September 2023
Webinar: Clinical Validation Appeals – Back to the Basics
Questions and Answers

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?
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.

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. Must every progress note contain a mention?
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. I have seen certain 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.

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:
Where do we find the criteria to use for appeal justification?
Answer:
A good place to look is on the payer's website. If you can't find it there, the payer representative should be able to help.

Question:
"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."

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:
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?

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." 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:
Are you sending the entire medical record with the appeal or is it okay to only send specific documents?
Answer:
We send the entire medical record so the reviewer can also see anything they wish and not have to look elsewhere should they have a question about the medical record. We try to make it as easy as possible for the reviewer to find in our favor.

Question:
Can we ask questions after the webinar?
Answer:
Sure! There are email addresses of the speakers at the end of the webinar slides. You can also use the "Ask the Expert" feature of the AHDAM website at
https://www.ahdam.org/contactexperts

Question:
As a supervisor, how do you address coders who stand firm on "that's what the doctor documented" and that is how they are coding it; they are not willing to submit queries because they feel like they are questioning the physician's integrity when they are asking if a condition is truly being treated.

Answer:
If staff are refusing to send queries when they are warranted according to Coding Guidelines, AHA Coding Clinic guidance, and (hopefully) your policies and procedures surrounding queries, then these questions must be asked: 1) are they are being non-compliant, and 2) if yes, what are the consequences for noncompliance?

Another question to consider is if these are queries that should have been asked concurrently (or post discharge but prior to final billing) by a CDS with a clinical background?

The AHIMA/ACDIS Guidelines for Achieving a Compliant Query Practice provide information about best practice regarding queries. If you don't have policies or procedures addressing when to query, it should be strongly considered.

ACDIS just came out with an addendum to the 2022 update of the guidelines. While it is geared toward trends in denials, there is information in there that might be helpful to you regarding your question. You can find it at https://acdis.org/resources/guidelines-achieving-compliant-query-practice%E2%80%942022-update.
Here it is (highlight added):

Addressing Feedback Related to Denial Trends

Denial trends have indicated that payers have been challenging diagnoses obtained through query by questioning query compliance. These challenges should be evaluated to ensure they reflect compliance versus best practice. *Coding Guidelines* and *AHA Coding Clinic* guidance consistently state that when the documentation is unclear, the provider should be queried. Provider queries are a necessity, allowing both CDI and coding professionals to effectively clarify the health record and to capture appropriate patient complexity and reimbursement for resources provided.

The *Guidelines for Achieving a Compliant Query Practice*, published jointly by AHIMA and ACDIS in 2022, provides best practices for query professionals to produce compliant provider queries. The writers encourage organizations to draft query policies and practices based upon this guidance, thereby supporting a compliant query process. These policies should be agreed upon within the contracting process, and they should be used to evaluate query compliance and defend that compliance when challenged. Both entities, healthcare organizations and payers, should hold each other responsible for following these policies when writing and evaluating queries.

Based on all of the above, I suggest have policies and procedures surrounding queries in place, make the policies, procedures, and expectations known to the staff, let the staff know the consequences of noncompliance, follow through with the consequences if there is noncompliance.

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 format is to demonstrate what was denied and the difference in DRGs, then excerpts from the medical record (documentation of diagnosis, pertinent physical/operative findings, written rationale for diagnosis), then pertinent lab/radiological findings, then pull it all together in the Justification for Appeal, then support our stance with evidence based literature excerpts, then a closing.

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

Answer:
It's very difficult to appeal successfully if you don't get specific denial letters. We suggest several things: 1) calling the payer and asking what was denied and why, and asking for a copy of the denial letter if you did not receive one at all 2) have a conversation with the payer representative and tell them you are not getting what you need in order to understand what was denied and why it was denied.

As far as appealing such a denial if you can't get anything specific: if you know the diagnosis(es) that was denied, you can decide how to proceed.

- If it's a denial for sepsis, for instance, you should 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, you should start out with a coding appeal and appeal why the coded principal diagnosis was correctly sequenced.
- If there is nothing at all to go on and it's not a diagnosis commonly denied for clinical validation, start with a coding appeal and explain why the coding was correct.

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, you should revise your initial response to include responses to new reasons for denial that were not addressed at the first level.

Question: Where is a good site to obtain Peer Reviewed current clinical literature?
Answer: I am not aware of just one site for all the different diagnoses that are denied. Here are some examples/ideas:

- If you want to know about sepsis 3 criteria, you could go to 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, you could 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 also be a good source to ask since they need to be knowledgeable about such a wide variety of things – they 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: 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: If a payer or review entity already has a medical record sent by HIM, should we send record again so we can insure page numbers match?
Answer: Yes, that would be best practice. You want to make it as easy as possible for the payer to find in your favor.

Question: Is there any recourse when the auditor just disregards coding guidelines? For instance we're frequently told that encephalopathy is inherent in the F10-F19 series of codes so encephalopathy cannot be coded with overdoses.
Answer: Absolutely. You should address the issue thoroughly in your appeal (explain why their rationale is incorrect) and ask for the specific resources they used to make their determination. If that is not effective, ask for a meeting with the payer representative (get your physician advisor or a coding supervisor involved if applicable) and explain what is going on. Inform your contracting department and see if there are any recourses via that avenue.

Question:
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: 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. You want to make it as easy as possible for the payer to find in your favor.

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?

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

> Sepsis was denied because there was not consistent documentation of the diagnosis and that it was found only in response to a query.
> A query was posed because there were clinical indicators to suggest diagnoses 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**."
>
> 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:
How do you respond when the payor is refusing to accept query responses posed after discharge?

Answer:
I would check to see what the contract with the payer states. My guess is that your contract states that they will not accept any answers to post discharge queries. If that is the case, I suggest trying 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, I suggest sending a copy of that, along with your appeal, and 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: 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 in order for coverage, then yes, the codes must be listed as required in order for payment to occur. However, 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.
Regarding clinical validation denials: we are not aware of any CMS requirements for clinical validation.