Questions & Answers from Denial Avoidance:
Five Proven Strategies for Reducing Your Denials
Presented by Kimberly Carr and Jon LaFleur, March 30, 2017

Question
What would you recommend to NOT annoy physicians and keep their continued cooperation and participation?

Answer
KIM: Physicians are very competitive. They love to see how they are doing compared to their peers. In my past life, I would always do a monthly comparative and post it in the physician’s lounge or anywhere physicians would congregate. Example:

Physician A: Answered 75% of their queries with a 1.75 difference in DRG weight, 30% difference in SOI and 105% difference in ROM
Physician B: Answered 100% of their queries with a 3.00 difference in DRG weight, 80% difference in SOI and 400% difference in ROM
Physician C: Answered 89% of their queries with a 2.59 difference in DRG weight, 69% difference in SOI and 200% difference in ROM

I would never actually give the physician’s names, but this made them all take notice. If I was late getting this out, I would get calls from the physicians. I also gave gold, silver and bronze star certificates of documentation. Some of the physicians had them framed and put in their office.

JON: I think it is a matter of being straight-forward. Let the docs know why you are asking the question so they can wrap their minds around all the odd subtleties of the work we do. Oftentimes they are busy enough with their own work that they can’t be bothered by all the “nitty gritty” details that we want and need to know to do our work and do it well.

If you are getting considerable push back. I recommend connecting with your physician liaison or whichever physician is in the best position within your organization to serve as a correspondent of sorts. Difficult physicians will often respond better to a fellow physician.
Question: If a third-party payer auditor recommends a DRG change because the clinical indicators for a specific diagnosis are not met and the diagnosis meets coding guidelines, would you update the coding on the account?

Answer:
JON: I think a lot of it will be case-to-case. If you receive a clinical validation denial that will prove more cost effective to appeal, then I would work to support your claim when appropriate. Often, denials auditors don’t have the complete record and this may be an instance of providing additional supporting documentation, and that will be the end of that. Other times, the auditors will make a good argument and you can fire back with our guidelines for reporting diagnoses as documented, but each third party auditor will operate under different framework and requirements and your responses will vary. In the end, it usually will come down to the lost revenue from a denial versus the investment involved in appealing the denial. You will need to review each case under that knowledge.

KIM: I think it will also depend on whether the denial is for an overpayment or if there has not been a payment yet. A lot of third-party payers will deny an account before they even make a payment. If you agree with the third-party auditor’s recommendation, you must make the change and send in a new claim to get payment. If you disagree, always appeal.

I have found it’s hard to win clinical validation denials; if the diagnosis is supported by our CG, then I would not spend the productive hours to remove the diagnosis. Sometimes this can be very time consuming. If you do decide to remove the recommended diagnosis, make sure to document why the diagnosis was removed and when. This will protect the coder in case of a coding validation audit.

Question: Do you have a recommendation for clinical validation queries?

Answer:
KIM: I think it is always a good idea that our queries contain the clinical evidence of a disease process. For example, include the RIFLE criteria in your acute kidney injury/acute renal failure query. If the physician can see what the clinical indicators are for each stage, he will be able to better diagnose the patient. Not only will this give you a better supported diagnosis, this is also a good way of providing education to the physician.

JON: Under the current recommendations, clinical validation audits should only be performed by a clinician, preferably one with a coding credential. That being said, if your organization has “qualified” individuals, there are a few different options for substantiating diagnoses.

My first recommendation is education. Provide references and resources to physicians, encouraging them to detail how each active diagnosis is clinically significant to the hospitalization and how they are evaluating and managing that diagnosis. Obviously, many of the chronic conditions will have little bearing on the DRG and will mostly be determined to be clinically significant either by specific coding clinics or when paired with a specific medication or treatment. Often when physicians are aware of the reasons we query when we do, they are more enthusiastic about providing complete documentation the first time rather than getting a barrage of queries.
If there is a specific diagnosis in question and a query is warranted, I often found it helpful to state that the documentation supporting whichever diagnosis was in whichever note on whichever day. I will then ask, for the sake of completeness, if the physician could describe either the framework upon which the diagnosis was contingent or if the physician could overtly specify how the diagnosis was being evaluated and managed. In my experience, these sorts of clarifications usually were best initiated as a conversation; so much is lost in translation in written queries that it often makes more sense to allow for “back and forth.” I would usually also let them know that I would leave a formal, written query in the chart so they would have an opportunity to formalize our conversation. Then when they found the query, they would have some context. I typically got more meaningful responses with less pushback.

Lastly, it would be easy to slip out of compliance with this sort of process, particularly when it comes to verbal queries. It is of utmost importance to maintain the integrity of the process by having your auditors adhere to strict and compliant query standards.

**Question**

When appealing denials based upon the third-party payers clinical criteria (i.e. Acute Renal Failure), if the condition is well documented throughout the chart but the patient doesn’t meet the clinical criteria, do you recommend we appeal it?

**Answer**

JON: This is going to depend on several factors, most prominently whether it will cost more than the denial to appeal. If it is more cost effective to appeal (or it is just a matter of principle), then demonstrate why the diagnosis is legitimate. If, in your example, the denials auditor uses RIFLE to deny acute renal failure, but you have KDIGO criteria met, then cite that and appeal it; both criteria sets have expert and industry support. If it is a more ambiguous denial (encephalopathy, acute respiratory failure, etc.), then you need to look at each encounter on a case-by-case basis. You might find that you agree with the auditor! If, however, you hop into the account and find that the nuances of the hospitalization align with the diagnosis, consider moving forward. Again, if the appeal is going to cost twice what you lose on the denial, that may influence your decision.

KIM: I agree with Jon. I used to say “appeal everything,” not realizing that there was a cost to appeal. If it’s going to cost you $1,600 to appeal a $2,000 case, I would advise to just forget it unless there is STRONG evidence for you appeal. Sometimes it’s radiology, lab or pulmonary notes that the auditor did not review that would support the diagnosis clinically. Again, these clinical validation denials are hard to win. Clinical validations are usually done by a physician. If you are lucky enough to have a physician on staff that could help with a peer-to-peer conversation with the physician that denied the case, have your physician pick up the phone. Sometimes a conversation is all that is needed.
Could you recommend a process for when a coder notices that a diagnosis does not have strong clinical indicators? Who starts the process? Where does the coder go with questions? What is the process?

JON: Establish a process for flagging cases that fit under this umbrella. Each organization will have their own process for dealing with clinical validation issues. If you have CDI, start there. If you use pre-bill audits, consider that as an initiation point. If coding identifies the issue, determine how these should be escalated. This may be as simple as emailing encounter numbers to the coding supervisor for delegation or sending it off to whoever is designated as your clinical validation liaison.

Ultimately, it must be a process that makes sense for your organization and considers your organization’s nuances, physicians, and personnel. A successful process is contingent upon congruence with your organization’s processes and practices. If it doesn’t make sense for your organization, you will spend all your time fighting uphill battles and never getting your queries answered!

KIM: Often times, facilities hire outside vendors to help with this process. It always good to get a set of fresh eyes on an account that is in question.

In the pneumonia and osteomyelitis question, what if the patient had a pneumonia requiring IV antibiotics that would have required admission.

JON: It is going to be contingent on the language of the notes, the tests and labs ordered, and the medications given. A pneumonia treated with IV antibiotics may require an inpatient stay in and of itself; however, some of these pneumonias are otherwise relatively uncomplicated. Did the chest x-ray markedly improved on day two? Is podiatry consulted? Is vascular consulted? Did they consider revascularization prior to amputation? Did they have to change antibiotics a few times to get the pneumonia in control?

In my opinion, surgery, specifically an amputation, is a much more significant and riskier endeavor than IV antibiotics and should outrank the pneumonia for principal position. If the procedure were something else, perhaps non-excisional debridement, maybe it would be a little less clear, but again, a surgical procedure will almost always carry a greater risk than IV antibiotics. Lastly, consider the circumstances of the encounter: is this a patient coming in to the ER and being admitted for a necrotic toe who also happens to have a pneumonia or is this a patient coming to the ER and being admitted with shortness of breath, cough, fever, and fatigue who just happens to have a compromised toe requiring amputation?

KIM: I agree with Jon. Just know that the 980 DRG family is going to be reviewed. Make sure that the documentation and clinical indicators are as complete and accurate as possible and there is no question about the principal diagnosis that would give any auditor a reason to downgrade the DRG.
**Question**
What about an escalation policy for clinical validation?

**Answer**
JON: An escalation policy is an excellent idea. Determine who you have on staff and who currently meets the cooperating party’s criteria for clinical validation audits. Determine what, within the framework of your organization, is a process that makes sense. Can you escalate cases simply by emailing them to your auditor and CC coding leadership? Do you have CDI and can you send these cases to them? Do you have a physician or clinical liaison? Build something that makes sense for your organization. The process at a level-1 university trauma center and a critical access hospital will look profoundly different.

KIM: Also consider a vendor to help in your escalation process. In my past life, we had a vendor to which we escalated documentation/clinical indicator issues.

**Question**
Severe sepsis - Can we apply the coding convention "with" and assume a cause-and-effect relationship between sepsis and acute organ dysfunction when no other reason for acute organ dysfunction is stated by the physician?

**Answer**
JON: First, in your example, significant changes will be coming once our sepsis guidelines change to reflect SCCM’s new criteria [Sepsis-3]. In these cases sepsis only exists when there is organ dysfunction secondary to the infectious process. Under our current framework, however, I think it is prudent to have a clear link between the infectious process (and its sequelae) and the organ dysfunction. However, the guidelines do support that “with” should be interpreted to mean “associated with” or “due to” when it appears in a code title, the index, or the tabular instructional notes. I would dare say that, in most cases, cause and effect relationship is likely implicit. However, there are always outliers. In cases where doubt exists, it will only benefit you to clarify and make no assumptions. It will save a lot of headaches to query now rather than contend with denials and appeals a month from now.

**Question**
Are we able to ask/email any questions anytime to Kimberly or Jonathan, and will it cost?

**Answer**
KIM: We are happy to informally respond to questions you might have regarding the content of our presentation. If you were interested in something more formal or official, we would also be happy to get you connected with someone in our client services department. Keep in mind it may take some time to get back to you.