



When Worlds Collide: Clinical Validation and Medical Necessity

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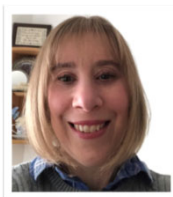
Lewisburg, PA



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Presented By



Alyce Reavis, MSN, RN, CCDS, CCS, is the CDI auditing coordinator at Evangelical Community Hospital in Lewisburg, Pennsylvania. Reavis has been a nurse for nearly 12 years following a 12-year career as a public educator. Her clinical experience includes adult ICU, dialysis, pediatrics, NICU, mother/baby and outpatient adult case management, and her CDI experience includes serving in the role of preceptor, developing educational sessions and materials to help team members prepare for the CCDS exam, and creating an orientation program for UR and CDI staff. Reavis received an ACDIS scholarship in 2021 and served as a member of the ACDIS Forms and Tools Committee. Currently, she serves on the ACDIS Furthering Education Committee and on the Leadership Council in addition to being a member of the Central PA ACDIS Chapter. She presented at the 2022 ACDIS National Convention in Orlando, Florida.

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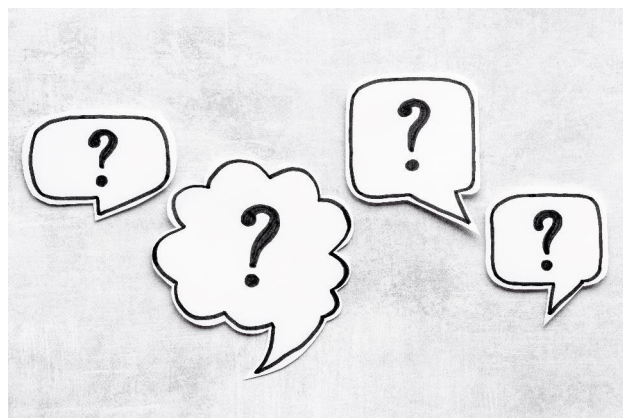
Learning Objectives

- At the completion of this educational activity, the learner will be able to:
 - Identify and evaluate the need for a facility definition of a clinical diagnosis
 - Choose elements of Interqual® and Indicia MCG criteria that help support a clinical facility definition
 - Recognize the ways that Utilization Review (UR) and CDI can collaborate in creating a facility definition
 - Identify documentation to report Z codes that can support medical necessity and criteria

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Questions to Ponder



- Does my facility develop and utilize clinical definitions?
- Does my facility develop clinical definitions in conjunction with the Utilization Review (UR) team?
- Does my facility develop clinical definitions with medical necessity criteria embedded?
- Is the CDI team at my facility familiar with documentation and codes that support medical necessity that assist the UR team?

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Once Upon a Time

- Upward trend in clinical validation denials for acute respiratory failure
- Outside auditors noted opportunities missed for clinical validation queries
- No prior facility clinical definitions
- Disagreement and confusion between CDI, UR, and providers regarding what is and is not acute respiratory failure

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After Some Research

- Clinical criteria and code assignment—AHA *Coding Clinic*, Fourth Quarter 2016, pp. 147–149
- AHIMA Practice Brief *Clinical Validation: The Next Level of CDI* (January 2019 Update)

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Statement From the AHIMA Practice Brief

- “CDI and coding professionals are united by the goal of ensuring accurate clinically valid documentation and reporting, which drives hospital and physician profiling comparatives, patient severity/mortality depiction, and financial outcomes—all of which are critical to the healthcare facility’s survival. The roles of coding and CDI professionals are vital to the organization’s patient care and national profiles, compliance with regulatory mandates, and financial stability.” (p. 5)

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Coding Clinic, Fourth Quarter 2016, pp. 147–149

- “A facility or a payer may require that a physician use a particular clinical definition or set of criteria when establishing a diagnosis, but that is a clinical issue outside the coding system.”

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Necessity Is the Mother of Invention

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Example of Denial Type Received

Comments: Based on our clinical review, the medical documentation supplied does not support the assignment of Acute Respiratory Failure With Hypoxia, code J96.01, as a secondary diagnosis. Our medical review of the case finds that the secondary diagnosis of Acute Respiratory Failure With Hypoxia, while documented by the physician, is not clinically supported. The following is the decision of our clinical reviewer: This individual presented to the hospital for fatigue and shortness of breath on exertion. Upon arrival to the Emergency Department, the patient was 88% on room air and was placed on 1.5L oxygen nasal cannula. The oxygen saturation came up to 94-95% in the Emergency Department. The patient was found to be COVID-19 positive and was started on Remdesivir and Dexamethasone. It was documented in the Progress Notes that the patient had dyspnea on exertion and a cough. There were diminished breath sounds and diminished wheezes. The patient required supplemental oxygen ranging from 1-3 L via nasal cannula during the hospitalization and his oxygen saturations were 87%-98% on and off oxygen supplementation. Respirations ranged from 16-22. The chest x-ray showed no infiltrates or consolidation. Upon discharge, the patient showed no signs of COVID-19 pneumonia and was discharged home on Dexamethasone for 5 days. He did not go home on any oxygen supplementation. He received no nebulizer treatments during the hospitalization. There was no documentation of clinical indicators of respiratory failure such as inability to speak, a respiratory rate equal to or below 10 or equal to or above 24 - sustained, accessory muscle use, diaphoresis, headache, intercostal/subcostal retractions, grunting, flaring nostrils, tracheal tugging, adventitious breath sounds, stridor, cyanosis, cardiac dysfunction - tachycardia or cardiac arrest, central nervous system depression with decreased respiratory rate and/or shallow breathing and abnormal or ineffective respiratory rhythm/patterns. The patient was responsive to supplemental oxygen. Acute respiratory failure with hypoxia is not supported clinically as a complication for this episode of care. Therefore, Acute Respiratory Failure With Hypoxia, code J96.01, will be deleted as a secondary diagnosis for this case.

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AHIMA Brief Used as Reference for Denial From the Payer

- “This brief emphasizes the need for clear and accurate documentation and that a query would need to be completed when it appears that a documented diagnosis is not clinically supported within the patient’s health record.”

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Evangelical's Internal Findings

- Patient presented to the ER triage, RN reporting SOB at rest with no history of respiratory/lung disease.
- One sat of 88% on RA in the ER and requiring 1.5–2L with sats 91–96% and RR 18–22.
- ER exam with unlabored breathing and rales. No concerning respiratory exam findings throughout the stay.
- O₂ and COVID treatment without nebs needed.
- Labs with serum CO₂ 29 and Anion Gap of 14 which are both WNL. No ABG or VBG.
- Max O₂ requirement was 3L for a little over 24 hours with stable respiratory assessment from nursing and RR 16–18. DOE was their only reported issue.
- On RA for last 12 hours of stay with no need for home O₂ eval or home O₂.

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Let's Talk About It....

Medical Necessity

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What Is Medical Necessity?

According to Medicare, medically necessary care is defined as, “Health care services or supplies needed to diagnose or treat an illness, injury, condition, disease, or its symptoms and that meet accepted standards of medicine.”

[Source: www.medicare.gov/glossary/m](https://www.medicare.gov/glossary/m)

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What Are Medical Necessity Criteria?



Criteria sets for specific conditions and procedures



Helps the UR team and providers determine level of care and status



Used to help establish intensity of service, requests for initial authorizations for care, and continued authorizations for prolonged stays

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How Does Evangelical Use Medical Necessity Criteria?

Two different criteria sets: MCG and Interqual®

Determined mainly by payer preference

Interqual® for Medicare and those payers that we do not know their preference

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Of Note

- Did meet medical necessity for COVID-19 in Interqual®
- The criteria includes oxygen saturation of <90% and below baseline (does not specify RA versus with supplementation)
- Supplemental oxygen (no specific delivery or FiO₂)
- Query was placed for COVID pneumonia based on indicators

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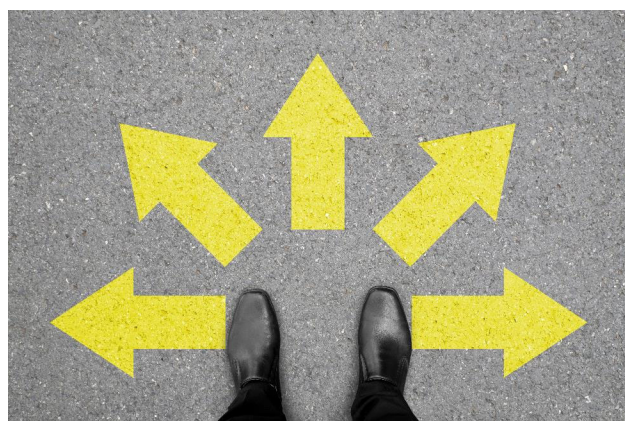
Furthermore

- Discussed with CDI team and physician advisor
- As eluded earlier, consensus was difficult to ascertain
- Particularly in a case with a COVID patient

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And So, It Began



- Collaboration between CDI auditor, director, and physician advisor for initial parameters
- Medical journals, pathophysiology books, outside auditor recommendations
- MCG and Interqual® criteria
- Deep dive into what payers were calling respiratory failure
- Presentation to hospitalists, ER, critical care, anesthesia, and surgery for feedback and additional considerations

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A Look at MCG Criteria for Respiratory Failure

- New (acute) need for mechanical invasive or noninvasive ventilation (High O₂ flow, BiPAP, VAPS)
- Severe respiratory distress, (RR >30 BPM) and severe hypoxemia (PaO₂ <50mm Hg on >50%FiO₂ or P/F ratio < 200), altered mental status
- Severe ventilation deficit: Hypercarbia (pCO₂ >40 mm Hg, pH less than 7.35)

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A Look at Interqual[®] Criteria for Respiratory Failure (Acute Level)

- Oxygenation: pO₂ < 56 mm Hg and < baseline; O₂ sat less than or equal to 89% and < baseline
- Requires supplemental oxygen

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Intermediate Level

- NIPPV: BiPAP or CPAP
- Oxygen greater than or equal to 40%

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The Final Product

Acute Respiratory Failure – ECH Facility Definition Criteria

- Clinical Indicators:
 - Tachypnea or low RR (ie, RR greater or equal to 24 or less than 10)
 - dyspnea/increased work of breathing
 - wheezing or poor air flow
 - Altered mental status
 - Hemodynamic instability
- Ventilation/gas exchange indicators:
 - Accurate SpO₂ < 91% and requires (at least) 4L/min NC for correction
 - Acute respiratory acidosis – arterial pH < 7.35 or venous pH < 7.3
 - Alternative Diagnostic support:
 - pO₂ < 60 mmHg OR decrease by (at least) 10 mmHg from baseline
 - OR P/F ratio < 300
 - pCO₂ > 50 mmHg with change in pH
 - OR increase by (at least) 10 mmHg from baseline
- Treatment: unanticipated physiologically required need for intervention
 - Mechanical ventilation or NIV
 - At least 2hrs higher flow supplemental oxygen – HiFlow, NRB, NC at least 4L/min
- Diagnosis requires at least 1 component from each category above
- Exceptions to consider:
 - Airway protection – ie, mechanical ventilation provided prior to, and to avoid respiratory compromise, not meeting indicators noted above
 - Post-op pulmonary insufficiency that is not unexpected given the patient's risk factors and nature of the procedure (ie, COPD or OHS/OSA patient undergoing abdominal surgery remains intubated overnight and extubated the following day)
 - Post-procedural pneumothorax (as a known procedural risk) without clinical compromise, ie, not meeting the clinical, ventilatory, and treatment indicators above (even if placed on supplemental oxygen for treatment)

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Query Template for More Standardization

Respiratory Failure Query Template Evan Facility Definition

Documentation in the medical record indicates that this patient has been admitted with or diagnosed as having:

The following is also documented in the medical record:

- Symptoms:
- Respiratory Rate:
- ABG: pO₂ < 60 (indicate actual) on room air; or pO₂ ___ on ___ liters oxygen
- pO₂: if < 91% (indicate actual—on room air)
- pCO₂: if > 50 / pH < 7.35 (indicate actual: pCO₂ = ___ / pH = ___)
- P/F Ratio =
- Treatment with:

Based on your medical judgment, can you further clarify the diagnosis related to these findings in the progress notes such as:

- Acute Respiratory Failure (please specify hypoxic or hypercarbic)
- Acute on Chronic Respiratory Failure
- Chronic Respiratory Failure without acute exacerbation
- Other cause (please specify)
- None of the above / Not applicable

If any of the above diagnoses have resolved, you may specify as such.

VALIDATION:

Acute respiratory failure is documented in the medical record.

(Use clinical indicator fields as above)

Please provide additional clinical indicators supportive of the documented diagnosis of acute respiratory failure.

-- Condition was evident because (please document in your next progress note)

-- Condition was ruled out and amended documentation provided in the medical record

-- Clinically unable to provide additional clarity regarding the diagnosis

-- Other (please specify)

-- Unknown

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What Was the Benefit?

- Still early to determine effect on the back end
- Early findings showing decrease in front-end denials as patients meet the medical necessity criteria

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The Future

- Sepsis
- Acute kidney injury
- Encephalopathy



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Supporting Medical Necessity

How Z codes can help support medical necessity criteria

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Review of Z Codes

- Indicate history, health status, or another problem that may not be an illness or injury alone but can influence patient care
- Indicates outcome of a delivery
- Usually assigned when there is significance to the episode of care

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Have You Heard This?

- “Z codes have their place, but if they don’t affect the DRG or SOI/ROM, why should I be concerned?”

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Interqual[®] Cellulitis

- Acute criteria requires cellulitis be present: immunocompromised patient, over a prosthesis or implanted device, or orbital
- Intervention of antibiotic and IV fluids running at least 75 mL/hr
- Otherwise meets observation level of care
- NIPPV or oxygen delivered at FiO₂ of 40% required at intermediate level (does not require location of cellulitis or antibiotics)

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Let's Say a Patient is Admitted With Cellulitis Located at a Joint

- + Z96.6, Presence of orthopedic joint implants
- + Z96.62, Presence of artificial elbow joint
- + Z96.63, Presence of artificial wrist joint
- + Z96.64, Presence of artificial hip joint
- + Z96.65, Presence of artificial knee joint
- + Z96.66, Presence of artificial ankle joint
- + Z96.69, Presence of other orthopedic joint implants

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How About Cellulitis in MCG?

- Failure of outpatient therapy as indicated by:
 1. Progression or no improvement after adequate trial
 2. Adequate antibiotic regimen: Penicillin-allergic patient regimen, resistant organism regimen

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Codes That Can Support These Points

- Category Z16, Resistance to antimicrobial drugs
- Z88.0, Allergy status to penicillin

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MCG Criteria for UTI

- Admission indicated by one or more of the following:
 - Kidney transplant recipient with suspected pyelonephritis
 - IV fluids
 - IV medications
 - Fever

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What Supports This Criteria?

- Z94.0, Kidney transplant status

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MCG: Gastrointestinal Bleeding, Lower

- Coagulopathy that is not quickly reversed (e.g., advanced liver disease, irreversible anticoagulation therapy, thrombocytopenia)

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What Supports This Criteria?

- Z79.01, Long term (current) use of anticoagulants

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MCG Cardiology General Recovery Care Guideline (GRG)

- Patient can meet inpatient criteria for the following: “Pre-existing pacer-dependent atrioventricular heart block with permanent pacemaker malfunction requiring adjustment, repair, or replacement not feasible in observation care.”

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Another Z Code Opportunity!

- Z95.0, Presence of cardiac pacemaker

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Another Opportunity for That Same Criteria Set

- “Surgical or device complication (e.g., valve replacement complication, pacemaker, LVAD or ICD dysfunction)”

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Z Codes That Support This

- Z95.2, Presence of prosthetic heart valve
- Z95.3, Presence of xenogenic heart valve
- Z95.4, Presence of other heart-valve replacement

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UR and CDI Collaboration

- This is always a benefit
- Each team should be aware of how the other functions
- UR can alert CDI when medically necessary documentation is missing
- CDI should have awareness of common medical necessity criteria sets, especially those that are common front-end denials

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References

- AHA Coding Clinic, Fourth Quarter 2016, pp. 147-149
- Centers for Disease Control and Prevention. (2022, October 5). *Antimicrobial Resistance*. www.cdc.gov/drugresistance/about.html
- Baberi, E, Baddour, L., & Chen, A. (2022, August 22). *Prosthetic joint infection: Epidemiology, microbiology, clinical manifestations, and diagnosis*. UpToDate. www.uptodate.com/contents/prosthetic-joint-infection-epidemiology-microbiology-clinical-manifestations-and-diagnosis?topicRef=110530&source=see_link
- Clinical Validation: The Next Level of CDI: AHIMA Practice Brief (January 2019 Update)
- Medicare. (n.d.). *Glossary*. Medicare.gov. www.medicare.gov/glossary/m
- Santos, C., & Brennan, D. (2022, September 28). *Urinary tract infection in kidney transplant recipients*. UpToDate. [www.uptodate.com/contents/urinary-tract-infection-in-kidney-transplant-recipients#:~:text=Urinary%20tract%20infection%20\(UTI\)%20is,risk%20of%20hospitalization%20and%20death.](https://www.uptodate.com/contents/urinary-tract-infection-in-kidney-transplant-recipients#:~:text=Urinary%20tract%20infection%20(UTI)%20is,risk%20of%20hospitalization%20and%20death.)

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Thank you.

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