well.
- In a perfect world, the payer and the hospital should agree on the criteria to be used for the most common denied diagnoses that you see – perhaps as addendums to the the contract.

**Has your state mandated certain criteria for certain diagnoses?*

Example: New York mandates sepsis 2 criteria to be used throughout the state. Payers will still deny using sepsis 3 criteria, but they are frequently overturned in favor of sepsis 2 in New York when that information is sent with an appeal AND when the appeal is able to be advanced out of the payer's levels of appeal.

Question 2

Question:
Some of our DRG Validation refund requests dispute the validity of a diagnosis if all providers don't mention it.
Common one for this is Type II MI. Cardiologist does, discharging physician does not. Must every progress note contain a mention?

Question 2 Answer

Answer:
Normally, no, every progress note does not have to have a diagnosis documented in each and every progress note. Coding guidance does not mandate that.

However - payers often have published criteria that must be met or they will issue a denial. That might be the case in this situation. Check the payers' websites to see what is in their criteria to clinically validate a Type II MI. Some payers require that a cardiologist, in addition to the attending, document the diagnosis and agree with each other.

If you don't see it in the payers' criteria, you could do several things: 1) in your appeal, ask for the reference that states whatever they are claiming must be met 2) talk to the payer representative and ask where to get that information. 3) If you see this a lot, check your contract and try to change anything that needs changed.

Question 3 and Answer

Question:
Is it appropriate to include web-links in a rebuttal? For a simple example, a drug web link when units vs mg should be reported on a claim. Thank you!

Answer:
Sure! The idea is to make it easy for the payer to find in your favor. If that means to insert links to help support your stance, go for it.

Question 4

Question:
Where do we find criteria to use for appeal justification?
Where is a good site to obtain peer reviewed current clinical literature?

Question 4 Answer

Answer:

1. Payer website – use their own criteria in the appeal if the payer misinterpreted their own criteria *(It happens – a LOT!)*
2. There is not one site for all the different diagnoses that are denied that we are aware of. Here are some examples/ideas:
   - If you want to validate sepsis 3 criteria: https://jamanetwork.com/journals/jama/fullarticle/2492881.
   - If you want to learn about COPD, the Gold report is a great resource: https://goldcopd.org/2023-gold-report-2/
   - If you want to learn about KDIGO criteria, go to https://kdigo.org
   - For malnutrition, do an internet search for ASPEN criteria and/or GLIM criteria – whichever one you need – and find it that way.

Oftentimes, hospitals have access to many clinical journals – on line or physical copies - that all can use.

- Try your hospital library if you have one– ask the librarian for help.

Your physician advisor would be a good source - they need to be knowledgeable about a wide variety of things – and need to look up things all the time.

- If you don't have a physician advisor, ask your supervisor or a physician you know and are comfortable with.

Question 5

“I understand your rationale for case study, denial 1, but 89% is not resp failure, many people live at this. The patient was heading into resp failure and got medical care in time to prevent the critical condition. Not sure how the diagnosis of resp failure can be defended in this scenario. Please explain.”

Question 5 Answer

Answer: A sat of 89% for somebody without chronic respiratory failure is diagnostic of acute hypoxic respiratory failure according to the following:

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

Excerpts include:
"Acute respiratory failure is defined by any one of the following:

- 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]

Question 6

Question:
We are getting sepsis denials when the organ dysfunction is said not to be "remote."

For example, sepsis due to pneumonia with acute resp failure as the organ dysfunction. They use Sep-3 and SOFA. How do you address this issue?

Question 6 Answer

Answer:
SOFA criteria are not dependent on whether the organ dysfunction is local to the underlying infection or remote from the underlying infection. While it is certainly possible that a local infection of, for example, pneumonia might cause respiratory failure, it is also possible that a dysregulated host response to the pneumonia could cause the respiratory failure.

That is where the examining and treating physician documentation is so important. If the treating physicians link the respiratory failure to sepsis, we suggest using that in your argument: something like “The examining and treating physicians specifically documented that this patient’s sepsis led to the respiratory failure. The opinion of the reviewer is simply that - an opinion of a non-treating and examining reviewer of the medical record of unknown qualifications/credentials.”

You could even ask the reviewer to verify their reason for denial and reveal the source document that states organ failure must be remote from the underlying infection for sepsis to be present.

Question 7 and Answer

Question:

- Are you sending the entire medical record with the appeal or is it okay to only send specific documents?
- If a payer or review entity already has a medical record sent by HIM, should we send the record again so we can ensure page numbers match?
- Medical records have already gone out to the payor by the time we appeal. Can excerpts (Screenshots) from the record be included in lieu of page numbers from the medical record?

Answer:

We send the entire medical record so the reviewer can see exactly what we said was in the medical record, the page numbers where it can be found, and anything else they wish to see and not have to look elsewhere should they have a question about the medical record.

Best practice is to send the medical record again with your appeal. Reference pertinent information/pages of the medical record in your appeal. The reviewers usually want to be able to find the information in the medical record themselves. Just providing screen shots could make it difficult for them to do that. Make it as easy as possible for the payer to find in your favor.

Question 8 and Answer

Question:
Is your justification for rebuttal in the beginning of the appeal letter, or at the end as a summarization?

Answer: Actually, neither. The "Justification for Appeal" is in between. Our templated format is to demonstrate (in the following order after a formal business heading and greeting):

- what was denied
- the difference in DRGs
- expectation
- excerpts straight from the medical record (documentation of diagnosis, pertinent physical/operative findings, written rationale for diagnosis, treatment)
- pertinent lab/radiological findings
- justification for appeal (a narrative)
- evidence based literature excerpts
- closing

Question 9 and Answer

Question: Do you have examples of language in contracts that indicate facility does not agree to accept payer-specific clinical criteria for certain dx?

Answer: This is something you would need to discuss with your contract department and possibly your legal department.

AHDAM cannot give legal advice.

Question 10 and Answer

Question:
We frequently see diagnoses being disputed by the payer/auditor because the diagnosis is only on a query. There is not consistent documentation to support this diagnosis.

How would you defend this on an appeal?

Question 10 Answer

Answer:
The reason for this type of denial is not clinical validation – **it's coding**.
The ACDIS/AHIMA Guidelines for Achieving a Compliant Query Practice apply when responding to that denial reason. Be sure you use the guidance in effect at the time of the coding.

For example:

Payer: Sepsis was denied because there was not consistent documentation of the diagnosis and it was found only in response to a query.

Hospital Response: A query was posed because there were clinical indicators to suggest diagnoses or conditions other than what was documented. It is appropriate to do so per the ACDIS/AHIMA Guidelines for Achieving a Compliant Query Practice, *date or update date*).

> "II. When to Query
> Queries may be necessary in (but not limited to) the following instances:
> a. **To support documentation of medical diagnoses or conditions that are clinically evident and meet the Uniform Hospital Discharge Data Set (UHDDS) requirements but without the corresponding diagnoses or conditions stated**." (*emphasis added*)

To not query in such a condition would be in violation of the above standard.
As such, we fully expect the diagnosis of sepsis to be accepted. Anything less is in violation of The ACDIS/AHIMA….

If you need assistance, your coding or CDI department should be able to help with this as well.

Question 11 and Answer

Question: How do you respond when the payor is refusing to accept query responses posed after discharge?

Answer: Check to see what the contract with the payer states.

- Does the contract state that they (the payer) will not accept any answers to post discharge queries?
  - If that is the case, try to get that changed because your chances of success are quite limited without a change.
  - Many hospitals have policies that state post discharge **but pre-billing** queries are appropriate.
    - ✓ **Your contract should reflect whatever the policy states**.

If your contract does not reflect the above restriction, and you have a hospital policy and procedure regarding post discharge queries, send a copy of that, along with your appeal, stating that a query was posed in compliance with the hospital policy and procedure because….

If no policy exists regarding post discharge queries, it is advised that one is made.

Question 12 and Answer

Question: Are Medicare coverage guidelines relevant when appealing coding or clinical validation denials from Medicare Advantage payers?

Answer: If an NCD or LCD lists certain codes that are required for coverage, then yes, the codes must be listed as required for payment to occur.

- All coding guidance must be followed when choosing the correct codes for the case.
  - NCDs and LCDs do not dictate how something must be coded.
- These are usually medical necessity cases mistaken for coding or clinical validation.

Regarding clinical validation denials: we are not aware of any CMS or Medicare requirements for clinical validation in Medicare Advantage cases.

Question 13 and Answer

Question: We rarely get specific denial letters so how do I appeal such a denial?

Answer: It's very difficult to appeal if you don't get specific denial letters, but it can be done.
Suggestions:

Try to get the rationale for denial.

- Call the payer, ask what was denied and why, and ask for a copy of the denial letter if you did not receive one at all.
- Have a conversation with the payer representative and tell them you are not getting what you need to understand what was denied and why it was denied.

If the above fails…but you know the diagnoses that were denied:

- If it's a denial for sepsis, start with an appeal from a clinical validation perspective as that is usually what is behind denials for sepsis.
- If it's a principal diagnosis that was not removed but sequenced as a secondary diagnosis, start out with a coding appeal and explain why the coded principal diagnosis was correctly sequenced.
- If it's not a diagnosis commonly denied for clinical validation, start with a coding appeal and explain why the coding was correct.

- *continued on next slide* -

Question 13 Answer, Continued

2. If you don't know what the denied diagnoses are, but you have the billed DRG and the revised (by the payer) DRG, you can often make an educated guess as to what was denied.

- Example: **Billed MS-DRG 190, COPD <u>with MCC</u>; revised MS-DRG 191, COPD <u>with CC</u>**
  - This tells us the principal diagnosis was not denied, but any and all MCCs were denied
  - Consider:
    - ✓ Do you know how to read the claim (UB04) to figure out all the billed diagnoses and determine which were the MCCs?
    - ✓ If there were 2 MCCs, it would be worthwhile to appeal both (if one remains denied, you might get the other to preserve the DRG)
    - ✓ If there were more than 2 MCCs, it might be worthwhile to only appeal the strongest MCCs.
      - What is your policy?

3. If you get a denial and everything except the principal diagnosis was denied – all secondary diagnoses, all procedures – it could be the medical record was requested but not sent.

Many times, **decision letters that are in response to the first level appeals** have a fair amount of information why a diagnosis remained denied.

- If there are further levels of appeal available, revise your initial response to include responses to new reasons for denial that were not addressed at the first level.

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.
   - If it's a CV denial, appeal using clinical rationale (with just a smidgeon of coding rationale).
   - If a coding denial, appeal using coding rationale.
   - If a dual CV and coding denial, appeal using both clinical and coding rationale.
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. 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:

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