AMERICAN COLLEGE OF PHYSICIAN ADVISORS

Best Practices for Proactive Defense Against Clinical Validation Denials

ACPA CDI Committee

ACPA Town Hall Disclaimer

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Introductions

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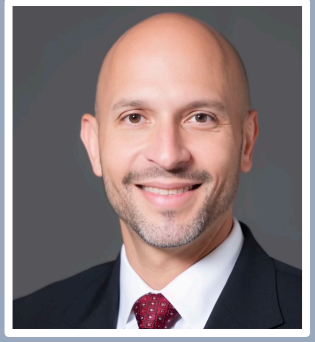

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Agenda

- Case Example
- Basics of Clinical Validation Denials
- Data and Measuring Success
- Payer Perspective
- Documentation Improvement: Institutional Guidance Documents
- Documentation Improvement: CDI and Tools

Case Example

Dr. Sansrita Nepal

MCC Removal

DENIAL

Remove secondary DX of E43.0 Severe Protein Calorie Malnutrition

Denial Rationale:

Documentation within the medical record was conflicting regarding the diagnosis of Unspecified severe protein-calorie malnutrition. While malnutrition was documented on progress note, other provider documentation was unclear and/or inconsistent regarding this condition. History and physical stated: appearance: well-developed. Progress note stated: not ill appearing, normal weight. Consult noted cachexia PE: not ill appearing. It is the hospitals responsibility to identify when documentation in the medical record is unclear or conflicting and in such instances a pre-bill provider clarification would be appropriate.

WHY WE ARE CORRECT:

- **BMI (Calculated): 16.33, Overall patient likely meeting <50% estimated needs for >3 months given significant weight loss and report of food insecurity. Meeting criteria for severe malnutrition. Per chart review, patient with 5.8kg (11% significant) weight loss in 5 months.**
- **CDI Query issued and answered favorably for Severe Protein Calorie Malnutrition**
- **Documented by Attending in Progress Note & Discharge Summary**

WHY PAYOR IS CORRECT:

- **Documentation states: "He is not in acute distress. Normal appearance. He is normal weight. He is not ill-appearing or diaphoretic."**

Outcome?
We lost.
Despite CDI Query & Physician Response, this case was let go after post-payment review with our Compliance team.

$7,976.39 Denied

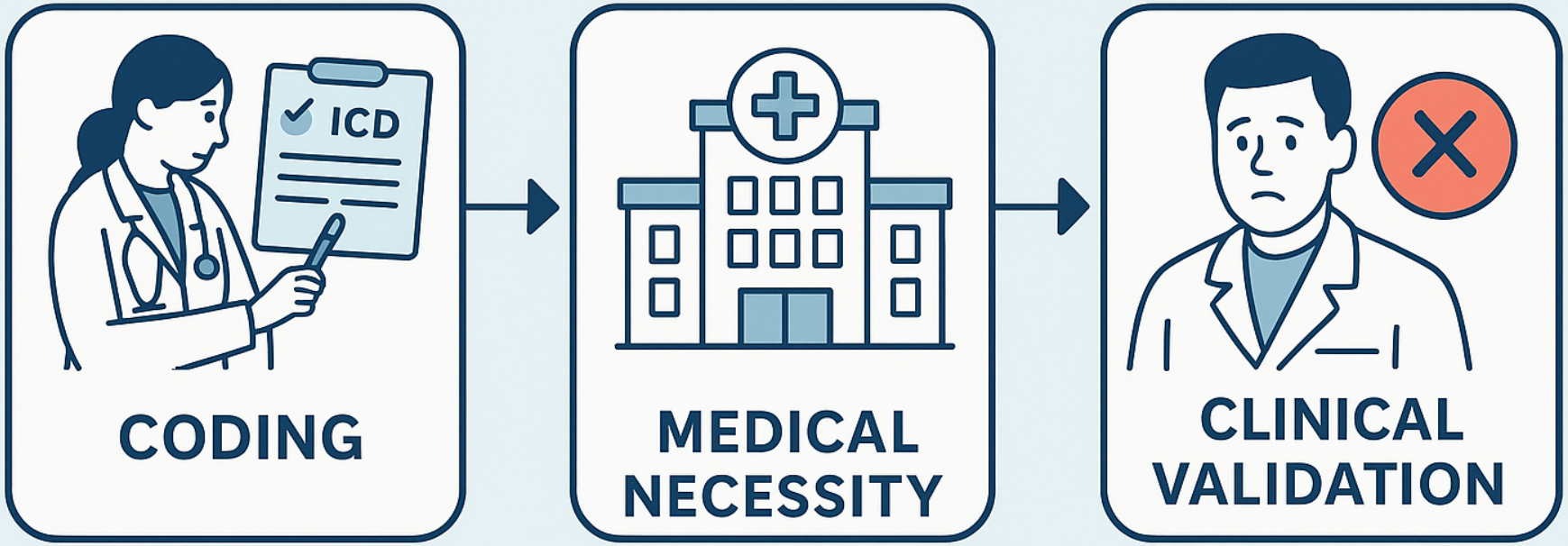
Poll Question #1

Who in audience functions in a capacity related to clinical validation denials?

Basics of Clinical Validation Denial

Dr. Waldo Herrera

CLINICAL VALIDATION DENIALS



A clinical validation denial occurs when a documented diagnosis is not clinically supported by the patient's signs, symptoms, diagnostic testing, or treatment.


CLINICAL
VALIDATION
DENIAL
DIAGNOSES

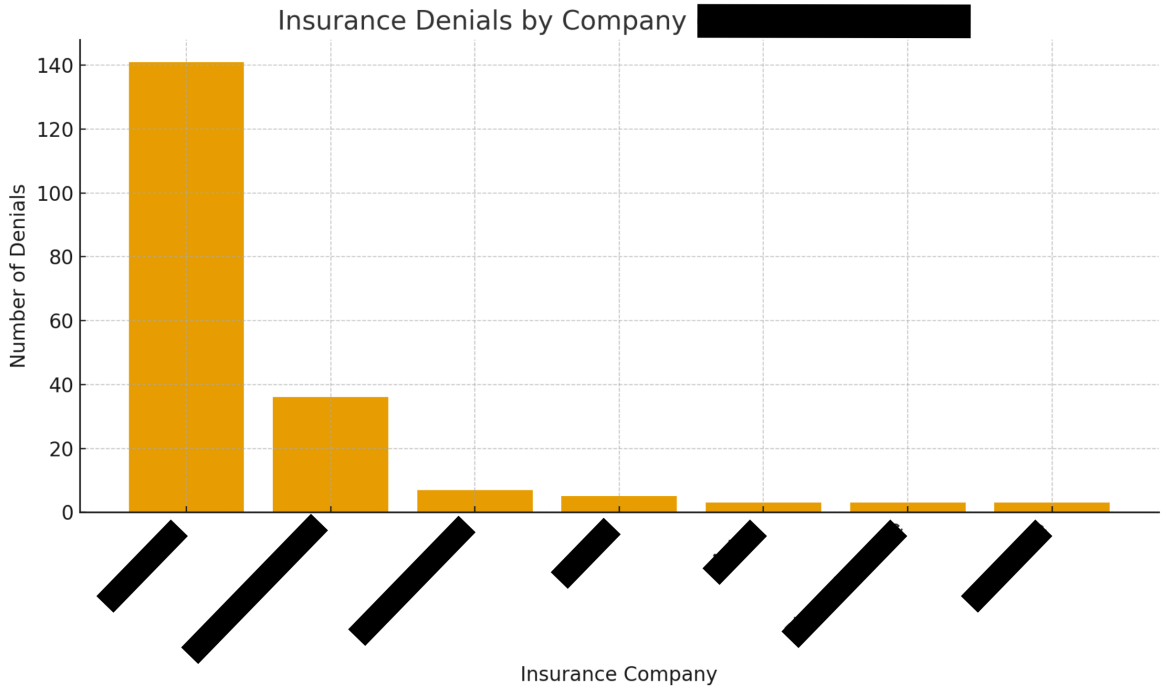
Data and Measuring Success

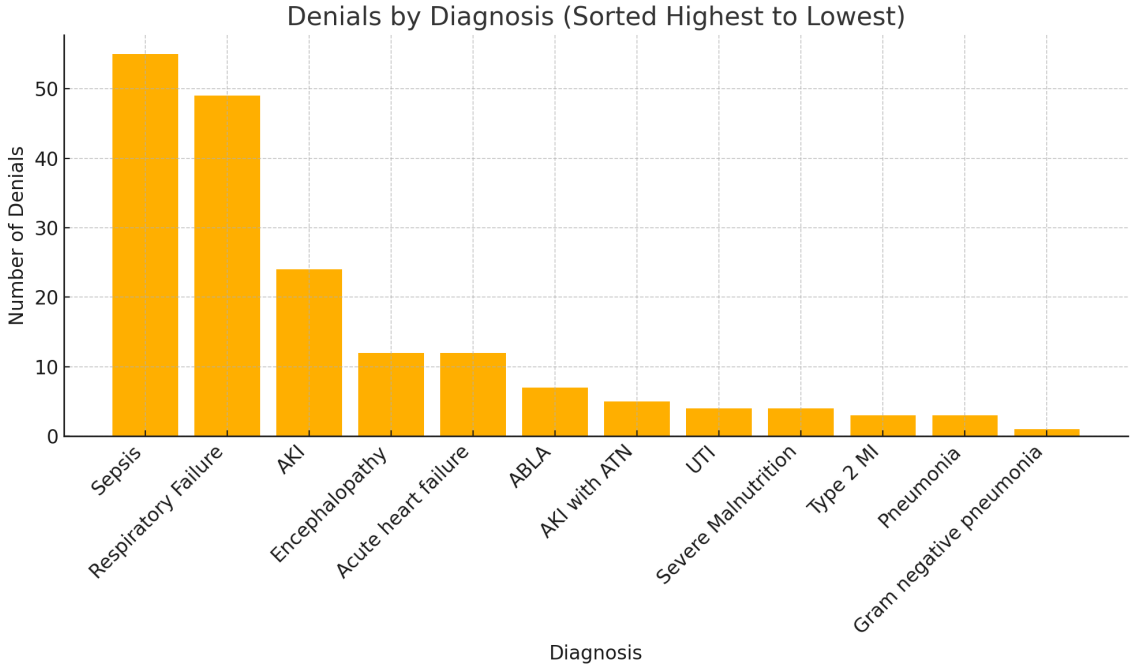
Dr. Robert Oubre

Clinical Validation Denial Data

- Data points
  - Denial letter date
  - Payer
  - Vendor
  - Original DRG
  - Revised DRG
  - Audited codes
  - Denial dollar amount
  - Strength of appeal (weak, weak-moderate, moderate-strong, strong)
  - Dates of levels of appeals
  - Result of appeal
  - Date of completion
  - Discharging physician

Clinical Validation Denial Data





Payer Perspective

Dr. Vic Freeman

Clinical Validation Denials – Payer Perspective

Clinical Validation Reviews generally have 2 parts

DRG Validation (by a Coder) and Clinical Validation (by a Clinician)

- ***DRG Validation:*** *Ensures that Coding Rules are followed*
  - ***Coding Dilemma****: "Likely NSTEMI due to Demand…" = NSTEMI???*

- ***Clinical Validation:*** *A retrospective clinical record review*
  - *To determine what diagnoses truly impacted the hospital stay;*
  - *To use very strict clinical criteria to assess clinical diagnoses, in order To limit the highest DRG payments to the sickest patients;*
  - *To advance the payor's role in Value-Base Care Reimbursement*

Top 3 Ways to Minimize Clinical Validations Denials

1) Avoid citing diagnoses as "active" for the hospitalization---

When they cannot be validated in the hospital record findings…

Encephalopathy – Reported by Family, Nursing Home, "OSH"

(But the patient is Alert & Fully Oriented for the hospitalization)

Sepsis / Acute Resp. Failure cited by a transferring hospital or ED

(But the patient does NOT meet the criteria on arrival/admission)

2) Cite clinical validation criteria for Dxs--- when first listed

3) List All MAJOR Diagnoses--- in the Discharge Summary

Key Clinical Validations Denial Target Diagnoses

1) Type 2 MI (vs Demand Ischemia vs Troponinemia)

e.g. If flat/mildly elevated Troponins + No EKG changes

2) Acute Heart Failure (vs Fluid Overload)

e.g. Based solely on LE Edema + Elevated BNP / No Pulmonary Edema

3) Acute Tubular Necrosis (vs Acute Kidney Failure)

e.g. No ATN-finding and Creatinine reaches baseline in a few days

4) Tox/Met Encephalopathy (vs Delirium, Intoxication)

e.g. Sundowning, CVA/TIA, Post-Ictal, simple lethargy

5) Severe Malnutrition (vs Moderate, Unspecified)

e.g. No clinically documented weight loss or reduced energy intake

Documentation Improvement: Institutional Guidance Documents

Dr. Joseph Cristiano

Documentation Improvement: Guidance Documents

Guidance Documents

- Informed by both peer reviewed medical literature and official coding guidelines
- Created by both clinical subject matter experts and CDI and coding leaders
- Can be directed to CDI/Coding AND/OR Clinical Staff
- Output in form of alignment documents/policies internal guidance
- Drive consistency approach to querying for clinical validation by CDI and coding practices
- Excellent substrate for education for both CDI/coding, appeals team, and clinical staff
- Can provide ammunition for your appeal letters

Documentation Improvement: Guidance Documents

POLICY GUIDELINES

A. Coma: The National Institute of Neurological Disorders and Stroke (NIH NINDS) describes coma as a broad term 'profound or deep state of unconsciousness…an individual with coma is alive but unable to move or respond to his or her environment…may occur as a complication of an underlying illness or result of injuries.'

B. The pathophysiology of coma is not completely understood but can descriptively be depicted as arousal and awareness which lasts typically greater than 1 hour.
   1. GCS (Glasgow Coma Scale) has been described as a cornerstone of the assessment of a patient's state of arousal or lack thereof in the setting of coma. GCS is also a powerful predictor of survival and neurologic outcomes in the critically ill patient population and in those patients with head trauma, non-traumatic coma, ischemic and hemorrhagic cerebral vascular accidents.
   2. Delirium and encephalopathy specifically represent acute confusional states characterized by fluctuations and impairment in attentiveness. While changes in level of consciousness is frequently associated with confusional states, coma can be distinguished by the profound degree and persistence of unconsciousness.

C. Institutionally, coma is described most centrally as related to a patient's GCS.

D. Diagnostic Criteria:
   1. GCS: Severe impairment in level of consciousness that is acute and best measured within the initial 24 hours of admission.
      a. GCS < 8 considered out proportion or in the absence of pharmacologic sedation.
      b. Measured by the provider and/or critical care nursing staff.
      c. Persistently < than 8 on at least 2 measurements at least one hour apart.
   2. A diagnosis of coma must be associated to the suspected or confirmed underlying etiology:
      a. Traumatic brain injury
      b. Primary intracerebral hemorrhage
      c. Ischemic stroke
      d. Hypoxia-ischemic or anoxic brain injury
      e. Severe metabolic derangement, toxin or medication related
      f. Seizure
      g. Infectious process

E. Documentation Elements:
   1. Coma, encephalopathy, and altered mental status are not interchangeable terms. Coma strictly requires satisfying the impairment in GCS as noted above.
   2. Documentation must explicitly include the patient's GCS score at the time of diagnosis.
   3. Provide documentation is strongly encouraged for all suspected or confirmed etiologies to the coma diagnosis.

Documentation Improvement: Guidance Documents

A. **Encephalopathy:** The National Institute of Neurological Disorders and Stroke (NIH NINDS) describes encephalopathy as a broad term "for any diffuse disease of the brain that alters brain function or structure" with further elaboration that "depending on the type and severity of encephalopathy, common neurological symptoms include progressive loss of memory and cognitive ability, subtle personality changes, inability to concentrate, lethargy and progressive loss of consciousness."

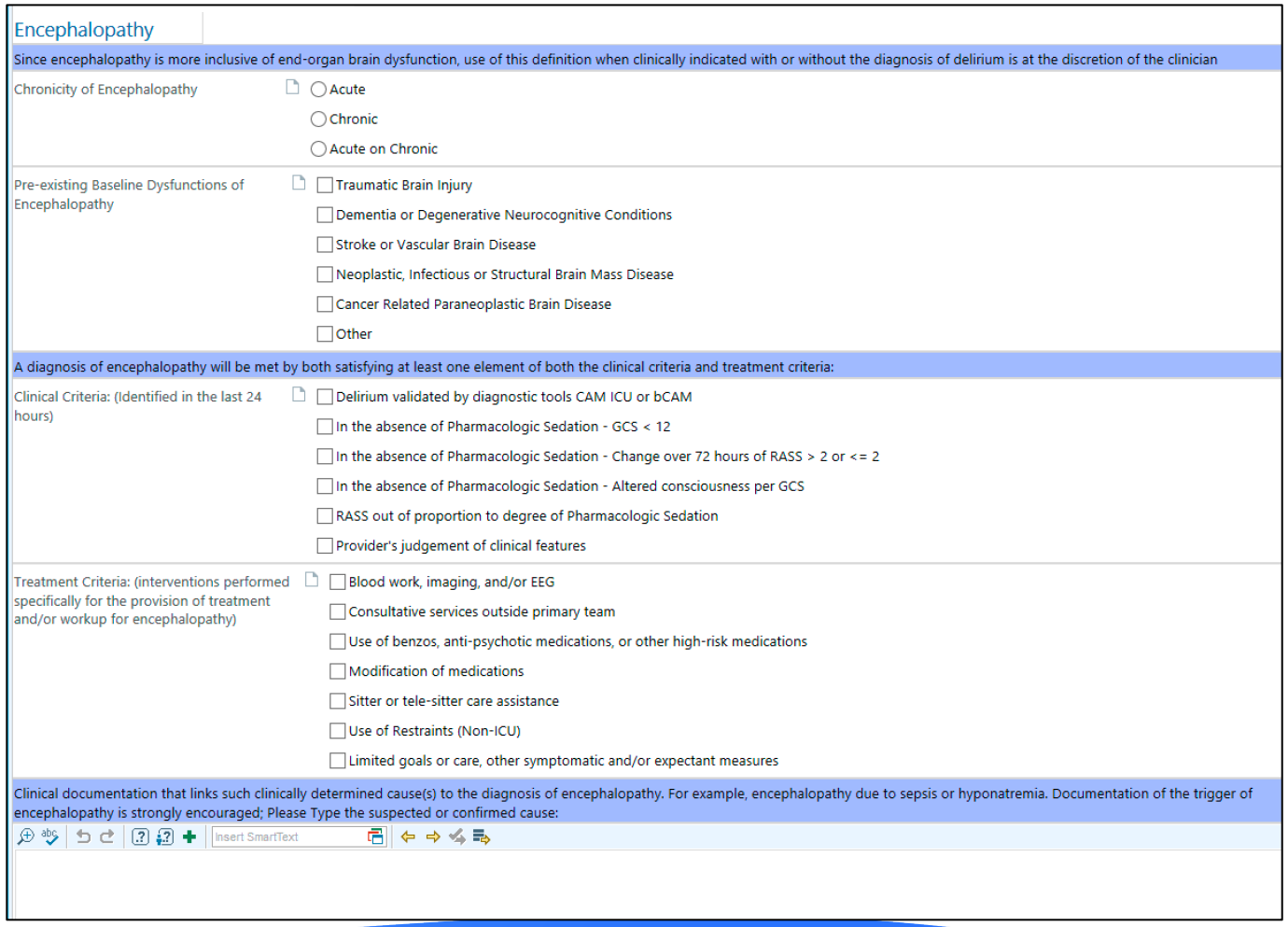
B. The pathophysiology and definitions for delirium and encephalopathy have significant overlap and frequently describe patients with similar clinical conditions. However, these terms are not interchangeable.
   I. Encephalopathy represents a disease spectrum for cerebral/brain dysfunction with varying clinical manifestations including the acuity, severity and the etiology (s).[1] Due to the heterogeneity of the condition, there is not universally accepted diagnostic criteria for use in clinical care in the biomedical literature.
   II. Delirium has specific clinical manifestations as defined in DSM-V including a disturbance in attention over a short period of time with disturbance in cognition[2]. Specific validated assessment instruments are available and include but not limited to the CAM, CAM-ICU and bCAM.

C. Institutionally, encephalopathy can be defined for clinical documentation using the term below (Section D). Since encephalopathy is more inclusive of end-organ brain dysfunction, use of this definition when clinically indicated with or without the diagnosis of delirium is at the discretion of the clinician.

D. **Diagnostic Criteria:**
   I. Acute vs Acute on Chronic Vs Chronic: Describes the time-based nature of a patient's clinical manifestations of encephalopathy.
      a. Acute: Encephalopathy suspected to have developed over hours to days in the absence of baseline brain dysfunction.
      b. Chronic: The presence of pre-existing baseline brain dysfunction for at least 3 months' duration that requires management, and/or treatment during an episode of care.
         i. Traumatic Brain Injury
         ii. Dementia or degenerative neurocognitive conditions
         iii. Stroke or vascular brain disease
         iv. Neoplastic, infectious or structural brain mass disease
         v. Cancer related paraneoplastic brain disease
      c. Acute on Chronic: The presence of clinical manifestations of encephalopathy that has developed over hours to days in the presence of pre-existing baseline chronic encephalopathy.
   II. A diagnosis of encephalopathy will be met by both satisfying at least one element of both the clinical criteria and treatment criteria:
      a. Clinical Criteria: The presence of any one of the following diagnostic criteria identified within the last 24 hours
         i. In the absence of pharmacologic sedation, an altered level of conscious as determined by absolute GCS < 12 or change in 2 over 72 hours, RASS > 2 or < -2
         i. In the presence of pharmacologic sedation, an altered level of consciousness as determined by GCS or RASS out proportion to degree of pharmacologic sedation.
         ii. The presence of delirium as determined by validated diagnostic tools including but not limited the CAM-ICU or brief CAM (b-CAM).
         iii. Treating provider's judgement of clinical features consistent with encephalopathy (including but not limited to alteration in level of consciousness, disorientation, inattentiveness, disorganized thinking, agitation, hyperactivity or other signs or symptoms)
      b. Treatment Criteria: Any of the following interventions performed specifically for the provision of treatment and/or workup for encephalopathy that includes but is not limited to:
         i. Blood work, imaging, and/or EEG
         ii. Consultative services for management out of scope of the primary team
         iii. The use of benzodiazepines, anti-psychotic medications, or other high-risk medications intended for management of encephalopathy
         iv. Modification of medications relevant to management of encephalopathy
         v. Sitter or tele-sitter care assistance for a patient needs as a result of encephalopathy
         vi. The use of restraints (in the non-ICU setting)
         vii. In patients with limited goals of care, other symptomatic and/or expectant measures for management of encephalopathy
   III. Etiology or cause for a patient's encephalopathy: We encourage the diagnostic evaluation for the causative factor or etiology for a patient's encephalopathy. Additionally, we strongly encourage clinical documentation that links such clinically determined cause(s) to the diagnosis of encephalopathy. For example, encephalopathy due to sepsis or hyponatremia.

E. **Documentation Elements:**
   I. Delirium and encephalopathy are not interchangeable terms, when clinically applicable we encourage documentation of encephalopathy when present and satisfying the aforementioned definition.
   II. Provide documentation of the acuity of encephalopathy (acute, chronic, or acute on chronic) and the clinical criteria satisfying the diagnosis.
   III. Provide documentation of all suspected or confirmed etiologies to the encephalopathy diagnosis.

Documentation Improvement: Guidance Documents



Encephalopathy

Since encephalopathy is more inclusive of end-organ brain dysfunction, use of this definition when clinically indicated with or without the diagnosis of delirium is at the discretion of the clinician

Chronicity of Encephalopathy
- ◯ Acute
- ◯ Chronic
- ◯ Acute on Chronic

Pre-existing Baseline Dysfunctions of Encephalopathy
- ☐ Traumatic Brain Injury
- ☐ Dementia or Degenerative Neurocognitive Conditions
- ☐ Stroke or Vascular Brain Disease
- ☐ Neoplastic, Infectious or Structural Brain Mass Disease
- ☐ Cancer Related Paraneoplastic Brain Disease
- ☐ Other

A diagnosis of encephalopathy will be met by both satisfying at least one element of both the clinical criteria and treatment criteria:

Clinical Criteria: (Identified in the last 24 hours)
- ☐ Delirium validated by diagnostic tools CAM ICU or bCAM
- ☐ In the absence of Pharmacologic Sedation - GCS < 12
- ☐ In the absence of Pharmacologic Sedation - Change over 72 hours of RASS > 2 or <= 2
- ☐ In the absence of Pharmacologic Sedation - Altered consciousness per GCS
- ☐ RASS out of proportion to degree of Pharmacologic Sedation
- ☐ Provider's judgement of clinical features

Treatment Criteria: (interventions performed specifically for the provision of treatment and/or workup for encephalopathy)
- ☐ Blood work, imaging, and/or EEG
- ☐ Consultative services outside primary team
- ☐ Use of benzos, anti-psychotic medications, or other high-risk medications
- ☐ Modification of medications
- ☐ Sitter or tele-sitter care assistance
- ☐ Use of Restraints (Non-ICU)
- ☐ Limited goals or care, other symptomatic and/or expectant measures

Clinical documentation that links such clinically determined cause(s) to the diagnosis of encephalopathy. For example, encephalopathy due to sepsis or hyponatremia. Documentation of the trigger of encephalopathy is strongly encouraged; Please Type the suspected or confirmed cause:

Insert SmartText

Documentation Improvement: CDI and Tools

Dr. Rima Mercado

Documentation Improvement Strategies:

1. Education and teaching of correct language – “blame it on the language”

   Clarification of Terms and CDI equivalents- target areas of highest queries:

   vasoplegia – shock; urosepsis UTI/Sepsis ; troponemia- type 2 NSTEMI

2. Group specific template after concensus and review of guidelines

3. Review of metrics and comparables

4. Direct feedback to providers and regular meetings

5. Newsletters

6. Create templates for frequent queries (morbid obesity – incorporation of weight in progress note; BMI in SPCM)

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Pocket Guideline example:

DHMC CT Surgery Pocket Guidelines V2.1

RESPIRATORY

Post-Operative Respiratory Failure	Acute Pulmonary Insufficiency	Acute on Chronic Respiratory Failure
- Prolonged post-operative pulmonary ventilation> 24hrs - Excludes OR routine exit until extubation + additional hours following re-intubation - Causes such as ARDS, pulmonary edema and/or any patient requiring vent > 24 hrs. - Unplanned Reintubation - > 72 hours of 5L or 40% FiO2 more, unable to wean*	- > 24 hours but < 72 hours of 5L or 40% or more* After 24 hours, if still requiring: - 5L or greater O2 (BIPAP, Hi Flow) After 72 hours, if still requiring: - Any amount of continuous O2 - If previously weaning, but later would require increasing O2 again Cause needs to be specified – (*due to; result of*) (Atelectasis; pleural effusion, etc.)	- Specify if acute and/or chronic (if previously on O2) - Known chronic lung/cardiac condition that was treated (COPD, CHF, Neuromuscular condition, ILD, etc) or addressed this admission as cause of increased O2 need (steroids for COPD, Lasix for CHF, etc..)

CARDIAC

Cardiogenic Shock^	Distributive Shock^	Other Shock (please specify)
- Requiring inotropic therapy > 24 hours - cardiac index (CI) <1.8 L/min/m2 without hemodynamic support - Cardiac index (CI) <2.2 L/min/m2 with support - Use of EC Circ or VAD; IABP (in a subset if placed during Sx in shock setting) - PCWP > 15mmHg (if available)	- Requiring vasopressor therapy > 24 hours in the setting of preserved cardiac function - in clinical setting of shock ^ ***NOT A PSI***	- Persistent hypotension with MAP < 55 and/or evidence of target organ damage - SEPTIC *(PSI)* -HEMORRHAGIC *(PSI)* - ANAPHYLACTIC - HYPOVOLEMIC
Atrial Fibrillation^		
Document as a **POST –OP COMPLICATION** if with **any** of the ff: - Requires cardioversion - Higher level of care - Hypotension requiring longer pressors - Prolonged hospital stay than expected		
Heart Failure	**Acute**	**Chronic**
Specify: - Acute, chronic or acute on chronic AND - Systolic, diastolic or combined	- Specify if systolic or diastolic (or combined) - Evidence of volume overload, weight gain or elevated BNP (pulmonary edema, O2 need, anasarca), +JVD - Use of continuous infusion/IV Lasix diuresis to manage volume	- Specify if systolic or diastolic (or combined) - Stable known prior to surgery (systolic or diastolic - Evidence of Low EF (systolic) or impaired relaxation (diastolic)

SYSTEMIC/NEUROLOGIC

Delirium (Uptodate)	Encephalopathy(ACP Medicine)	Acute blood loss Anemia (ACDIS)
- Develops acutely over hours to days - Waxing and waning mental status with periods of orientation - Deficit in attention and awareness - Can be hypoactive or hyperactive	- cerebral dysfunction in the absence of primary structural brain disease - longer lasting and more pervasive than delirium Specify: Toxic – effect of drugs, toxins, poison, infection (UTI etc.) or meds Metabolic – dehydration, acidosis, organ failure *(hepatic, uremic, electrolyte abnormalities etc.)* Septic – confusion in setting of sepsis Anoxic – decreased brain perfusion	- Signs and symptoms (tachycardia, hypotension) + - Significant identified blood loss (documented EBL in Op note) and/or - Requirement for blood transfusion and/or - Post op Day 3 Hgb < 8.5 with documented drop and/or - Total Drop ? (TBD)

*Institutional Parameter; ^ Not a HAC/PSI

Update 11.22.22

CDI Newsletter example:

Clinical Documentation Improvement

Quarterly Newsletter

July-Sept. 2024

Takeaways……

- Acute Blood Loss Anemia should **ONLY** be documented if symptomatic, requires increased frequency of monitoring and/or treatment
- Please be aware of automated template verbiage and modify as appropriate- *always include documentation to support diagnosis*
- Document the etiology and/or *all* types of anemia if multifactorial (d/t meds, ckd, vit.deficiency, etc)
- Document the acuity of the blood loss anemia
  - Acute
  - Chronic
  - Acute on chronic

"No! This isn't the place to order a blood transfusion!"

Acute Blood Loss Anemia

The World Health Organization (WHO) defines anemia using hemoglobin levels as follows:

- Men < 13.0 g/dL
- Women < 12.0 g/dL
- Pregnant women < 11.0 g/dL

- A drop in Hgb of >2.0 g/dL, causing the patient to become anemic AND with symptoms i.e.: *fatigue, chest pain, shortness of breath, dyspnea on exertion, palpitations secondary to tachycardia, hypotension or generalized weakness.*

- Blood transfusion is **NOT** required to substantiate the diagnosis of acute blood loss anemia.

- ***Even if the amount of blood lost following surgery is expected*** and routinely associated with the procedure, acute blood loss anemia is still present if anemia occurs *and* ***warrants monitoring****, evaluation, treatment,* ***increased use of resources****, or extends the length of stay*.

- Keep in mind that a smaller drop in Hgb is more significant in chronic anemia where the patient has a lower baseline (e.g 1g/dl drop in CKD).

- ABLA is **NOT** classified as a complication of care.

- ABLA can be acutely multifactorial (trauma with diffuse ecchymoses + surgical blood loss).

- Anemia due to acute bleeding (GI bleed, fracture, epistaxis, etc.) are coded separately and both would need to be documented to be captured.
(e.g. Acute diverticular bleeding with acute blood loss anemia.)

"Acute Blood Loss Anemia *with Hemodilution*" is not true "blood loss" so should be best avoided. This is subject to increased audit and denials.

Documentation Tips To Prevent Denials Please Include:

Specify primary cause for Hgb drop:

- **Acute blood loss anemia**
- **Spurious/Pseudo drop in Hgb due to hemodilution**

***EVERY* diagnosis *MUST* meet the UHDDS (Uniform Hospital Discharge Data Set) guidelines**

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

- **clinical evaluation; or**
- **therapeutic treatment; or**
- **diagnostic procedures; or**
- **extended length of hospital stays; or**
- **increased nursing care and/or monitoring**

Who We Are And What We Do

The Clinical Documentation Improvement (CDI) departments at DHMC and Cheshire Medical Center consists of a group of highly trained RNs with a combined level of expertise and experience encompassing all service lines.

We ask questions (queries) to establish, clarify, and confirm the most appropriate ICD 10 diagnoses to match the patient's condition and care provided.

Click the link below to access the CDI website for contact information and more educational resources:

http://one.hitchcock.org/intranet/departments/clinical-documentation-improvement/clinical-documentation-specialist---rn

References: WHO. Haemoglobin concentrations for the diagnosis of anaemia and assessment of severity. Vitamin and Mineral Nutrition Information System. Geneva, World Health Organization, 2011 (WHO/NMH/NHD/MNM/11.1)
http://www.who.int/vmnis/indicators/haemoglobin
Pirsee. Bleeding and acute blood loss anemia. Coding Corner. ACP Hospitalist. February 2012
https://acphospitalist.org/archives/2012/02/coding.htm 2. Pirsee. Blood loss anemia. Coding Corner. ACP Hospitalist. January 2016
https://acphospitalist.org/archives/2016/01/coding-blood-loss-anemia.htm
Clers20/20. Documentation Guide (windows.net)
ICD-10-CM Official Guidelines for Coding and Reporting FY 2024
https://www.cms.gov/files/document/fy-2024-icd-10-cm-coding-guidelines-updated-02/01/2024.pdf
Cartoonstock.com

The Impact (query example):

Please review the following and provide your response in the progress notes.
Clinical Indicators:

Hemoglobin 2/9 (13.2) 2/10 (7.9) 2/11 (5.6-6.6-7.8) 2/12 (7.6)
2/9 Op Note with Estimated Blood Loss: 600
2/11 PRBC blood transfusion

2/10 OT progress note "Balance:
Sitting Static: supervision for safety unsupported due to dizziness
Sitting Dynamic: supervision for safety unsupported due to dizziness"
2/10 PT progress note "Dizziness with position changes that lead to pauses and rests during evaluation"
2/11 PT progress note "Sitting EOB with reports of dizziness and diaphoretic, sat about 15 minutes"
2/13 Orthopaedics progress note with "Stable anemia (7.6 2/12 - no AM labs yet today)

Please clarify the following:

- **Postoperative blood loss anemia**
- **Acute Blood Loss Anemia**
- **Other**

Query response: POD#3 Hgb was 6.6, down from 9.6 prior to surgery. Hemoglobin drop associated with anemia from acute blood loss from surgery; symptomatic-dizziness (CC captured)

Use of terms such as **suspected, possible, or probable** (associated with a specific diagnosis that is being evaluated, monitored, or treated as if it exists) **are acceptable** and can be coded in the inpatient setting, when documented at the time of discharge (i.e., in the discharge summary).

IMPACT (will vary per DRG)

DRG	Relative weight calculation used for payment	Geometric length of stay (days)	National Mortality Rate	Financial Impact (Medicare)
Pre-Query Baseline DRG w/o cc/mcc 482	1.5884	3.2	0.00	$16,718.13
Pre-Query DRG with cc 481	2.0749	4.5	0.00	$21,709.32

43 y/o female with morbid obesity, DM type 2, hyperlipidemia and hypertension, BMI 42. Gastric bypass performed yesterday.

Current Documentation:

Primary Dx: Morbid obesity

DM Type 2
Hyperlipidemia
HTN

Addition of Metabolic Syndrome:

Primary Dx: Metabolic syndrome
CC: BMI 42 - Morbid obesity

DM type 2
Hyperlipidemia
HTN

MSDRG	Relative Weight	Geometric Mean LOS
DRG 621 – OR Procedures for Obesity w/o CC/MCC	1.555	1.3 days
DRG 620 – OR Procedures for Obesity with CC	1.6856	1.7 days

Impact: Increase expected length of stay and increases reimbursement

Questions

Roundtable with Panelists

Closing Comments

Roundtable with Panelists

AMERICAN COLLEGE OF PHYSICIAN ADVISORS

Thank you. Questions?