



## Clinical Validation Denials: How to Play and Win the Game

**Carrie Alme, MD**

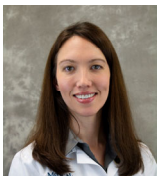
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Froedtert and the Medical College of Wisconsin  
Milwaukee, WI



1



### Presented By



- **Carrie Alme, MD**, is a Physician Advisor for Froedtert Hospital in Milwaukee and an Associate Professor and Internal Medicine Hospitalist at the Medical College of Wisconsin. She has been a Physician Advisor for eight years, focusing on utilization review and denials. She continues her 15 years as a Hospitalist specializing in advanced heart failure and enjoys advocating for patients.

2

2

## Learning Outcomes

- At the completion of this educational activity, the learner will be able to:
  - Recognize the ways clinical validation denials are an increasing foe for Physician Advisors and hospital systems
  - Evaluate potential allies and specific processes to enable short-term wins
  - Examine options to approaching conversations with Administration and Payors for sustained positive impact

3

3

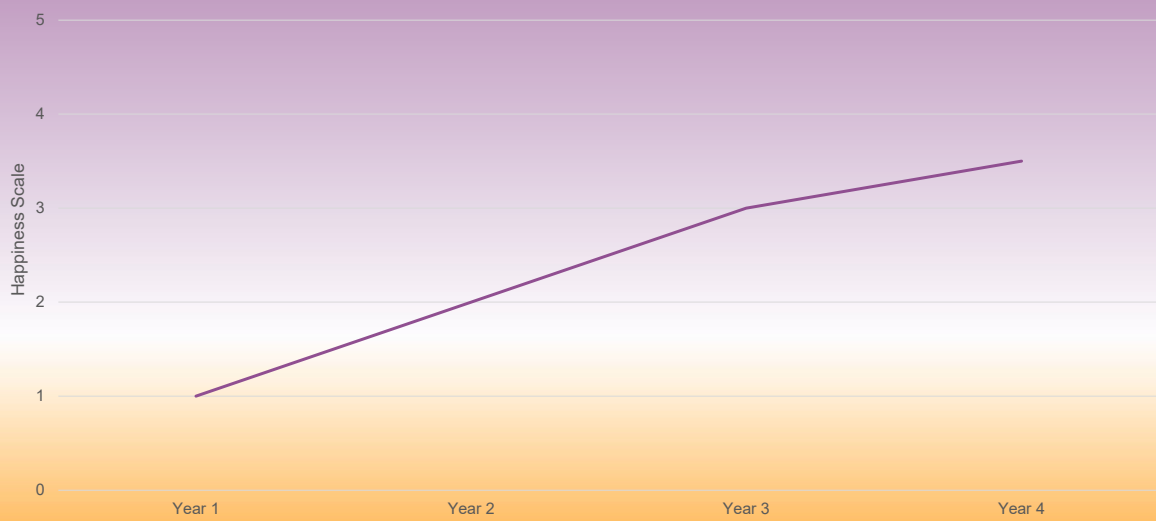
## Overview

- Background: Definition and exploring the problem
- Short Game: Work the system in place
- Long Game: Work to change the system

4

4

## Personal Happiness With DRG Work



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**flourish**  
CDI IN BLOOM | **accis 2023**



## Background

**hcpro**

6

## What Are DRG Denials?

- In these denials, auditors assert that the diagnosis or condition coded is not valid for “clinical reasons”

DRG	293	292	291
	<b>Acute Heart Failure Exacerbation</b> (Diastolic or Systolic) <ul style="list-style-type: none"> <li>No Comorbid Condition</li> <li>No Major Comorbid Condition</li> </ul>	Heart Failure <ul style="list-style-type: none"> <li>Yes CC</li> <li>No MCC</li> </ul>	Heart Failure <ul style="list-style-type: none"> <li>+/- CC</li> <li>Yes MCC</li> </ul>
CMI	0.6737	0.9707	1.4809
GMLOS	2.1 days	3.9 days	5.8 days
Payment	\$6066.51	\$7982.18	\$11367.19

7

7

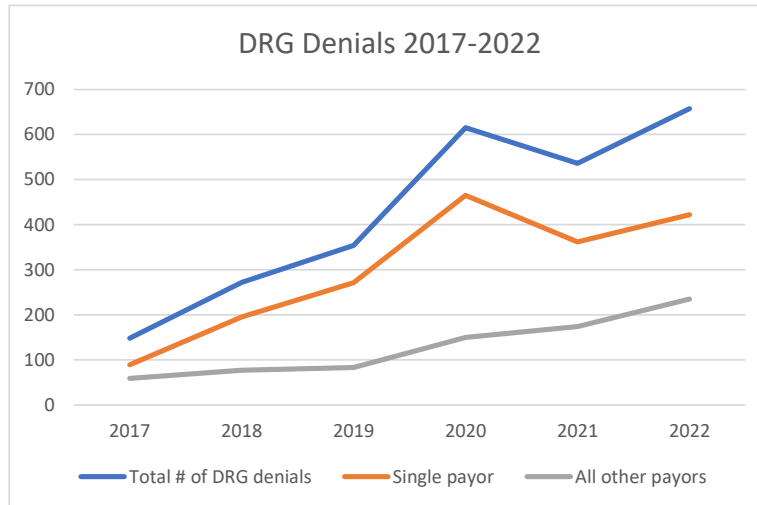
## The Problem

- Increasing Volume
  - At our academic tertiary care center of 700 beds, the percent of these denials of a single payer census has increased 6.5-fold over the course of 5 years (0.82% to 5.34% of their covered patients)

8

8

## The Problem



9

9

## The Problem

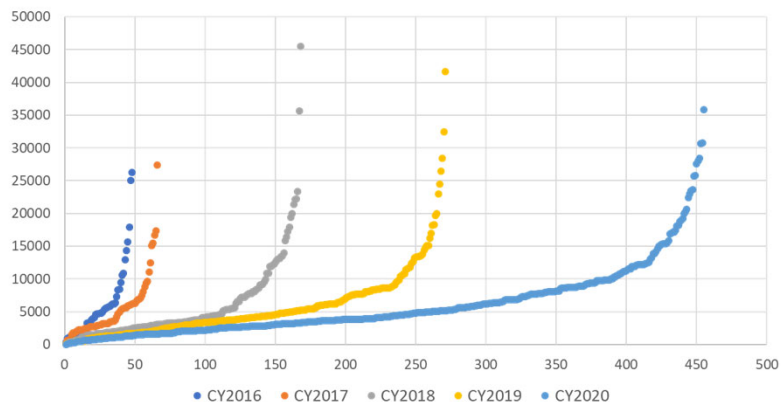
- Flooding the Zone
  - Increasing amount of lower dollar denials

10

10

## The Problem

Distribution of Dollars-at-Risk Per Denial with the Total Dollars-at-Risk Each Year of a Single Payor's Clinical Validation Denials by Calendar Year



11

11

## The Problem

- Moving Target
  - Varying clinical definitions used by Payors and even used by third parties contracted to work for the same Payor.
- Prolonged Process
  - Multiple touches required: Appeals take 2, 3, 4 attempts.
- Infringement on Doctor/Patient Relationship
  - "Even though sepsis was documented in the H&P, progress notes and discharge summary, it is the hospital's responsibility to make sure the diagnosis was accurately documented."

12

12



## The Short Game: Work the System in Place

13

## The Short Game: Work the System in Place

- Tracking System
  - Creation of a centralized way to know the status of denials (for us, a shared excel document). This allows for prioritization of effort and adequate analysis of data to drive change over time.
  - What to track: Appeal dates, outcomes, diagnosis denied, payor, third party, dollars at risk, internal communication...
  - Add in a grading system of likelihood to win

14

## The Short Game: Work the System in Place

- Key Players
  - Identifying team members who understood the nuances of clinical validation:
    - Coding Support Coordinator
    - Physician Advisors
    - Clinical Documentation Specialists
    - Coding Specialist
  - Once a denial is identified for the appeal process by the Physician Advisor/Clinical Documentation Specialist, our Clinical Documentation Specialist writes an appeal utilizing templates designed to address Payor clinical definition discrepancies
  - We utilize coding support for nuances that undoubtedly arise along the way

15

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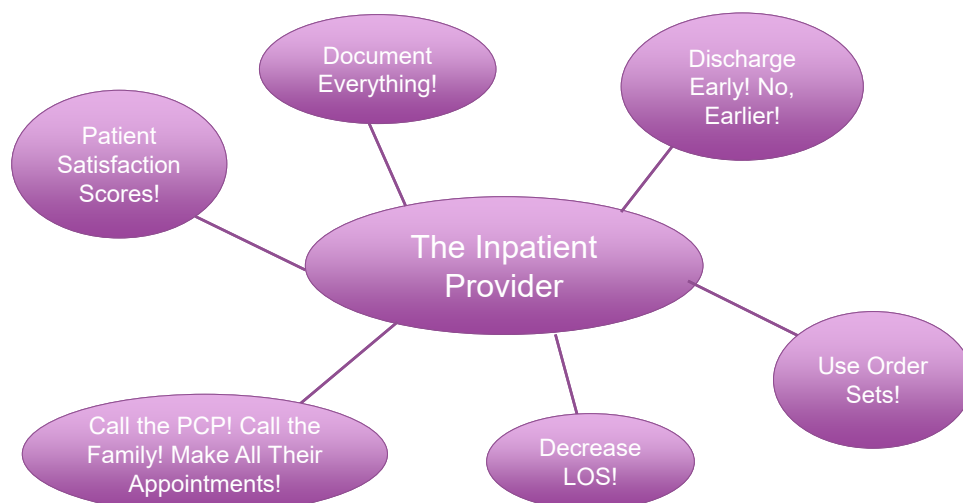
## The Short Game: Work the System in Place

- Pick what to appeal
  - Various factors to consider: Amount of resources, win rates, efficiency
- Keep appealing
  - Keep succinct, make templates, **address what is being denied**, ask for payor criteria (same language)
- Increasing autonomy
  - Use your CDI staffs' expertise

16

16

## The Short Game: Work the System in Place



17

17

## The Short Game: Work the System in Place

### Teach to the Test

- 96% of the time, providers will be doing no value add
- Rules constantly change
- Costs money to teach and reteach
- Documentation has an opportunity cost

### Let Providers Be Providers

- Trained to diagnose and treat
- Maintain positive relationship
- Work on low-lying fruit—DO make clinicians aware that these types of denials are happening behind the scenes with key documentation points highlighted

18

18


## The Short Game: Work the System in Place

- Enhance Documentation
  - Focus on the commonly denied diagnoses
    - Sepsis
    - Malnutrition
    - Respiratory failure
    - AKI/ATN

19

19

Attn: Recovery Services  
PO Box 740804  
Atlanta, GA 30374-0804

 UnitedHealthcare®

05/19/2020

**“While the patient presentation warranted consideration of sepsis as a possible diagnosis, there was no documentation of SOFA score of 2 or more points attributed to the infection by the physician. Provider states patient is not toxic appearing and soft B/P more likely 2/2 dehydration which improved with fluids”**

Please review overpayment notes in Direct Connect for Claim UID 188565551.  
Payment of DRG 871 is not supported. Review supports DRG 194. A review of the records submitted did not validate A41.9 as a diagnosis for this admission. The medical record is examined for consistent documentation of the condition and clinical evidence supporting the diagnosis. While the patient presentation warranted consideration of sepsis as a possible diagnosis there was no documentation of SOFA score of 2 or more points attributed to the infection by the physician. Provider states patient is not toxic appearing and soft B/P more likely 2/2 dehydration which improved with fluids. There was no physician query to clarify discrepancies and inconclusive documentation. Consistent with coding guidelines and medical record documentation the diagnosis code has been removed. Please refer to ICD-10 CM Official Guidelines for Coding and Reporting, Bauer et al. (2016). The Third International Consensus Definitions for Sepsis and Septic Shock (Sepsis 3). JAMA Lakhmiri et al. (2016). Kidney Injury and Chronic Kidney Disease as Interconnected Syndromes. NEJM 2014.

Claim UID	Patient Name	Patient Acct #	Overpaid Audit #	First DOS	Last DOS	Date Paid	Amount Paid	Payment Check #	Amount Overpaid	Overpynt Balance
						01/11/2020	\$20,344.31	TR 81470127	\$5,094.25	\$5,094.25

Amount Enclosed:

20

## Sepsis

Diagnosis	ICD-10	Clinical validation tips (Avoid getting the diagnosis denied!)
Sepsis	<p>Sepsis (MCC) Severe sepsis (MCC) Septic shock (MCC)</p> <p>*ICD-10 still has all 3 of these choices *Urosepsis means nothing (if you say urosepsis, you WILL get a query) – must say Sepsis secondary to UTI</p>	<p>Payers focus the most on SOFA criteria* (although multiple definitions)</p> <p>However, if there is ANY organ dysfunction, linking it to the sepsis is essential</p> <p><i>“Sepsis secondary to pneumonia with organ dysfunction including acute kidney injury &amp; persistent hypotension”</i></p>

21

21

## Sepsis Documentation Examples

- 1. Sepsis secondary to PNA—PNA seen on imaging, elevated procal and productive cough. Sputum cx pending. Sepsis with end organ dysfunction including AKI, AMS (GCS 14), thrombocytopenia, and hyperbilirubinemia.
- 2. AKI secondary to sepsis—replete with IVFs, treat underlying PNA/sepsis, monitor I/Os.
- 3. Hyperbilirubinemia secondary to sepsis—improving with treatment of underlying infection
- 4. Thrombocytopenia secondary to sepsis—improving with treatment of underlying infection

22

22

- **Per H&P** "Today she was very weak and lethargic. She was not able to get up and walk which is unusual for her. She was also confused stating the room was hot "when it was cold and vice versa". She also had chills and appears warm." The admitting provider documented "Sepsis secondary to UTI" with concern of recto vaginal fistula. IV Ceftriaxone was continued and Flagyl was added. (Date of Service 7/26/2019 at 0000)
- **Per Medical Progress Note** "Sepsis 2/2 UTI: - UA positive on admission; SIRS: Fever, tachycardia, tachypnea. Urine cx from 7/24 (obtained by PCP) growing >60k E coli / >40 k E faecalis, sensitivities pending. Hx incontinence, though some concern of possible fecal matter in vaginal vault (? possible recto-vaginal fistula)". Temp max on 7/26/2019 = 102.9 F (Date of Service 7/26/2019 at 1008)
- **Per Medical Progress Note:** "Remains febrile (T-max 102 this morning) . . . Sepsis with UTI". IV Ceftriaxone was continued and Flagyl was changed to IV. IV Vancomycin was added. **Infectious Disease Provider was consulted.** Temp max for 7/27/2019 = 102.5 F (Date of Service 7/27/2019 at 1137, 1348)

23

23

### Written Request to Appeal Denial

To Whom It May Concern:

We have received notification from Optum Recovery Services on behalf of UnitedHealthcare that a claim had a DRG re-assignment for \*\*\* admission from the dates of 12/10/2019 to 12/16/2019. In this determination, Optum Recovery Services determined that the documentation did not support the inclusion of the primary diagnosis of Sepsis, resulting in a change of the DRG from 871 to 194. We disagree with this DRG revision and request reconsideration.

\*\*\* is a 44 year old female with a past medical history of lupus, hypertension, GERD. Her presentation and treatment included:

Pertinent Labs:

Flowsheet				
	WHITE BLOOD CELL COUNT	PROCALCITONIN	LACTIC ACID	CREATININE
Ref. Range	Latest Ref Range: 3.9 - 11.2 10 <sup>9</sup>	Latest Ref Range: <	Latest Ref Range: <	Latest Ref Range: <
12/13/2019 1612	19.4 <sup>▲</sup>			2.51 <sup>▲</sup>
12/13/2019 2127		9.06 <sup>▲</sup>	2.2 <sup>▲</sup>	
12/14/2019 0054			2.8 <sup>▲</sup>	
12/14/2019 0454	18.4 <sup>▲</sup>		0.9	1.57 <sup>▲</sup>
12/15/2019 1027	8.7			1.03
12/16/2019 0657	8.1			1.02

24

24

- Patient presented to the ED with generalized body aches, chills and fevers. She has a one day history of more than 10 episodes of vomiting and 4 – 5 episodes of diarrhea. She has had a cough for weeks and was started on an antibiotic one day prior. She received 2L IVF Bolus and admitted for Sepsis, AKI, hypotension, and N/V/D. WBC Count 19.4 and **Creatinine 2.51 (2 SOFA points)**, HR 117, BP 75/44 (**MAP 54**) (**1 SOFA Point**) (Date of Service 12/13/2019 at 1551)
- Patient was seen recently by Pulmonology for chronic cough and completed a course of antibiotics for LLL consolidation without improvement. She was started on a second course of antibiotics with Levaquin and took one dose PTA. (Date of Service 12/15/2019 at 0836)
- Patient discharged and was treated for sepsis secondary to community acquired pneumonia. Patient was positive for Chlamydia Pneumoniae and instructed to continue Levaquin. Patient is on prednisone 5 mg but treated with stress dose Hydrocortisone 50mg TID during admission. (Date of Service 12/16/2019 at 0956)
- **Her SOFA score is at least 3 confirming the diagnosis of sepsis.**

The Sepsis-3 consensus definitions for sepsis and septic shock (See clinical reference 1) clearly define Sepsis as a **life threatening organ dysfunction caused by a dysregulated host response to infection**. Specifically, it defines **organ dysfunction as an acute change in total SOFA score  $\geq 2$  points consequent the infection**. As you implied as essential to the diagnosis of sepsis, the SOFA score includes multiple forms of organ dysfunction (once again, please see Table 1 in clinical reference 1).

System	Score	0	1	2	3	4
Respiration	$P_{aO_2}/F_{iO_2}$ , mm Hg (kPa)	$\geq 400$ (53.3)	$< 400$ (53.3)	$< 300$ (40)	$< 200$ (26.7) with respiratory support	$< 100$ (13.3) with respiratory support
Coagulation	Platelets, $\times 10^3/\mu\text{L}$	$\geq 150$	$< 150$	$< 100$	$< 50$	$< 20$
Liver	Bilirubin, mg/dL (mmol/L)	$< 1.2$ (20)	1.2–1.9 (20–32)	2.0–5.9 (33–101)	6.0–11.9 (102–204)	$> 12.0$ (204)
Cardiovascular	MAP $\geq 70$ mm Hg	MAP $\geq 70$ mm Hg	MAP $< 70$ mm Hg	Dopamine $< 5$ or dobutamine (any dose) <sup>b</sup>	Dopamine 5.1–15 or epinephrine $\geq 0.1$ or norepinephrine $\geq 0.1^b$	Dopamine $> 15$ or epinephrine $> 0.1$ or norepinephrine $> 0.1^b$
Central nervous system	Glasgow Coma Scale score <sup>c</sup>	15	13–14	10–12	6–9	$< 6$
Renal						

25

## Malnutrition Workflow

Notes

New Note Create in NoteWriter Edit **Attest** Remove Cosign Sign

All Notes Prog Notes Consults Procedures H&P OR/Anesth D/C Sur

1 of 1 note displayed. All loaded.

Time Mark the patient to be notified of new updates. [Time Mark](#)

Author Name	Author Type
Abertam, John, RD, CD	Dietitian

Avocado, Edward - Attestation by ASPARAGUS, CHRIS

Type: Nutrition Diagnosis | Service: Nutrition

Abertam, John, RD, CD Dietitian Cosign Needed Nutrition Nutrition Diagnosis Note 8/26/2016 9:16 AM

**Nutrition Diagnosis Note (Provider Attestation Needed)**

Provider: To clarify patient diagnosis, attest and complete the note.

**Nutrition Diagnosis:**

Recommend diagnosis of Unspecified severe protein-calorie malnutrition  
In the context of chronic illness (anaplastic thyroid cancer)  
As evidenced by significant weight loss, depletion of muscle mass and depletion of subcutaneous fat

**Provider Documentation**

Based on assessment of patient, the diagnosis is [NUT Malnutrition Diagnosis 23332]

**Malnutrition Plan of Care:**

[Provider Malnutrition Plan of Care 24571]

**Malnutrition Present on Admission:**

[Malnutrition Present on Admission 25708]

End Sign Cancel

26

26

## Malnutrition Workflow

Based on assessment of patient, the diagnosis is {NUT Malnutrition Diagnosis:23332}

Unspecified severe protein-calorie malnutrition  
Moderate protein-calorie malnutrition  
\*\*\*

{Provider Malnutrition Plan of Care:24571}

Agree with nutrition assessment and plan of care in Medical Nutrition Therapy care plan note.  
Agree with nutrition assessment and plan of care in Medical Nutrition Therapy care plan note, with exception: \*\*\*  
Disagree with nutrition assessment and plan of care in Medical Nutrition Therapy care plan note because \*\*\*.

{Malnutrition Present on Admission:25708}

Yes, the condition is present on admission at the time of the order to admit patient to inpatient status.  
No, the condition is not present on admission and developed during the inpatient stay.  
Clinically, unable to determine if the condition was present on admission.  
Unknown.

27

27

Abertam, John, RD, CD	Dietitian	Attested	Nutrition
<b>Attestation signed by Asparagus, Chris at 8/26/2016 9:32 AM</b>			
<b>Provider Documentation</b>			
Based on assessment of patient, the diagnosis is Unspecified severe protein-calorie malnutrition			
<b>Malnutrition Plan of Care:</b>			
Agree with nutrition assessment and plan of care in Medical Nutrition Therapy care plan note.			
<b>Malnutrition Present on Admission:</b>			
Yes, the condition is present on admission at the time of the order to admit patient to inpatient status.			
Chris Asparagus, MD 9:32 AM			

**Nutrition Diagnosis Note  
(Provider Attestation Needed)**

**Provider: To clarify patient diagnosis, attest and complete the note.**

### Nutrition Diagnosis:

Recommend diagnosis of Unspecified severe protein-calorie malnutrition  
In the context of chronic illness (anaplastic thyroid cancer)  
As evidenced by significant weight loss, depletion of muscle mass and depletion of subcutaneous fat

### Nutrition Intervention:

Meals/snacks:  
-Continue general diet and encourage intake as tolerated

28

28



## The Long Game—Work to Change the System

## The Long Game—Work to Change the System

- Track the Data
  - Find a system that works for you
  - Pick your metrics (denials by payor, win rate on diagnoses, number of appeals, etc)
  - Find meaningful ways to communicate the data
    - May be time limited with your audience, make it impactful and consistent

## The Long Game—Work to Change the System

- Engage with the C-Suite
  - Scope of the problem
    - Trends
    - What's at risk

Single Payer Sample	Percent of Total Hospitalized Patients	Percent of Available Cases Denied	Money at Stake
2019	27%	3.57%	\$2.0 Million
2020	28%	6.40%	\$3.6 Million

31

31

## The Long Game—Work to Change the System

- Engage with the C-Suite
  - Speak their language: less interested in Payor's behavior and more interested in financial bottom line
  - Preparation for the ask of future resource needs

32

32

## The Long Game—Work to Change the System

- Payor relations
  - Understand their classification systems
    - Ask them for the clinical definitions they are using (know their rule book!)
    - Get the annual updates
  - Regular meetings at a cadence that works for you \*\*\*
  - Work towards exchanging data
  - Provide appropriate pushback when they aren't playing the game appropriately and when the clinical definitions provided aren't evidenced-based

33

33

## The Long Game—Work to Change the System

- Engage with Contracting
  - Collaborate with your contracting department to improve the process over time
  - We presented clinical validation denials data, including the **rapidly increasing volumes** and egregious examples of **conflicting clinical criteria** in the same payor's denials
  - We meet with Contracting and Payors jointly to hold Payors accountable

34

34

## Summary

- Current trends show DRG denials are increasing in frequency
- Short game
  - Build your team and data tracking system
  - Appeal succinctly, stay in the game
  - Work on documentation but don't go overboard
- Long game
  - Engage with the C-Suite
  - Contracting is one of your most valuable partners
  - Hold Payors accountable and work on relationships
- Celebrate the wins!

35

35

## Acknowledgements

- Thank you to:
  - Dr. Julie Kolinski
  - Dr. Grant Sinson
  - CDI team: Laura McLaughlin, Holly Case, Julie Abraham
  - Coding Team: Janet Dodson, Tracy Czubakowski

36

36



## Thank you. Questions?

[calme@mcw.edu](mailto:calme@mcw.edu)

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